GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 3 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY NINETEEN)

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.
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THE CHAIRMAN: Good morning, everybody. Mr Kark.

MR KARK: Can I just indicate the schedule for today, please. The first witness that we have is Dr Ravindrane and I will be calling him in a moment. We have then got a statement to read to you, or parts of a statement to read to you, from Mr Richard Samuel. Although Professor Ford was here yesterday, I have released him today. I have taken that decision because before he is called there is quite a lot still to do. We have chronologies, which I am afraid are still not finalised, although we are getting very close to finalisation. I know that the defence would like you to have read through, certainly at some stage, Dr Barton's statements, certainly prior to the time that Professor Ford is cross-examined. I also want to resurrect the issue of whether you should have Professor Ford's reports at this stage. Knowing that we were rising, I think the suggestion is 3.30 today, I did not frankly want Professor Ford hanging around with the possibility that we might be able to get an hour's worth of evidence, but frankly with the likelihood that he would not. So I hope that was the right decision. He will be available to give evidence on Monday. I think he is making a request through me that the Panel might sit at 10.00 to allow him to catch the 6 o'clock train from Newcastle rather than come up the night before, and I wonder if consideration could be given to that at some stage.

THE CHAIRMAN: We can do that right. The Panel do not have any objections. The only observation is that we know that it is going to be a tight week in terms of other things happening. On Wednesday, for example, we will not have use of the room. If you are content---

MR KARK: We might be inviting you to sit until the end of the days, 5 o'clock, when Professor Ford is giving evidence, but that might be affected by whether you receive the reports or not, but I will raise that argument later.

THE CHAIRMAN: Very well.

MR KARK: Can I start then, please, by calling Dr Ravindrane. The Panel might just want to turn up their chronology for Patient H.

ARUMUGAM RAVINDRANE, Sworn
Examined by MR KARK

(Following introductions by the chairman)

Q Dr Ravindrane, I should start by thanking you for being so accommodating because you have been waiting for a long time to give evidence, and so thank you very much for your attendance here today. Dr Ravindrane, I want to ask you, please, about the time when you were employed as a registrar and then a specialist registrar at the Queen Alexandra Hospital back in the late 90s, but can I ask you first of all what your current occupation is?

A I am a consultant geriatrician at Queen Alexandra Hospital.

Q How long have you held that post as consultant geriatrician?

A I am a consultant since 2 January 2001.

Q Could you pull the microphone slightly closer to you. You have a soft voice and I do not want to have to ask you to repeat everything you say. Just tell us a little bit, please, about the training up to the time that you were employed as a registrar at Queen Alexandra Hospital. First of all, where did you qualify?
A I qualified in India in 1981. I trained in general medicine in India till 1987. Then I worked as a hospital practitioner in India till 1989. I came to UK for further postgraduate training in September 1989. I passed the PLAB test of the GMC in September 1989. After that I started training in the UK initially as a senior house officer in general medicine between November 1989 till ---

Q The exact dates perhaps do not matter.
A ---July 1992.

Q From 1989 you effectively went through the normal route, as it were?
A Process of training. Then I became a general medical registrar in 1992. I worked one year at Stockport as general medical registrar, then one year at Wrexham in North Wales, again as a general medical registrar, then three months at Cardiff as general medical registrar.

Q Can I just cut this a little bit short. At what stage did you begin focusing on geriatric medicine?
A That is 1994 I started my career in geriatric medicine as a staff physician at Worthing Hospital in West Sussex.

Q When did you take up your first post at the Queen Alexandra Hospital?
A I came back to training in December 1997, but I became a specialist registrar in geriatric and general medicine at Queen Alexandra Hospital in December 1997.

Q Have you been there ever since effectively?
A I was specialist registrar till February 2000 at QA in Portsmouth, then I went to Southampton General Hospital to complete my training in geriatric medicine, which I completed in December 2000, and then I became a consultant from January 2001.

Q Going back to the Queen Alexandra Hospital?
A I went back to the Queen Alexandra, yes.

Q We have got a good picture of your training and your career up to that time. Now, I want to take you back, please, to the time that I think you were a specialist registrar and you came to deal with a patient called Robert Wilson. Now, I know that you have made a number of statements about that. If there comes a time when you need to refer to the statements you can, but I do not think you will need to because I am going to take you through the notes that were made in relation to that patient. If you look to your left you should see a file with a large "H" on, a patient bundle for Patient H, and if you could start, please, by turning to page 166. You will find the page numbers that I am going to refer to have a little line either side of them. I am afraid you will see on occasions there is a multiplicity of page numbers, but it is page 166 that I want you to turn to first.
A I have got it.

A Q We can see that it appears that on 23 September 98 (the date is not terribly clear) the patient had been admitted to Accident and Emergency, and was this at the time when you were working at the Queen Alexandra Hospital?
A I was, as a specialist registrar at Queen Alexandra Hospital.

Q As a specialist registrar what sort of patients were you then dealing with?
A As a specialist registrar I was trained both in general medicine and geriatric
B medicine. We were part of the general medicine on-call duty, so I would be looking after all the acutely ill medical patients coming into the hospital, either through casualty or direct admission to the wards.

Q Can everybody hear the evidence? (To the witness) You are quite softly spoken, so if you can imagine you are shouting across a busy ward. I do not suppose you ever do, but---
C A Okay. Sorry.

Q Now, this is not your note, I think, that we are looking at here, is it?
A This is not mine.

Q Okay, but we can see that the patient had had a fall, he had fractured his left humerus, is that right?
D A Yes.

Q That was the cause of his admission. Then I want to turn, please, to the first document that you would have written upon. If you could go to page 171. So this is a few days after his admission. Do we see your writing on this page?
A I can see my writing on this page, yes.

E Q Is it both the top and the bottom?
A Both the top and the bottom.

Q So the first entry, I think, is 25 September. Does this note follow an examination of the patient?
A It does.

F Q The patient would then have been on one of your wards.
A He was.

Q Would this examination have taken place in the presence of anyone else?
A It would have, yes.

Q Who else is likely to have been there?
G A I do not remember exactly now who was with me. Most probably when I do the ward round as a registrar there would have been a nurse present at the time, and also another junior doctor.

Q Possibly a senior house officer?
A Senior house officer.

H Q Can you just take us through your note, please.

A A I have written on 25 September 1998 "high [gamma GT]", it is an abbreviation.

Q The relevance of which is what?
A Gamma GT is an enzyme produced by the liver. I do not know the exact reason, but it is usually high in people who have a high alcohol intake.

Q Is it linked potentially to liver disease?
B A It could lead to liver disease.

Q The next entry?
A I think I have written "[high] MCV" and "[high] INR", probably that is what I meant when I wrote that, indicating that he has mean corpuscular volume of the red blood cells. "MCV" stands for mean corpuscular volume, which refers to red blood cells---

C Q We have had so much intricate information in this case that I am going to try and cut to the chase; are all these indicators of a high alcohol intake?
A In my opinion, yes.

Q Right. Can we move to the next entry.
A "still in pain", possibly from the fracture he sustained. His left arm was bruised. Sensation was normal. Normally after a fracture of a bone in the upper limb we have to
D be careful about complications from the fracture, so normally we would be testing for sensation because of any neurological nerve damage.

Q Right.
A So his sensation was normal. Also, vascular complication; it can press on the brachial artery, resulting in loss of blood supply, so I checked his wrist pulsation, which was normal.
E

Q That was all right.
A I suggested regular pain relief, and I think it is magnesium hydroxide, probably for---

Q That is certainly what it was when you wrote your statement.
A Yes.
F

Q You would have given him that for what?
A For possibly constipation.

Q "T4", is that a reference to his thyroid function?
A Total T4 and TSH both refer to thyroid function test. TSH is the thyrotropic hormone produced by the pituitary. It is slightly elevated, indicating his thyroid was
G probably under-acting.

Q That can affect the metabolism rate of the body?
A Not at this level.

Q It is not low enough for that?
A Not low enough for that.
H

Q Could I ask you to keep a finger there, please, and we are going to have a look at some prescriptions that you have written. If we could go, please, to page 113 and 114. 113, I do not think that is your prescription, is it?
A No.

Q Can you help us with what it is?
A I think it is chlordiazepoxide.

Q Which would be for what?
A Normally when patients are admitted to hospital and if they happen to have excess alcohol intake, since they are not consuming any alcohol in the hospital, there is a chance, there is a risk, I would say, of alcohol withdrawal symptoms, and the sedation are usually given to prevent or treat alcohol withdrawal symptoms.

Q All right. Could you look to a prescription on the following page, page 114.
A Yes.

Q I think the top half at least is dealing with pain relief.
A Yes.

Q Would this be pain relief in relation to the pain that he had in his arm as a result of the fracture?
A I think so.

Q Have you yourself actually written these prescriptions?
A The signature, it looks like min, those top two.

Q Let us just have a quick look at those, please. The first prescription is?
A Is codydramol, which is a combination of paracetamol and codeine.

Q Is that regarded as a medium level analgesic?
A It is a medium level analgesic.

Q And you wrote this prescription on 25th, we can just make out, I think, so that was on the same day as the note we have just been looking at?
A Yes.

Q And the level of co-dydramol that you are prescribing is what, please?
A It is two tablets.

Q What is the dosage rate of co-dydramol, do you know? Is it 5 mg?
A One tablet contains 500 mg of paracetamol and 30 mg of codeine.

Q We can see that that was given to him until, is it, 30 September?
A He had a dose I the morning of 30 September.

Q And then it looks as if he was switched to paracetamol?
A Yes.

Q Is that your prescription for paracetamol?

A A As well; in fact I stopped the co-dydramol. I can see my signature there and crossed it off and then I wrote up the paracetamol on 30 September.

Q If co-dydramol is a mid-level analgesic, how would you describe paracetamol?
A It is a mild analgesic.

Q Is it the lowest level or is there something below paracetamol?
B A I cannot think of anything below paracetamol

Q You will need to use another marker, I am afraid. Could you also turn to page 106 just to see what other drugs this patient had been on. Turn to 106 and 107. These are not your prescriptions, I do not think, are they?
A They are not my prescriptions.

C Q But we can see I think on the day of his admission he was given morphine, and is that at a dose of 2.5 mg?
A Sorry; it is not my prescription.

Q And you cannot read it?
A I cannot read it.

D Q It may be 225 mg PRN I suppose. That was started it seems on 23 September and it was given to him also on 24 September twice --- no, 24th and it is rather difficult to read the next date, but in any event by the time you came to him on 25th I think your prescription would have taken over, as it were?
A Yes.

