GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 25 June 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTEEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

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

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THE CHAIRMAN: Good morning. Mr Kark.

MR KARK: May I call Mrs Shirley Hallmann.

SHIRLEY SANDRA HALLMANN, sworn

(Following introductions by the Chairman)

THE CHAIRMAN: We do understand that answering questions can be a very gruelling experience for witnesses. I will say now that throughout your evidence, if at any time you feel the need for a break, you merely need to say so and I will stop the proceedings and give you that break. If I do not hear anything from you, I will attempt to break about once every hour, so that you and, indeed the advocates and the Panel, can take a break. We do not like to have a witness having to answer questions for more than an hour at a go, but you do not have to go on even that long if you are finding it is becoming difficult. Is that all clear?
A Thank you very much.

THE CHAIRMAN: I will pass you to Mr Kark.

Examined by MR KARK

Q Is it Shirley Sandra Hallmann?
A Yes, it is.

Q Is it Mrs Hallmann?
A Yes, it is.

Q I want to start by asking about your professional background. I think in due course you came to work as a nurse at the Gosport War Memorial Hospital. Is that right?
A Yes, it is.

Q I want to ask about your training before that and your experiences before that. When did you qualify as a nurse.
A In July 1971.

Q I think you also qualified as a midwife in 1972. Is that right?
A Yes, I did.

Q You worked in America for a while?
A Yes.

Q You also worked, following that, in various hospitals in Portsmouth and Southampton?
A Yes, I did.

Q Prior to your getting to the Gosport War Memorial Hospital, which you did in January 1998, what had been your previous experience of working for the elderly?

A Before I got there, I think every field the nurse works in these days, unless you are actually on a children's ward, you have a mixture of elderly people. We had – I would say about 50 per cent of the ward I worked in, in Southampton was elderly. That was in acute medicine. Before I left there I actually completed the Care of the Elderly Course, the EMB 998, sorry, the 941 – I am sorry, it is the EMB 941 – with a view to going into elderly care. From there I went to Moorgreen Hospital, which was the rehabilitation unit for elderly people.

B Q Where was that based?
A Moogreen Hospital, that is at Hedge End just outside of Southampton.

Q What experience, if any, had you had of palliative care?
A Not specifically, up until that time, none, not specifically. I had had people who were terminally ill on acute wards but not in a specific unit.

C Q Obviously working with the elderly, you would have come across patients who were being treated in a palliative manner?
A Yes.

Q What I understand you are saying is that you had not worked specifically on a palliative care ward or in a hospice or anything like that?
D A That is correct.

Q In January 1998 you go to the Gosport War Memorial Hospital. What was your grade as a nurse at that stage?
A I was employed as an F-grade, which was the senior staff nurse, the deputy ward manager.

E Q By that time you would have been in nursing for over 25 years?
A Yes.

Q The ward that you went on to, I think, was Dryad Ward?
A Yes, it was.

Q We have heard that the Ward Sister on that ward at that time would have been Nurse
F Hamblin?
A Yes, it was.

Q Or should we call her { Code A }?
A Yes.

Q If you were a deputy ward manager or a senior staff nurse, would that put you one
G below Code A
A Yes, it did.

Q Was there anybody else on Dryad Ward on the same level as you?
A No.

Q Does that mean that there were occasions, if Sister Hamblin was not available, when
H you would deputise for her?

A A Yes.

Q Did you have specific shifts that you would perform or did you have a rota. How did it work?
A The off duty was done by various people. It changed hands several times while I was there as to who would complete the off duty. It was not a specific rota. We had specific shifts, but people would work different days depending on if they had made special requests
B or people were on annual leave.

Q We know obviously that there were night shifts at Dryad Ward and there were day shifts.
A Yes.

Q Did you ---
C A I was on the day shift.

Q That would mean what, from when to when?
A I believe it was 7.30 until, I think it was, 4.15 and from 12 until 8.15, 8.30.

Q Do those times include the handover time when there would be a handover to the nursing shift?
D A Yes, they did.

Q I want to ask you, first, about your impression of Dryad Ward when you arrived there. You had been in numerous hospitals before you got to the Gosport War Memorial Hospital. What were your first impressions of Dryad Ward and how it was run?
A When I very first got there I was impressed with it. It was very clean. Although everyone was very elderly, there were no odours to the ward. Everybody appeared to be well
E looked after.

Q Did that mean that patients were therefore being looked after in terms of their hygiene and their bodily care?
A Yes.

Q We have heard quite a lot about **Code A** in this case, as you will appreciate, but,
F again, when you first arrived, how did you regard her as a manager of that ward?
A When I first arrived, as a good manager. I did not have any concerns.

Q Her nursing?
A No concerns when I arrived on the ward.

Q You met, presumably, Dr Barton?
G A Yes, I did.

Q Obviously we have heard quite a bit about her role on this ward and on another ward, Daedalus Ward. Did you ever work on Daedalus Ward?
A No, I did not.

Q You can tell us a little about Dr Barton's role on Dryad Ward. How often would you
H see her?

A A If I was on the morning shift, we would see her daily, Monday to Friday. She would come in approximately about 7.15 to 7.20.

Q What would she do?
A It would depend on who was on duty. If Code A was on duty, she would come in early and she would get a quick handover from the night staff and do a doctor's round with Dr Barton.

B Q Sister Code A would?
A Yes. If I came in I did not come in until half past seven and Dr Barton would be waiting to do a ward round, which sometimes she was in a hurry and wanted to get on, but I would have to wait until I had handover from the night staff because I did not know if there were any changes, so I could not do a ward round until I had done that. She would go into all the patients, Monday to Friday, and see them all.

C Q At the time when you worked there, 1998/1999, approximately how many patients did you have on Dryad Ward, what was the average?
A Average about 16/17.

Q There were a few more beds, I think, than that, so that means you were not at full capacity?
D A No, we were not, we had empty beds.

Q When you arrived, did you have an impression of how Dr Barton worked with Sister Hamblin?
A Yes, very closely.

Q Was there an appearance of trust between them?
E A Yes.

Q I want to ask about your knowledge of the use of morphine with the elderly prior to your getting to the GWMH. You told us that you had worked with the elderly, you told us you had worked with some patients who were on palliative care?
A Yes.

F Q Does it follow from that, that you would have had some experience of the use of morphine?
A Yes, I had.

Q Whether as Oramorph or diamorphine – morphine in its very various guises.
A Yes.

G Q Had you, yourself, administered morphine to patients who were in need of it?
A Yes, I had.

Q Did there come a time when you, yourself, had any concern about the use of morphine on Dryad Ward?
A Yes, I did.

H Q Tell us what those concerns were?

A I was concerned that often I would go home on an early shift at about 4 o'clock and we would not have any patients on a syringe driver. I could come back on a late the next day and somebody who would be on a syringe driver and it could be somebody that I had not expected to be because the previous day they would have been eating and drinking et cetera. On a couple of occasions I asked my ward manager why that patient was on a syringe driver.

Q That would be?
B A Code A , and more than often I would just get "because" and she would walk away from me and I never had an explanation. It became such an issue that I actually went home and, not discussing the individual patients, but I used to discuss it with my parents who lived in the next road to myself and tell them my concerns.

Q It was a concern to you sufficient that you would go home and worry about it?
A Yes. My mother actually wrote it in her diary.
C
Q I am going to stop you, because what your mother did – you have to stick to what you saw and what you did?
A That is fine.

Q You said that when you raised this with Code A "more often than not", were the words you used, she would simply say "because". Did you try and pursue that any further
D with her on those occasions?
A No, because I felt I was really dismissed and it was just "because" and she would actually walk away from me.

Q To put this into context, I think there came a point much later on when there was effectively a grievance procedure. Is that right?
A Yes.
E
Q You complained of harassment?
A Yes, I did.

Q Who were you complaining about?
A Dr Barton and Code A

F Q When did that arise, just so we understand the chronologies?
A I believe it was in 1999.

Q We will come to that in due course and how that arose. You told us there were occasions when a patient who had been eating and drinking one day would be found on a syringe driver the next.
A Yes.
G
Q When you found a patient on a syringe driver, and I appreciate that this may be a generalisation, did you find that they were generally able to eat and drink once they were on a syringe driver?
A Not usually. Usually they became progressively worse and they became more sleepy and more sedated.

H

Q While you were working on Dryad Ward, did you ever see anybody who had been put on a syringe driver come off the syringe driver and leave the ward?
A No.

Q Did you ever see anybody who was put on a syringe driver and lived through as it were?
A No.

Q Did you have, prior to coming to the Gosport War Memorial Hospital, any moral objection to the use of syringe drivers or morphine?
A None at all.

Q Had you used them yourself?
A Yes, I had.

Q Tell us, please, about how they came to be initiated on Dryad ward with any particular patient. I am not asking you at the moment to focus on one patient, but your understanding about the authorisation for their use. How did a syringe driver begin, as it were, with a patient?
A Every patient that was admitted to Dryad had a syringe driver, had morphine and midazolam written up for them on admission on the PRN side of the drug, which is "to give as necessary". If it was thought that a patient needed that analgesia, then the prescription was there for the nurses to initiate the use of.

Q Who wrote up those prescriptions on admission?
A Dr Barton.

Q Is that a practice that you had ever come across before?
A No.

Q Or since?
A No.

Q Once the prescription was written up who could make the decision to initiate a syringe driver?
A Dr Barton or any of the nursing staff that were on duty.

Q Could you keep your voice up?
A Dr Barton herself or any of the nursing staff that were on duty.

Q Or any of the nursing staff who were on duty?
A Yes.

Q Did you ever initiate the use of a syringe driver with a patient without consulting Dr Barton?
A I think I possibly may have done. I cannot state any particular patient.

Q What about the dosages that were put into the syringe driver. Who would decide on the dose to initiate the patient, as it were, onto the syringe driver?

A A It could feasibly have been left to the nurses. I obviously cannot speak for other people, but I do not believe that I have ever set one up without having initiation from Dr Barton as to how much I could start it with.

Q Certainly, you say, when you did it you would discuss the dose with Dr Barton?
A Yes, because I just did not feel it was a decision I would want to make on my own really.

B

Q You have told us of Code A s reaction to you when you raised these issues with her. How did your relationship with Sister Hamblin continue?
A Very badly. Deteriorated.

Q And in what sense did it deteriorate?
A I think when I first started, Code A . I am sorry. I do not know how far you
C want me to go back. Do you want me to ---

Q Tell us about your relationship with Sister Hamblin?
A Code A did not want an F grade on Dryad ward. She had made it very clear to the hospital manager that she did not want an F grade on Dryad ward.

Q That was your grade?
D A Yes. The senior staff nurse.

Q Right?
A She had been persuaded by Barbara Robinson, who was the hospital manager at that time, to actually appoint someone to the role. I did not feel it was personal to me. I think it just probably ---

E Q The grade?
A --- would have been anybody who would have been appointed to the role. She had quite a firm hand on the ward and unless she was actually absent, I felt really that I was actually without a role because the sister ran the ward, and all the E grade staff nurses would have their allocated patients, and I was left in a limbo area really. But the situation declined, because Code A had quite extensive leave and I acted up into the manager's role.

F Q That is what I was going to ask about, so let us just pause for a moment. I think there came a time when Code A had some time off?
A Yes, she did.

Q Would that be because she was ill?
A Yes, she was.

G Q Can you remember how long she was off for approximately?
A I believe there was a period of four months at one time when she was off.

Q When was that? In which year?
A I think it must have been 1999.

Q So you had started in January 1998?
H A Yes.

Q You had worked all the way through 1998?
A Yes.

Q During that period had you relationship with Code A already been deteriorating?
A Yes.

Q Then we get to 1999 and at some point in 1999 Code A has four months off, or approximately four months off. Can you remember when in 1999?
A No, I really cannot.

Q During that period when she was off, what happened on the ward? Who took over her role?
A I did.

Q How did you work with Dr Barton during that period when Sister Code A was not there?
A I can only say it was all right, because Dr Barton and Code A I felt had a very good working relationship and I did not feel I quite had that working relationship with Dr Barton that she did.

Q And to be fair, Sister Code A had been working there for a very long time?
A Yes, she had.

Q Before your arrival?
A Yes, she had. A long time.

Q Were there on occasions during that period discussions between you and Dr Barton about whether any particular patient should go onto a syringe driver?
A I honestly cannot remember.

Q Was there a period when you had to transfer to another hospital for a while?
A Yes. I had been quite unhappy on Dryad ward for a long time and mentioned on several occasions that I might like to move back up to the acute hospital at Queen Alexandra. I was offered to go up there for a month to help out of their winter crisis.

Q Their winter crisis?
A Yes.

Q Is that an annual event?
A Yes, it is. It is when people go down with the flu and wards are short-staffed and big pressure on beds. So I had gone up there for a month to help on one of their acute wards.

Q Was that with a mind possibly eventually to transferring to –
A Yes. I was quite undecided.

Q Tell us about your return to the Dryad ward. Did you have any conversations with anybody?

A A Yes, I did. It would be with Dr Barton and with Code A about the possibility of moving, the prospects of moving.

Q Right. Specifically did you speak to Dr Barton? I want to ask you about your conversation with Dr Barton.
A I did speak to her about the possible move. I cannot remember any of the conversations. All I know is I had spoken to her about it.

B

Q Was there some suggestion of having upset somebody?
A Yes, there was. Code A ward sister, said to me that I had upset Dr Barton and she said to me, "But I don't want you to talk to her about it." I cannot leave things like that; I cannot work like that. So I spoke to Dr Barton in our treatment room one day when we were on our own, and I said, "I believe I have upset you, and if I have I am sorry." And she said, "Oh no, it is not that, but you do not understand what we do here." That was really the
C end of the conversation.

Q Were you two alone?
A Yes.

Q This was in 1999?
A Yes.

D

Q And this was upon your return after the month off at the Queen Alexandra?
A Yes.

Q When you asked if you had upset her, she said, "It is not that. You do not understand what we do here."
A That is right.

E

Q What did you understand by that?
A I assumed at the time that it was regarding the syringe drivers. The use of the syringe drivers.

Q Did you take her up on it and say, "Hold on. What are you actually saying?"
A No, not at that time I did not.

F

Q And when you came away from that conversation how did you feel about it?
A The same as I always did: very unsatisfied – dissatisfied – that I did not have an answer.

Q You had worked previously with patients on palliative care. Have you worked since with patients on palliative care?
G A Yes. I have actually worked in specialised palliative units since then.

Q You told us a bit about your concerns about the use of syringe drivers?
A Yes.

Q What about the quantities of morphine that was being put into them. Did you have any views either way about the quantities of morphine that were being used on Dryad ward?
H A I think the quantities were too large to actually start off with.

A

Q So they were starting off, you thought, on too high a dose?
A Too high of a dose.

Q Did you challenge any of the doses at the time you were there?
A Yes, I did.

B Q Who did you speak to?
A I spoke to my hospital manager, Barbara Robinson, when I was in the acting up role as a G grade.

Q I am going to stop you about the conversation.
A Sorry.

C Q It is difficult to hear you. You are dropping your voice.
A Sorry.

Q It is all right. It is very tempting for you and me to have a conversation, as it were.
A Sorry.

Q It is very important that everybody else hears it.
D A Sorry.

Q Okay. You said that you spoke to your hospital manager?
A When I was in the acting up role as the G grade, as the ward manager, I used to have clinical supervision with Barbara Robinson. Supervision is a meeting between yourself and another person that you are confident in, and they help. You discuss issues of nursing and things. That is when I brought it up.

E

Q We do not want to know what she said back to you, as it were.
A No. That is fine.

Q But did anything change as a result of that conversation?
A No.

F Q You have told us that the amount of morphine used as the initial dose was, in your view, on occasions too high. What about the increases in dosage?
A I thought they were too high as well. I thought they were increased too quickly and by too large an amount.

Q We have heard in this case about the Wessex protocol, and some nurses have heard of it and some nurses have not. Did you know about the Wessex protocol?
G A Not as such. Is that like the analgesic ladder?

Q That is the next question I was going to ask you. What most nurses have heard of is the analgesic ladder. You are nodding. Is that a "Yes"? You have heard of it?
A Yes. I know the analgesic ladder.

Q The concept of the analgesic ladder I think we all know fairly well now, which is that
H you start at the lowest dose ---

A A Yes.

Q --- capable of dealing with the pain that the patient is suffering?
A Yes.

Q Is that a concept that you understood?
A Yes.

B

Q Did you have an understanding of how the doses were meant to be increased? If a patient was still suffering from pain, did you have an understanding about the incremental dosage increase?
A Yes. When a patient was on a syringe driver, if what they were on was not controlling their pain we would have – we called it – a top-up dose. It was a dose to be given as necessary in between to help their pain. Then the next day, when it was reviewed, it would
C be looked at how much top-up they had needed, then the dose adjusted accordingly.

Q Is this your experience on Dryad ward, or is this your experience elsewhere?
A Elsewhere.

Q If there had to be an increase in the morphine on a syringe driver, did you know what the maximum was, the guideline was, for the maximum increase?
D A No.

Q How did you find that it actually worked on Dryad ward when a patient did apparently have an increase in morphine?
A I am sorry? When you say "how did it work", do you mean how do we decide how much?

E Q On Dryad ward, when a patient's morphine was increased ---
A Yes?

Q How was it done? I do not mean physically how is it done, but how much was the increase by, in general terms?
A There was not a set guideline as to how much it should go up by.

F Q Was there a method of deciding how much it should go up by? You just explained in other places where you have worked you would use a top-up dose, as it were ---
A That is right.

Q --- for what is called break-through pain?
A No, there was not.

G Q There was no system?
A No.

Q You have told us about Dr Barton writing up prescriptions in advance?
A Yes.

Q And we have seen, and you know, that she would write up a range of, say,
H diamorphine or midazolam?

A A Yes.

Q Did you know why that was being done? Was that ever explained to you?
A Yes. Some of Dr Barton's colleagues were very reluctant to actually prescribe syringe drivers and it was done so that if the patient needed something and she was not actually on duty or was not there that we had cover, so that the patients could have pain relief without having to go through trying to get somebody in, to actually prescribe one.

B

Q Was that your experience that it was difficult to get somebody else in to write up such a prescription, or was that as it was when you arrived?
A That is how it was when I arrived. Because they written up, I never had to call anybody in to write one.

Q If Dr Barton was not available, what would happen?
C A Sorry? In what regard?

Q You told us that the prescriptions were written up in advance?
A That is correct.

Q That your understanding was it had been difficult to get other doctors to initiate syringe drivers in the same way?
D A Yes.

Q So if Dr Barton was not there, what was your experience of how nurses would deal with increase? What would they do?
A To say it was hit and miss is all I can say. It was up to us to actually just look at it and see how much pain we thought the patient was in and to increase it accordingly to what we thought.

E

Q You have just mentioned assessing pain?
A Yes.

Q I expect all members of the Panel have heard, and no doubt you have, of pain charts?
A Yes.

F Q It is a tool that is just an assessment system?
A Yes.

Q Did you have any such assessment system on Dryad ward?
A Not that I recall.

Q And apart from being used to control pain, was diamorphine ever used for any other
G purpose that you can remember when you were on Dryad?
A No.

Q So your recollection is, it would only be used if the nurse thought the patient was in pain?
A Yes.

H Q I want to turn to the issue of hydration.

A A Right.

Q Again, we have heard quite a bit about it. Were there hydration kits available?
A No.

Q Can you just describe what a hydration kit would be? What is a hydration kit?
A Giving somebody fluids, usually subcutaneously, just under the skin via a needle, to
B keep them hydrated.

Q We have heard of the difference between subcutaneous and intravenous?
A Yes.

Q Can we focus on the latter first, the intravenous. Have you ever put a patient on an intravenous drip, or is that something that has to be done by a doctor?
C A No. The doctor does it at the moment.

Q But have you dealt with patients who have been on intravenous drips?
A Yes, I have.

Q Have you dealt with patients who have been on intravenous drips and syringe drivers?
A Yes.
D

Q So the syringe driver is being used to control their pain.
A Yes.

Q And the intravenous drip is being used to hydrate them.
A Yes.