Q Then if we look underneath that there is a nurse prescription, as it is called, for
E paracetamol. It may be 23 September as well, and then underneath that codeine phosphate was also given on 23 September and it looks as if that was stopped on 25th? Right at the bottom, do you see the last entry on page 196?
A 25th at 11.30, yes.

Q Codeine phosphate, last one given on 25th September at 11.30?
A Yes.
F

Q Then over the page there are two entries for morphine prescribed on 3 October. This is jumping forward in time of course but since we are here we might as well look at these prescriptions. 3 October, morphine, and it looks like that was given on 3rd and possibly 5th or 6th and then underneath that we can see codeine phosphate was given again on 8th, 9th, 12th and 13th. None of those are your prescriptions?
A None of them are my prescriptions.
G

Q If we could go back now please to the clinical notes at page 171, I think you next saw the patient three days later on 28th?
A Yes.

Q Can you just take us through your note, please?
A I noted his renal function was deteriorating. NA is the abbreviation for sodium;
H the sodium was low in his blood – serum sodium. Again I noted that he had low TT4 and

high TSH and I queried hypothyroidism. He was dehydrated in my clinical opinion at that time. No JVP: I could not see elevation of jugular venous pressure, which indicates a fluid overload.

Q Is that a good thing or a bad thing?
A It is bad thing. Jugular venous pressure is elevated in heart failure. Jugular venous pressure is very low in dehydration, so we need a normal level of jugular venous pressure.

Q He was dehydrated?
A He was dehydrated.

Q What action did you take. If we can see to the right hand side of the page, is it stop ---
A I stopped his diuretics, which will make his dehydration worse because he will pass more urine. I started him on intravenous fluids, and I wrote IV fluids, and I suggested to the doctors to repeat his Us and As, that is urea, electrolytes and creatinene.

Q Was that so that you could see how well his kidneys were then working?
A I could assess his kidney function and also I could assess how severely he was dehydrated.

Q Can we go over the page to the following entry. The next entry is not made by you, is that right, but the bottom one is?
A The bottom one on 30 September was mine.

Q We can see the day before that he was seen and there is a note at 2 that he had impaired renal function and there is a suggestion is it I think of alcoholic hepatitis?
A I could say it but that is not my entry.

Q I entirely understand. It is still identified that he is hypothyroid?
A And also I did find that he was hypothyroid.

Q I may have missed it but were you taking any action on the hypothyroidism? Were you giving him any drugs for that?
A Unless I see it through the prescriptions, I cannot say that we have done anything to treat his hypothyroidism. There is no indication from the clinical notes that I could say he was given thyroxin, which would be a replacement for hypothyroidism.

Q Can you go to your entry on 30th, please. We can all read it: "Renal function slightly better". Is it "still drowsy"? Do you see it?
A Yes, I see it.

Q And underneath "still drowsy" you have written what?
A "No flap". Flap is a clinical sign; normally when patients were asked to stretch out their hand like *this* if they have liver disease and so many medical conditions which can cause flap, they cannot maintain in a sustained fashion, so they will have flap if they have liver problems or liver failure.

Q So no flap is a good indication?
A It was a good indication, yes.

Q "Apyrexial, no fever": is that the next entry?
A Yes.

Q It is difficult to read this but I am going to take this from your statement. Is it "100 systolic"?
A When I gave the statement, that is what I thought it was: 100 systolic blood pressure. I cannot be sure now.

Q Would that be a good thing or a bad thing?
A I do not remember the patient now. It depends upon what his previous blood pressure was. If his blood pressure had been high and suddenly dropped to 100, it was a bad thing, but if it had remained at 100 for a long time, there is no change in his condition.

Q 100 systolic of itself is not a high blood pressure?
A It is definitely not a high blood pressure. It could be low blood pressure.

Q We can see at the bottom of the page "Stop all sedations". What is underneath that? Is it "fluids ---"
A I think I wrote "continue fluids".

Q Why were you stopping sedation?
A Because he was drowsy and because if there was a suggestion he could have liver disease, sedation will make it worse.

Q Why? I am not asking for a chemical explanation but why would you not want to give sedatives to somebody who had liver disease?
A Normally we would try to avoid sedation in people with liver disease because liver disease itself will lead to sedation and so it will aggravate or increase the drowsiness.

Q And so if you do give somebody with liver disease sedation, do you have to take extra care?
A We normally take extra precautions, care.

Q Is it as a result of the previous alcoholism that you have to be particularly careful of sedation or is it because the alcoholism may have led to liver disease?
A I was careful here because he was drowsy already. That was the reason I think – I do not remember now – I stopped this sedation.

Q But if you see in the notes that somebody has got liver disease, that is a signal to you, is it, to be cautious about sedation?
A Yes.

Q Can we go to the next page, 173? There is a ward round I think by a registrar, which is not yourself. Is that right?
A The entry was not mine.

Q Can you just help us, and I appreciate it is not your writing, but if we look at the bottom of that entry "stop fluids mane", meaning the next morning?
A Yes.

Q "Dietician" and then "consider---"
A "NG tube tomorrow".

Q Is that naso gastric tube?
A Naso gastric tube.

Q Why would that be being considered?
A Probably he was not eating enough to maintain nutrition.

Q Can we then have a look at your entry, which I think is next, dated 2 October '98 and just take us through that, please.
A He was "still very sleepy, sleeps in the morning, awake at night. Oedematous" – that is he was having fluid retention; I thought it was ---- to increase all the (steroidism) that is possibly secondary due to his liver condition and also intravenous normal saline. He had a massive bruise, low albumen.

Q I am sorry to ask you to pause; the massive bruise was where? It may be obvious from the injury?
A I presume it was from his left arm, from the fracture of the humerus.

Q The fact that he is oedematous, can you tell us where he was oedematous?
A I do not remember the patient now but usually they are oedematous if they are bed ridden, in the legs and the back, what we call the back sacrum.

Q "Stop IV fluid". Why?
A Because I thought he was getting oedematous secondary to intravenous saline.

Q Meaning that it was the saline itself which was causing his swelling?
A Probably I assumed he was not able to excrete sodium because of his kidney and liver involvement.

Q Then underneath "Stop IV fluid" what do we see?
A "Encourage protein drink".

Q Again it may be obvious: why were you doing that?
A To build up his nutrition, to improve the albumen in his blood so that his fluid retention will come down.

Q The note that follows after "protein drink", is that a reference to a psychiatrist geriatrician?
A In those days we used to call them psycho-geriatricians. Now they are called consultants in mental health for older people.

Q A different label but the same creature?
A Yes.

A

Q Why were you considering that referral?
A I honestly do not remember why I asked for it.

Q Might that be referable to his alcoholism and depression?
A Possibly.

B Q "For LTC"?
A LTC means long-term care.

Q What did you mean by that phrase with this patient?
A The long-term care is NHS continuing care in a National Health Service facility where they will have both nursing, medical and other specialist input.

C Q If we look below that we can see your referral I think to the psycho-geriatrician which reveals your thinking: "We will value your opinion regarding this gentleman with…" Can you read the next bit?
A "with alcohol abuse/liver disease. He is very withdrawn and depressed."

Q Again, if we can just follow on through this note and go to the following page, 174, I think we can see a note on 2 October '98 "seen by dietician"?
D A Yes.

Q I am not going to read all the way through it but we can see that he will be ordered a high protein diet "and will continue top be encouraged with the supplement drinks over the weekend" and there needs to be an accurate record of what he takes. There is a suggestion that naso-gastric feeding might be the only method of meeting his nutritional requirements. That is not your note but I think your note does appear below
E that, 4 October?
A Yes.

Q Just tell us, please, what you have written?
A "Still sleepy. Encouraged diet. Eating well now. Credit Kingsclear list. ? LCT." That is long-term care.

F Q Kingsclear? Is that a rehabilitation ward?
A It used to be a rehabilitation ward at St Mary's Hospital.

Q Why were you considering a rehabilitation ward at St Mary's?
A Once his acute condition was treated we would be looking at ways to discharge patients. It could be either rehabilitation in the process of physiotherapy and occupational therapy for a few weeks. Then a discharge to a safer destination after that.
G So probably that was the reason I thought he should be considered for rehabilitation.

Q The clinical notes continue, of course, if we look over the page. I am not going to go through those. He is seen by an SHO and by a dietician on 6 October. He is seen by another SHO on 7 October, where there is still said to be severe swelling. We can see at the bottom he is not keen on a residential home. If we go over the page, please, to 176, I do not think any of your writing appears, but we do see at the top on 8 October that he is
H now eating and drinking. Below that, we can see on 8 October, that day, he is seen by

A a psychogeriatrician. His note starts: "Thank you for asking me to see Mr Wilson who presents with..."

MR JENKINS: It is Dr Luznat.

MR KARK: We have heard from Luznat, so I will not take you through that. Over the page, please. We will come to another note, I hope, of yours.

B A Yes. On 9 October you can see my entry there.

Q Can you take us through that?

A "Gross oedema. Eating well. Barthel only 5. On Trazadone and add diuretics. Repeat Us&Es, LFT. High social services." Probably I wanted them to refer him to Social Services for nursing home placement.

C Q If we go to your final entry, I think if we go to the following page, 178, there is a ward round by an SHO on 12 October. Then do you see him on 13 October?

A Yes.

Q Again, can you take us through your note, please?

A It is my ward round. "Still needs both nursing and medical care. He is also in danger of falling and the risk may remain for a while till he is fully mobilised. He also

D needs special needs to be attended to regarding the left arm which is ..." I cannot read.

Q When you wrote your statement you thought that was "which was swollen".

A Probably, yes. "So I feel a short spell in long-term NHS bed." Can I turn the page now?

MR KARK: Yes.

E A "Will be appropriate. Still very oedematous. Weight keeps going up."

Q Weight keeps going up? Yes?

A "Albumen is still low at 23. Add Frusemide. Review with Us&As."

Q What is that all about?

A It was my assessment of his medical condition to see where he would be

F appropriate; whether to send him home, or to send him to a rehab ward or to a NHS continuing care facility. I think I summarised my thoughts at that time that he needed long-term NHS care, because of his multiple needs; of both medical nursing and ----

Q So he is not at that stage in a fit state to go home.

A No.

G Q But not necessarily requiring an acute ward on a hospital bed there.

A No.

Q I am sorry. The last entry you made was "review with..."?

A With Us&As. Review with results of urea electrolytes.

Q Is that looking at his kidney function again?

H A Yes.

A

Q Half-way down the page underneath the dietician notes we see the results of 13 October. Do any of those help us as to his kidney functions?
A His urea electrolytes and creatinine were within normal limits on that date, but his albumen was still low at 24 and his bilirubin was elevated at 48. His alkaline liver enzyme was also elevated at 181.

B Q Can you give us a picture of this man's state of health on 13 October?
A I assessed him on 12 October.