E Q We have heard a little bit about this, but I am going to ask you. The difference between an intravenous drip and a subcutaneous drip – I understand one goes under the skin and one presumably goes into a vein, does it?
A Yes.

Q But in terms of how the subcutaneous drip works and how much you can get into a patient, what is the difference?
F A It is not always effective putting it in subcutaneously. If the patient is not very well or they are not absorbing fluid, sometimes the fluid in a subcutaneous can actually collect under the skin. It depends what the condition of the patient is.

Q To your recollection on Dryad ward, did you use any subcutaneous hydration?
A No.

G Q To your recollection when you were on Dryad ward, did patients continue to eat and drink after they had been put on a syringe driver in general terms?
A No.

Q So if a patient was on a syringe driver, what would happen about their hydration on Dryad ward?
A They were not given any.
H

Q What effect in general terms would that have upon the patient?
A Do you want factually or what my understanding is?

Q Factually would be best.
A It is different, because I actually did some research on it for a project. Actually, it was recommended that hydration can actually make a patient more uncomfortable, because fluid can collect in their lungs and everything and if they are dehydrated they are actually more settled and more comfortable.

Q So this is for the patient who is on a syringe driver, but presumably unconscious.
A Yes.

Q I am sorry. I led you on that. Let me just correct that. Are there occasions when a person is on a syringe driver but not unconscious generally? Have you found that in other hospitals?
A Yes.

Q If they are on a syringe driver but conscious, would they on occasions still be able to eat and drink?
A Yes.

Q Because the syringe driver is simply there to control their pain.
A Yes.

Q If a patient is unconscious, it hardly needs you to say it, but can they eat and drink?
A No.

Q So the only system of hydrating them would be either subcutaneous or intravenous.
A Yes.

Q Once a patient is on a syringe driver and not being hydrated, would the patient deteriorate?
A Yes.

Q On another issue – and I do not need for the moment need to take you to an example, because we all know them very well and I think you will recognise the phrase as well without having to see it in the note – do you remember seeing the phrase, "Happy for nursing staff to confirm death"?
A Yes.

Q Was that something that was written into the notes of some patients by Dr Barton?
A Yes.

Q Did you have an understanding of why that was put into the notes?
A Yes. Because we were GP led and we obviously did not have doctors present in the hospital who would know the patient, it was so that we could actually verify the patient's death and the patient could then go to the hospital mortuary and then the doctor who had seen the patient last and who knew their condition could then come in at a later date and actually certify the death.

Q Is it a phrase or something similar which you have seen elsewhere other than on Dryad ward?
A Yes.

Q The same or not quite those words?
A No. Exactly the same.

Q Could you tell us – we may look at some examples in due course – what the frequency was of Dr Barton writing that into the patient's notes on their arrival at Dryad ward? Was it any more or any less than elsewhere?
A I really do not remember ever seeing it with a patient arrived on Dryad. I know it was when they were on a syringe driver.

Q We may look at that in due course. I am going to turn to deal with some of the patients who I think you dealt with, but before I do, can you just tell us what the back end of all of this was? How did you come to leave the Gosport War Memorial Hospital and in what circumstances?
A Well, I had put a grievance in about Sister Code A and Dr Barton.

Q The nature of your grievance was what?
A I felt at the time that they would be more than happy for me to actually go, but there was also – do you want to know what was in the grievance or – because there is something quite relevant, but I do not know whether you want to hear it or not.

Q I think I am going to let Mr Langdale explore this if he wants to. There was a grievance procedure. It went through an internal Trust procedure, did it?
A Yes, it did.

Q And you left the hospital?
A Yes. The outcome was that there was going to be some liaison between Sister Hamblin and myself and I felt that no matter how much liaison there was, it was an unworkable situation and so I applied elsewhere.

Q Is it fair to say that this was not entirely about the use of syringe drivers and diamorphine, that there were other issues as well?
A There were other issues as well, yes.

MR LANGDALE: Please do not lead, is my request to my learned friend. It was not about syringe drivers at all. Perhaps the question could be rephrased.

MR KARK: I do not have details of the grievance.

MR LANGDALE: If you would ask the witness perhaps.

MR KARK: I will. If Mr Langdale wants it explored, I am happy to do so. (To the witness) Tell us what the grievance was.
A It was mainly the personality between myself and Dr Barton and Code A. I do not feel that we worked well together. Syringe drivers were a small part of it. They were not the main part, but they were a small part of it.

Q When you talk about not working well with Dr Barton and Sister [Code A] what was the background to that?
A It was about the medication, because we had quite a bit of disagreement over it.

Q I am going to move on to deal with some of the patients that you actually dealt with. The first one I am going to ask you about is a lady called Ruby Lake. This is our file F. If you would look to your left, you will see a file which has a big F on it. I am not going to spend very long on this patient, because certainly I think in your statement you indicate that you had no recollection of her. Is that right?
A Yes. I do not remember the lady.

Q At the beginning of that file, if you open it, you will see that there is a chronology. I am not going to run through the whole chronology, but effectively she came to your hospital because back in the beginning of August, 5 August, she had a fall and she fractured her left femur at the neck. She had been admitted to the Royal Hospital Haslar on 5 August and then she eventually came to you on 18 August. When a patient came over to your ward, can you give any assistance as to what sort of documentation they would arrive with?
A They should have come with their hospital notes.

Q Were there occasions when they did not?
A Yes.

Q Can you give us any idea of the frequency of that happening?
A No, I am sorry, I cannot.

Q Could you turn to page 394? We can see that there is an entry about halfway down the page. You were not this lady's designated nurse, I do not think. If we go back to page 391, we can see that Lynne Barratt was the nurse. Have you made any entries on this page?
A Yes, I have.

Q There is just one that I want to ask you about in particular and that is the entry on 19 August. Is that yours?
A Yes, it is.

Q Can you just read it through for us, please?
A It says:

> "11.50 [complained of] chest pain. Not radiating down the arm – no worse on exertion. Pulse 96. Grey around the mouth. Oramorph 10 mg/5ml given. Doctor notified."

And I have signed it. Then I have gone on to say:

> "Pain only relieved for a short period – very anxious. Diamorphine 20 mg, midazolam 20 mg commenced in a syringe driver."

And I have signed it again.

Q You made that note. Who directed the commencement of that syringe driver? Are you able to tell, or not?

A A No, I am not. I said that I have notified the doctor, so I assume I would have discussed it, but that is only an assumption.

Q If you could keep a finger there, please, but also go back to page 368e, is that a prescription for diamorphine written by Dr Barton?
A Yes, it is.

B Q It is for a variable dose of between 20 and 200 mg of diamorphine.
A That is right.

Q Could you turn also to page 368b? We can see there a prescription for Oramorph, 10 mg in 5 mls.
A Yes.

C Q That has been administered on 18 August at 1415. So that is on the day of this lady's arrival at your hospital I think.
A Yes.

Q Then twice the following day: in the very early hours of the morning, quarter past midnight, and at 11.50.
A Yes.

D Q Neither of those I think are your administration.
A No, they are not.

Q On 19 August, this patient had 20 mg of Oramorph and it follows that that would have been ingested orally.
A Yes.

E Q Did you know anything about the conversion rates between oral morphine and subcutaneous morphine in the form of diamorphine?
A Yes.

Q What was your understanding of what the conversion should be?
A That the whole dosage would be added up and then divided by three, and that would
F arrive at the amount of diamorphine that should be given.

Q That would be the equivalent dose.
A Yes.

Q Going back to page 368e, we can see that in fact this patient was started on 20 mg.
A Yes.

G Q On the basis of what you have just said, does that follow the guideline indicated?
A I think it could well do on this one, because 20 divided by three would be six point something and obviously if this lady was still having pain, it would have had to have been increased a bit, but also the minimum prescription we had was 20.

Q I understand that. I am not disputing that. The minimum prescription is in fact
H 20 mg.

A A Yes.

Q So that is, on this prescription, the lowest that you could start, or could you go lower than the prescription?
A No, because that would be myself prescribing and I am not authorised to prescribe.

Q I wholly understand that the lowest dose that you are allowed within this prescription
B to start at is 20 mg.
A Yes.

Q But if you were applying the guideline that you have just told us about, would you have started on 20 mg?
A On this one, possibly, yes.

C Q Tell us why.
A Because the lady had had 20 mg of Oramorph and obviously it was not enough; she was still in pain. So therefore an increase was indicated. So I would not have been unhappy giving it. Well, I was not unhappy, I started it.

Q You told us earlier that you – I do not think you were able to furnish us with the specifics of how an increased dose was meant to work; what the increment was meant to be.
D A But I had not increased that, because this was what the prescription was on here.

Q I understand. You are doing what the prescription tells you to do.
A Yes.

Q Your note, going back to page 394, was that the patient was complaining of chest pain, which was not radiating down the arm and was no worse on exertion.
E A Yes.

Q What is the significance of those words, please?
A Because if somebody was complaining of chest pain, I would want to try and assess whether I thought they had some cardiac involvement.

Q Does this appear at least to be a cardiac problem or not?
F A No. Having said that, it is not always – elderly patients can have silent heart attacks, where there are no indications at all. So this was only doing a preliminary, trying to assess what I thought was wrong.

Q On the face of the note, is that ---
A It did not look as if this indicated that she had any cardiac involvement.

G Q You have noted – this is at 11.50 – that Oramorph was given because of the patient's pain.
A Yes.

Q How quickly would you expect Oramorph to work?
A Half an hour or 40 minutes.

H

A Q We know that the syringe driver was commenced at 1600 hours: four o'clock in the afternoon.
A Yes.

Q Can we take it from what you have said that this was not an occasion when you challenged the use of a syringe driver?
A No, obviously not.

B Q Can you help us as to whether this would have been an occasion when you spoke to Dr Barton first?
A That is what is indicated by the notes. It says the doctor was notified.

Q I just want to follow that up, because "doctor notified" follows from the Oramorph note.
C A Yes.

Q Then after that, you have written:

"Pain only relieved for a short period – very anxious. Diamorphine 20 mg, midazolam 20 mg commenced in a syringe driver."

D A Yes.

Q In terms of the starting of the syringe driver, can you help us as to whether you would have had a conversation with Dr Barton first?
A I would assume from that, yes, I had. But that is only an assumption, because I have not written it.

E Q The next note I do not think is yours?
A No.

Q We can see the note has been made:

"Condition appears to have deteriorated overnight."

F Are you able to tell from your note whether the patient was conscious, first at 11.50 and, secondly, once the syringe driver had been commenced?
A The patient was obviously conscious when I wrote "very anxious".

Q Thereafter? Once that level of diamorphine kicks in, as it were, would you expect the patient to remain conscious or not?
A Not initially. Initially the patient would be very sleepy if it had just been
G diamorphine, but as patients get used to it, they do get used to it and they stay awake, but it would have been, I think, the midazolam that had made the patient sleep.

Q If we go back to the prescription sheet, page 368E, have you signed off on any of these drugs at the top, the diamorphine? It is quite difficult to read these.
A No, I have not.

H Q You have not?

A A No.

Q Do you see that on the 20th the prescription continues so far as the diamorphine is concerned?
A Yes.

Q You may need to get the original of this if there is any issue about it, but the
B midazolam, if you look two entries below, on the 20th increases to 40. It is quite difficult to see it, but can you see, I think it is three boxes up from the very bottom?
A I cannot really make it out to be honest because there is a line through it.

Q It has been crossed through unfortunately and destroyed?
A I think that is Sharon's Ring's initials over the top of it.

C Q So far as the word "destroyed" is concerned, when a syringe driver came to the end of its life or in terms of the drugs being finished or a prescription was changed, and I suppose decreased or increased, you would have to get rid of the old syringe driver contents and start afresh?
A Yes. We would write in the back of the controlled drugs book that it was destroyed and two people would sign it.

D Q That is what happened apparently on 20 August. On the 21st we can see that the diamorphine is increased three-fold. Did you have anything to do with that increase?
A No, I have not signed anywhere, I have not signed that and there is nothing in the notes to say that I have increased that.

Q As we can see below, the midazolam is also increased to 80. We can take it from your previous answer that you had nothing to do with that.
E A No.

Q Before we move on from this patient, and it may be we give you a break once we have, could I ask you to go back to page 78 but also have a finger in page 373. Page 373, perhaps we could start with that first, is 18 August 1998?
A Yes.

F Q That is the day of this patient's admission to your ward?
A Yes.

MR KARK: We have become well used to reading these Barthel ADL indexes and if we have a look at this, her feeding ability is 2, transfer is 1, which means she needs major help, but her mobility is that she can walk with the help of one person and she needs a bit of help with dressing and toilet. She is independent on her grooming, so her total score there is 9.
G

MR LANGDALE: I am sorry, I hesitate to interrupt, but it sounds as if my learned friend is going to be asking this witness about the notes with which she had nothing to do, did not see at the time and played no part in.

THE CHAIRMAN: I have to say that that is not uncommon in the way that this case has been progressing, with questions from both sides of the room. We have had notes put to
H people who had no particular part in them and they were being put to them, I have

understood, on the basis that they were, nevertheless, familiar with the customs and procedures of that particular ward at that particular time and they were being asked whether they could comment on them.

MR LANGDALE: That is absolutely right. There has been a reason, in terms of setting context and so on, but I do object if this witness is being asked to make a comment about an entry made by somebody else, in this case Dr Barton. She was not involved in the admission of the patient in any way at all and my learned friend is seeking to make a point which he can make perfectly properly with other witnesses who did have dealings with this in due course. To ask this witness to give an opinion in respect of a matter where she was not present and is unable to give an opinion as to why somebody would have written something, I do object.

MR KARK: Can I deal with that. If the Panel are against me, they are against me. I was not going to ask the witness's opinion, I was going to ask her about her experience because she has told us – and the note I was going to come to is the very last note Dr Barton made, "I am happy for nursing staff to confirm death" – that that is something she has read often, not only at this hospital but many other hospitals and it is not an uncommon note to be made. It was in that context I wanted to ask her whether, in her experience, that is the sort of note she has seen with this sort of patient previously.

THE CHAIRMAN: Within that context, that would appear to be absolutely in keeping with the tenor of questions we have had from both sides of the room.

MR LANGDALE: In the form my learned friend has put it, with respect, I agree.

THE CHAIRMAN: Very well, keep within that context.

MR KARK: (To the witness) Let us move on from the lawyer's squabble. You see that note Dr Barton has made at the bottom, "I am happy for nursing staff to confirm death", you have told us that is a note you have seen elsewhere in those terms?
A Yes.

Q Have you seen that sort of note in relation to this patient with a Barthel score like that?
A Yes, in a patient who had a known terminal illness, yes.

Q In a patient with a terminal illness you have seen that before?
A Yes.

Q Let us imagine for a moment that this broken neck of femur is not a terminal illness, have you seen that sort of note being made for this sort of patient?
A No.

MR KARK: Sir, would that be a convenient moment to break.

THE CHAIRMAN: We are going to take a break now. May I remind you that you are still on oath and we are simply interjecting into your testimony. Whilst that happens, please do not discuss this case with anybody. Thank you very much. I think the Panel assistant will take you now and hopefully get you some refreshment. We will be back just before 11 am.

(The Panel adjourned for a short time).

THE CHAIRMAN: Mr Kark.

MR KARK: Could I ask you to put away the F file and take out the G file. That is the file for Mr Arthur Cunningham. Again, I ought to start by asking you whether you have any independent recollection of this patient at all. Does that name, Arthur Cunningham, mean anything to you?

A Nothing at all, no.

Q You have dealt with a vast number of patients and there is no criticism of you for that. I want to see if you can help us about this patient for whom I think you cared. Would you turn to page 861. This gentleman came over to your hospital on 21 September, so that is the day shown at the top of this piece of paper. He had been seen at the Dolphin Day Hospital.

A Yes, I do.

Q Tell us about that?

A It is a day hospital where the patients go and they are medically assessed and they can have physiotherapy.

Q Where is it?

A It is at the Gosport War Memorial.

Q It is the GWH?

A Yes, it is.

Q On the same campus?

A Yes, it is, same building.

Q I think you have made the first note. Is that right?

A Yes, I have.

Q Can you take us through it.

A I have:

"Admitted from DDH..."

which is Dolphin Day Hospital.

"...with history of Parkinson's, dementia and diabetes. Diet controlled diabetic. Catheterised on previous admission for retention of urine. Large necrotic sore on sacrum. Seen by Dr Barton."

I have signed it and it carries on:

"Dropped left foot. Back pain from old spinal injury."

I have initialled that.

"14.50 Oramorph 5mg given prior to wound dressing."

A

I have initialled that.

Q I entirely appreciate that you cannot remember the individual patient, so I am not going to ask you about this. A large necrotic sore on the sacrum, would that be something that is likely to give the patient a degree of pain?
A Yes, it is.

B

Q So far as changing the dressing is concerned, we can see that Oramorph was given?
A Yes.

Q It is difficult to read, but it is "prior to the dressing being changed"?
A Yes.

C

Q It may be obvious, but can you tell us why would that be done and would the wound dressing itself cause pain to the patient?
A Yes, it would because it is the actual cleaning of the wound and dislodging the dressing is actually quite painful, and it is quite common practice to give analgesia before doing a dressing of that type.

Q If we look at the following entry, I appreciate it is not yours, but we can see there is a
D note that the patient remained agitated until 20.30 and we know that a syringe driver was commenced at 23.10?
A Yes.

Q That was not your decision?
A No.

E

Q You had no role to play in it?
A No.

Q I led you on that. Did you have any role to play in that decision?
A Not to my knowledge, no. It depends, I do not know what shift I was on but it is not – no, it says here commenced at 23.00, that is at night and I would not have been there then, no.

F

Q If a syringe driver is commenced that late in the evening, would you be able to assist us as to upon what authority that would be done, or is that something outside your knowledge?
A I really do not know.

Q You did not do nights?
A There was a night sister on who would cover our ward at night so that would be her
G decision.

Q If we go to the next page – you are also at the bottom of this page, are you not?
A Yes.

H

A Q The bottom of page 861, we are now the day after admission and the patient is already on a syringe driver. Can you tell us your note?
A I put:

"Mr Farthing has telephoned. Explained that a syringe driver containing diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode when Arthur tried to wipe sputum on a nurse saying he
B had HIV and was going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself."

And I have signed it.

Q That is your note. Is that something that you had witnessed personally or is that
C something being relayed to you by the night staff?
A I would have witnessed that because if the night staff had, I would not ever write something that the night staff had related, the night staff would write their own notes.

Q If he was removing his catheter, that would be his urinary catheter?
A Yes, it would.

D Q Does that bring this incident back to mind at all?
A No, not at all. I really do not remember this gentleman.

Q At the top it says:

"Mr Farthing has telephoned. Explained that..."

E Then the note continues.

Who would be having that conversation with Mr Farthing?
A I would assume that I had because I made the entry.

Q Can we go over the page to 862. We can see at the top of the page that the syringe driver is continuing and then do you make a note on 23 September?
F A Yes.

Q

"Seen by Dr Barton has become chesty overnight. To have hyoscine added to the driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed. To phone him if any
G further deterioration."

A Yes.

Q Is that a conversation you were having with Mr Farthing?
A Yes, I must have done.

H

Q I have not asked you about hyoscine. We have heard a lot about hyoscine. Is that a drug that was fairly frequently used?
A If a patient came chesty, it would help dry out the secretions on their chest to make them more comfortable.

Q In your experience, once a patient was on a syringe driver, is that something the patient sometimes suffered from?
A Not necessarily. Patients can walk around with syringe drivers up, it depends what is in there.

Q You are quite right and I am using a syringe driver in a certain way. What I mean is, if a patient is flat on their back and diamorphine is going into their system, does it sometimes happen at least that they cannot get rid of their secretions?
A Yes.

Q Rather than continuously trying to suction them out?
A You cannot always suction, it depends. If it is low down you would not be able to reach it anyway and suction is quite distressing.

Q Do you have experience of patients then getting chest problems?
A Yes.

Q As a result of the secretions?
A Yes.

Q Hyoscine is a useful drug?
A Yes, it is.

Q Because it minimises or lessens the secretions?
A That is right.

Q The next note I think is that of Sister **Code A** Is that right?
A Yes, it is.