Q Yes.
A In which I summarised that he was still oedematous and he is requiring both medical and nursing care. That was the reason I wanted him to go to an NHS facility.

C Q We can see from the note on the following page, which is not yours, that he was transferred the following day after 14 October to Dryad Ward for continuing care.
A Yes.

Q Just to remind you, I think you made this comment in your statement about this man; that he may have stabilised, in your view, and maintained some level of health. Equally, you say, he could have died suddenly or quite quickly due to his condition. His
D liver function was abnormal. Does that still reflect your opinion of this patient at that time?
A I think so.

Q What reservation, if any, do you have?
A I honestly do not remember the patient now.

E Q With this gentleman, at this stage of his transfer, having looked at what appear to be your continuing concerns about his kidney function, would care still have to be taken using sedatives with him, or had that moment passed?
A Sorry. Could you please repeat the question?

Q Bearing in mind this patient's kidney function at this point when you last saw him on 12 October, would care still have to be taken in relation to sedation, or had that
F moment passed and he could be sedated normally?
A In anyone we prescribe sedation we have to be careful. Particularly if they have liver disease, we have to be very careful.

Q That is all I ask you about that patient. I am going to turn to Mr Packman, if you take up File J. If you turn, please, to page 55. This gentleman the Panel I think will probably remember was a very large gentleman who was admitted to accident emergency
G at the QAH on 6 August 1999. We are looking now at an entry by you on page 55. I am not going to ask you to go all the way through them, but if you look at the few pages before, you will see clinical notes relating to this patient's care at the Queen Alexandra Hospital. The point at which I think you come into the picture is on the day of his transfer to Gosport War Memorial.
A Yes.

H Q Can you help the Panel? This note that we see on 23 August 1999 on page 55, this

is your writing?
A It is my writing.

Q Can you tell us, please, where this assessment of the patient took place?
A Shall I ...?

Q We know he was transferred on this day, 23 August, to Dryad Ward.
A It happened in Dryad Ward at Gosport War Memorial Hospital.

Q What were you doing on Dryad Ward that day?
A As part of my training in geriatric medicine, I used to attend Gosport War Memorial Hospital under Dr Reid for getting training in rehabilitation and experience in continuing care.

Q So how often during your daily routine, as it were, would you be going over to the GWMH?
A I do not know how long I attended that. Normally we have this type of training in spells, six weeks or eight weeks. So I would have gone to Gosport once a week for probably between six to eight weeks.

Q Right.
A But I do not know exactly how long I attended.

Q If you go to Gosport once a week, does that mean you spend a whole day there, or you do a session, which would be half a day? How long would you be spending?
A It depends whether I attended the day hospital in the morning and the ward round in the afternoon with Dr Reid. It could be the one day, or just the half a day ward round.

Q Can you recall meeting Dr Barton at the GWMH?
A Yes.

Q Can you give us any idea of how often you would have had interaction with her?
A Probably once a week, Tuesday afternoon in the ward round, very briefly.

Q Very briefly on Tuesday afternoon?
A Yes.

Q Would you be doing a ward round with her, or would you just come across her on the ward?
A I would be doing the ward round with Dr Reid, who was my consultant at the time. If I remember correctly, Dr Barton used to attend at the same time another ward round with Dr Lord. So I do not remember Dr Barton joining the ward round. I do not remember.

Q But you remember seeing her.
A Yes.

Q This entry on 23 August 1999, can you remember whether you were on your own, or whether or not you were with anybody?
A I would have been with the ward sister in the Dryad Ward.

Q Do you remember Code A
A I do remember Code A

Q Do you think that is who you would have been with on this occasion?
A Not necessarily. It could have been any of the ward nurses who could have accompanied me.

Q Can you take us through your note about Mr Jeffrey Packman on 23 August?
A "Problems. Obesity. Arthritis bilateral knees (that is both knees); immobility; pressure sores; on high protein diet. Melena stool on 13/8/99. Haemoglobin stable. Albumen 29. Number 5(?) constipation. On Doxazosin. Mental test score very good. No pain. Better in himself. No AJVP."

Q Sorry. What does that mean?
A It means he is fluid overloaded. Or he may be dehydrated. It is abnormal (?) finding; that is we do not see jugular venous pressure normally.

Q "CVS cardiovascular system." I ticked it, indicating it was normal. RS (respiratory system), I ticked it. It means normal. PA (per abdomen) I wrote "obese," indicating he had a large abdomen.

Q Can I ask you to pause? In order to make this entry, what was the process that you actually went through with the patient? Does this require an examination or not?
A Absolutely.

Q Just take us through a standard examination that you would have performed with a new admission patient.
A I would have gone through his medical notes which were sent from Queen Alexandra Hospital. Then I would have introduced myself to the patient. After asking his permission, I would have gone through some of the questions I would have wanted to ask him. Then again with his permission I would have examined him, taken his pulse, noted his blood pressure, which the nurses would have done it. Then position him in a comfortable posture, then examined him; his heart lungs and examined his abdomen by making him to lie flat.

Q At some stage obviously you have made a note about all of that?
A After finishing the examination we normally write in the notes.

Q Let us just go on through the rest of the note and then we will come back to the issue of note taking. "Legs"?
A "slightly oedematous.
Chronic skin changes.
Ulcers dressed yesterday.
Need reviewing later this week".

Normally nurses take the dressing and see whether the ulcers were healing.

Q So that would mean having a look to see what is happening underneath?
A Underneath the bandages.

Q Can we just go back a little bit, I am sorry to do this, "Legs slightly oedematous". You told us a little bit about that. That is likely to be the result of what?
A Swelling of the legs in elderly patients, there are so many reasons for them to have swelling of legs. It can be dependent oedema, what we call dependent swelling, because the hands, the feet, the fluid collects there, or it could be due to low protein or due to heart failure, or it could be due to fluid overload.

Q Can we look at what you have recorded underneath that: "Need reviewing later this week", and then what are those comments that we see?
A I wrote "[Repeat] Hb U/E LFT Friday".

Q Why did you make that note?
A Because he had "? melaena", that is passing black stool, on 13 August, I wanted to monitor his haemoglobin to make sure that the haemoglobin remained stable, indicating he was not bleeding.

Q We will have a look at his haemoglobin in a moment. I just want to come back to the issue of this examination. Can you help us, so far as you are concerned is this a standard examination that you performed, is it a very high level examination that you performed? Where would you put it?
A It is a standard examination that I would have performed.

Q The notes that you have made, we can all do things better in life, but looking back on it now how do you regard this note?
A It could have been a bit more in detail, I am sorry to say.

Q Well, I am not criticising it, but I just want to know where you would put it. You think it could be a bit more detailed?
A It could be a little bit more detailed.

Q All right. How long would this sort of examination have taken you, do you think?
A Gosport War Memorial Hospital, it is a continuing care and rehab hospital, so we do not normally get very sick acutely ill patients, so we would be looking at nearly twenty patients in a one half-day session, so normally it would be a quick examination, but someone transferred newly on the same day, as you suggested, I would have spent a little bit more time with Mr Packman.

Q The reason for that would be what?
A To make sure that we assess him thoroughly in a more detailed way.

Q So you know what you are starting with, as it were?
A Exactly.

Q How long do you think this examination would have taken you approximately?
A I do not remember how much time I spent with Mr Packman.

Q You cannot give us an idea of whether this is a five minute examination, a half hour, an hour?
A I would say about fifteen to twenty minutes, but I may be wrong. I do not know.

Q As you have become more experienced, are you able to do your examinations rather quicker now than you did when you were a specialist registrar, or is there a sort of standard you have to perform?
A As we get more experience we get quicker.

Q Your fifteen to twenty minutes, is that with the benefit of your knowledge now or is that what you think you would have been doing then?
A What I would have done then.

Q Could we have a look, please, at the drug chart at page 173. Do you see a drug chart beginning on 23 September, the day of this examination?
A Yes.

Q Are these drugs that you prescribed?
A Yes.

Q Can you just take us through them briefly. Doxazosin?
A Doxazosin is anti-hypertensive; that is given for blood pressure, high blood pressure.

Q Frusemide?
A Frusemide is a diuretic, a water tablet.

Q I am just making a note as you speak. Clexane?
A Clexane is a type of heparin called low molecular weight heparin, which is an anticoagulant.

Q Why were you prescribing Clexane at this time?
A To prevent venous thromboembolism.

Q Because the patient was in bed?
A In bed.

Q Underneath that, paracetamol?
A Paracetamol is an analgesic, and 50/50 cream is a topical cream for the skin, and magnesium hydroxide, which is a laxative.

Q Over the page, page 174, we have moved on, I think, to 25 August, and I do not think those are yours, are they?
A No.

Q Could we go, please, to have a look at some haemoglobin levels and just ask your assistance as to what we can glean from them. I think if we go to 214 – I am sorry, if you look at the page following that, we can see that his blood had been checked on 12 August, I think, so that would have been when he was at the QAH?
A Yes, Anne Ward, QA.

A Q Anne Ward. In fact, if we look on the following page, 6 August 99, I am afraid these are not in a terribly helpful order, so we have got at page 218 6 August 99, then we have got 216 12 August, then I am afraid we have got 215 which is 19 August---
A I do not have a 215.

Q Have we not put the 215 in? Do the Panel have 215, which is on its side? Ah, some do. Can I ask for some copies to be made. I do not know if Mr Langdale has got it,
B and if he has I am the only one in the room without it, because I have just sent mine off for copying.

THE CHAIRMAN: Obscured beneath the print is the usual marking with two horizontal lines, but it is in at page 220.

MR KARK: Oh, I see. Well, I am going to go back to 218, having sorted that out,
C because that is the earliest for the haemoglobin and I have not got the later document anymore; I will have it back I hope soon. Can you just help us, please, the haemoglobin, is that the entry in the bottom left hand corner?
A Yes.

Q On this document that we are looking at, page 218, which is referring to 6 August, we can see haemoglobin, is it 15.2, or it might be 15.7?
D A Sorry, it could be 15.2 or 15.7.

Q Can you just tell us what that means, what we should be looking for?
A Haemoglobin is a protein in the red blood corpuscles. The normal range is between 12 and 16. It is slightly different for men and women. Men have got a slightly higher level than women. The average 12 to 16 is normal.

E Q What are you looking for when you are looking at haemoglobin?
A It is the level of haemoglobin in the blood.

Q So far as this patient is concerned, why were you asking for haemoglobin to be checked?
A When I saw him at Gosport War Memorial Hospital there was a suggestion that he had been passing black stool in QA.
F
Q Is that an indication potentially of bleeding?
A Bleeding.

Q Would that be gastrointestinal bleeding in this case?
A If he had been passing black stool it would have been a gastrointestinal bleeding.