Q Just, please, for your confirmation, could you go back to the drug chart at page 758?
A Yes, I have that.

Q Can you help us as to whether you administered any of these drugs?
A No, none of them.

Q Does it follow from that that when we see the increase in diamorphine which we see on the 24 September, to the right hand side of the page, two increases in fact, of 40 mg, I think, and then 60 mg, that those would not have been your decision?
A No, they are not mine.

Q Just back to the nursing notes, please, page 863: again, I am afraid this is not a particularly good copy, but I do not think your writing appears on that page, does it?
A No. None of that is mine.

A Q And the following note is the end of the notes in that, and we can see that is not you either.
A No.

Q We put that file away, please. Pick up the next, which is your file H, and that is our Mr Robert Wilson. Mr Wilson: again I have to ask you – do you have any independent recollection of this patient whatever?
B A I do not remember this gentleman either.

Q This is a gentleman who we know had alcohol problems. I think he had had, apparently, alcohol liver disease. May I just ask you this. Were you aware of any particular issues in relation to the use of morphine with somebody who had previously been an alcoholic? Or was that not something within your learning?
A No. I know we are careful… I know in patients that are up and mobilising we are
C very careful what they have if they are an alcoholic but if a patient is a palliative patient it would not make any difference at that stage if you are going to give palliative drugs to somebody.

Q You just used the expression, "If a patient is a palliative patient"?
A Uh-hum.

D Q How is that decision made, and who makes it, that a patient is destined for palliative care rather the curative care or rehabilitation?
A It should be a joint decision. Usually it should be a joint decision. It should be after a conversation with the doctor and the patient if they are able, and the relatives and the staff.

Q Right.
A So everyone can come to an agreement.
E

Q And how did it work in Dryad ward – do you remember?
A Dr Barton did used to speak to the patient's relatives.

Q If palliative care was ---
A I do know that she did speak to the relatives. I do not know if she spoke to all of them because obviously I cannot speak on her behalf but I am aware that she did speak to relatives.
F

Q At other places where you have worked, where a decision is made to begin treating a patient palliatively – and I am using that in a sense of not trying to cure the problem, not trying to rehabilitate. Is that the right way of looking at it or… You help us. What does palliative care mean to you?
A It means that a patient has a disease that they are not going to recover from, that will only worsen. If the patient is capable, it is their decision.
G

Q Yes. It is obvious perhaps: when you talk about a disease that "they are not going to recover from," in other words it is an end of life ---
A Yes.

Q --- issue?
A Yes.
H

A Q Again, in other places where you have worked, what sort of note would you expect to be made, if any, about that sort of decision, that a patient is now for palliative care?
A When I worked in palliative care, the doctor would speak to the patient themselves if they were capable and/or the relatives and then would document the conversation that she had had and what the outcome was.

B Q So there would be, you have seen in the past have you, specific notes relating to the decision?
A Yes.

Q We have heard in this case, and I just want to ask you very briefly about it, about various notes that are made on a patient's records. For instance, let me just give you an example, "Not for 555" and "Not for resuscitation". You understand those terms, do you?
A Yes.

C Q We have also heard the term "For TLC"?
A Yes.

Q "For tending loving care"?
A Yes.

D Q Does that have any particular relevance in terms of palliative care? Is that an expression you have seen before in that context?
A Yes, it is.

Q And if you see TLC on a patient's note, what would you understand that to mean in relation to that patient, in normal circumstances?
A That there is not to be any active treatment that would actually prolong life, but for
E example if a patient was for tender loving care and they actually maybe developed a chest infection that was quite distressing to them, I would still expect that to be treated. It is to relieve symptoms rather than to actually lengthen life.

Q So you would not want the patient to be suffering from distressing symptoms?
A No.

F Q You would do what you can to relieve the patient of the symptoms, but you would not be curing the patient?
A That is right.

Q The words, "Please make comfortable": we have seen that on frequent occasions in these notes. What would your understanding of that be?
A I would keep the patient pain-free.

G Q Would that have any significance in terms of a decision for palliative care or not?
A This is all one and the same.

Q They are one and the same?
A Yes, I think so. If a patient is for TLC, it means really they are not for active treatment.

H

A Q Yes?
A But doctors express what they mean in different ways, so that is how I have always accepted that, but they are not for active treatment, as I said, to prolong life, but it would be relieving any symptoms that they had.

Q So, "Please make comfortable" is the same as "TLC"?
A Yes.

B Q Finally – and this is an expression we have already dealt with but I just want to know whether it has any significance in relation to the matters that we have been discussing: "Happy for nursing staff to confirm death." Does that have any significance in relation to any decision that the patient is destined for palliative care?
A Sorry. Could you say that again?

C Q Yes.
A Sorry.

Q The note that we looked at earlier, or discussed earlier: "Happy for nursing staff to confirm death."
A Right.

D Q Which you say you have seen elsewhere?
A Yes.

Q And you must have seen on Dryad ward?
A Yes.

E Q Does that any significance in terms of the decision to treat a patient palliatively or not?
A No, I do not think so. I think the "Happy to confirm death"… It could be somebody who maybe had a heart attack and were not going to resuscitate for various reasons. But no, no.

F Q In what circumstances would you expect to see that note? Would you see it for every patient who comes onto Dryad ward or not?
A No. If a patient was expected to die.

Q I got diverted. We were dealing with Mr Robert Wilson. Could I ask you, please, just to turn up page 266A.
A Right.

G Q This gentleman had come over to you, as we can see, from Dickens Ward at QAH. He had on occasion had morphine. More frequently he had had something called codeine phosphate?
A Yes.

Q Is that a drug you are familiar with?
A Yes.

H

Q But in the days prior to him coming to your hospital, he had been on paracetamol and on occasion codeine phosphate. All right?
A Right.

Q If we look at page 266A, do we see an entry by you right at the beginning?
A Yes.

Q Again, can you just take us through this please?
A

"Received as a transfer from Dickens Ward at QAH.
History of left humerus fracture. Arm in collar & cuff. Code A
Code A

That is left ventricular failure .

"Chronic oedematous legs. [Seen by] Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles."

And I have signed it.

Q And who would have given that Oramorph? I appreciate Dr Barton prescribes it?
A With a (inaudible). If the prescription sheet is there it will say.

Q Would you go back to page 263. We have all inserted the better version now.
A Yes, I have signed it. I gave it.

Q Would you have known at this stage what the patient had been on previously?
A Yes, we would have had the prescription chart.

Q And he is now being put on 10 mg diamorphine, which is given to him ---
A No. Oramorph.

Q I beg your pardon. You are quite right. Oramorph. I am looking at Oramorph and I am reading diamorphine. Oramorph. 10 mg of Oramorph, which he is given twice, I think, on the day of his arrival, one by you and one by another nurse?
A Yes.

Q Can you tell us why he was put on Oramorph?
A I have no idea except for the fact that he has got left ventricular failure so it is very possible that he was in a degree of heart failure when he came in, and Oramorph can help that. But I would not know the reasoning at this time.

Q And this is a prescription of 10 mg in 5 ml. Underneath that we can see that there is a range of between 2.5 and 5 ml, so it could be 5 ml up to 10 ml.
A Sorry, I have to turn back again.

Q I am sorry. It is 263, a few pages earlier.
A Yes.

Q So who would make the decision to start of at 10 mg?
A At this time I really do not know. I may have made the decision. I may have discussed it with Dr Barton. I really cannot say.

Q All right.
A I do not know.

Q Then we can see, if we stay on the drug chart just for a moment – we will go back to the nurses' notes – we can see on the 16th, so two days after admission, he has put on the syringe driver?
A Yes.

Q Is that your entry?
A Yes, it is.

Q At 16.10?
A Yes, it is.

Q If we keep a finger there, but go back to page 266A. ---
A Do you want me ---

Q Go on.
A Do you want me to read it?

Q Yes, please.
A

"Patient very bubbly chest this p.m. Syringe driver commenced 20 mg diamorphine and 400 mg (sic) hyoscine ---"

THE SHORTHAND WRITER: Please could you slow down.

MR KARK: It says, "Patient very bubbly chest this p.m."
A "…. very bubbly chest this p.m."

Q This is the entry on 16 October 1998 with "pm" next to it. Yes?
A Yes.

"Syringe driver commenced 20 mg diamorphine and 400 mcg hyoscine. Explained to family reason for the driver. Wife informed of patient's continued deterioration. Has been to visit …"

And I have signed it.

Q The decision to start him on the syringe driver would be taken by whom?
A At this time I could not tell you. I really do not know. I am sorry.

Q Does it follow from that answer that the decision at what rate to start him on was ---
A Looking at it, as Dr Knapman had been in that morning, Dr Barton obviously was not present that day, so I would assume that myself and the other nurse on duty had made that decision.

A

Q And that was within the prescribed range ---
A Yes.

Q --- by Dr Barton?
A On the entry before it said Dr Knapman was there. That means Dr Barton was not even on duty that day.

B

Q Why are you presuming, as you seem to be, that Dr Knapman would not have taken the decision to start the patient on the syringe driver?
A I am sorry? Why ---

Q You see the note above – "Seen by Dr Knapman". Yes?
A Yes.

C

Q "… as deteriorated overnight"?
A Yes.

Q Yes? And then your note pm. "Patient very bubbly chest this pm. Syringe driver…". You are saying that was a nurse decision?
A I think it could well have been.

D

Q Why do you say that?
A I am looking at the time that it was started, it was ten past four. Doctors usually made their rounds after their morning surgery. I would just lead to that conclusion. I cannot obviously state, but that would be the conclusion I would come to.

Q We know that the diamorphine continued on the 17th. I do not think you made an
E entry on the 17th, but could you go to 267. We can see an entry, I think, initialled by Sister Hamblin at the top. And the next one is Sister Code A as well. In fact, you have not made any other notes on this ---?
A No.

Q --- nursing note.
A No. Nothing on there.

F

Q Going back to 263, we can see that the dose was continued on 17 October of diamorphine and then increased in the afternoon to 40 mg, and then increased the following morning to 60 mg. Do you see where I am?
A Yes.

Q Did you make any of those entries?
G A No, I did not.

Q You tell us: did you take any part in that decision-making process?
A No, I did not.

Q We are almost there. Could you go to 282, please. I do not think we need you to comment particularly. We can read – is it your writing on this page?
H A Yes, it is.

A

Q If we keep a finger there, please, and go back to page 274, which is the Barthel index, you, I think, were the named nurse for this patient?
A No. I was not the named nurse for any patients on Dryad.

Q I am sorry. If we go to 282 again.
A Sorry. I have put that in there because I did the care plan, but I would not have been
B the named nurse because as an F grade I did not have named patients.

Q I see. It was just ---
A Sorry. It just because ---

Q --- you were "Named nurse"?
A Sorry, no. It is because I complete the care plan.
C

Q If we go back to 274, would you have completed the Barthel score?
A No. It is not my writing.

Q It is not? Okay. But is that Barthel score consistent with your note at 282 as to the sort of assistance?
A Sorry, I just do not have that. I do not think that is my writing.
D

Q All right. It may not matter too much.
A Not it is not. It is not my "w". Sorry.

Q But he has a Barthel score of about 4?
A Yes.

E Q And we can see the comments made about the assistance that he required, and that seems consistent with your note, does it, at 282?
A Yes.

Q Had you yourself filled in Barthel scores for patients?
A Yes.

F Q You have made various other notes, but I am not going to take you through them, because I think they are all obvious. On the issue of named nurses, who would decide who would be the named nurse for a patient?
A There were three E grade staff nurses on the unit and they all had I believe eight patients each that they were responsible for. They had one of the bays and two of the single rooms each. Depending on which room the patient went into depended on who was the main nurse.
G

Q There is one other matter that I meant to ask you about and that is the use of midazolam with this patient. If we go back to the drug chart at page 263 – and again, I am really asking for your experience on the use of midazolam and then move on – we can see that the midazolam was also increased on 18 October.
A Yes.

H

A Q In your experience, what was midazolam used for?
A As sedation.

Q That is different to pain relief.
A Yes, it is.

Q Are you aware that diamorphine would have a sedative effect?
B A Yes. I do not know the reason; I do not know why at that time we put the patient on that, because I do not remember him.

Q So you cannot give an explanation as to why the midazolam would have been given?
A I am sorry, no, because I do not remember the gentleman.

Q You can put that file away, please. Can you take up file J, please? That is the patient
C Mr Geoffrey Packman. This gentleman had effectively fallen at home and he was admitted to Dryad ward, your ward, on 23 August. I just want to go to a note at page 63, please, first of all. Again, do you have any independent recollection of this patient?
A If he is the gentleman I am thinking of, I think he was the gentleman who had stayed on the toilet for about three days and had the most horrendous pressure sore on his bottom and legs.

D Q That was pretty memorable, I expect?
A Yes, it was actually.

Q Can we look at page 63 together?

"Admitted from Anne Ward following an episode of immobility and sacral sores. Catheterised."

E

Then is it, "On profile bed"?
A Yes. We had to order a special bed in for him because he was a large gentleman.

Q This is your note at the top, is it?
A Yes.

F Q I am not going to go through all of that. Can we go to the bottom of the page, please, because I think your writing next appears right at the bottom. We can see at 1900 hours on 26 August, "Dr Barton here." Can we just pause there for a moment? That is seven o'clock in the evening. What would Dr Barton have been doing there at seven o'clock in the evening?
A She may have come in late for somebody that she was worried about or I may have phoned her and asked her to come in.

G

Q Then:

"For Oramorph 4 hourly. Wife see by Dr Barton, explained Mr Packman's condition and medication used."

Who would have given that explanation?
H A Dr Barton.

A

Q If we go over the page to 28 August, I think you have made a note.
A Yes.

"Remains very poorly – no appetite has refused all food. Wife visited - very distressed as she is having surgery this coming week – QA Thursday"

B And I have signed it.

Q At this time, this patient was on Oramorph only.
A Yes.

Q Did that have an effect at all on people's appetite?
A Not really, because I think if Oramorph actually relieves their pain, they eat.

C

Q This discussion with the wife, who would have had that discussion?
A I believe Dr Barton, because at seven o'clock his wife would have been in there.

Q I do not think your name appears further on that page, does it?
A No.

D Q But if we go to the top of the following page, page 65, there is a crossed-through entry.
A Yes. I made an error. I wrote that about the wrong patient.

Q The reason you crossed that through is because, although you have used his name, it is the wrong patient?
A Yes, it is.

E

Q We know that this patient was in fact started on diamorphine on 30 August. Again, could I just ask you, please, to turn up the drugs? You will find the start of the drug chart at page 171 and then I am going to ask you to turn to page 174. Page 174 should be headed "Daily Review Prescriptions".
A Yes, I have that.

F Q Do you see under "Diamorph" that Dr Barton has written a prescription for between 40 and 200 mg of diamorphine?
A Yes.

Q Did you administer any of that?
A I have signed the one on the 2nd, which is for 90 mg.

G Q So the day before, the patient had been on 60 mg and you increased it up to 90 mg at 1540 in the afternoon?
A Yes. I have signed that.

Q Can you help us, please, on what authority you did that?
A At this moment, no, I cannot.

H

Q Does it follow that you cannot say whether that would have followed a discussion with a doctor or not?
A I really cannot remember, I am sorry, and I do not think there is anything documented.

Q In any event, it is an increase which is allowed for within the prescription.
A Yes.

Q Were there occasions when you yourself would increase the administration of the drugs based on the prescription alone?
A I am sorry, do you mean if the patient needed extra, would I look at the prescription and see if I was allowed to give it and then increase it?

Q If in your view the patient needed extra, would you give it without reference to anyone else?
A Yes.

Q Provided it was within the prescription written?
A Yes.

Q Then if we go to page 56, underneath "1.9.99", there is an entry which I think in fact is for the 3rd, according to our documents. It may help us all if we write in, if this is convenient, "3.9", just so that in future we know. Is this an example of you verifying somebody's death?
A Yes, it is.

Q Is this the procedure that you would go through: you would check their breath sounds, their heart rate, their pulse and you would check their pupils?
A Yes, I would.

Q You were allowed to verify death in this case. Why?
A I would assume because it was written in the notes.

Q If you look at the top of the same page, do we see Dr Barton's note, "I am happy for nursing staff to confirm death"?
A Yes.

Q You have told us that you did have a recollection of this man. Is that because of the extent of his pressure sores?
A Yes.

Q I want you to look at one other patient. You have not made a statement about this, but I hope there will be no objection. I would just like you to look at a drug chart for Patient I, who is Enid Spurgin. Could you have a look at page 178? This is a lady who had had a fall and fractured her femur and came to your ward on 26 March. If you look at both pages 174 and 178. First of all, do you have an independent recollection of this lady?
A I do not remember this lady at all.

Q It may not matter at all, but have you in fact administered any of these doses as far as you can see?
A It looks like I gave the metoclopramide at one o'clock. That is all.

A

Q Metoclopramide is given for what?
A Anti nausea.

Q Finally, I just want to ask you this. You have told us that here was an unfortunate end to your time at Dryad ward and you moved on.
A Yes.

B

Q Did you move on to a place called Jubilee House?
A Yes, I did.

Q Was that immediately after Dryad ward?
A Yes, it was.

C Q Are you still working now?
A Yes. I work in the community now.

Q How long did you work at Jubilee House for?
A About four years, I think.

Q What sort of work do they do at Jubilee House?
D A It is palliative care.

Q Did they use syringe drivers at Jubilee House?
A Yes, they do.

Q Did they use diamorphine at Jubilee House?
A Yes, they do.

E

Q Midazolam?
A Yes.

Q When you were at Jubilee House, were the practices that you saw the same or different in any way to the practices you had seen at Dryad ward?
A Different.

F

Q How different?
A The doctor would come in. No syringe driver was pre-prescribed. The doctor would come in daily. We had a GP who came in Monday to Friday and a consultant would come in; a palliative care consultant would come in once a week. If we had a patient that we were concerned about who maybe could not swallow the analgesics any more, they would be reviewed. The doctor would actually speak to the patient and ask them what they wanted: did
G they want to be kept comfortable, did they want to be pain-free and have their anxiety allayed? It would be discussed and then a small starting dose would be worked out using the analgesic ladder.

Q Was that – it may be obvious from what you have just said – a ward where there was a doctor there the whole time, or was there just a clinical assistant?
A No. One of the local practices covered us Monday to Friday and the palliative care
H consultant, as I said, would come in once a week on a Thursday, but we could phone her if

A we needed to and, if we had somebody we were quite concerned about, she would actually come in if she was available and see the patient as well.

Q When the doctor came in, how long would they spend on the ward?
A It varied. However long they needed to.

Q Was it one ward?
B A No. It is 25 single rooms. They would not see everybody; only the patients that they needed to see.

Q So the differences in the practice, I just want you to set them out for us clearly, if you could. First of all, was it the initiation of the syringe drivers?
A Yes.

C Q The starting doses?
A Much smaller.

Q And increases. Were they different?
A They were very controlled and titrating them, depending on how much the patient had had, as top-ups. They used to titrate it, depending on how much top-up the patient had had through the last 24 hours. So if they needed an increase, they would have a look at that and
D then maybe add a little, because obviously their pain was not controlled.

Q Was that similar or different to what you had seen at Dryad?
A Different.

Q At Jubilee House, did they allow patients to die in pain?
A No.
E

MR KARK: Would you wait there, please?

THE CHAIRMAN: I think we will break at this point, Mr Langdale, rather than interrupt you in a matter of minutes. We will return at 12.05, Mrs Hallmann, when Mr Langdale will start with his questions. I remind you that you remain on oath. Please do not speak to anybody about the case. Thank you.
F

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back. Mr Langdale.

Cross-examined by MR LANGDALE

G Q As you will appreciate I am going to be asking you some questions on behalf of Dr Barton. I appreciate in this case it is sometimes difficult to avoid moving from topic to topic and having to cross reference things, but I am going to try to keep things in compartments as much as I can. May I start with something which you dealt with towards the end of your evidence a little while ago. You told us you worked as a nurse at Jubilee House?
A Yes.
H

Q I will come on to Jubilee House in a moment, but that is a ward attached to Queen Alexandra, is it?
A No.

Q Is it attached to any hospital?
A At the moment it is now Portsmouth City Trust.

Q Was it physically?
A It is a separate building off site, but it was actually run by East Hants.

Q Just the physical thing, how close is it to QAH?
A Half a mile.

Q But was it attached to that hospital in any way in terms of services?
A No.

Q You spent four years there. This is not an exercise in detailed dates, but four years. Is that right?
A Yes.

Q So we think of you being there from 2000 to 2004?
A Yes, roughly, yes.

Q What grade were you there?
A I went there as an E-grade staff nurse, just a staff nurse, yes.

Q Grade E?
A Yes.

Q When you were at Dryad, you were grade F, if I remember correctly?
A Yes, I was.

Q Is going back to grade E going backwards or what is it in terms of career?
A Career wise it was going backwards. It gave me a job away from Dryad, and I wanted to leave Dryad and I needed another job and that is the one I took.

Q I think you had an opportunity of going to Queen Alexandra?
A Yes, as an E-grade.

Q As an E-grade?
A Yes.

Q It was a choice between Queen Alexandra and Jubilee, was it?
A Yes.

Q You spent four years at Jubilee as grade E and then you left?
A Yes.

Q What have you been doing since, have you still been working in nursing?
A Yes, I work on, it is called, the Rembrandt Unit. It is a community unit based at another hospital. We are, physically, in the hospital grounds but we are not actually part of the hospital.

Q Are you given a grade for that as well?
A I am an E-grade there as well.

Q You have been E-grade, in effect, since you left Dryad?
A Yes, I have.

Q Dealing with Jubilee in general terms, obviously a very different situation with regard to the provision of medical facilities in terms of doctors being there and being available?
A Yes.

Q There will be a number of doctors, presumably, who carried out the functions from time to time at Jubilee?
A Same as there was at Dryad Ward.

Q Doctors might be there for two or three hours per day?
A Not usually that long, no.

Q Four or five days a week – actually there – I am talking about back in 2000 to 2004?
A They would come in five days a week at lunch time between their surgeries, the same as Dr Barton did.

Q But spending more time on the ward than Dr Barton, would you say?
A As much time as they needed to.

Q In general terms, did that compare more or less the same with what Dr Barton did?
A Probably there a bit longer, I would say.

Q There a bit longer.
A Yes.

Q Also they would be more available in terms of getting hold of a doctor to come to the ward if necessary than they were on Dryad?
A No, probably about the same.

Q A consultant, you told us, would come once a week?
A Yes.

Q And would be available if you needed the consultant?
A Yes.

Q That is something different to Dryad I think.
A Sister Code A used to be able to contact the consultant we had when I first went there, Dr Lord, if she needed advice about anything, but that did change when Dr Lord left and we had Dr Reid.

A Q In terms of the availability of the consultant, in terms of the consultant doing a once-a-week round on Jubilee, one ward, would you agree or disagree with the suggestion that that was rather more consultant attendance than there was at Dryad?
A Yes.

Q Obviously you have told us about the use of the analgesic ladder. Again at Jubilee there might be times, depending on the condition of the patient and their needs, when you
B would have to jump a step, omit a step on the analgesic ladder. The needs of the patient would cause you to do that because of the pain they were suffering?
A No, I do not agree.

Q You never had an incidence of that in your time at Jubilee?
A Not that I recall.

C Q You were asked about a number of patients, and I am going to turn to those first before I ask you about more general matters. I turn, first, to the patient who has the designation Patient F, Ruby Lake. If you turn to page 394 and look at the entry – you have already looked at this – on 19 August halfway down the page, "Complaint of chest pain" and so on. The Oramorph was given by you, or it does not matter who gave it to her, but Oramorph 10 mgs?
A Yes.
D
Q "Doctor notified"?
A Yes.

Q That signifies what, a notification to Dr Barton probably?
A I would have phoned to say what symptoms the patient had.

E Q I am looking at the time, 11.50. Is that something you may have notified her about when she did a lunch time visit, or something you would have telephoned her about, or are you unable to say?
A If I put "doctor notified", that meant I actually telephoned.

Q You telephoned her to say that that is what had happened?
A Yes.
F
Q You found, as your next bit of the note indicates, that the pain was only relieved for a short period, "very anxious", and then the diamorphine was commenced?
A Yes.

Q If you had been unhappy about that, you would have said so to the doctor, would you not?
G A Yes, I would have done.

Q I appreciate the difficulties of trying to remember something which took place a long time ago, but does this appear to be a possible picture because you administered this at a later stage, the diamorphine, and we have the time on the drug chart. It is consistent with Dr Barton, perhaps, having come in at lunch time and you having spoken to her?
A It is consistent.
H

Q We cannot say for certain, but it is consistent because it is later on in the afternoon that you started with her saying:

"If this continues, then I think it would be sensible to start the syringe driver."

Had you disagreed with that, you would have said so to Dr Barton, would you not?
A Yes, I would have done.

Q On occasion, can I ask you this generally, just leaving this patient for a moment, had you on occasion ever spoken to Dr Barton about, perhaps, it not being the appropriate time to start a syringe driver?
A Yes, I have.

Q Would that be once or more than once?
A More than once.

Q On those occasions she listened to what you had to say and the syringe driver, she would indicate, "All right, we will delay it and see"?
A No, not always.

Q Are you saying there was an occasion when you administered diamorphine via a syringe driver when you had said to Dr Barton, "I do not think this is appropriate"?
A No, not myself personally.

Q You may have discovered that that happened without yourself being present---
A Yes, I did.

Q --- during what had happened to the patient between the time you spoke to Dr Barton and the time of the administration?
A Yes.

Q There was never an occasion when you said to Dr Barton, "I wonder if it is right to start it now", or suggested that you had that view, there was never an occasion when Dr Barton said, "No, I am ignoring that, I am going to go right ahead", was there?
A No.

Q She listened to what you had to say and would indicate, "All right we will leave it for a bit"?
A Yes.

Q You indicated to us that, obviously, this patient was conscious when you noted down, "Very anxious"?
A Yes.

Q We have had to look at a number of notes made by a number of different nurses, and it is quite helpful to have what is actually meant by a particular nurse in respect of a particular note. In your experience patients, when they were initially given diamorphine, might well be made sleepy by it, I think was the expression you used, and then they get used to it. There is

no dispute about it, we have heard about that. In you view, it was the midazolam which contributed to them feeling sleepy?
A Yes.

Q The administration of diamorphine and midazolam was quite common?
A Yes.

Q And something that you have seen occurring at Jubilee. It is a sensible combination, so far as you can judge. I appreciate that you are not a doctor, but it is a sensible combination in your experience?
A Sorry, there is something you said just now, I am sorry, something I disagree with.

Q What shall I do, shall I go back? What is it you would like to clarify?
A It was just the bit when you said about Dr Barton would not give the medication and would agree to delay it. But I felt – well I know for a fact – that was done when I was off duty because I actually have a written statement saying that.

Q I am not suggesting you are wrong, but there might have been occasion when you said to Dr Barton, "I wonder whether it is right to start it now?" expressing that view in those sort of terms?
A Yes.

Q And later on, on a different shift, a later shift, the patient might have received diamorphine on a syringe driver?
A Yes.

Q That is what you say, on occasion, had happened?
A Yes.

Q I was making the point that when the patient was on the syringe driver, albeit not at your hands but later on, there had been an intervening phase when you would not know what the state of the patient was except by the notes because you were not there?
A No, that is true.

Q The point I was trying to make, and you correct me if I have it wrong, is that there was no occasion when Dr Barton, if you spoke to her, indicated that it was your view that perhaps it should be delayed. There was no occasion when Dr Barton said, in effect, "I am ignoring that, I am going to start him or her on the syringe driver"?
A Not to me, no.

Q Obviously there must have been authority to start the syringe driver later, otherwise, presumably, it would not have been started?
A I do not agree. I am sorry, I really do not agree. It is quite a contentious point this with me.

Q You just do not know what happened after you left, do you?
A I do not know, but Dr Barton actually wrote a statement when I put in my grievance saying it was easier to change drug regimes when I was not on duty.

Q That may well be the case and I will come to that, if necessary, later on. What I am talking about is what Dr Barton did when you raised with this her. I am making the point that you would not know, yourself, what had happened to the patient after you had gone off duty?
A No, that is true.

Q Can we go back to what I was asking you about in relation to that. There was no problem with your understanding my question, or giving the answers you were clear about, in relation to diamorphine and midazolam used together?
A Yes.

Q In your experience, both on Dryad and at Jubilee, they were an effective and sensible combination?
A Yes.

Q In relation to Ruby Lake, you are not criticising anything that happened, so far as you are aware, when you were involved in the treatment of that patient?
A No.

Q May I put it in this way. You are not somebody who would hesitate to criticise if you felt criticism was due?
A No, that is true.

Q Can we turn to the next patient you were asked about in this group we are dealing with. That is Patient G, Mr Cunningham. If we turn to page 861. We dealt with the entry you made at the top of this page?
A Yes.

Q You mentioned the sores, which you described as horrendous, on the sacrum. Perhaps it was another patient you mentioned where you used that word in respect of the sore, but "large necrotic sore on the sacrum, seen by Dr Barton" and so on. Oramorph given prior to the dressing of the wound, which you said was something that was sensible to do and I think we can all understand precisely why. You indicated you, yourself, had not been involved with the commencement of the syringe driver, which was later on that day, and you explained that, apart from the fact it is not your writing, you would not have been on duty at 11 o'clock that evening?
A Yes.

Q The next day you had dealings with Mr Farthing?
A Yes.

Q When you spoke to a relative, you gave them the true picture when you spoke to them, did you not?
A Yes.

Q You were not somebody who was being deceptive in any way when you were talking to a relative?
A No.

Q You were confident in explaining to him why the syringe driver had been commenced?
A I must have been because I have written it on there, yes.

Q I appreciate you were not involved in starting it, but if it appeared to you to have been something that was wrong, you would not have said what you said to Mr Farthing, would you?
A No.

Q Because you indicated what the reason was, for pain relief and to allay his anxiety?
A Yes.

Q A history is set out which it appears you had actually witnessed yourself.
A Yes.

Q Plainly a case, perhaps we can note, of somebody who had been on diamorphine and midazolam, although not necessarily for very long, who certainly was not rendered so sleepy or unconscious or anything like that so as to prevent him from doing what he did?
A Yes.

Q You had seen that and it did not surprise you that the syringe driver was continued as it was?
A Yes. What do you mean "continued"?

Q During that day, the syringe driver was continued?
A Yes.

Q If you look over the next page, I appreciate it is not your entry, the same day it was changed?
A Yes.

Q If you move on to the next page, 862, you dealt with the other entry in your handwriting. Do you have 23 September?
A Yes.

Q
"Seen by Dr Barton. Becoming chesty overnight. To have hyoscine added. Stepson contacted and informed of deterioration."

That would have been you, would it?
A Yes, it would have been if I have written that in there, yes, it would.

Q That would be you telling him the true story as you observed it?
A Yes.

Q
"Mr Farthing asked if this was due to the commencement of the syringe driver and was informed..."

That is by you.

A

"... that Mr Cunningham was on a small dosage which he needed."

Is that correct?
A Yes.

Q That expressed your view. Again, you are not a doctor but that expressed your view?
B A Yes.

Q And you were saying to him – and there is not criticism, of course . I am sorry – he was saying to you to phone him if there was any further deterioration?
A That is correct.

Q A situation you were no doubt quite familiar with?
C A Uh-hu.

Q I think that is the end of any entries by you with regard to that patient. May we move on, please, to the next one in the order in which you were asked about these things. That is Mr Wilson, Patient H. Just before I ask you about any particular entry with regard to that patient, you were indicating to us that in terms of the decision to go to palliative care, that that normally would be something that would be a product of joint discussion. Yes?
D A I am sorry? For a patient, you mean?

Q Forget about the patient for the moment.
A Sorry.

Q I am just going to your evidence, just to make sure I have it right. When the point had been reached when palliative care seemed to be the only option left.
E A Yes.

Q All right?
A Yes.

Q There would normally be a discussion about that issue?
A Yes.
F

Q Involving, you have told us, the doctor?
A Yes.

Q The nurses?
A Yes.

G Q It might be one, it might be more than one?
A Yes.

Q And the relatives?
A Yes.

Q And that would happen, would it not?
H A Yes.

A

Q Obviously the ability of the patient to make any helpful contribution to that would depend on the state of the patient?
A Yes.

Q And there were obviously a number of patients on Dryad who were not in a state to give an informed view about that. Right?
B A Uh-hum.

Q That in particular was why one needed to try and bring in the relatives?
A That is the ideal, but looking at the notes, it looks as if not all relatives had been told because it looks there as if with Mr Farthing I had told him the next day.

Q Yes?
C A But some relatives, to qualify that, do not always want to be called at night.

Q One appreciates there is a whole range.
A Yes.

Q Some relatives are not really that interested?
A No.
D

Q Some patients may barely have received a visit from a relative?
A That is right.

Q Some relatives were much more pressing?
A That is right.

E Q For whatever reason, and this is not a criticism of them, but might as a matter of practicality be more demanding on your time ---
A Yes.

Q --- in terms of wanting an explanation or wanting assistance or whatever?
A Yes. They are all different.

F Q Exactly. But the general picture, assuming there was not something to prevent it happening, would be that there would be a discussion ---
A Yes.

Q --- where feasible, involving the relatives?
A Yes.

G Q In your experience – you cannot speak for every case obviously. All right? And you told us, I think, that Dr Barton herself would speak to relatives and, indeed, she might come in specifically to speak to a relative at the hospital?
A Yes, she did.

Q In relation to this particular patient, may we look please at page 266. I think it has sometimes been described as 266A. I just have the 266, but I think maybe 266A was a
H

A replacement with better copying. I am told that is 266B. I do have 266B, which I think is the clearest copy we have of that page.

THE CHAIRMAN: Mr Langdale, I think all it was was that 266A had some additional notations on it. The quality of the copies is the same. The fuller one, if you like, is "A".

MR LANGDALE: I am going to stay with 266 because there is less to look at. We can B always move to 266A if necessary. However, I do have a 266B which seems to be a blow-up version of 266. It does not matter. The important thing is that you have a clear copy of what I am asking about. (To the witness) Here we dealt with the note on admission at the top of the page – all right?

A Yes.

Q For 14 October, made by you and the Oramorph being given?

C A Yes.

Q Again, I appreciate every time I ask you this, you can only speak as a nurse. You are not making a criticism of that, are you?

A No.

Q You were asked about the decision to start the Oramorph, because it was a variable D prescription, in the sense it could go from 5 mg to 10, or 2.5 ml to 5. It looks as though you decided to start it at 10. This is not a criticism. Would you agree?

A No. I could not say at the moment because I do not know.

Q You simply do not know?

A No, I do not know.

E Q But it might be that you would feel it appropriate ?

A It could have been

Q Yourself.

A Yes, it could well have been.

Q That is as far as we can take that, I think.

F A Yes.

Q Then, on the 16th, on that same page – 16 October –

> "Patient very bubbly chest this p.m. Syringe driver commenced 20 … diamorphine, 400 … hyoscine. Explained to family reason for driver. Wife informed of patient's continued deterioration. Has been to visit."

G

It might have been – I know you cannot say now after this distance of time – but it might have been that it was your view at some time after midday – we can check on the drugs charts and so on – that you made the decision that his condition justified the commencement of the syringe driver?

A Yes, it could have been

H Q Obviously if the doctor is there, you would always check it with the doctor?

A A Uh-hu.

Q If you were in real doubt about it, you might make an effort to contact the doctor, or whoever was on call? There might be occasions where, if in your view this was justified, you would feel it right to start it?
A Yes.

B Q The object being to stop the patient being in unnecessary pain?
A Yes.

Q I appreciate you cannot now precisely remember, but you said, "It looks as though I and the other nurses…", because you would always consult with another nurse, would you not?
A Yes, I would.

C Q "I and the other nurse (or nurses) had made that decision." Dr Barton not on duty that day, is what it looks like?
A That is right.

Q There is no dispute about that?
A That is right.

D Q It was administered at 4.10 in the afternoon. All right?
A Yes.

Q You were taken through the administration of the medication so far as Mr Wilson is concerned, not only the diamorphine but also the midazolam, and I think it is right to say that you, in your view, did not think that any of the dosages of drugs in the case of Mr Wilson
E were excessive?
A No.

Q I am going on a statement that you made to the police a long time ago. I appreciate that. I think you had had the opportunity when you made your statement about Mr Wilson's case, that you had had the opportunity of reading some of the notes?
A Yes.

F Q And you said you had no issues with Mr Wilson's care?
A No. That is right.

Q That is all I need to ask you about that particular patient. Can we move on, please, to Patient J. This is the patient where you used the words, he had a most horrendous pressure sore?
G A Mr Packman.

Q It is Mr Packman, that is right.
A Yes.

Q You may also remember with him, he was an unusually large gentleman?
A Yes, he was. I remember because we had to order a special bed. We had not had one
H before.

A

Q That obviously created nursing problems of its own anyway?
A Yes.

Q We started there, I think, at page 63 when Mr Kark was asking you some questions. The admission you dealt with at the top of the page on 23 August. Is that right?
A That is right.

B

Q I do not need to go through all that. Then we took it up again, I think so far as you are concerned, with 7 o'clock in the evening at the bottom of the page at 19.00.
A Yes.

Q Is that you?
A Yes, it is.

C

Q "Dr Barton here. For Oramorph 4 hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used."

So obviously it follows you were there when that was discussed or spoken about?
A Yes.

D

Q And would it be right to say that Dr Barton on this occasion was not being either rude or harsh, otherwise you, no doubt, would have noted it or remembered it?
A Not to my knowledge.

Q Indeed, in terms of Dr Barton speaking to relatives, so far as you witnessed it, did she ever come across to you as being rude or harsh with relatives?
E A No. Outspoken more, I would say. Not rude or harsh.

Q Forthright?
A Yes. Yes.

Q Similarly, I think there is another note by you on the following page, page 64, on 28 August. That is you, is it not?
F A Yes, it is.

Q "Remains very poorly – no appetite…". That is where you were making the comment about how Oramorph might in fact in your experience sometimes have the effect that it got patients to eat?
A Yes, if they were pain-free.

G Q It relieves the pain?
A That is right.

Q I was not clear, and it is my fault, not yours. Were you indicating that Dr Barton was there? There is no reference to it. I may have misunderstood what you said. I think it probably is you dealing with the wife. Yes? "Wife visited – very distressed"?
A Yes, sorry. On the 28th? Yes. Yes.

H

A Q I just want to be clear that this ---
A I would have put "Dr Barton" if she had been there.

Q I was going to say that exactly. You had recorded it.
A Yes.

Q So that is you speaking to the wife and, again, can we take it that you did that in, as
B you saw it, a helpful and relaxed way?
A I believe so.

Q It is difficult to always judge oneself but that is what you would say. I need not trouble you with the crossing out on page 65, but may we move on, please, to page 174. There you were asked on page 174 in relation to the diamorphine, towards the bottom of the page ---
C A Yes.

Q --- where the range is 40-200?
A Yes.

Q And you told us that looking at the date heading for that section over towards the right, 2 September. Yes?
D A Yes.

Q "2.9.99." The administration of 90 mg – because it has gone up from 40 to 60, on the second day, and then 90 by the time we get to the 2nd. All right?
A Yes.

Q All right?
E A Yes.

Q Administered by you. Yes?
A And again, you would not have administered that amount of diamorphine by way of increased unless in your view the patient's condition justified it?
A That is right.

F Q Obviously these decisions are sometimes difficult to make, are they not.
A I have never made that decision on my own because I have always had a colleague on to discussed it with.

Q I am not suggesting to the contrary. Assuming there is not a doctor there?
A Yes.

G Q And nursing staff have to make a judgment?
A That is right.

Q Based on their experience and all the rest of it. It would not be just one nurse suddenly deciding, "Oh well, I am going to up the dose." It would always, in your experience, be two nurses discussing it?
A Yes.
H

A Q And if it was a junior nurse to you who had noticed the patient's condition deteriorating and was concerned about it, they would tend to come to the senior nurse on duty?
A Yes, this would.

Q If you are there. If Code A was not there it would be you they would come to?
A Uh-hum.