G Q Right.
A I wanted to check his haemoglobin to make sure that it is remaining stable, that there is no further bleeding, or no bleeding.

Q If there is a bleed from the GI, what are we going to see happening to the haemoglobin?
A It would be dropping. The level would be dropping.
H

Q So if we look on 6 August first of all, page 218, we can see it is probably, I think, 15.7, so within the normal range?
A Yes.

Q 12 August, which is the page before, it looks like 11.5.
A Yes.

Q 19 August, which is the page we have now found again – yes, it is 220 with a line either side or 215 in large writing – haemoglobin 12.9. Are you with me?
A No, sorry.

Q Can we just pass this to the witness just to make sure he is looking at the same page. (Same handed) Sorry, Dr Ravindrane, that is our fault. Can you see 19 August 99 now?
A Yes.

Q Haemoglobin 12.9.
A Yes.

Q Then page 214, with a line either side of it---
A Yes.

Q ---haemoglobin is 12.9, yes?
A Yes.

Q So at that stage, we have heard that this patient had been on Clexane.
A Yes.

Q His haemoglobin apparently was being watched.
A Yes.

Q He had had one occasion, I think, of a black stool.
A I was told that he had.

Q At this stage, when you assessed him on 23 August, and you prescribed Clexane, was there at that stage any reason not to do so in your mind? Page 55, if you want to go back to your clinical note.
A I do not think I prescribed Clexane. I just continued Clexane, which he came in on---

Q You continued it?
A Continued with Clexane when he came in from Queen Alexandra Hospital.

Q Okay. If this patient had a GI bleed would you have continued Clexane?
A No.

Q Why not?
A It would have aggravated this bleeding.

A Q Having come back to 23 August, let us just remain with him at the Gosport War Memorial, and I am going to ask you to look at two other areas of his care. Could you go to page 75, please, with a line either side of it.
A Yes.

Q This is a "Lifting/Handling Risk Calculator".
A Yes.

B Q We can see that he was above eight stone. We know this gentleman was very well above eight stone.
A Yes.

Q Under "Mobility" we can see "Can stand but unable to walk, unable to assist, dead weight" and he scored 10, meaning he is really unable to move himself.
C A Yes.

Q Under "Special Risks" we can see 5 is put into the box again "Pain", so he had pain?
A Yes.

Q He has scored a total on the lifting/handling risk calculator of 20.
D A Yes,

Q The risk calculator, is that designed to assess risk to him or to those looking after him?
A I honestly do not know. I did not make this assessment.

Q In these days of health and safety I expect it would be those looking after him.
E Can we move on, please, to the "Waterlow Pressure Sore Prevention/Treatment Policy", page 76. It is the following page after the risk calculator. This is now a note made on the day following yours, and I am not going to spend very long on this. He is shown to be obese. In relation to his skin there is an entry that he has broken skin, is that right?
A Yes.

Q There is an entry that he has peripheral vascular disease, he is in fact bed bound
F and he has got poor appetite, yes?
A Yes.

Q These forms would be filled in by whom?
A By nurses.

Q Okay. Finally, on this area of the annotations, can we look at page 78, with a line
G either side---
A Yes.

Q ---to look at his Barthel score. 23 August 99 he scored 6, and he is, we can see, continent, he is independent feeding, he is dependent in relation to his toilet, he needs major help in relation to his transfer, which means getting out of bed, effectively, does it not?
H A Yes.

Q Mobility is marked as "unable"; dressing he needs help but he can do half unaided. Stairs obviously he cannot do and bathing he is dependent on others to help him and he scored 6. It is not the worst score that we have seen in this particular case, but it is not a very good score, is it?
A I would say 6 is a very low score.

Q And that is on the day that you saw him. A nurse would fill this in?
A A nurse would have filled it in.

Q Can we go back to your notes at page 55? There is a note "? Malaena"?
A Yes.

Q Can you tell us what that is please? You have made a passing reference to it already.
A Probably I would have been told that he has passed black stool and that is why I queried it.

Q For that reason you would have been watching what was happening in relation to his haemoglobin, as we have seen?
A Yes.

Q Could we go to page 84 of these notes?
A Yes.

Q Does your writing appear on this page at all?
A Not on 84. This is a nursing care plan normally.

Q If we look at the entry for 25 August, it is rather difficult to read I am afraid, but can we see a reference I think it is to fresh blood?
A I can see the entry, yes.

Q Fresh blood in the bowel action would indicate what?
A Some fresh blood present, indicating there could be bleeding.

Q If we go to page 63, and I am sorry to jump about in the notes, we can see a further reference to that; first of all on 25 August "passing fresh blood per rectum".
A Yes, I see it.

Q "? Clexane verbal message from Dr Beasley to withhold 18.00 dose and review with Dr Barton mane". Then I think it is "Mick", which was a name a lot of people used for him, "also vomiting". Now, that is not your note, is it? That is a nursing note again?
A Yes, not my notes.

Q Then on 26 August we can see: "Fairly good morning, no further vomiting – Dr Ravi contacted re Clexane. Advised to discontinue and repeat haemoglobin today and tomorrow" and then "not for resuscitation"? Yes.
A Yes, I see it.

Q Let us just deal with that in stages. First of all, do you recall this contact, and it looks as if it was from Sister Code A
A I do not remember the conversation but probably I would have spoken to her on the phone.

Q It appears that you advised discontinuing Clexane, and that would accord with the evidence you have given earlier?
A Yes.

Q If you thought there was a bleed, you would stop it?
A Yes.

Q Would you also have asked for a repeat of his haemoglobin?
A Probably, yes.

Q "Not for resuscitation": first of all, can you recall, did that come from you?
A I do not recall that coming from me.

Q Might you, at this stage of a patient's care, have taken a view that he was not for resuscitation?
A Probably that decision would already have been made somewhere down the line when he was being looked after, either at QA or at Gosport.

Q I understand that, but this note appears to be a reflection of a conversation with you. You have got no recollection of it.
A No.

Q Would you ever take the decision that a patient as not for resuscitation over the telephone?
A No.

Q Not for resuscitation in your mind means what?
A Just that, not offering cardiopulmonary resuscitation.

Q If there is a cardiac arrest?
A In the event of a cardiac arrest.

Q Is it an indication that the patient is not for continuing care or for any other medical care?
A Not at all. What I meant was that other treatment should continue.

Q With this patient, if you had found on your initial examination good evidence that he had a GI bleed ---
A Sorry, could you please repeat the question?

Q If on your examination you had found good evidence that he then had a gastro-intestinal bleed, what action, if any, would you have taken?
A It depends upon the patient's condition at the time. Could you please repeat the question?

Q Yes. If you had found that this patient had a GI bleed, a gastro-intestinal bleed, what action, if any, would you have taken?
A I would have assessed his pulse, blood pressure, and assessed his circulation, assessed all other vital parameters and if he has been bleeding excessively, then I would ask for further treatment.

Q What would that further treatment be?
A Again, depending upon the patient's condition, if the patient was willing to have other treatment, probably I would have started an intravenous drip, kept him probably nil by mouth, as we call it, not to eat or drink, and considered giving him --- I am not sure what was the protocol back in '99 because it is all changed now; now currently we would give intravenous omeprazol to suppress the acid but I do not remember what the protocol was at that time, and probably I would have spoken to my senior consultant and decided what else I would have done at that stage.

Q You would have taken advice?
A I would have taken advice.

Q Just in relation to the entry "not for resuscitation", can I take you back to one further document at page 48, because you were indicating that that is not a decision that you would have made, as it were, over the phone, but it may have been made earlier. If you go to page 48 of the notes, we can see this is an entry for 7 August '99.
A Yes.

Q You will be pleased to know that I am not going to go through the whole of this note which I do to think is yours?
A It is not mine, no.

Q I think we can see at the bottom of that there is the following comment: "Agree not for" and it looks like 535 --
A It is 555.

Q And that is an indication that his patient is not for resuscitation?
A Yes.

MR KARK: I have a little more to ask the doctor, but this might be a convenient place to break.

THE CHAIRMAN: Doctor, we are going to take a break now. I remind you that you remain on oath, so you should not speak about the case to anybody, nor should anybody speak to you about the case. You will be taken to a place where you can at least get some refreshment.

(The Panel adjourned for a short time)

MR KARK: Doctor, you will be pleased to know that I have very few questions about the next and final patient, but I think you wrote a letter in relation to her and I want you to look at it. It is Elsie Divine, Patient K. There are two documents I am going to ask you to look at. The first is a clinical note at page 145.
A Yes.

Q Just to remind the Panel, this lady, as we will see, was being reviewed in April of '99 by Dr Ravindrane but she is not admitted to the QAH until 9 October '99 and then she is transferred to Dryad wad on 21 October '99, and so we are looking at a period six months prior to her admission. I am not going to spend very long on this, Doctor, but just seeking your help, please. If you have a finger in 145, could you also go to 81? Is 145 a note made by you?

A Yes.

Q And is page 81 a letter, I expect typed by somebody else but dictated by you in relation to that same clinic?

A Yes.

Q What I am going to do is concentrate on the letter first of all and then we will have a brief look at your clinical notes to see if there is any addition that we need to make to your letter? Were you reviewing this lady on 1 April '99? Do you have any recollection of her at all?

A Not at all.

Q You say:

"Thank you for referring this lady to Dr Logan's clinic."

Dr Logan's speciality was?

A Dr Logan is a geriatrician.

Q "I have seen her on behalf of Dr Logan. She has been complaining of increasing swelling of her feet. Her routine blood test suggested a high ESR" –

meaning?

A High erythrocyte sedimentation rate.

Q "…mild anaemia, renal impairment and low protein with serum albumin 20. Today she is not complaining of anything apart from swelling of her legs. Her urine test today showed +++ protein with no blood. Her past medical history includes hypothyroidism and mild congestive cardiac failure. She is on Frumil 1 per day and Thyroxin 100 mcgms. She lives with her grand-daughter who looks after her.

…blood pressure was 150/90"

JVP is what?

A 1 centimetre.

Q Yes, but is it jugular venous pressure?

A Yes.

Q Just pause there for a moment. What is that an indication of ?

A A It is a slight elevation of jugular venous pressure. We normally see a jugular venous pulse just about the clavicle and probably hers was slightly elevated.

Q And that would be an indicator for what?
A Of congestive cardiac failure.

Q "....she has got massive pitting leg oedema. There is no lymphadenopathy." That means?
B A No enlargement of lymph glands.

Q "Breasts normal. Cardiovascular system revealed a short systolic murmur, chest was clear, para-abdominally it was soft, and central nervous system examination was normal."

C This is a full examination of the patient?
A It was a full examination of the patient.

Q "In summary, this lady who is hypoproteinaemic ---"
A Yes. Hypoproteinaemia means low protein in the blood.

Q "... is probably suffering form nephritic syndrome with renal impairment."
D
Can you put that into plain language for us?
A She has leakage of protein in her urine. She had 3+ protein in her urine when the urine was tested in the clinic, indicating that she was leaking protein in her urine. That is usually a condition in the kidney called nephritic syndrome which allows the protein to escape into the urine. Because she was losing protein in the urine, I assumed her low protein in the blood was because of the leakage in the urine.

E
Q All of this, in your view, might be arising from what?
A I thought it is all probably coming from a condition called multiple myeloma, which is a condition in the blood. There is increased secretion of immunoglobulin by a cell called the plasma cell, which is a haematological or a blood condition which is not akin to leukaemia but something similar – increased plasma cell production and an increased immunoglobulin in the blood.

F
Q We know that this lady was also under the care I think of somebody called Dr Cranfield, I think it was, who was also looking at the possibility of this lady having this condition?
A When I saw this lady, I was not aware of her being under Dr Cranfield, otherwise I would have mentioned that in the letter.

G Q I think you take the view that she is probably suffering from nephritic syndrome with renal impairment, which is all probably secondary to myeloma. Over the page, you have arranged a few tests, including, is it, urine and electrolytes?
A Urea and electrolytes. CRP is C-reactive protein, which is a protein which will go up in any inflammatory condition. A very high CRP indicates inflammation in the body.

Q And LFT is
H A It is a liver function test, thyroid function test.

Q Myeloma screen?
A Myeloma screen includes measuring the immunoglobulins in the blood and also doing a protein electrophoresis whereby they can see which protein is elevated, which immunoglobulins are elevated. I also asked for a urine Bence Jones, which is immunoglobulin which is normally leaked into the urine because the kidneys cannot retain them – urine Bench Jones protein. I also arranged for a full blood count, ESR, which is erythrocyte sedimentation rate.

Q I think in your statement about this lady you sum this lady's condition up as the following, and I am going to lead you, if I may: Her blood pressure was normal for a lady of her age, which was 88. She was not in pain or breathless. Jugular vein pressure was 1 centimetre. This indicates how well your heart is working. 1 centimetre is just above normal, showing that her heart as not working to its full capacity. This was nothing to worry about. Is that still your view?
A Yes.

Q Her legs were swollen with fluid which when pressed by your finger, the indentation stayed. So that is when you talk about massive pitting?
A Pitting oedema.

Q Her glands, lymph and breast were normal. Her heart examination with a stethoscope revealed a murmur. This is turbulence across the heart valve when the heart is pumping. This is quite common in the elderly. Her chest was clear. An abdominal examination was normal along with the central nervous. She was suffering from low protein in the blood, losing protein in the urine, with a kidney malfunction which could be secondary to myeloma, which you then decided to investigate.
A Yes.

Q I do not think that you dealt with this patient again?
A No.

Cross-examined by MR JENKINS

MR JENKINS: I am going to ask you questions on behalf of Dr Barton. Can I just stay with that last patient, please? I am going to ask that some documents be circulated so that they can be inserted into that bundle. I know Mr Kark already has a copy of these. He was given them at least a week ago.

THE CHAIRMAN: Mr Kark, are you content for the Panel to receive that?

MR KARK: I am sure I was given them. I have no objection at all.

(Documents circulated)

THE CHAIRMAN: These are for insertion into the bundle on the pages indicated.

MR JENKINS: They are marked with two page numbers. That is how they are marked in the originals. The Panel may choose to put a ring around the first of the numbers in each case. (Document handed to witness) I wonder if you could take us through these

documents, because you will be in a position to explain what we are looking at. These are blood results of Mrs Divine?
A Yes.

Q If we are start at the last of them. That gives the earliest specimen in time. It shows a specimen taken on 22 October 1999. It shows, along the bottom line, the tests that were ordered by the doctor. Yes?
A Page number 351?

Q That is right.
A Yes.

MR JENKINS: Towards the bottom of the page, underneath the details of the patient (name, date of birth, hospital number) there is an indication of the requesting clinician, which would be the consultant's name typically?
A Yes.

Q Then the report destination. We have heard that the letters there relate to the Gosport War Memorial Hospital, Dryad Ward.
A Yes.

Q Underneath that there is a line clinical details. What is inserted is "CCF" which is congestive cardiac failure.
A Yes.

Q Then we have some details of a lab number. We then have details of the results of the biochemistry report.
A Yes.

Q Then there are various forms of analysis. The first we turn to is NA, which is the metal sodium?
A Sodium.

Q Then potassium, then various others?
A Yes.

Q The fourth is urea?
A Yes.

Q The fifth, creatinine.
A Yes.

Q Then various others along the top line, including cholesterol. Then on the bottom line, some form of protein, albumen and other tests that are done.
A Yes.

Q In many of those cases, just underneath the indication of the type of test -- for example sodium (NA) -- there is an indication of a range: 135 to 146?
A Yes.

A Q Is that the normal range?
A Normal range.

Q I think these reports are designed so that if a figure outside the normal range appears, you get a little star or asterisk.
A Yes.

B Q So that, for example, looking under K (potassium), we have a figure of 5.2 for a test from 18 October. We have an asterisk next to that, because it is outside the normal range for potassium.
A Outside the normal range.

Q If we look at the various figures, we see quite a lot of asterisks or stars for the blood results that are shown on these tests.
C A Yes.

Q Creatinine, which is the fifth one across, on the top row of boxes, shows a range for men and a range for women.
A Yes.

Q F. relates obviously to females. It is a rather lower range; a slightly smaller range.
D A Smaller range.

Q But it starts at a lower level as well.
A Yes.

Q I think we can see, if we look over time, that during October -- and there are entries for 10 October, the bottom one, and 21 and 22 October -- there is some fluctuation
E in the creatinine level on the first sheet, page 351.
A On 351 there are only three dates, 18, 21 and 22.

Q That is right. It appears to go down, then up again, following the dates.
A Yes.

Q They start at 201, the earliest in time; then it goes down to 161 then back up
F somewhat to 187.
A Yes.

Q If you go on to the next sheet in time, which is page 345 -- so the first of the four sheets we have inserted -- the urea and creatinine levels are both outside the normal range.
A Yes.
G

Q And the creatinine figure has changed again from the one we have most recently seen on the 22nd.
A Yes.

Q If we go on, please, to page 347, we can see a creatinine figure, this time for 9 November 1999 at 200.
H A Yes.

Q And on the last page of the four, page 349, there is an entry for 16 November 1999. We can see the creatinine level has shot up to 360.
A Yes.

Q Very markedly elevated?
A It looks like that, yes.

Q I am not going to ask more questions about those documents or that patient. But it is an indication of decreased renal function.
A Worsening renal function.

Q Thank you. Can I take you back to Patient H, Mr Wilson, please? I am not going to take you through the records in any detail at all with regard to this patient, but I want to refer to some of them. These are the problems that Mr Wilson presented with in the few weeks after his fall, towards the end of September 1998. He presented plainly with a broken left humorous, a fracture.
A Do you mind if I refer to these?

Q Not at all. (Pause) I will need to remind you of the pages you were looking at. You were looking originally at page 166 of Mr Wilson's records.
A Yes, I have got it.

Q The information we have is that Mr Wilson's fractured humorous was not repaired in the three weeks or so before he left the Queen Alexandra Hospital.
A I was not aware of that.

Q I want to look at the medical problems with which he presented. He was suffering from depression over the period of time that he was dealt with and early dementia, if you check page 118. You want to start on page 117.
A 117, I have got, yes.

Q I do not need to take a great deal of time about this. If you turn over to 118, there is a reference to "Examination, mental state." Eight lines down: "Mr Wilson admitting there was no point in living." Clearly he was low in mood at the time.
A I could say, yes.

Q Dr Luznat gives a summary, in the third paragraph from the end: "It seems as though Mr Wilson may have developed an early dementia. Alternatively could be an early Alzheimer's disease or vascular-type dementia. In addition, he seems to have developed depression."
A Yes.

Q She is prescribing trazodone.
A Yes.

Q In the paragraph below, noting that she hopes he tolerates it, in view of his liver and renal failure. Those were two other problems that he had: liver disease and renal impairment.
A Yes.

A

Q We have seen the records which indicate that he was diagnosed as being hypothyroid. Again, the first reference was page 172. It was queried at an earlier stage, we think, and we have heard from you that you had not identified any treatment that was being provided for his low thyroid function.
A Yes.

B Q In addition, there was gross oedema. We have seen that in a note of yours towards the end of the picture, just before he is transferred. That is the note at page 177.
A Yes.

Q I think there is note that is: "Weight keeps going up." Again, that is a note of yours at page 179.
C A Yes.

Q Third line down.
A I saw it. I could see it.

Q That is not because of his diet, as I understand it. That was to do with him retaining fluid.
D A I assume so, yes.

Q I think he had grossly swollen limbs and had put on a great deal of weight whilst at the Queen Alexandra. Again, because this was increasing heart failure.
A I am not sure he had heart failure.

Q All right. Let me take you to some nursing records to show the information that
E the nurses may have received from the doctors. Page 16, if you would. As you see, there is a reference to 7.00 p.m. This is 1 October, people could see from the dates on the previous page, and lower down on this page. There is a reference to: "Robert states that he is desperate for sleep. Tends to be awake at night and asleep during the day; typical of alcohol withdrawal." I do not know if you are able to help with that observation.
A Sorry. I did not make entry.

F Q I understand that, but are you able to help us with whether it would be typical of alcohol withdrawal for someone to have an unusual sleep pattern?
A I am not sure.

Q What you have told us is that you noted he was drowsy during the day, and you considered it might be due to his liver function. Are you able to comment on this note, and the suggestion that it may be because he had not been sleeping at night time?
G A Sorry? Could you repeat the question?

Q What you told us was that he was drowsy and you were concerned that it might be to do with his liver function, and the effect of any medication that had been provided?
A Yes.

Q This was an observation from nursing staff that his sleep pattern (being awake at
H night and drowsy during the day) would be typical for someone withdrawing from

alcohol.
A I am not sure.

Q I am asking you to comment.
A People do not sleep at night, but we do come across patients at hospital, they do not sleep very well at night -- mainly because of the noise; particularly in an acute hospital -- and they do tend to sleep during the daytime, if that is what -- probably that is what the entry meant.