B Q Similarly, you yourself, if you thought it was necessary to increase would consult another nurse?
A Yes, I would.

Q That is a given. But it is quite a difficult decision to make, sometimes, is it not? You have to hold the balance and keeping the patient out of best?
C A That is right.

Q And making sure you are not giving them too much?
A Uh-hum.

Q It is not always easy, is it, to decide?
A No. That is why, if I am on with another nurse, which usually I am, I say to them,
D "Would you go and have a look and tell me what you think."

Q Sorry. We quite understand that. Whether it is a joint decision ---
A Yes.

Q --- or whatever, in the end it is probably you who has to say, because you are the senior nurse, if you are the senior nurse, a joint decision having consulted, but it is quite a
E difficult decision sometimes to make in your experience. Yes?
A No, not always.

Q All right.
A No, I would not agree because if a patient has pain, there is usually some indication, either turning them or their facial expression. I do not find it is a difficult decision to be quite fair, to assess pain, because there is always an indication.
F

Q I am not going to press you on that.
A No.

Q It is what you have to say about it that we are interested in.
A Yes.

G Q Patients might be exhibiting pain even if they are drowsy?
A That is right.

Q Or even if they are slipping sometimes in and out of consciousness?
A No, that is right.

Q They can indicate by what you have just described, or signs of agitation and distress?
H A That is right.

A

Q Which can be indicators of pain?
A Uh-hum.

Q But in any event, I appreciate that you cannot remember the precise circumstances. You did what you did for good reason, as you saw it at the time. Yes? With regard to the administration of diamorphine?
B A Well, I must have done.

Q Obviously, because you simply would not have done it if you thought it was wrong?
A That is right.

Q I do not think I need to trouble you with any further with that patient. Can we move on, please, to patient I, the last of the group you were asked about. You were asked about
C certain entries with regard to Enid Spurgin, but another one, or possible two I need to ask you about in addition to what you were asked to look at. You were asked to look at page 174, I think. We had better just turn that up to make sure I do not get anything wrongly described. That is the drug chart again. In case I do have it wrong, is there an entry there by you on 12 April? 12?
A Is this the drug chart?

D Q Yes. I have 174 at the bottom. Diamorphine top left.
A No.

Q The dates are 12, 13, 14 and 15.
A No. That is not my signature.

Q Very well. That is not you?
E A No, it is Code A and I Code A

Q Code A Thank you. That is the first, and then the LB?
A .

Q Just checking again with you, if I may. The next page, 178, I think you said there was something there?
F A Yes. I signed the metoclopramide at one o'clock.?

Q I need not trouble you with that. Then can we go back, please, to page 134. It is part of the summary. Do you see just over half way down there is an entry on 11 April – 11.4.99?
A Yes.

Q Where she talks about the nephew telephoning. That is not your handwriting?
G A No.

Q All right? But would you be kind enough to look at the last line: "S/B Dr Barton."

A Yes.

Q "To commence syringe driver"
H A Yes.

A

Q Is that you?
A Yes, it is.

Q It may not be too good on the photocopies. We can there is a different initial in the line above that, or different signing on for the person who did the note earlier on. All right?
A Yes.

B

Q That note, if the last line is you and anything on the following page by you?
A No.

Q Would you just help us, please, with the signature for the 12th - 12.4 – at the top of the following page. "[Seen by] Dr Reid. Is that… It looks like Code A s signature. It is not an additional initial, is it? Or is it? I better see what you say. "[Seen by] Dr Reid…"?
C A No, no. It is Barrett. It is the "B", and then there is a long line, and then ---

Q It is a continuation of her name?
A Yes.

Q I just want to make absolutely sure. I am not suggesting to the contrary, but just looking at that last line on 11.4.99, obviously the patient had been seen by Dr Barton - right?
D A Yes.

Q And had indicated to you that the syringe driver being commenced?
A Yes.

Q It would appear that you did not take exception to that, because that is what happened?
E A Yes.

Q Once again, if I can ask – and this again is not a criticism – if you thought that was wrong, you would have made your opinion clear.
A Yes, I would have done.

Q I have not dealt with those particular cases. I need to ask you about some more
F general matters, if I may. When you arrived on Dryad in 1998, would it be right to say that prior to working on Dryad, you had not really done a lot of palliative care?
A Not a lot, no.

Q It was all fairly new to you?
A Yes.

G Q In general terms, did you find that general patient care on Dryad was excellent?
A Yes.

Q Not just at the beginning, but I am asking you in general terms.
A No. In general terms, it continued until I left, yes.

H

Q Obviously I have documents and statements you have made and things of that kind. They were all very well looked after.
A Yes, they were.

Q Indeed, I think you expressed it in the way of saying you were very impressed with the level of patient care on that ward.
A Yes.

Q I appreciate there were clashes between you and Code A and I am going to try to avoid going over past history and disputes, although I may have to touch upon it. But there was a clash between you.
A Yes.

Q She is a strong personality.
A Yes.

Q You are hardly a weakling in that department either.
A Yes.

Q The clashes could never really resolve themselves and there remained a difficult working relationship, whoever's fault it was, throughout the period of time with which we are concerned.
A Yes.

Q Nonetheless, whatever criticisms you may have had of her, did you find her to be an excellent nurse?
A Yes.

Q I think we can put it in this way. She ensured that the staff under her kept up the standards.
A Yes.

Q Rather like, I think in your view, an old-fashioned type of matron in a hospital.
A Yes.

Q Somebody who worked closely with the nursing staff, although she was the one who made the decisions.
A Yes.

Q Did you find that the nursing staff generally under Sister Hamblin – and we are looking at Dryad ward obviously – were quite a close-knit group?
A Yes, fairly close.

Q Was an element of your dissatisfaction – and I am not raising this by way of criticism, but just as a fact – the fact that you felt excluded from the group?
A No.

Q Not at all?
A No.

Q You felt fully integrated into the group, did you?
A I think as much as anybody could have been.

Q So far as Dr Barton was concerned, did you find her to be a good and experienced doctor?
A Yes.

Q You may have had a disagreement ---
A Yes.

Q --- about some issues, but she was somebody who was caring about her patients.
A Yes.

Q Indeed, somebody who was aiming, even if you might have felt you could criticise certain things, always aiming for the best for her patients.
A Yes, I would agree with that.

Q Similarly, Code A, whatever you might have disagreed with her about, again, that was something which was the case with her so far as you could judge it.
A Yes.

Q Whatever issues there may have been, to use the word which actually always means "problems", with regard to your feeling you had been harassed, did you find that Dr Barton at all times remained civil to you?
A Yes.

Q And displayed a professional attitude?
A Yes, always.

Q In terms of Sister Code A, you indicated I think – I just want to be clear about this – that there had been an occasion when you had spoken to Sister Code A in these circumstances. This is my way of putting it and you can tell me if I have it wrong. There was a time when you had gone off from being on the early shift, the shift starting round about seven o'clock in the morning. When you came back the next day, you saw that a patient was on a syringe driver and in your view of the patient's history from when you had been tending to them, you could not understand why the patient had been put on the syringe driver.
A That is right.

Q So on that following day, you spoke to Sister Code A and asked her why that was the case.
A That is right.

Q It was on that occasion I think – I appreciate this is not Dr Barton, but I just want to get it straight what you are saying – she said, "Because" when you asked why and you did not really get an explanation.
A That is right.

Q I think it would follow from that, whatever may have been the rights and wrongs of what she said, you of course did not know what had happened so far as the patient's condition between the time you left and the time that the syringe driver had been started?

A A That is true. However, there was a time when I had discussed with Code A and with Code A about the use of the syringe drivers to the extent where Code A actually had a doctor come in from Countess Mountbatten House, which is a hospice near Southampton. Dr Bee Wee came in and actually gave us a talk on the use of the drivers and---

Q I do not mean to interrupt you, but I was coming on to that.
B A I am sorry.

Q It is not your fault. Let us deal with it now.
A Sorry. It is just that it seemed to follow on.

Q I am very happy to ask you questions about that. It was a topic I was going to come to. Let us deal with it now. You say you had spoken to Code A
C A Yes.

Q First of all, I am going to try to get from you – and I am not going to criticise you if you cannot remember – when about would this have been that this meeting took place?
A I would think in 1999, I believe. I cannot remember the exact year.

Q 1999 rather than 1998?
D A Maybe. I cannot say for certain, I am sorry. I was only there two years.

Q Can you help us with this? Would this be before you raised your complaint against Dr Barton and Sister Code A
A Yes.

Q We know that that was in the spring roughly of 2000. So it looks like 1999. Probably
E the latter part of the year.
A It may be. I do not know.

Q You had spoken to those two nurses about your concern about syringe drivers being ---
A About the use of them.

F Q --- started too early.
A Yes.

Q It is not that you were complaining that a syringe driver should not be used, your view was ---
A No. I had no problem with syringe drivers.

G Q You have made that clear. I am not suggesting you had. You thought in some cases a syringe driver was being started too early.
A Yes.

Q Maybe you were right, maybe you were wrong, but that was your view.
A Yes.

H

Q You have told us that on occasion – and I am not suggesting this happened a lot – you had said in a particular case to Dr Barton, "Does it need to be started so quickly?" or something like that. We have covered that already. How did it come about, as you saw it, that there was a meeting arranged with Dr Bee Wee? Could you help us with that?
A Because I think other people had complained to Sister Code A about the use of the syringe drivers and she felt that there was some concern and she contacted Dr Bee Wee, who came out to our unit and actually gave us a talk.

Q So it was Sister Code A who had arranged for a doctor to come to a meeting about this?
A Yes.

Q You think – and I am not criticising you – maybe somebody else or other people had spoken to Sister Code A
A Yes.

Q That is something you learned from what others had said to you.
A Yes. I cannot say for sure.

Q We have heard from other nurses. If you cannot say for sure, I am not going to bother to ask you, because you would be speculating. Sister Code A arranged a meeting which Dr Bee Wee attended.
A That is right.

Q You said she came from – just help us.
A She came from the Countess Mountbatten Centre, which is a hospice just outside of Southampton and she gave all of us, all the staff, a talk on the use of syringe drivers and the analgesic ladder.

Q So this meeting was at the instigation of Sister Code A
A Yes, I think so.

Q Dr Bee Wee spoke to you about this.
A Yes.

Q Was Dr Barton present at the meeting?
A No, I do not think so.

Q It is very difficult to recall.
A I do not think so.

Q Can you help us as to who was present? Sister Code A you.
A I have a feeling Anita Tubritt might have been there from nights. There was quite a lot of us. I think Code A I cannot remember everybody who was there. I know we had a lot of people. The room was quite full.

Q No doubt it was explained by Dr Bee Wee by way of clarification that there was a need to use syringe drivers in appropriate cases and were your concerns allayed, laid to rest, by what you heard from this expert in palliative care?
A Not really.

Q Even after the explanation had been given, for whatever reason, you still were not happy?
A No, some of us were not. I think Code A and I had talked about it and we felt that the information she gave us, everybody already knew, about using the analgesic ladder, but that was not always instigated.

Q That was presumably mentioned at the meeting?
A No, it was not. I do not think anybody brought it up.

Q Do you mean to say that you sat there at the meeting and did not raise your concerns?
A It is very hard to do that when you are actually sitting there, with all your colleagues and your ward sister and Dr Bee Wee, who was from another hospital, and actually say that.

Q Forgive me. Was that not the entire point of the meeting: to assist with your concerns, because you have told us you expressed concerns to Sister Code A she arranged the meeting. I am trying to find out from you why you did not say anything?
A Because I could not see the point. To be fair, I do not think, to actually turn round to a doctor from another unit and say, "Well, our syringe drivers are being used too soon", I could not see what input she would have on that. She was there to teach us the proper way to use them and that is what she did.

Q Forgive me for pressing you on this. Why on earth did you not raise it?
A Probably the same reason other people did not go to a hospital manager with it. I think everyone was a bit reticent.

Q On your account, you have not hesitated to speak out about this and indeed on your account there were other nurses who agreed with you.
A That is right. It is very, very difficult to speak out. It is not easy. It is really, really hard to do.

Q Do you mean that everybody sat there and nobody raised a single question?
A No, they did not.

Q I have to ask you. If that was the purpose of the meeting, brought about as a result of your concerns, why not say ---
A I do not know that it was necessarily my concerns. All I know is that the meeting was arranged for us to have this talk from this doctor.

Q In order to deal with the concerns that you had, and maybe others as well, about the syringe drivers being commenced too soon. That was its purpose, was it not?
A That was the purpose in our mind, but it might not have been the purpose in Code A Code A s mind. She may have thought it was just to clarify why we used them. We all knew why we used them, but it was when they should be instigated and that was the problem that some of us had.

Q Forgive me. You are not a person who hesitates to speak out, are you?
A But it is not always easy to do it.

Q Can you help as to what the problem was, as a nurse, a grade F nurse, sitting there, saying to Dr Bee Wee, "I'm a bit troubled about how we decide when to start the syringe drivers"? What was the difficulty about saying that?
A Because she had already told us when to start the syringe drivers. She went through the analgesic ladder with us. But her telling us when we should be using them and what was put into practice was a different issue. She was not working on our unit, so she had no input into our unit. Even our hospital manager was aware of the difficulties we had, because I spoke to her about it and all I was told was, they were aware, but nobody ever got anything done.

Q I think your answer is perhaps indicating that there was no difficulty about your saying to Dr Bee Wee, without getting excited about it, "I feel sometimes syringe drivers are started too early." Can you help us with that? An easy question and the whole point so far as you were concerned.
A Not really. She was from a different trust and she would have had no input into our unit. It was for our hospital trust to actually instigate those changes and those changes should have come from the top and the top knew what was happening.

Q I am going to ask you once more. What was the problem about just saying that to Dr Bee Wee, when she is right there at the meeting?
A Well, I thought I had made that quite clear in what I have just said to you. She had no input in our unit. She came from a different unit, she was not part of our hospital, she came from a hospice to explain to use the use of the syringe drivers. She explained the analgesic ladder, but we already knew the analgesic ladder. We needed somebody who could actually -- I am sorry, I am getting really upset.

(The witness left the room)

MR LANGDALE: Sir, it may be appropriate to have an adjournment.

THE CHAIRMAN: I think so, Mr Langdale. On the subject of that particular question, I think the witness has answered it to the best of her ability. Certainly I understand what she is saying and I understand what you are saying. I am not sure that we are ever going to get any further on that.

MR LANGDALE: Sir, I entirely agree and I was not going to ask any more. I was going to let her finish her answer. I can leave that particular topic very easily and move on to something else.

THE CHAIRMAN: Very well. What I suggest is that we do break for lunch now and that will give the witness an opportunity to compose herself.

MR JENKINS: Sir, before you do, can I just raise a matter of housekeeping, please? We are hoping to call Dr Althea Lord, whose name the Panel has heard a number of times. She is presently in New Zealand, in a not terribly heavily populated part of the country, and we are trying to set up the possibility of a video link on Thursday 16 July and Friday 17 July. Obviously there may be objections to us calling a witness over a video link, but because she is in a fairly remote part of the country, we need to set up the arrangements now. You will be aware of the time difference between here and New Zealand. If she were to do a slot between 8.00 p.m. and midnight her time, that would correlate to between 9.00 a.m. and 1.00 p.m. our

time. What we are hoping to set up is a link for both those dates, three weeks from today, Thursday 16 July starting at 9.00 a.m. for the Panel and again the following day, Friday 17 July, 9.00 a.m. to 1.00 p.m.

(The witness returned into the room)

THE WITNESS: I apologise for that.

THE CHAIRMAN: That is perfectly all right. What are going to do now, it is past one o'clock, which is the time we would normally break for lunch, we are going to take the luncheon break now and return at 2.05. The reason we are still sitting is because Mr Jenkins has raised a matter of housekeeping about the availability of a future witness and we are just working out the details for that. You are absolutely free now to go and get some lunch, leave the building if you wish and get some air, and if you could be back for 2.05, that would be great.

MR LANGDALE: In case it assists, perhaps the witness could be told I am not going to be asking any more questions about the Bee Wee meeting.

THE WITNESS: That is fine. I am happy to continue with it.

THE CHAIRMAN: What I have already said to Mr Langdale in your absence is that I at least, and I think the rest of the Panel, understood very clearly what you were saying and what your point was. We understood his too and the fact that you are not coming together is by no means a difficulty for us. We felt that there was not perhaps any value in him continuing and he agreed that he was going to not continue with it.

MR JENKINS: If I can just finish, I would invite the Panel to check their diaries for those two mornings: Thursday 16th and Friday 17th, if it is possible for the Panel to do that over the lunch adjournment.

THE CHAIRMAN: But those are both dates that we are due to sit. I am not aware certainly of any difficulties in the pipeline and I am getting clear "no"s from everybody else. Mr Kark, I take it that you are reasonable confident that the GMC case will have finished by that time?

MR KARK: The GMC case I would hope will have finished a while before that. It is possible that we would then be in the middle of Dr Barton's evidence, if she gives evidence. We will cross that bridge of course when we come to it. Can I just mention this?

We have been in some discussion about expert reports. We have not yet had an expert report; we do not know if an expert is being called. If it is proposed, however, to use Dr Lord as an expert to comment upon Dr Barton's method of dealing with patients with whom Dr Lord did not deal, then it seems to us that she would then – I do not know if this is intended; it may be that my learned friend can help.

MR LANGDALE: I am perfectly happy to do that. I do not envisage Dr Lord being asked about other patients. She will be asked about her views, her opinion and her expertise as a consultant and she will be asked only about the patients with whom she had dealings. I am not proposing to ask her to give an opinion about a patient with whom she had no dealings.

THE CHAIRMAN: Presumably she may be asked questions about the general customs and procedures of the ward at the time when she was there.

MR LANGDALE: Of course. We are going to be hearing, for example, as a GMC witness, from Dr Reid and Dr Tandy, who no doubt will be covering some of those areas. I know exactly what my learned friend's concerns are and I am not for a moment suggesting they are inappropriate concerns, but they will not arise.

THE CHAIRMAN: So it would appear that there is no particular difficulty. Thank you very much indeed, both of you. We will make it ten past two.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back everybody. Mr Langdale.

MR LANGDALE: I want to turn to one or two particulars matters and then I want to deal with things that you said about the harassment complaint that you made with regard to Sister Hamblin and Dr Barton. You said in your evidence that every patient, and I stress that, every patient, admitted to Dryad Ward had a syringe driver and diamorphine written up on admission. Do you really mean that, every patient?

A Every patient that I can remember that I dealt with.

Q Every patient that you remember that you dealt with?

A Had a syringe driver written up.

Q You dealt with Enid Spurgin, Patient I, she did not have a syringe driver written up on admission.

A Right.

Q I think certainly at least three of the patients that the Panel are considering did not have syringe driver written up for them on admission, so would you like to amend your answer to say that, "Sometimes patients on admission..."?

A No, I would say most of the time.

Q Most of the time?

A Yes.

Q You also indicated in your evidence, and this is a different matter in a different context in relation to Gill Hamblin, and you felt she did not want somebody like you – I do not mean this personally – somebody like you at your grade acting as her number 2. Is that right?

A Yes, it is.

Q You felt left in limbo?

A Yes, I did.

Q I put to your earlier on that one of the reasons for you being unhappy in your position is that you felt excluded. Do you now agree that in fact you did feel excluded?

A No, you said as a member of the team, if I remember rightly.

A Q Excluded, yes.
A No, not as a member of the team, not of the team in general, no.

Q You have spoken about an occasion when you had been speaking – without going into too much of the tangled history – with Code A and Dr Barton about the possibility of moving. That was moving to QAH, was it not?
A That is right.

B Q Code A at some point, you told us, said that you had upset Dr Barton?
A That is right.

Q You spoke to Dr Barton and said, "I believe I have upset you".
A That is right.

C Q And you told us your recollection was that she said, "No you have not, but you do not understand what we do here"?
A That is right.

Q Did you take that to mean that you had concerns about dealing with palliative care?
A I am sorry, say that again.

D Q When she said, "You do not understand what we do here", you understood, I think you told us, that you thought it was about regarding syringe drivers.
A That is what I took to be the meaning. That was my interpretation of it.