Q All right. You said it is not your entry, so I will not press you on it. I want you to let me take you to page 22, if I may. There is a nursing entry in the middle of the page for 13 October: "Reviewed by medical team. Continues to require special medical/nursing care oedematous limbs at high risk of breakdown. Right foot already about to beak down. This is due to oedema." It may be there is a letter or a notation before the word 'oedema". "... secondary to cardiac failure and low protein. Also at risk of self-neglect and injury if starts to take alcohol again. Needs to have 24-hour hospital care until healed arm." This is relatively shortly, a day or so, before Mr Wilson was discharged from this hospital. Are you able to comment on the proposition that his oedematous limbs were due to cardiac failure?
A I would say due to combination of so many factors. I do not remember the patient, so I cannot specifically say whether his oedema was due to heart failure.

Q What you said in your statement -- and let me get the words precisely right -- in relation to Wilson was. At the time of transfer you do not recall Mr Wilson. But having read his notes, you can say he was unwell. He may have stabilised and maintained some level of health. Equally, he could have died suddenly or quite quickly due to his condition."
A I gave that statement, yes.

Q Was that because, when you made that statement, you had noted all the things I have mentioned: the liver disease, the renal impairment, the gross swelling of limbs?
A I took into account the whole thing.

Q I am grateful. Is it your experience that patients with multiple medical conditions can take a sudden turn for the worst?
A Usually hospitalised patients can take a sudden turn to the worst.

Q I am going to turn to the next patient, Patient J. I will go through a little of the history you have been taken through already.
Can we start with the history of haemoglobin and any bleeds that he may have had, and if we start, please, at page 218. (To the chairman) Sir, I have drawn a chart with dates, times and figures on, and I am sure the Panel may find it useful if they do something similar, and, sir, I am dealing with this obviously chronologically. (To the witness) 218 is the first page, which shows a result from 6 August 1999.
A Yes.

Q Again, I am just looking at haemoglobin for these purposes and the result is 15.7.
A Yes.

A Q The next document we have in the sequence is page 216. This is a sample taken on 12 August.
A Yes.

Q It is not entirely clear what the haemoglobin figure is, it could be 13.5 or maybe 11.5, but we are able to confirm, if we look at page 50 of the clinical notes, because a doctor has helpfully written in.
B A Sorry, could you please repeat that page number?

Q Sorry, page 51, I beg your pardon. We see, and it is Dr Chatterjee's note, I think, on the third line down of that entry on page 51, he has written in 13.5, which I think clarifies the figure that is not easy to read on page 216.
A Yes.

C Q Unfortunately, these notes are not in time sequence. If we turn over from page 51 to page 52 we move to 16 August and 18 August, I think; page 53 takes us back to 13 August. It may be useful for people to note at the bottom of page 51 that the next page is page 53. If we are looking at 53, we have an entry in a different handwriting from that of Dr Chatterjee, and this person too has noted a haemoglobin of 13.5 at the top of their entry. So we have seen a drop in haemoglobin levels from 6 August from 15.7 down to 13.5 on 12 August. It looks like this gentleman has had a significant bleed.
D A He had a drop in haemoglobin, yes.

Q I think if we look at the nursing records, there is a nursing entry on page 136, and towards the bottom of the page we can see the date of 11 August---
A Sorry, could you please repeat the page number?

Q Yes, 136. Do you have a date in the left hand margin of 11 August and then a
E time below that of 13.45 "Loose black stools"?
A Yes.

Q There is then an entry below, again dated 11 August, "Care as per plan. Black stools noted. Dr Chatterjee aware" is what the note appears to say.
A I can see.

F Q Black stools means there is blood?
A Not necessarily. Black stool can be due to discolouration from medication.

Q All right, but that, combined with the drop in haemoglobin that we have seen between 6 August and the sample taken on 12 August, is likely to relate to an intestinal bleed?
A Possibly.
G

Q Yes. I think following on, if we are doing a chart, the next result that we have is on page 220. This is the document Mr Kark calls 215, but we know he is wrong, sir, but I refrain from any other comment! This is a sample tested on 19 August and the haemoglobin is 12.9. Next one, if we go to 214, sample on 20 August, and am I right to say 12.9? Probably. The next one is after the transfer to the War Memorial Hospital, it is page 212, and we will note on this document to the extent that we can read it that the
H

A consultant is given as Dr Reid, we see it is the War Memorial Hospital, the clinical details are given as obese and CCF, which stands for congestive cardiac failure you have told us.
A Yes, "CCF" stands for "congestive cardiac failure.

Q The sample is taken on 24 August 1999 and the haemoglobin figure is given as 12.0.
A I can see it, yes.

B

Q People will note that there appear to be a doctor's initials which may be "JAB", I suggest Dr Barton's. If we go on, I think the last in the sequence, if we turn one page forward to 210, Dr Ravindrane, again signed by Dr Barton, it is specimen dated 26 August 1999, clinical details are "bleeding PR", rectal bleeding, and the haemoglobin has gone down dramatically to 7.7.
A Yes, I can see.

C

Q So that is the end of the charting, I think. There are drops in the haemoglobin level between 15.7 on 6 August and 13.5 on 12 August. We have looked at the nursing records, which show that on the 11th Mr Packman was passing black stools. Your note at page 55 refers to "? melaena" on 13 August.
A Yes.

D Q I think if we look at pages 50 and 51 do we see any entry – 50 deals with 11 August, 51 deals with 13 August – do we see any entry from Dr Chatterjee indicating that he is aware of melaena? I do not know that we do on page 51.
A On page 50 and 51 Dr Chatterjee has not mentioned anything that he was having malaena.

Q Right. I have already commented that we have to go to page 53 to see other
E clinical entries for 13 August. We have seen the top entry and reference is made to the haemoglobin level. On the bottom entry, again different handwriting, there is reference to "black stools overnight". That would be the night of the 12th?
A Yes.

Q There is an entry lower down, is it "chase Hb"?
A I assume so, yes.

F

Q Again, if we go back to our chart, we will know that there is a drop from the haemoglobin level recorded on the 12th of 13.5 down to the haemoglobin level recorded on the 19th down to 12.9. If there was a further rectal bleed would you expect that to be reflected by a drop in haemoglobin?
A Fluctuation of about one gram is quite common day to day.

G Q So the picture, if we go back to Dr Chatterjee's note on page 51, is that there had been some black stool noted on the 11th, and a significant drop in haemoglobin noted on the 12th. Dr Chatterjee, according to this note on page 51, is not apparently aware of any further black stools that you have referred to on the 13th, although clearly one of the doctors is. We have just seen the note on page 53, on the 13th, "Black stools overnight. Chase haemoglobin".
A Yes.

H

A Q Does it appear that this patient is stable or is he clearly not stable as at 13 August?
A I could not possibly comment. I did not see him at the date.

Q All right, but he has had what would appear to be two rectal bleeds over the course of the last couple of days?
A He had black stools reported by nurses. That is all I can …

B Q All right, but what clearly is anticipated on the entry we have at page 51, it is the last full line of Dr Chatterjee's entry, "Transfer to Dryad ward on 16/8/99".
A Sorry, could you please repeat that?

Q Yes. On page 51, Dr Chatterjee's note "Transfer to Dryad ward on 16/8/99".
A Yes.

C Q That apparently was what was planned---
A Yes.

Q ---although for reasons that do not appear in the notes it did not happen.
A I do not know what date he came to Gosport.

Q Well, you saw him on the day he was admitted, page 55, on 23 August.
D A Usually, it all depends upon the availability of the bed situation in Gosport.

Q We know that, thank you for helping us, but the proposition I am putting to you is that he clearly was not stable as at the 13th, albeit that discharge to the Dryad Ward was planned for three days later, and you have said you cannot tell us because you had not seen the patient.
A I had not seen him.

E Q I understand. Anyway, the transfer to Dryad was on 23 August. We have seen your note several times at page 55, and we know that you prescribed Clexane. Again, I do not think I need to point to where you have prescribed it. If people want to make a note, it is page 173. We have looked at it. I think in fairness this patient had been on Clexane for some period of time. Can I invite your attention to page 182.
A Yes.

F Q This shows that for the period in August before his admission to the War Memorial Hospital, again which was on the 23rd, we see along the top line that Mr Packman was receiving Clexane twice a day for a couple of weeks.
A Yes.

Q Clexane again is an anticoagulant.
G A It is.

Q There were bleeds or black stools on the 11th and 12th during that period of time and doctors were following his haemoglobin level.
A Yes.

H

Q Are you able to tell us whether there may have been bleeds that Mr Packman suffered shortly before his transfer, or about the time of his transfer, to the War Memorial Hospital?
A Sorry, could you please repeat the question?

Q Yes. Are you able to tell us whether Mr Packman may have suffered further bleeds either shortly before his transfer to the War Memorial Hospital or at about the time of transfer? The reason I ask is we have noted that there is a drop in his haemoglobin level between the 20th of 12.9, again page 214, and 24 August, which is the day after his transfer, page 212, of 12.0; 12.9 down to 12.0 over a four day period in what we have seen is a continually dropping haemoglobin level.
A I cannot possibly say when he bled.

Q What happened after that was that there was fresh blood noted, and we know from the nursing records --- We have been asked to look at page 63. Do you have page 63?
A Yes.

Q At the top of that we will note it is 23 August, which confirms what I have suggested to you, that Mr Packman was transferred in on 23 August?
A Yes.

Q We have seen your clerking note on 25th, two days after transfer, "passing fresh blood rectally".
A Yes.

Q And the nurses, as you would expect, check what Mr Packman is being prescribed, note that he is on Clexane, the anticoagulant, and seek medical advice in relation to that?
A Yes.

Q They speak to a Dr Beasley who advises them to withhold the dose and again that is clearly what happens. If people want to cross-refer to page 172, it is a nursing document "Exceptions to prescribed orders" and in the top line the Clexane is withheld. There is a time put in and noted by one of the nurses. The reason is shown; it is because he is passing fresh blood per rectum. If we were to turn over the page, we would see the Clexane that you had prescribed, doctor, just continuing the prescription that Mr Packman had been receiving at the QA. We see Clexane, the third drug down on the chart, is withheld on 25th and he does not get it again. Back, if we may, to page 63, the plan is that Mr Packman would be reviewed the following day. Clearly the doctor is anticipating Dr Barton's attendance.
A I can see the entry.

Q What happened was that you were contacted, as we see, on 26th, this entry, about the Clexane, and the nursing staff very sensibly asking your advice?
A Yes.

Q Your advice was that it should be discontinued, and again we have seen that it was. Your advice was that there should be a repeat haemoglobin done, and we have seen that at page 210. When that was reported, it showed a dramatic fall down to 7.7. Again, I have suggested Dr Barton at some stage saw that and has initialled it as having noted its

A comments, noted the readings. Now, you cannot recall this discussion with Sister Hamblin?
A No, I cannot.

Q This was in relation to a patient that you had clerked in and assessed a couple of days before on 23rd. Yes?
A Yes.

B

Q We know that the nursing staff will have had the medical records. Clearly they did for you to know that there had been the question of malaena on 13 August. You will have learned that from the records?
A Yes, definitely.

Q What we have seen in relation to this patient is that, if you turn to page 47, right at
C the bottom of the page, we have heard from a Dr Dowse who made this entry with a review with the registrar: "In view of premorbid state and multiple medical problems, not for CPR in event of arrest." That is a not for 555 entry effectively, is it not?
A Yes.

Q We know that it is said again by a different doctor on page 48, by Dr Chatterjee. We know that it is said by Dr Chatterjee again on page 50?
D A Yes.

Q He says it again on page 51. If we turn to page 106, this is a QA document, and we see in the top left corner the patient is being admitted to Anne Ward on 6 August. This is the front sheet of a folder of some kind, is it not?
A This is the clerking sheet, yes.

E Q We see the contact details of the next of kin. We see personal details of the patient. Right at the bottom of the page, on the right hand side, we see entries agreed for resuscitation status and the views of various doctors were recorded. That I think is something that happened back in the Nineties?
A I am sorry; I did not understand the question.

Q This kind of document would exist back in the 1990s, that entries would be made
F about the resuscitation status and what it was to be of the patient?
A Yes. We still make the decision in different ways.

Q Can I take you back to page 63? S Code A s note appears to deal firstly with the morning and her contact with you and then deal with what happened at lunch time. Do you follow?
A Sorry, I do not understand you.

G

Q I am suggesting that there is a natural break in the middle of the fourth line where Code A is dealing with separate episodes throughout the day. She makes an entry about a fairly good morning, Dr Ravi contacted, and deals with what was dealt with with you and then goes on to say that he was unwell at lunch time "seen by Dr Barton this afternoon". Do you follow?
A Yes.

H

Q I am suggesting that the "not for resuscitation" is an entry she made, having discussed this patient's case with you over the telephone?
A I do not agree with that. It looks like it could have been a summary of events that happened.

Q Well, a nurse would not make that decision, would they?
A The decision of not for resuscitation had already been made for the patient by two consultants, so it was just a continuation of the decision the other consultants made.

Q I understand. You have told us you would not make such a decision over the telephone?
A If the patient had not been for resus, I would not have made that decision on the phone the first time.

Q I understand that exactly. You would want to have the patient in front of you if you were making such a decision?
A If I am making a first time decision for someone's resus, I would assess the patient carefully myself.

Q I understand but what you and I have seen is that on four occasions in the past couple of weeks doctors had entered the notation that this patient was not for resuscitation?
A Yes.

Q If Sister Hamblin had raised with you the question of whether Mr Packman should be for resuscitation when she spoke to you ---
A She would have already been aware that the patient was not for resus.

Q All right. If she had raised it with you over the telephone, what would you have said?
A If you are asking me whether I would have reversed the decision for 555, probably I would not have reversed the decision.

Q If she told you over the telephone, if she said, "Look, he has been assessed as not for resuscitation" on the documents that she had ---
A There is no reason to reverse it.

Q I understand. What you say in your statement in relation to Mr Packman --- Forgive me. Can I deal with the transfer? Are you able to tell us why Mr Packman was transferred from the Queen Alexandra Hospital to the War Memorial Hospital?
A I did not make the decision to transfer him.

Q No, but are you able to tell us whether it means his conditions was improving as he left the Queen Alexandra or was it likely that this was just to move him to anther hospital?
A I cannot comment on that. They would not have transferred him if he is not stable.

Q Let us agree they should not have done, but it is clear that there was a further bleed very shortly after his transfer?

A A Yes.

MR KARK: I am so sorry, but just so that there is no confusion about that answer, the question started, "Let us agree they should not have done …" meaning, as I have understood it, they should not have transferred him if he was not stable rather than they should not have transferred him.

B MR JENKINS: If a doctor is dealing with Mr Packman after he has had a massive bleed, which may well be the position Dr Barton was dealing with him in on the afternoon of 26 August, any doctor would have to make an assessment of the patient at that point?
A Yes.

Q And has to assess how best his needs can be met?
A Absolutely, yes.

C

Q Although we know that the pervious decisions of other doctors that Mr Packman should not be for resuscitation do not mean that he should not be treated fro his problems?
A That could be my understanding, yes.

Q There will be a reason why the doctors are making that assessment at all?
D A Sorry. I do not understand your question.

Q If you ever made an assessment of a patient not for 555, why would you be doing it at all?
A That would be specifically for offering the treatment of cardiopulmonary resuscitation whether the CPR would be beneficial to the patient. If we think there would be a likelihood of a patient having a cardiac arrest, that would be for most patients
E coming into hospital, so we do assess everyone from the CPR point of view and we would be taking into account the patient's wishes. If the patient is not able to make a decision about themselves, friends and relatives then decide what is best for the patient depending upon the current guidelines, guidelines from the GMC and from the BMA.

Q Sure, and tell me if I am wrong but I am assuming that most patients admitted to hospital do not have "not for resuscitation" written into their notes?
F A I do not recall what was the protocol, what was the policy, on resuscitation back in 1999. Now we do tend to encourage patients to discuss with us what their idea is on CPR and so we would be making a decision for almost every patient coming into the hospital, taking into account their wishes.

Q Sure, but I think the law has changed. There is now the Mental Capacity Act 2005 which requires doctors to look actively at what the patient's wishes might be in
G certain circumstances. I want to look back at the 1990s, if I can. There were patients where a doctor may say "not for resuscitation". I just want to explore with you the circumstances in which the doctors might say that of a patient and what you have told us is that the doctors would say that if in their view a patient was not appropriate, was not suitable, for resuscitation, that they would be unlikely to benefit from it?
A The treatment would be unlikely to be successful.

H

A Q I want to know if you can help me in what circumstances the doctors would even think that? If a patient goes in with a broken arm, a young fit patient, can you conceive of circumstances in which a doctor would be writing "not for resuscitation"?
A Unless the patient comes in with a living will or advance directive saying not for CPR.

Q We do not need to worry about advance directives or living wills, but would you
B agree with me that if a young fit person went into hospital with a broken arm, nobody would have dreamt of putting "not for resuscitation"? It was wholly inappropriate.
A I cannot answer the question.

Re-examined by MR KARK

Q I only have one matter to ask you and I want to get the right page first. Could
C you go back to Patient K, page 349, which was one of the new documents that Mr Jenkins put in?
A Yes.

Q It is just to seek your assistance, please, as a doctor because we have one doctor on the Panel but most of the people in the room are lay.
A Could you please repeat the question?
D
Q Page 349, the creatinine level is obviously very much above normal?
A 360 was very much above normal.

Q Normal being between 45 to 90?
A Yes.

E Q And the creatinine level in this case being at 360?
A Yes.

Q You described that, or this was put to you and you agreed with it, it was very markedly elevated?
A Yes.

F Q No misunderstanding about that but I just want to have an idea of what creatinine levels can go up to. If you have somebody who is so ill for instance that they are on dialysis, what sort of levels are we talking about with creatinine?
A It all depends upon what was the level before. Someone who has what we call chronic renal impairment, that is longstanding renal impairment, some of them would have an elevated creatinine ---

G Q Throughout their illness?
A Yes, but a sudden rise indicates that there is an acute process going on with a chronic condition.

Q So there is a sudden change?
A A sudden change.

H

Q I understand. Again, I just want to come back to my point: can you give us an idea of what levels you have dealt with in the past and in what circumstances? Have you dealt with levels higher than this or not?
A Absolutely, many higher levels than this, yes.

Q Can you just tell us in what circumstances?
A Recently I saw a man --- Am I allowed to describe this?

Q Do not give the name of the person but you can certainly give a description of his illness.
A An elderly gentleman came in with an acute obstruction of his kidneys and his creatinine was more than 1000.

Q Obviously you have to look at the patient?
A It all depends upon the patient's individual situation, yes.

Q With this lady, are you able to say with your assessment of her whether this was potentially treatable?
A I cannot comment on that. I did not examine her.

Q It depends what the underlying issue is?
A Exactly.

THE CHAIRMAN: Doctor, I mentioned earlier that there would come a time when members of the Panel would have an opportunity to ask questions of you. I am going to look now to see if any of them do have questions. Our medical member, Dr Roger Smith.

Questioned by THE PANEL

DR SMITH: Good afternoon, just a couple of points for clarification. You were asked about Mr Wilson, who is H, and about his hypothyroidism, which I think was the term that was used when you were being questioned?
A Yes.

Q You were asked about his hypothyroidism. You may or may not want to look again at the results which are on page 171 of H. I bring this up, because it is a fairly technical area. Would you agree?
A You mean the thyroid?

Q Thyroid functions tests. They are a fairly technical area. My lay colleagues would not understand.
A Renal function test is commonly tested in hospital; almost everyone coming into hospital. The clinical condition of hypothyroidism goes with the levels we see here, but also the clinical condition of the patients. We do come across slightly abnormal thyroid functions test. But what we normally do is to repeat them after an interval, to see whether -- because even an acute condition -- acute illness, sorry -- can make the thyroid test a bit abnormal.

Q That is what I wanted to ask you about in slightly more detail, so my colleagues understand what you say. On page 171 on 25 September, the total T4 level, the

A Thyroxin level, is 67, which is below the lower limit of normal of 70.
A Yes.

Q And the thyroid stimulating hormone is 4.6, which is slightly higher than the upper limit of normal.
A Yes.

B Q Together, that would broadly indicate what?
A Hypothyroidism, low acting thyroid.

Q Is there another way of expressing that than hypothyroidism?
A It is a decreased secretion of thyroid hormone from the thyroid gland.

Q You said it, but let me ask you so it is clear what you mean. Did you say that (a)
C there can be a fluctuation of these tests in an acutely ill patient?
A Yes. That is my understanding, yes.

Q Are you saying, by saying that, that this is not an indication of a primary thyroid gland abnormality?
A Yes. That may be the reason why we did not start him on treatment.

D Q And further, what degree of thyroid gland abnormality do these results indicate?
A If he has true hypothyroidism it would be a mild hypothyroidism, if that is what you meant. If you could repeat the question.

Q Mild hypothyroidism.
A Yes.

E Q And in the normal turn of things, either in in-patients or outpatients, is this a level, if you thought it was hypothyroidism (an underactive thyroid gland), would you treat it with thyroxin?
A I have become a consultant now, so my experience is definitely more than it was in 1999. If I see such patients now, probably I would repeat it after three months, and if it is remains hypothyroid (that means remains low), or gets worse, then I will treat it with thyroxin.