Q Might I ask you, why did you not say to her, "What do you mean", or were you satisfied in your own mind that that is what she must mean?
A I do not remember saying anything else to her after that actually.

E Q For clarification, you have spoken about somebody I think you described as the hospital manager?
A That is Barbara Robinson.

Q I just wanted to make sure we are talking about the same person, that when you say that you are referring to Barbara Robinson?
F A Yes, I am.

Q You say that you thought that increases of doses, an increase of a dose, they were increased by too large an amount?
A Yes.

Q Is that right?
G A Yes.

Q You told us also that you did not know what the guidelines were with regard to increases?
A That is right. Well no, apart from titrating them to top up doses, but that did not always happen, patients were not always given top up doses in between.

H

A Q What I am asking you is, and it is not your fault it is mine, is there any suggestion by you that you thought that the increase in a dose range, within a dose range, that is what I am asking about, in relation to subcutaneous analgesia – and let us keep it to diamorphine, I appreciate it often involves midazolam as well – that sometimes the increases were too large. Maybe I have misunderstood you?
A No, I think sometimes they were.

B Q Not in the cases we looked at when I looked at the cases you had dealt with, the three or four we looked at earlier on?
A I would have assumed that those – I cannot say for certain because I cannot remember most of those patients – I would have actually discussed that with one of my colleagues or with Dr Barton.

Q You told us you, yourself, would not increase a dose if you thought the increase was
C too great.
A No, that is right.

Q I have drawn your attention to those cases because when you say, "I was concerned about it", your concern was that somebody within a dose range was increasing it by too much. My point is that, if you did not know what the guidelines were for increases in dosage, how could you make a judgment about that?
D A Because we did not have the guidelines written down, but actually to either double or put up by a third it just seemed rather a lot and the change in a patient would be quite dramatic.

Q It seemed to you quite a lot?
A Yes.

E Q You would sometimes notice a change in the patient?
A Yes.

Q But not in the ones that you dealt with out of the twelve people we have been considering?
A I may have done, but I have not documented in there and, as I say, I cannot remember those patients.
F

Q In terms of guidelines, we have been dealing with a document, a handbook, which has had more than one name. Some people seem to call it the Wessex Protocol, or Wessex Protocols, and other people describe it as the Palliative Care Handbook. There was one of those available, was there not?
A Not to my knowledge, I have not seen that.

G Q I am going to ask you to look at a document. If you turn to file number 1, this is a file you have not looked at before but I want to ask you about this. Do you see this file has tabs?
A Yes.

Q Would you turn to tab 4. Obviously this is a photocopy, so it would not look exactly like the handbook itself, but does that ring a bell with you looking at it?
A I do not remember ever seeing this document.
H

Q That is all I need to ask you about that if it does not ring any bells with you. Can I hold up a document, Palliative Care, something looking like that, does that ring any bells with you (document shown)?
A I do not remember seeing it.

Q I will not press you on it if you do not remember it. In terms of the question of increasing a dose, it was something, in the cases that you dealt with, which you would make your own judgment about within the dose range prescribed?
A No, not always. I believe that sometimes I would have discussed it with Dr Barton when she came round or with my colleague.

Q You would not involve yourself with an increase, you have already told us this, which you did not think was appropriate?
A That is right.

Q So you would make your own judgment about it in consultation with others?
A Yes.

Q In your experience you were not aware of any other nurse who was increasing doses too much, were you, because you would have raised it with them?
A I did raise it with them, I raised it with Code A

Q No, with any nurse, forget Code A
A She was a nurse.

Q But you had a senior role amongst the nursing staff under Code A My question was, were you aware of any nurse on Dryad, under you in the order of things, who, in your view, increased a dose by too much?
A Not to my knowledge.

Q Because if there had been such a nurse, somebody junior to you, you would have spoken to them about it, would you not?
A Yes, I would have done.

Q I want to turn to the question of, I think you used the expression, to make sure we are talking about the same thing, "I put a grievance in". Is that right?
A Yes, I did.

Q I think that was in the early part of 2000?
A I cannot remember the exact year.

Q We will look at some documents which may help us with that?
A Yes, I did.

Q That was a complaint alleging that you had been harassed in some way by Sister Hamblin and Dr Barton?
A Yes.

MR LANGDALE: I think you wrote a letter to a Mrs Cameron. The date of the letter – I will show you a copy of we need to – is 24 March 2000, a letter where you were writing to

A complain about the way you were being harassed. I am going to ask you to look – I think we have copies of these documents. (To the Panel) It may be that some of these will have to come to the Panel. If, in some cases, I can deal with the points when the witness has looked at it and there is no dispute about the document, it may be it will not be necessary.

THE CHAIRMAN: You have photocopies to hand?

B MR LANGDALE: Of what I am proposing to put to the witness, yes, but I want to start with this letter, just one copy first to the witness. (Same handed)

MR KARK: May I see it as well?

MR LANGDALE: Of course. One copy to Mr Kark. (Same handed). (To the witness) If you would read it through, it is just one page. May I make some things clear, I do not want to
C get involved in all the details of the problems that there were between you and Code A so I am not concerned with that. If you want to say anything, do not let me stop you, but I am trying to avoid everybody getting involved in a past dispute. You were suggesting that syringe drivers, or the use of syringe drivers, had played a part in your complaint about being harassed, so I am directing my questions in particular to that issue.
A Yes.

D Q When you look at the letter, which is writing to complain about the way you are being harassed at work, would you agree that nothing at all is said in that letter about syringe drivers, their use or doses of medication?
A No, it is a very general, open letter.

Q There may be a good reason, so the first thing is, "No, there is not". I am going to ask for the Panel to have a copy of the letter now we have established that. I think it is right you
E should receive it. I am sorry to burden the Panel with more documents, but I think we need to deal with it. (To the witness). You can take in the date, 24 March, top right.
A Yes.

THE CHAIRMAN: The Panel are receiving that and marking it exhibit D1 (Document distributed and marked D1).

F MR LANGDALE: I am not going to read out every word. You are writing to complain about the way you are being harassed at work, almost to the point of leaving your job. You want to evoke the Trust's harassment policy:

> "I know that things have gone so far that the informal stage would be of no use...
>
> I work Dryad...I am constantly being harassed by my line manager Code A to
> G consider moving to QAH as an E grade.
>
> Recently I have received similar overtures from Dr Barton. It is obvious to anyone listening that I am not wanted on Dryad Ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the status quo to apply.

H

A I realise things are going to be uncomfortable, but I have reached the end of my tether and know that what is happening is not right."

That is what starts the process.
A Yes.

Q In due course the matter was looked into by somebody who had the title of the
B Investigating Officer?
A That is right.

Q That was Rosemary Salmond. Does that ring a bell?
A Yes.

Q You had a meeting with her some six days after your letter. You will not remember
C the date, but you had a meeting with her about it?
A Yes, I did.

MR LANGDALE: We have notes of the meeting and I will ask you about that meeting. Would you, first, have a copy of the notes. These are notes you signed, so it can be clear to the Panel and the Legal Assessor that the witness signed the notes of this meeting. Take a moment to read through it, if you would. If that is coming to the Panel now, there is no
D difficulty about it because the witness has signed it.

THE CHAIRMAN: We will receive that as D2. (Document distributed and labelled D2).

MR LANGDALE: Having had an opportunity of reading through that, would you agree that there is nothing there in relation to syringe drivers, their use or medication.
A There is not, nothing specifically mentioned, no.
E

Q The real thrust of your complaint was that you felt you were being encouraged in an unfair way to move on to QAH. Is that right?
A Yes, I still do feel that, yes.

Q I am not seeking to be the arbiter of the rights and wrongs of that, but that is what you felt?
F A Yes, I did.

Q You mentioned in the course of the questions I asked you earlier on, you said something that Dr Barton had said in relation to this investigation into the complaint about her saying that it was easier really to agree with you rather than have a contentious dispute; not my words, not yours?
A Not your words, that is not what is in the letter.
G

Q You were referring to the notes you had seen in the course of the complaint of a meeting between Dr Barton and the Investigating Officer. That is what you were talking about, was it not?
A That is right.

MR LANGDALE: I am going to ask you to have a look at this. I do not think there is any
H dispute or any problem about it being admitted to the Panel because it is a document

A Dr Barton signed, compiled by the Investigating Officer, the witness has referred to it, we know what we are talking about it, so it seems to me that it is sensible that the Panel have it now.

THE CHAIRMAN: We will admit that as exhibit D3.

MR LANGDALE: If you would read through that. When you get it, if I can say to the Panel,
B you will see that in handwriting what says Shirley Hallman has been amended to Hallmann, that is my handwriting, it is not on the original.

(Document was marked D3 and circulated)

A (After a pause for reading) Yes, I have read it.

C Q I will just wait for the Panel to finish. (After a pause) I am not proposing to ask you about the detail of that, because that is what Dr Barton was saying to the investigating officer. I am not going to get locked in to what she may have found you to be like at certain times, and so on and so forth. That is not the issue are really concerned with, but the passage you were talking about – that is why I want us all to see it is the passage in what is the third paragraph down.

D "In describing Shirley Hallmann's manner Dr Barton felt…"

et cetera, et cetera.

"It was often easier not to disagree…."

and so on. That is the passage you were referring to. Is that right?
E A Yes, it is.

Q Then lastly, if I may, I may be able to take this through without us all having to look at more pages. If you deal with my questions and answer them, if your answer involves having to look at the document in detail, please say so.
A Right.

F Q As you know, because you would have received a copy of it, you got a report of the investigation into the allegations of harassment by Staff Nurse Shirley Hallmann relating to Gill Hamblin, clinical manager, and Dr Jane Barton, clinical assistant?
A Yes, I did.

Q That is how the report was headed. The report reviewed what the purpose of the investigation was, the documentation which had been used in compiling the report, and set
G out the issues which had led you to make the allegation or the complaint - right?
A Yes.

Q In the report, it had spoken about the changing role of Dryad ward and the change had produced a more demanding client group and increased expectations of relatives and carers which had increased the service pressures of the ward. Is that something that you felt?
A Not really, no.
H

A Q All right. If it does not come from you, I am not concerned about it. If it is in a section of the report ---
A Only because at that time we were not full up. The beds were not all full so actually we adjust our workload.

Q If it is not your view, then I will not ask you about it. It set out what the perspective was from Gill Hamblin's point of view, and the perspective of Dr Barton and so on, and gave
B some background information about what other people have said, which I need not trouble you with. Then the investigator, at the end of the report, made certain observations and came to a conclusion?
A That is right.

Q Would you agree that nothing was said in that report about the issue of syringe drivers or medication?
C A No. They were not mentioned.

Q You will know that because I expect you read it pretty carefully. It indicated in terms of the conclusion, which is pretty short, that "Misinterpretation, fuelled by poor communication, differences in perceptions, professional rivalry and unsubstantiated expectations seems to be the theme of the investigation rather than a calculated and malicious attempt to drive Shirley Hallmann from the ward. In fact, both defendants" – and that in
D these circumstances means Gill Hamblin and Dr Barton – "appear to have played quite supportive roles when asked for advice by Shirley Hallmann in the past." That was the conclusion reached?
A Yes it was.

Q As I say, in the circumstances I do not think it is necessary for us to have the entire part of the report. If Mr Kark wants to put it in as a document, I will not object. I am trying
E to cover what may be the relevant parts. (To the witness) That may not have made you particularly happy, but that is what the investigation produced.
A No. It did, because they were going to actually then have liaison between myself and Sister Hamblin to sort out the issues, but I decided to leave.

Q I think perhaps we can summarise it in this way. Whatever efforts were made by you, Gill Hamblin or anybody else – but really it is between the two of you – you found that
F working with her during the rest of the year was something you found not appropriate, and you decided you wanted to leave?
A That is right.

Q Again, whatever the clashes were.
A Uh-hum.

G Q Then there is one final matter I need to ask you about, simply for clarification. I asked you about your having said what you said about the case of Mr Wilson, Patient H – do you remember – when I asked you about what you had said in the statement to the police about, you had no complaints about his care or the doses of medication that he received?
A Right.

H

A Q Right? I just want to try to clarify with you, if you can. Do you remember what notes – because you mention in the statement looking at notes. Do you remember what notes you had seen with regard to that patient? Had you seen the whole ---
A No. When the police came they showed me odd pages and odd portions of this. I never saw ---

B Q I just want to make it clear, using your statement, what it appears you saw when you said what you said.
A Right.

C Q Because if you did not see the whole range of notes, then you have to bear that in mind when we look at your answers. I think in relation to Mr Wilson you looked at prescriptions relating to 14 October and an "as required" prescription, with regard to paracetamol, which was never in fact given, and hyoscine. You also saw records of the 15 October, 16 October and the 17 October, showing the history of the drugs. Also the 18th. Shortly after dealing with those you said, "I would state in my experience none of the dosages of the drugs in the case of Mr. Wilson were excessive". All right? That is a passage I have already put to you?
A Yes. If I said that, then I said it.

D Q But we just to have establish what it was you had a chance of looking at. All right?
A Right.

Q Then you saw Dr Barton's entry with regard to 14 October and it is again, I think, in that context you said, "I have no issues with Mr Wilson's care, having read some of the notes." Can we take it that that is what you were referring to?
A It would seem so. I am sorry. It is a long time ago the police interviewed me.

E Q It is not your fault. You may have seen something else and the police did not put it in the statement?
A Yes.

Q But that is all we can go on to try and identify it?
A Yes. As I say, they showed me portions of notes and not even whole pages. I just saw pieces that they would produce, and they would be flicking back and forth, just showing me bits.

F Q We have indicated what those are ---
A Yes.

Q --- in the statement?
A Yes.

G Q And you also saw, I think, the ward controlled drugs records book?
A Yes. They did bring that.

Q They had that? Thank you. So you could check in relation ---
A Yes.

H

Q --- to things where you had withdrawn particular medication, and I think with that patient… You made two statements about him. You had seen the entry on 14 October which you referred to in another statement. Your entry, obviously, of 16 October we have covered. It is probably covered in the rest. A plan of the 14 October, the nursing plan – various pages of that. And the other drugs that were administered, which we have not been troubling with – frusemide and trazadone, and things like that – but also Oramorph and so on. The 14 October – probably reduplicating what you said in the later statement and on 16 October – you had seen those records. So far as you can tell at this distance in time, that appears to be what you looked at?
A Yes. If I had signed it with the police then, yes, that is what they showed me and what I read and what I said.

MR LANGDALE: That is all I need to ask you, thank you.

THE CHAIRMAN: Mr Kark.

Re-examined by MR KARK

Q Just in relation to that last topic first of all, in order to know whether dosages of drugs are excessive or not in global terms what would you have needed to have seen. It has been pointed out that you saw certain documentation?
A Right.

Q What would you have liked to have seen?
A As I say, I cannot tell you now what I saw but obviously, looked at the CD book (the controlled drug book), prescription chart and the notes as to how the patient was at the time.

Q And leading up to that point or not?
A I am sorry?

Q Leading up to that?
A Leading up to the change of the medication?

Q Yes. Exactly.
A Yes, the increase into it. Yes.

Q I want to go back to the grievance procedure. Do you have those documents, D1, D2 and D3 available to you still?
A Sorry, I do not know what numbers they are.

Q I am sorry. D1 is the letter dated 24 March?
A Yes, I have that here.

Q Then D2 was the note of the meeting held on 30 March?
A Yes.

Q Then D3 is a note of the meeting on 7 April?
A Yes, I have that.

Q The tenor of these was that you felt you were being encouraged, really, to move on?

A A Yes, I did.

Q Why do you think you were being encouraged – if you were right about that – why do you think you were being encouraged to move on?
A I think because I questioned.

Q Questioned what?
B A I questioned the use of the syringe drivers, the use of the medication and the whole way that we dealt with patients when they came in in control of their pain, etcetera.

Q Going back to the letter of 24 March, you end with these words:

"I realize that things are going to be uncomfortable but I have reached the end of my tether and know that what is happening is not right."

C

A That is right.

Q What were you referring to there?
A I knew that once I put the complaint in I would have to stay there and that I would have to work every day and obviously ---?

D Q Why?
A --- see these people. I am sorry?

Q Sorry. Once you put a complaint in you would have to continue to work?
A I would have to continue obviously to go into my job every day.

Q Right, yes.
E A And that could make things uncomfortable because it is never pleasant when a complaint has been made.

Q No. I understand that.
A I had reached the end of my tether with it. I had had enough. I had had enough of everything there, and I did not agree with the way that patients were treated. I did not agree with the use of the syringe drivers at times.

F

Q What I was trying to explore with you is when you used the words "and know that what is happening is not right" – what were you actually referring to?
A The way I was being treated and the treatment of the patients. And I think what was so very difficult, what the gentleman asked me before lunch, is that it is so difficult in the position that I was in to come into this sort of area and to actually be presented with a mode of working that was already in place. I had come in with a new set of eyes and looking at
G things maybe different. Because I had come from a new area and was seeing how these things were working, and they just did not seem right.

Q Mr Langdale put this to you, and you agree; that prior to Dryad you had not really had a lot of palliative care experience and it was all fairly new to you. You felt that was right?
A Yes, it was.

H

A Q You accepted that?
A But I had obviously dealt with patients who were dying in acute wards.

Q I understand that. So when you came to Dryad and were met with this way of working, and the increases, was that something you had come across before?
A No.

B Q Was it something you were comfortable with?
A No.

Q I think it is being suggested that the issue that you ventilated over syringe drivers was irrelevant to the grievance procedure. In your mind, was it irrelevant to the grievance procedure?
A No, it was not. I think that was part of the underlying problem. There were issues C between Gill Hamblin and myself. I cannot say there were not because there were, but they were personality issues and I cannot deny that.

Q All right.
A And I would not attempt to.

Q And those are quite separate?
D A Yes. This is a completely different issue and, as I say, we had this visit from Dr Bee Wee who, even in hindsight, I do not feel that I could have actually said to that doctor that this is what is happening, because that was not a doctor who could actually initiate any changes. They were not working for us.

Q I was going to come back to that.
A Sorry.
E

Q No, not at all. I was going to come back to that and I am afraid I was going to come back to the point at which you got upset.
A Sorry about that.

Q I am hoping not to upset you again.
A No, that is all right. I am all right now.
F

Q People get upset for different reasons, but I wanted to try and explore with you why it was upsetting for you. What was it about that scenario, that meeting?
A It was the whole scenario… I do not want to get upset again because it makes me think about it.

Q I am sorry. That is why ---
G A That is quite all right. It has been so frustrating.

Q What was frustrating?
A It was frustrating. I realised that patients change, and can change overnight. I know that. I know patients can rapidly go downhill in an hour and I am aware of that. I have been a nurse for a long, long time, but to actually come back on a shift to find a patient not responding and being on a syringe driver when the day before there was no reason, and to H have my manager just dismiss it as "because", because surely anybody, even a student nurse,

A has the right to question and certainly as an F grade I felt I did. Therefore I thought, I needed to know why these patients were being put on syringe drivers.

Q Right.
A It got to the point where I used to go home. I know what you said about my mother's diaries is irrelevant but the police actually took her (sic), because it was the only way I could prove that way back I had had concerns. Obviously I did not tell her details about patients
B but I can actually tell her details about the use of the syringe drivers, and that is when she wrote it down. And the police actually came and took her diary and copied it.

Q All right. In D3, which is the note of the last meeting, there is this line in the third paragraph. It talks about you sulking, and I am not going to go into that, but if you look three lines down, you see this. Are you with me?
A Yes.
C
Q
"In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working."

A That is right.

D Q And that accords with your evidence?
A Yes, and that is what happened.

Q You told the Panel that there were occasions when you objected to the use of syringe drivers?
A Yes, I did.

E Q And as a consequence of that they did not happen at that time?
A No. That is right.

Q And Mr Langdale has explored that with you, and he has explored the possibility with you that something might have happened to the patient to cause the syringe driver to start?
A That is right.

F Q You cannot say anything about that?
A No. That is right.

Q And that might be right?
A And that is fair comment.

Q But what was the rapidity, as it were, of the patient going on the syringe driver after
G your objection? How quickly did you find they were going on syringe drivers when the ---
A The following day was the earliest one I can remember.

(The Panel assistant approached the witness table)

Q I am sorry. This is not the right time to do that. Sorry. I will ask you that question again. Sorry – can you give us that answer again, if you please?
H A You said what was the quickest.

A

Q No, no. I know what my question was. What was your answer?
A The following day.

MR LANGDALE: "… was the earliest one I can remember."

MR KARK: Thank you very much. Thank you. You were asked about other nurses giving
B too much and you told Mr Langdale that you were not aware of other nurses giving too much, and I think Sister Hamblin ---
A Yes.

Q --- was being excluded from that reply. Can I just ask you: at the time when Sister Hamblin was there, not when she was on leave but when she was there, was it any part of your role to review the administration of drugs by other nurses?
C A When Sister Hamblin was there?

Q Yes.
A No.

Q You have told Mr Langdale – and again, this is my précis of what you said – when you were asked about increases, you said, "To double up seemed quite a lot and the change in
D the patient could be quite dramatic." Can you just give us an example of what you mean?
A Because by giving such a large increase to a patient, because it was not just the diamorphine that was increased, it was the midazolam as well, and it made the patient more drowsy and unresponsive.

Q You were asked about Mr Packman and the increase. It is file J, page 174. You were being asked about the increase. I think this is the increase up to 90 mg.
E A Yes, it is.

Q You said that you would not have administered that unless the patient needed it.
A That is right.

Q Is that something about which you would normally make a note, or not?
A I should have done. If I have not, then it was an omission on my part. I should have
F made a note.

Q Page 65 is where I think we have the relevant notes in relation to 2 September. We have the notes for 1 September, which are not yours, and then we have the note for 2 September relating to that increase.
A This is Code A s signature, I believe.

G Q Against the – ?
A The increase of the diamorphine.

Q Can you just help us about that? Why is Code A making a note about an increase that you apparently have authorised?
A I have signed the medication chart, she has signed the notes, because two trained nurses have to go and give it. So usually whoever gives it signs the treatment chart, but the
H notes, if we have both done it, either one of us could write that.

Q The last note before that occurring was:

"Incontinent of black tarry faeces on …"

I cannot read the next word.
A I think that is "settling".

Q Then:

"Peaceful night. All care given. Syringe driver satisfactory."

Is there any indication there why the diamorphine needed to be increased?
A No, there is not.

Q We can take it that perhaps you cannot now remember why that was.
A No, I cannot.

Q Patient Enid Spurgin. This is file I. There is just one matter to ask you about. I think if you turn to page 174, I think it was you who started her on that dose of 80 mg.
A No. That is Code A 's signature.

Q I beg your pardon. Did you have anything to do with that initiation of the dose?
A No, I did not.

Q You can put that file away. Could you go to Mr Cunningham's file, which is file G. It is the entry at page 861. You were asked about this by Mr Langdale. It was you speaking to Mr Farthing on 22 September.
A Yes.

Q You were explaining what was happening with Mr Cunningham.
A Yes.

Q The words that you begin with are:

"Explained that a syringe driver containing diamorphine and midazolam was commenced yesterday evening for pain relief …"

You were there the evening before, I think, were you?
A I am not sure, because I gave the Oromorph at ten to three. If I was on an early, I would have been on until 4.15 that day, or I could have been on a late. So I am actually not sure. I am sorry.

Q The syringe driver, I think we can see, did not start in fact until 11.00 p.m.
A That is right.

Q Would you have been on duty then?
A No. That would have been the night staff would have started that.

A Q So the basis of your information that you were handing over to Mr Farthing was based on what?
A It would have been from what I had been handed over by the night staff at handover in the morning at 7.30.

Q Not your own information, as it were, but that which you had received from others.
A Well, about when the syringe driver was started, no. Yes. No. That must have been
B from handover, the way I have written it, yes.

Q Would you be reviewing the decision to start the patient on the syringe driver, or simply explaining it?
A No. I would have just explained it.

Q Finally ---
C A Sorry. It reads differently when you read it a second time, does it not?

Q Is there anything else you want to say about it?
A I was thinking that I actually, the way I put it in the first place is that when I spoke to him, that was my information, but actually I think that had been told to me by the night staff.

Q That is why I asked you to clarify it.
D A The night staff would hand over exactly what had happened, so I would not have any hesitation in taking their word for what had happened.

Q You can put that file away. Finally, this. You were asked by Mr Langdale, after you had left Dryad, you had gone on to something called the Rembrandt Unit?
A No. I went to Jubilee House from Dryad ward, which is palliative care.

E Q That was where you had the GP doctor coming in during the day.
A Yes.

Q When he first asked you about this, Mr Langdale put to you that it was very different to Dryad ward and you agreed with him, but then you seemed to disagree when you were talking about the doctors and I just want to know what your evidence is about the similarities and differences.
F A The set-up with the doctors was more or less the same. We had a GP practice which would cover us from Monday to Friday and come in at lunchtime. Sometimes obviously they would be pressed for time as well and what they would do is, they would look at what needed to be done. If it was something really simple that could wait until the next day and they were busy, we could put it off to the next day, but if it was something that had to be done that day, they would do it regardless of how long it took. Then the consultant would come in weekly on a Thursday, which we did not have, a consultant weekly, at Dryad ward. That was the
G difference. At Jubilee we had a consultant weekly.

Q How often did you see a consultant at Dryad?
A I believe – I cannot remember if it was once a fortnight. I am actually not sure. It was not weekly.

MR KARK: Thank you very much. That is all I ask.
H

THE CHAIRMAN: Thank you, Mr Kark. We have reached the point now when two things would be happening. One, you would be entitled to your break, because another hour has passed, and two, the Panel would be asking you their questions. What we have been doing prior to going into Panel questioning mode is taking a few minutes for the Panel on their own to consider what, if any, questions they wanted to ask. So what we will do now is take an open-ended break and I will say we will break now, but the Panel will remain and consider, may very well then take its own break and we will call everybody back as soon as we are able to do so. I do not think it is going to be a long time, but it may be longer than the normal 15-minute or so break. So we will break now, please, ladies and gentlemen, and would all strangers please withdraw?

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. The Panel has used the time to focus our thoughts on the areas where we still require some assistance. I am going to turn now to Mr William Payne, who is a lay member of the Panel.

Questioned by THE PANEL

MR PAYNE: Good afternoon to you. It is just one question and it is with regard to this letter of grievance that you put forward. Do you have it?

A Yes, I do.

Q It may be that you feel as though you have answered this, but I just want to clarify it. It is the last paragraph:

> "I realise that things are going to be uncomfortable, but I have reached the end of my tether and know that what is happening is not right."

Is that solely relating to the relationship between yourselves or does that also mean the things that are happening on the ward with regard to the patients?

A Yes, that as well. It meant both.

Q It meant both?

A It meant both.

Q Was it just one specific aspect of what was happening to the patients, or was it a number of different aspects?

A It was the use of the diamorphine that was my big issue.

Q Solely, not anything else?

A No. On the whole, the patients on Dryad ward were really, really well taken care of.

Q It was just the ---

A Just the use of the syringe drivers that I had an issue with.

MR PAYNE: That answers my question. Thank you very much.

THE CHAIRMAN: I am also a lay member. We have heard from you that you did have this concern, particularly about the times when you felt that the syringe driver with the diamorphine and midazolam mixes were being initiated earlier than you would have expected.

A That is right.

Q We have understood very clearly that you have nothing against syringe drivers per se and indeed you accept that there are occasions when syringe drivers loaded with those sorts of medications may be very appropriate for a patient who has reached that stage in the terminal elements of their life when it is needed by them.

A That is right.

Q Your concern, as we understand it, is that there were times when patients appeared to be being put on to that regime when it was not justified, when it was too early.

A That is right.

Q What I would like to do is to try to understand whether, thinking back on it now, there were any particular triggers that you noticed, any things that would happen that would tend to make it likely that this problem that you saw, the early start on syringe drivers, occurred. You were answering questions earlier about patient G. That was Mr Cunningham, you recall, and there was a little initial confusion in your reading of the note when you gave your evidence first. I think the reason for that was actually made very clear, because I think you said words to the effect that you assumed that you had witnessed the poor behaviour of Mr Cunningham, because you would have expected, if it had happened the previous night, for the night staff to write it up.

A Yes, I would have done.

Q When you looked at it the second time, you realised of course that it had happened the previous night, but for reasons that we do not know, the night staff did not do what you would have expected and write up what was clearly some pretty horrendous conduct on the ward. All they did was record the words:

> "Remained agitated until approximately 2030. Syringe driver commenced as requested …"

And then the dosages, followed by the simple statement "Peaceful", which one might anticipate. I have two questions about that entry that you may or may not be able to help me with. The first is that there is a signature that follows it. Are you able to decipher that? Above your entry for 22 September, in the middle of the page, 21.9.98, "Remained agitated until approximately 2030." Would you recognise the signature there?

A No. I think it must be one of the night staff, but I am not sure who. I am sorry, I do not recognise that.

Q It would have been helpful if you had known, but the chances of you knowing perhaps would not be great. Are you able to comment on the phrase "as requested"? "Syringe driver commenced as requested." Would that mean anything to you from a look at the notes?

A I am sorry, no. I have no idea. I really would not have any idea, no.

Q If we are not able to ascertain who the writer was, that probably will remain a mystery for all time. But clearly this was a case in which there had been some, from a nursing point of view, shall we say some challenging behaviour on the ward.
A Yes.

Q It had been followed in short order it seems with commencement of syringe driver without what we have been told was the customary consultation with family?
A Yes.

Q There was another occasion we have looked at, I am not going to take you to it specifically because it was not a patient that you were involved in, but there was a patient who had had a tussle, a fight, on a ward with a nurse. Within one hour of that happening, that particular patient was also on a syringe driver with the same sort of mix of diamorphine and midazolam. Again, that was prior to any discussion with family. What I am wondering is whether, when you were first having concerns about people in short order going onto syringe driver at a time when you felt there was nothing you had seen that would have justified it, whether you noticed any particular triggers in common; for example, did it seem to be where patients had been challenging in their behaviour or in their needs, crying out in pain all night?
A It seemed to be for pain. May I refer to another case or am I not allowed?

Q By all means?
A There was a lady that came into us from, I believe she came from Haslar, who was actually in one of our single rooms. I cannot tell you her name it was so long ago. She had had a fractured hip and she was put on to Oramorph and was becoming very, very sleepy. Dr Reid, the consultant, saw her and he had this lady up and walking and he took her off of it all. She ended up getting better and actually being discharged. That was a case where this lady was in bed and drowsy and it was reviewed and she actually, as I say, progressed and became better. It was that sort of incident. I am not saying Oramorph does not have its place, but having seen what I had seen, I could envisage this lady having gone on and maybe not going home.

Q Of course the areas that we are looking into are involving patients who went on to the syringe driver and did not go home. Whilst it was heartening to hear that there were patients who were coming onto the ward and making great recoveries, what I am interested to know is whether you discerned any particular pattern, any particular triggers that would put patients on to this end of life regime?
A I think it was the pain triggers. It seemed to be mostly pain and, instead of using the analgesic ladder properly, steps were missed.

Q If I understand you correctly, you are saying that, principally, it was if somebody was in pain your concern was that they would, because of the pain, be put too fast on to the syringe drivers?
A Yes. I cannot truthfully ever say that I saw anybody put on a syringe driver because of behaviour.

Q That is very encouraging to hear, thank you. It follows also, does it, that it was not purely random. You say that you were not expecting people to go on and yet suddenly you would come back the day after and find that somebody was on the driver, that was not random then?
A No.

Q You are saying it would always have been because of pain?
A It seemed to have been but, from my point of view, that is why they went on. But, on the days, as I say, when I would come back and ask why someone had been put on a driver, I never ever got a satisfactory answer ever, so I cannot speak on why other people rationalised what they did – sorry, is that what ---

Q I think you did, but I want to focus on the pain issue. If I understand you correctly, you are telling me that on every occasion when you were surprised to find somebody had been put on the syringe driver, in your view earlier, that patient had been exhibiting pain?
A No, I never got an answer for that. The ones that I know that I was there or present, or that I was not surprised at, I knew had pain was fine. But the ones that I was surprised at, I had never been handed over that they had excessive pain, I was never given a reason why ---

Q I had misunderstood you. I thought you were saying that whenever anyone ended up on the syringe driver, it had always been because they were in pain?
A No.

Q I understand that there will have been many occasions when you saw people ending up on syringe driver and you were not surprised, and you are telling us, if I understand you correctly, that the common feature in those cases where you were not surprised is because the patient had been in pain?
A Yes.

Q I am asking you specifically about the occasions when you were surprised. Was there anything that you saw?
A No, because, as I say, I would go off duty one day and patients would be on analgesia – not morphine, but just analgesia, ordinary analgesia – and the next day they would be on a syringe driver and that is when I would be surprised because I did not see the rationale for it and I was never given any.

Q On each of the occasions when you were surprised, you were surprised because, on the papers and on your own knowledge and experience of that patient, there was no apparent reason for them to be put on to it?
A That is right.

Q When you did ask, you did not get answers so you still do not know?
A No.

THE CHAIRMAN: Thank you, that is most helpful. Mr Langdale, do you have anything arising out of the questions from the Panel?

<u>Further cross-examined by MR LANGDALE</u>

MR LANGDALE: I do in relation to two matters. On that very last point, when you were dealing with some questions asked by the Chairman, you said, in those cases when you would come back the following day and had been surprised to find that the patient was on a syringe driver, they had been on analgesia the day before.
A Yes.

A Q But not a syringe driver?
A No.

MR LANGDALE: So in those cases ---

MR KARK: Sorry, I thought the answer was not on opiates.

B MR LANGDALE: No, that was not what she said and that is what I am asking. You said "on analgesia". Does it follow that in those cases the patients might well have been on Oramorph before the syringe driver was put up?
A No.

Q Not?
A No.

C

Q Are you saying that in every instance?
A No, I am not saying in every instance.

Q Maybe in some instances, maybe not?
A Yes.

D Q But they were on an analgesia of some kind?
A Yes.

Q Back to your letter of complaint which you were asked about?
A Yes.

Q You said in answer to a member of the Panel, Mr Payne, that the last paragraph, and
E indeed the last words of the paragraph, meant not just the problem with being harassed at work, but also the use of syringe drivers?
A That is right.

Q To anybody reading that letter and, in particular Mrs Cameron no doubt, that would not be clear, would it, in any way at all?
A No, this was a very general letter that Betty Woodland, my Union representative,
F helped me to write because I went to her with my concerns and she advised me to make a grievance, which I did, and she sat down with me and helped me to compose this letter.

Q Sorry, can we repeat the names to make sure ---
A Betty Woodland, she is my RCN rep. She sat down with me and helped me to compose this letter.

G Q She did not tell you to leave out syringe drivers, did she?
A This was a very informal letter to put the grievance in.

Q Forgive me, what you say in the letter – look at it again – just over halfway down, you do give the reasons to Mrs Cameron, do you not?
A Yes.

H Q

A "I am constantly being harassed by my line manager Code A to consider moving to QAH as an E grade."

So you are making clear your complaint about her?
A Yes.

Q
B "Recently I have received similar overtures from Dr Barton."

So it is the same complaint about Dr Barton, is it not?
A Yes.

Q
C "It is obvious to anyone listening that I am not wanted on Dryad Ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the status quo to apply."

What I am asking you to clarify is, why not put in one extra sentence, "I am also being harassed...", or whatever the right word was, "...because I do not agree with what is happening with syringe drivers", if that was really part of your complaint?
A It was and two people knew about what was going one. One was Barbara Robinson,
D the hospital manager, and when I went down and saw Betty Woodland about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them.

Q I am sorry, it is your letter?
E A Yes, I know, but I still had my RCN representative to help me.

Q If you let me finish. It is your letter and, of course you listen to advice, but it would just have been one sentence, would it not, "I am also concerned about the use of syringe drivers"?
A It would have been, but I felt that I had been to my hospital manager who knew what the issues were, my RCN rep knew what the issues were. Nothing had been resolved or done.
F I was unhappy working under those conditions and at the time the only thing I could see was to leave.

Q So, "I know what is happening" is not right?
A The way I was being treated and what was happening on the ward.

Q Somehow Mrs Cameron is meant to read that in, is she?
G A No, that would have been what I would have explained later, but it never came up. I did not bring it up later.

Q You got your chance, of course, to say what it was that concerned you when you met with Rosemary Salmond?
A Yes, I did.

H

A Q This is the other document you looked at, six or so days after your letter. You were trying to get across to Rosemary Salmond what the nature of your complaint and concerns were?
A I was, but the thing is, the reason that... It was very, very hard for me, as a nurse, to actually sit and at the time it was very, very difficult to actually criticise the doctor's practice when... I mean somebody had already mentioned here today that I had not been in palliative care before and sometimes I used to go home and I used to think to myself, "Is it me, am I
B wrong, am I challenging the doctor, am I going to look silly when I challenge a doctor", because they are going to look at me and say, "You are not a doctor, you are only a nurse". In my heart of hearts, as an experienced nurse, I still knew that what was going on was not right. My issue was, in the end, that I did feel that Code A did not want me there anymore, I did feel that Dr Barton would have been happy if I left and, consequently, I did leave.

C Q You did not have any trouble making a complaint about the doctor?
A No, I did not.

Q You did not have any trouble saying what you felt about Dr Barton to Rosemary Salmond.
A No, I did not, but I had already raised the issue of the syringe drivers with my hospital manager.

D Q We appreciate that, I think we have the point. What I am asking you about is, why not say it in the meeting you had with Rosemary Salmond to demonstrate that your concerns were justified, that you had a legitimate ground for complaint?
A I just did not.

Q The reason you did not, I suggest, is because what you were really concerned about is
E what was in the notice of meeting, not the syringe drivers?
A You are actually wrong because, to be fair, this was so bad I was actually willing to go down to an E-grade from an F-grade and take a cut in money because I could not live with it any more.

MR LANGDALE: That is all I ask, thank you.

F THE CHAIRMAN: Mr Kark?

Further re-examined by MR KARK

MR KARK: I want to come back to the Chairman's questions very briefly. There were occasions when you were not surprised somebody was put on a syringe driver?
A That is right.

G Q In those cases the trigger was always pain?
A Yes.

Q There were occasions when you came back and found that somebody was on a syringe driver and you found it surprising?
A Yes.

H

A Q Are you saying that in some of those cases, the patient had been on opiate analgesia?
A No, some of them had not.

Q And some had not?
A That is right, yes.

MR KARK: That is all I ask.

B

THE CHAIRMAN: I am pleased to be able to tell you that after a whole day of giving evidence you have come to the end of that testimony. It is always stressful and difficult for witnesses coming before us at the best of times. You have had to come before us and endure a whole day of questioning from a variety of different people. I want you to understand we really do know just how very difficult that is and that we really do appreciate very greatly every witness who is willing to come and assist us in our enquiries. It is only by hearing
C from witnesses such as you that we are able to build up a clear and accurate picture. For your assistance in that regard, we are most grateful and you have our gratitude and thanks. You are now free to leave.

(The witness withdrew)

MR KARK: If the Panel can bear it, we have some evidence to read. I do not want to leave
D it too long and get too far behind. I wonder if it would be convenient now to go back in our list and to begin some of the reading and see where we get to. The statements we have to read are those of Jeanette Florio, Sylvia Griffin, Sharon Ring and Ingrid Lloyd. We propose to start that process now and perhaps you can give an indication when you have had enough.

THE CHAIRMAN: I would tell you that the Panel did not take a break when you were absent, it was a full discussion. I am not going to propose we break now, but to ask you to
E bear in mind that they will all be fairly tired at this stage.

MR KARK: Could we deal with two?

THE CHAIRMAN: The important point is that we should still be fresh and receptive when we hear this evidence.

F MR KARK: Particularly when hearing statements read because it is harder to concentrate.

THE CHAIRMAN: I think if we do two, that should be it.

MR KARK: I will ask Mr Fitzgerald to deal with those two.

MR FITZGERALD: These are statements that are made by witnesses who are unavailable
G now to give evidence. They are read on the basis that the defence accepts that, because they are unavailable they could be read, but it is not agreed evidence as such.

The first witness to be read is Jeanette Florio, a nurse. She made a statement dated 8 February 2006. This statement deals, in part, with Geoffrey Packman, our Patient J. It may be that it is sensible to have the files at the ready to deal with her entries in relation to that. The matter she deals with is of a general nature. She says:

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STATEMENT OF JEANETTE ELIZABETH FLORIO, Read

"I am a Registered General Nurse. I am current a D Grade Staff Nurse.

I qualified as a Registered General Nurse in August 1992. I trained at the School of Nursing, Queen Alexandra Hospital, Portsmouth.

From 1992 until November 1996 I worked on the new born unit at St Mary's Hospital, Portsmouth as a D Grade Staff Nurse.

From November 1996 until December 1999 I was employed as a D Grade Staff Nurse working night shift on Daedalus Ward at the Gosport War Memorial Hospital. On occasions I was required to work on other wards including Dryad.

My responsibilities as a D Grade Staff Nurse included overall charge of the ward which consisted of 24 beds. The ward was a mixture of continuing care for elderly patients and slow stream stroke rehabilitation for elderly patients.

I supervised two health care support workers. My responsibilities included administering drugs prescribed to patients.

I also looked after the patient's general well being during my shift.

Night shift commenced at 2015 and finished at approximately 0745.

My experience in the use of Syringe Drivers began whilst working on the newborn unit, neonatal, at St Marys Hospital.

At that stage between 1992 and 1996 I received training from senior colleagues in the use of Syringe Drivers. The Syringe Drivers were used for delivering intravenous drugs to newborn babies.

I received training for competence in the administration of intravenous drugs and additives on the 28/1/1993 (28/01/1993)."

I should point out, she later said something slightly inconsistent with that but it is what features in the statement.

"When I commenced working at Daedalus ward in November 1996 I was given supervision from senior colleagues in the administration of drugs delivered subcutaneously via a Syringe Driver to patients requiring palliative or terminal care.

From December 1998 until May 2001 I worked as an E Grade Staff Nurse on Dryad ward which was on day shifts. I can confirm that I was on duty as a D Grade Staff Nurse for night duty in 1999 on Dryad Ward.

I worked part time 30 hours per week at that time and my tour of duty would have been between 0730 and 1300 and between 1415 and 2030.

My understanding of the named nurse is that they would be the person who has the overall care of the patient when on duty and would be the person to whom the patient's family could confer.

My responsibilities on the ward could … be that I was in charge of the ward and the bleep holder for the hospital, that I would supervise Health Care Support Workers and Students, but my overall responsibility was the care of the patients.

I had not received training or certification in the administration of I/V drugs.

I have heard of the term the 'Wessex Procedures', the Analgesic Ladder. The term TLC, tender loving care, would indicate that a patient was coming to the end of their days. We would make them as comfortable and pain free as possible.

The term 'I am happy for staff to verify death' is a term I am familiar with at GWMH. This would mean that two members of staff would be available to verify death of a patient, when there was no Dr's on site.

Ward rounds were done most days at about 0800 hrs and Dr Barton would see any patient to whom it was indicated there was a problem.

I have been asked to detail my involvement in the care and treatment of the patient Geoffrey Packman. I do recall this patient due to his size and terrible bed sores on his buttocks. I believe that he had been stuck on the toilet. From reference to his medical notes … I can state that on page 65 of those notes, dated 2/9/99…"

and it is the entry for the second of the ninth 1999 –

"…. I have written, Diamorphine increased to 90 mgs/24hrs Midazolam 80mgs. I have signed that entry.

I can cross refer this to an entry … of the Dryad Ward Controlled Drugs Record Book … where I have witnessed Shirley Hallman administer 90mgs of Diamorphine [to] Geoffrey Packman.

I can cross refer this…"

and this is a note at page 174, the entries for diamorphine and midazolam at the bottom of the page –

"… to page 174 of the notes dated 2/2/99 at 1840 hrs which indicates that 90 mgs of Diamorphine and 80 mgs of Midazolam were administered to Geoffrey Packman by Shirley Hallmann and initialled by her.

These entries were written up by Dr Barton. In relation to the Diamorphine, this indicates that the dose was variable between 40 – 200 mgs … over 24 hrs. The dose appears to have increased from 40 mgs to 60 mgs to 90 mgs, which is quite a step up.

In relation to the Midazolam, the entry indicates that the dose was variable between 20 and 80 mgs … over 24 hours. This dose appears to have increased from 20 mgs to

A

40 mgs to 60 mgs to 80 mgs over the same period of time as the increase in Diamorphine.

The entry between 26/8/99 and 2/9/99 on page 174 of 40 mgs of both Diamorphine and Midazolam administered at 1545 on what appears to be the 1st is marked 'Dose Discarded' and initialled by Code A

B

This medication was administered not by me but by Shirley Hallmann. The decision to increase the medication would have been taken by a Dr, either by way of a verbal message or a phone call."

Sir, the next sentence is in poor English, but the sense is probably clear. I apologise; this is how it is written.

C

"I can't imagine that an increase in medication, especially the Diamorphine increase from 60-90 mgs, without authority of a Dr, and would depend on the patient's condition.

All nurses do is administer drugs which are prescribed by a Doctor.

I do not however see on the notes where this decision was recorded."

D

That is the end of the statement of Nurse Florio.

Can I move on, please, to a statement by Sylvia Giffin, also a nurse.

MR JENKINS: May I just say in relation to this lady, that she died a number of years ago. The rules of evidence are such that the prosecution could apply to read this statement. Sadly,

E

it will be obvious she cannot be called but we have allowed this statement to be read because of that reason.

As has been made clear, we certainly do not agree the contents.

THE CHAIRMAN: Understood. Thank you. The Legal Assessor is asking for clarification there. You are referring to the lady who is about to be read? Nurse Giffin?

F

MR JENKINS: Yes.

THE CHAIRMAN: Thank you.

MR FITZGERALD: Sir, this will take about ten to fifteen minutes, if that is acceptable to the Panel. (The Panel agreed) Thank you. I am very grateful.

G

The patient that will be referred to in due course is Gladys Richards, Patient E, if anyone wanted to have that file out.

The first statement made by Sylvia Giffin is dated 12 December 2002, her occupation being retired nurse. She said this:

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STATEMENT OF SYLVIA GIFFIN , Read

"In 1973 I commenced work at the Gosport War Memorial Hospital …

I worked at the Redcliffe Annexe which was a unit based approximately half a mile from the main hospital site. The Redcliffe Annexe was a unit of about 17 beds used for the elderly patients, who were coming to the end of their lives. I worked happily
B at the unit and felt that we treated the patients well and that we made them comfortable as they approached the end of their life. This was based on a 'tender loving care' type of treatment.

However this all changed when Code A took over as the sister for the unit in the early nineties. It seemed that she had a vendetta against people she did not like. She made it obvious that she did not like the night staff and she targeted me in particular.
C

I remember on one occasion that Isobel Evans, the senior nurse in charge of the unit, visited us early one morning stating the H Code A had complained about our work.

However, Evans congratulated us because she could not find any problems. The other problems with Code A was that she encouraged the use of syringe drivers.

D A syringe driver is a syringe attached to the patient that injects them over a 24 hour period to give constant pain relief.

Prior to Code A coming to the unit we rarely used the syringe drivers. However when she arrived their use escalated, although this was at the time when they were initially introduced. I felt this was wrong, because it seemed that most patients were going on drivers even when they were not in pain and their use was a matter of course
E rather than need. I felt that in the right circumstances the syringe drivers were the correct method to ease pain. But I did not agree with their 'blanket' use on patients.

The other problem with the syringe drivers was the fact that when they were first introduced we did not receive any formal training on their usage.

Another problem was the fact that on nights there was only one trained nurse and two
F untrained healthcare workers. Which meant that when I was on duty at night, I was the only trained nurse in the unit.

There was no medical care at night therefore if there was any problems with the patients and the drivers, I had to contact the main hospital unit.

The decision to place patients on the syringe drivers was entirely down the doctor
G responsible for the ward. This was Dr Barton. She was the unit doctor for several years.

I got on well with Dr Barton and felt she was a competent doctor.

However what usually happened was that Dr Barton would 'sign up' that a patient was suitable to be placed on a syringe driver then Hamblin or one of the duty staff
H

would decide if and when it was necessary to place the patient on it. This meant that if the drivers were required in **Code A** s opinion, the authority was already signed.

Eventually I spoke to my colleagues at the unit about my concerns over the drivers. I remember we had a meeting and it seemed that they shared my concerns. However when I complained to the management they did not support me because they were frightened of losing their jobs.

It was not until Anita Tubbritt, another nurse, became involved that I got any real support. Though I did approach Sister Goldsmith who was based at the main hospital building and she was also supportive.

Finally I contacted my union rep, Keith Murray, who wrote to Isobel Evans, the general manager for the nursing staff and conveyed my concerns.

Various meetings between staff and management were arranged but these were mainly aimed at pacifying our fears and make us feel that something was being done. We also had a meeting with the 'pain control people' in order to train us in the use of the syringe drivers.

I remember at one meeting Dr Barton stated that she felt we were accusing her of euthanasia. Despite these meetings and my protestations the use of syringe drivers continued to increase.

I cannot remember the names of any patients that I felt suffered or died because of the syringe drivers.

Another problem with the drivers that continued after the meetings was although the correct dosage of say Diamorphine was given to them, the dosage would automatically increase once they got used to it. This would also upset me a great deal.

Eventually I gave up complaining despite the fact I was not happy with what was occurring.

After a few years we moved to the new hospital building and we worked in different wards. Until after sometime we were once again 'ward based' and I ended up on Daedalus Ward.

In September 2002 I left the nursing profession after being on sick leave for a year with stress brought about by the problems I was having at the hospital.

A few weeks ago …"

bearing in mind this is her statement from 2002 –

"I became aware that there was an enquiry into work procedures at the hospital. Therefore I sent Anita Tubbritt copies of paperwork I had saved from the 1991 episode. This consisted of letters, reports and minutes of meetings."

A Sir, a selection of the paperwork relating to that of course is within our file number 1. We have looked at it already a little bit, and I am sure there will be further reference.

> "I would like to add that I worked on nights at the Redcliffe Annexe for ten years before someone died on nights.
>
> However once Hamblin arrived it became a regular occurrence."

B That is the first statement by Sylvia Giffin. She also made a statement relating more particularly to Gladys Richards dated 6 June 2000. She said this:

> "I am employed by Portsmouth Health Care Trust at Gosport War Memorial as a Staff Nurse."

C This was before she had resigned.

> "I have worked as a Staff Nurse at the War Memorial since 1972. I work mainly at Daedalus Ward on night duty for about the last three years, covering August 1998.
>
> The ward is mainly occupied by elderly patients. The ward is visited daily by a General Practitioner responsible for the treatment of the patients. The GP will
> D prescribe drugs and treatment which will be administered by the Staff Nurses on the ward.
>
> In August 1998, the GP in question was Dr Barton. A consultant would visit the ward once a week. This was Dr Lord.
>
> Dr Barton is also on call for any emergency cases. On other occasions when Dr
> E Barton was not only duty, a GP would be contacted via a Healthcall system based at Cosham.
>
> The patient capacity at Daedalus is twenty four.
>
> I work a permanent night duty at Daedalus Ward which would consist of 8.15 pm (2015) to 7.45am (0745). I work mainly Friday and Saturday nights.
>
> F
>
> In relation to the inquiry regarding Gladys Richards, I was at work on Thursday 20th August 1998 (20/08/1998) and Friday 21st August 1998 (21/08/1998)."

Sir, just referring to the chronology for a moment, it was on the 21st that Gladys Richards died, so this was the night before her death.

> G "On the ward with me on 20th August 1998 (20/08/1998) was Anita Tubbritt, Senior Staff Nurse, Code A
> Code A These three were on night duty with me on Friday 21st August 1998 (21/08/98).
>
> When I started work at 8.15 pm (2015) on Thursday 20th August 1998 (20/08/1998) I was made aware that Gladys Richards was on the ward. I do not recall receiving any
> H specific instructions regarding Mrs Richards care or treatment. I do not remember

who gave me the handover. I was aware at this time that Mrs Richards was on a syringe driver. The practice of using a Syringe Driver subcutaneously at the hospital has been in use for about ten to twelve years.

The syringe driver is commonly used at the hospital in order to relieve a lot of pain or discomfort. The driver is able to provide a constant level of pain relief as opposed to oral pain killers which wear off after a period of time causing the patient discomfort prior to the next administration of pain killers.

In relation to the drugs administered by a Syringe Driver, in August 1998, Dr Barton as the GP responsible for the ward, would have completed the prescriptions. This was backed up by a weekly ward visit by Dr Lord who would assess the treatment given to the patients.

The syringe drivers are used on all wards at the hospital to the best of my knowledge.

The care and treatment of Mrs Richards would have been part of my responsibilities overnight. Anita Turbritt was in overall charge of the ward and the hospital on 20th August 1998 (20/08/1998) and 21st August 1998 (21/08/1998). I was made aware, I believe by Jenny Brewer, another Staff Nurse, that Mrs Richards had had a fall. I cannot remember if Jenny Brewer told me anymore about the incident. I also remember that Mrs Richards had been in the ward previously before returning to Haslar and then returning to Daedalus ward.

Mrs Richards' daughter was present with her on Thursday 20th August 1998 … to Friday 21st August 1998. I spoke to her and learnt that she had previously worked in a nursing capacity. The daughter had concerns over the transport of Mrs Richards from Haslar Hospital to the War Memorial.

I do not recall administering any drugs to Mrs Richards. I would have checked her treatment card to ensure any drugs prescribed were to be administered however it would be unusual to administer drugs overnight.

I have been shown a prescription record for Gladys Richards. Having looked at this record I can state that I did not administer any drugs through the syringe driver or otherwise to Mrs Richards. I have looked at the record and noted that the syringe driver was loaded at 11.15 a.m. on Thursday 20th August 1998. The driver should last for 24 hours meaning that the night duty would not normally be expected to reload the driver.

I have noted the drugs that were administered to Mrs Richard … were as follows

Diamorphine, Haloperidol, Hyoscine and Midazolam. My perception of their effects are as follows

Diamorphine is for pain relief. Haloperidol quietens the patient down if they are agitated or jittery. Hyoscine stops fluid building up on the chest. Midazolam also quietens the patient down. Midazolam is not a strong drug.

Mrs Richards may have been taken off Oramorph and put on to Diamorphine via syringe driver as the Oramorph was not holding the pain. The syringe driver would ensure the pain relief was constant.

I do not recall giving Mrs Richards any fluids either by mouth or subcutaneously. Mrs Richards would not have been given fluids by mouth due to the fact that Mrs Richards was not conscious. She therefore would have choked if anyone had tried to force fluids or food into her mouth.

Mrs Richards was not given fluids subcutaneously. I recall that there was nothing to alarm me over Mrs Richards' condition. I did not receive any instruction to administer or not to administer any fluids to Mrs Richards.

I was not concerned about the drugs Mrs Richards was being administered. I could not comment on what effect the drugs were having on Mrs Richards as I had not seen her prior to the drugs being administered. I did not speak to a doctor regarding her drugs dosage nor did I alter the card of drugs given to Mrs Richards. I checked regularly on [her] and she appeared comfortable. The training received for the driver was on the ward with an instruction booklet in the treatment room. Without having at Mrs Richards' case notes I believe [she] died at about 4 am on Friday 21st August 1998. There was no attempt to resuscitate … I was able to pronounce death as her death was expected.

At that time both Mrs Richards' daughters and a granddaughter were present. I recorded death pronounced on the case notes and the nursing notes.

I would add that the other reason why a patient may not be able to take Oramorph is if they are unable to swallow. In this case the patient may be transferred to a syringe driver."

Sir, Sylvia Giffin was also interviewed by the police and there are a very limited number of further extracts that, in conjunction with the defence, we have agreed should be read. I will therefore just read these extracts from an interview conducted on 19 June 2000. She was asked by an officer about Dr Barton:

"DC COLVIN: Would she actually visit every patient daily or would it be more of speaking to the staff?

MRS GIFFIN: No, she would have gone into the office and speak to whoever was in charge at the time and depending what she, what messages were passed on, she would go and see the patients they wanted her to.

DC COLVIN: Right so if there was a specific problem with a patient she would visit but if there was change to a patient, there were no concerns then she wouldn't necessarily do so?

MRS GIFFIN: It would take her a long time.

A She was referred to drugs that were being administered to Gladys Richards and she was asked by the officer:

"DC COLVIN: Can you just talk us through the four drugs and just sort of describe what they're for and what the effects are?

MRS GIFFIN: Diamorphine erm is pain relief principally although it can be used when somebody is er sometimes they, people who are demented do scream and you're never sure whether it is pain or, or just an agitation of mind and diamorphine does help to address both things at once."

B

DC COLVIN: Are you able to comment on the doses and how much they are?

C MRS GIFFIN: (inaudible) still at 40.

...

MRS GIFFIN: Erm as far as I'm concerned that is a, a low dose given the fact that this woman was given over a 24 hour period.

D DC COLVIN: That's the diamorphine and ...

MRS GIFFIN: Diamorphine and (inaudible) it's not very dramatic at all.

...

MRS GIFFIN: Er I was on duty and she didn't show any signs of pain at the time when I was on duty so I would have thought that's probably the best level. Er (inaudible) hyoscine that is about average what most people have and 20 milligrams of midazolam is what I would expect, given that you've got haloperidol as well.

E

DC COLVIN: So they're all fairly ...

F

MRS GIFFIN: Yeah, no there's nothing that I would say, "Oh crumbs this is too much."

She was then asked more about Mrs Richards. She was asked:

"DC COLVIN: You recall when you came in on the Thursday ...

G

That is the night of the 20th to the 21st –

" ... and obviously Mrs Richards is there, what was your understanding of the treatment she was on? What was your perception of it in relation to her health?

H MRS GIFFIN: What am I supposed to say?

DC COLVIN: Was there anything made to you to feel that she was dying?

MRS GIFFIN: I don't think anybody would have said to me erm she is dying they would probably have said she's not very well and they would have told me when the syringe driver was first put out and erm it's just continuing care really.

DC COLVIN: Yeah. I mean obviously do you recall seeing the drugs prescribed on the driver? Would that have indicated to you that she was, she wasn't much, obviously she wasn't well but there was a chance that she would perhaps recover to some extent?

MRS GIFFIN: No I wouldn't have thought she would recover. I thought she would probably deteriorate slowly but I don't have a crystal ball I don't know how long that sort of thing could go on for.

DC McNALLY: Is it fair to say that the for use of a better word cocktail of medicines that she was given, that that cocktail is for … they've prescribed that for somebody in her condition who they believe is going to die and it's just a way of making them comfortable and pain free.

MRS GIFFIN: Yes.

DC McNALLY: Is that what those cocktail of drugs are for?

MRS GIFFIN: Basically yes.

DC McNALLY: If you were like if you went onto a strange ward and you saw these drugs administered to a woman that you didn't know, would it be a fair assumption that there's nothing else we can do for this lady …

MRS GIFFIN: Yeah.

DC McNALLY: ... and she's on her way?

MRS GIFFIN: Yeah.

DC McNALLY: Nobody ever mentioned that she was dying of anything specific?

MRS GIFFIN: No, no ... Well, I think it's one of those unspoken things that we all, we all accept really you know just (inaudible)

DC McNALLY: Mmm. When you say the unspoken thing is it's a case of there is nothing we can do for her?

MRS GIFFIN: Yeah.

DC McNALLY: And I take it that decision that there is nothing we consciousness do for her would be made by who?

MRS GIFFIN: Er well Doctor (inaudible) I presume.

DC McNALLY: Dr Barton.

MRS GIFFIN: Well she being the one that's there every day.

DC McNALLY: Yeah.

MRS GIFFIN: And er if she queried that she would have gone to Dr Lord and spoken to her but I don't know."

That concludes the evidence relating to Nurse Giffin.

THE CHAIRMAN: Thank you very much indeed, Mr Fitzgerald. We will rise now and reconvene tomorrow morning at 9.30.

(The Panel adjourned until 9.30 a.m. on Friday 26 June 2009)