F Q What I am getting round to saying is: is it not unreasonable that this gentleman was not put on treatment for what is being called hypothyroidism at this stage of his management?
A I would agree with that, yes. I would have not started him on treatment for this level.

G Q That is helpful. Secondly, with Mr Wilson as well, I think Mr Jenkins had invited you to agree that Mr Wilson, who was grossly oedematous had an element of heart failure. That is a statement rather than a question. I think Mr Jenkins invited you to agree that there was heart failure. I think you said that you really were not sure that he had. So can I take you to the same folder, H, and to page 167?
A Yes.

H Q That is a clinical examination done on the 23rd, I think we agreed, of September.

A At the bottom of both the drawings of the lungs, there is cardiovascular system (CVS)?
A Yes.

Q Can you just tell us what the third line down in "Cardiovascular system" means; what it says and what it means?
A It says "JVP (horizontal arrow)". Probably the person who assessed this patient felt that the JVP is not elevated.

B

Q In terms of the question as to whether Mr Wilson was at that stage suffering from heart failure, can you tell anything from that?
A When he came into hospital on the 23rd, looking at the entry -- I did not assess the patient on 23rd, but looking at the entry by the doctor who assessed him, I cannot see any features of heart failure.

C Q Yes, but can you explain to my colleagues what the evidence for that statement would be?
A Because his blood pressure was normal. The JVP (jugular venous pressure) was not elevated. His lung examination showed when we view what we call crackles in the left base only.

Q From that would you conclude that there is evidence of heart failure?
D A I would not say he was in heart failure at the time, no.

Q That is the second point. The third point is about patient J, which is Mr Packman. Just to put you back in the frame, it is quite difficult swapping between patients. This is the very obese gentleman who had the melaena stool. You said, again talking to Mr Jenkins -- I did not get your exact words -- you were taken to the difference between a haemoglobin of 13.5 and a few days later it had gone down to 12.9.
E A Yes.

Q And you said something like "a fluctuation of one gram is quite..." Usual? Was that the word?
A Quite expected.

Q Can you explain what that means to those who are not doctors?
F A Estimation of haemoglobin is not correct. It can fluctuate, even within the normally range.

THE CHAIRMAN: Whilst we always welcome persons in the public gallery, if they could try not to make movements or other gestures that might be distracting to those at this end of the room, while we are trying to concentrate on what the witness is saying.

G DR SMITH: I broke you in mid-flight.
A Okay. My understanding -- and I am not a haematologist.

Q Your opinion as a physician.
A When we measure haemoglobin in patients, sometimes we do see this fluctuation between either side of 0.5 to either plus or minus. Unless there are other indications that the patient is -- there is evidence of bleeding, we would not give too much importance to
H a slight fluctuation in the haemoglobin, because we do come across slight fluctuations.

A

Q In the ordinary course of events?
A Yes.

Q Mr Jenkins also pointed out that between 20 August in the QA and 24 August, which was now in Dryad, the haemoglobin had fallen further from 12.9 to 12.
A Yes.

B

Q That is still within 1 gram. But do you say the same thing about that 1 gram?
A Retrospectively probably no, because he had bleeding on the 25th.

Q Let me go back a step. When the gentleman was admitted to hospital on 6 August after a fall.
A Yes.

C

Q This large morbidly obese man who had had a fall and he had broken his shoulder, his haemoglobin was 15.7.
A Yes.

Q Which is considerably higher than 12?
A Yes.

D

MR JENKINS: Is this Mr Packman with the broken shoulder?

DR SMITH: Sorry. It is Mr Wilson. We are talking of Mr Wilson. No. We are talking of J Packman. He did break his shoulder, did he not?

MR JENKINS: No. He spent 24 hours on the toilet.

E

DR SMITH: He fell and had a large sore.

MR KARK: I think the confusion is that he is described in the chronology as "following a fall at home". But actually this is the gentleman about whom we heard evidence that effectively he had been in the bathroom and could not get out.

F

MR JENKINS: It took two ambulance crews to get him out of the bathroom. He was an extremely big man and he needed two beds. Many things happened to him, but I not think he fell.

DR SMITH: If there are situations where the hemoglobin might be higher than normal when a patient comes in in this kind of scenario which, let us me emphasise again, is a morbidly obese man who did not break his shoulder, but had fallen and was wedged in

G

the bathroom and had a sore.
A Normally we do see in elderly patients when they come in, they have a higher level of haemoglobin, because they are dehydrated; what we call haemoconcentration.

Q So there may be a reason why the haemoglobin is artificially high on admission.
A And when we hydrated him properly, it would have fallen down to 12.9.

H

Q Nevertheless on the 13th -- and I think Mr Jenkins also pointed to a nursing note

about the 11th -- there was a black stool.
A Yes.

Q We have a trend of haemoglobin downwards.
A Yes.

Q A definite trend downwards, even from 13.5 to 12.9, and a melaena stool; or 15.7 down to 12.9, with a black stool, rather. It would not be unreasonable to be concerned that there might have been a significant bleed.
A There should have been a -- yes.

Q Can you turn back to page 63 in Mr J? Remembering that you were attending with Dr Reid at the Memorial Hospital, undergoing some training with Dr Reid at that time, that is why you were at the Memorial.
A Training with Dr Reid.

Q You were here on this page, 26 August 1999, half-way down: "Dr Ravi contacted Re Clexane." Above that is the entry about passing fresh blood PR.
A Yes.

Q So we are all on the same level of understanding, "fresh blood PR" signifies what?
A There are two types of bleeding in the gastrointestinal tract. If any bleeding happens in the stomach, the acid discolours the haemoglobin, and when it comes down in the stool it becomes very black and tarry. If the bleeding happens below the stomach, where there is no acid, it can appear as fresh blood, like normal blood.

Q This is fresh red blood PR. Could it mean something serious?
A Yes.

Q It could.
A Yes.

Q A doctor was contacted, this is Dr Beasley in the above entry. There is a mention of Clexane. The next note, however, is the next day, the 26th. We deduced it is in the morning, I think, because the Sister has written ----
A I honestly cannot remember when she contacted me?

Q Say it again?
A I cannot remember what time she contacted me.

Q And it is not easy to tell from the note. But you were contacted about the Clexane.
A Yes.

Q Do you remember the conversation?
A Not at all.

Q With what we read on the previous note, and you were phoned about Clexane, do you think that it would be right to conclude that the bleeding was discussed with you?
A Possibly. Definitely she would have discussed the bleeding with me, yes.

A Q That seems likely?
A Yes.

Q That seems more than likely?
A Definitely she would have discussed the bleeding. I would have asked her where the bleeding was.

B Q So you knew about the bleeding that next morning.
A Probably, yes.

Further cross-examination by MR JENKINS

Q Going back to Patient H, Mr Wilson, the man with the broken arm. You told us, when answering Dr Smith's questions, that this would be mild hypothyroidism. You told
C us there can be thyroid fluctuations in an acutely ill patient.
A Yes.

Q What was Mr Wilson's acute illness during the time he was in hospital before transfer to War Memorial? He had a broken arm. (Pause) Do we have to come back to the list of matters I put to you, namely liver disease, renal impairment?
A Sorry? I did not ----
D
Q Do we have to come back to liver disease, the renal impairment and what I have suggested was a degree of cardiac failure?
A I would assume so, yes.

Q Yes.
A Of course, he had multiple problems.
E
Q Can I ask you to turn to page 70, again Patient H.
A Yes.

Q Dr Smith asked you to look at an entry where I think a junior doctor made some entries about Mr Wilson towards the start of his period in hospital. What we have on page 70 is an indication of Mr Wilson's ability to engage in the activities of daily living
F over a three week period---
A Yes.

Q ---starting with his admission on the 23rd. We know that there were a number of concerns to do with his mental health and his outlook on life, and he was certainly expressing a wish to die during some of it, and that may have affected what we are looking at, but are you able to tell us whether there was clearly a significant deterioration
G in his general condition during the time that he was in hospital?
A The score has come from 13 to 7 – gone down to 3 and then come up to 7, sorry.

Q It hits 3 at one point. Again, perhaps it is inappropriate for me to ask you as a doctor to look at this document, but is this, for the lay members of the Panel, a fairly graphic illustration of how Mr Wilson's condition deteriorated and then perhaps picked up a bit before he was subsequently discharged?
H A His ability to look after himself has deteriorated and picked up.

Q Can you give us the explanation for the gross oedema of his limbs and his weight going up when there were concerns about his nutritional intake, certainly before and whilst he was in hospital?
A I do not remember his condition now, but I was only shown the entry I made in the notes, so based on that I assumed, or based on the entry, that his gross oedema was secondary to hyperaldosteronism, that is increased level of aldosterone due to liver failure, which retains fluid, and also due to the intravenous fluid, he was given quite a lot, and also---

THE CHAIRMAN: I am sorry, the Legal Assessor is not able to hear. Could you speak up a little and perhaps a little more slowly.
A Sorry. I do not remember this patient, but I can only go by what I wrote in the notes.

MR JENKINS: Yes.
A When I wrote gross oedema I thought it was due to his liver failure, fluid overload and also low albumin. I do not remember whether this gentleman had any features of heart failure at the time, so I do not know.

MR JENKINS: Well, if you do not remember I will not ask you any more. Thank you.

THE CHAIRMAN: Thank you, Mr Jenkins. Mr Kark.

MR KARK: No questions, sir.

THE CHAIRMAN: Very well. Dr Ravindrane, that completes your testimony. Thank you very much indeed for coming to assist us today. May I add the apologies of the Panel to that already extended by Mr Kark for the considerable amount of time that you have had to expend waiting to get on, as it were. We cannot perform our function properly without the assistance of witnesses such as yourself, who take time to come to acquaint us with matters of detail that are often going back many years, but which help us to build up a clearer picture of the true situation at the time. We are most grateful to you for doing that and you depart with our thanks. Thank you.

(The witness withdrew)

THE CHAIRMAN: Mr Kark, would this be a convenient moment to break?

MR KARK: It certainly would, yes.

THE CHAIRMAN: Very well. Thank you very much. Two o'clock, please, ladies and gentlemen.

(Luncheon adjournment)

MR LANGDALE: Sir, may I just indicate to the Panel so it does not occasion any unnecessary delay, Dr Barton will not be here this afternoon. Some attention, in the ordinary course of events, it is not a new problem, but some attention needs to be given to

her leg, and that I think is being done this afternoon. So there is no need to wait for her to appear.

THE CHAIRMAN: Thank you very much for that indication. Yes, Mr Kark.

MR KARK: Sir, the next thing that was going to happen was I was going to read to you the final statement before we call Professor Ford, and you will see from the list that that is the statement of Richard Samuel. Following discussions between my learned friends and myself, there is one inquiry that has arisen that needs to be made, and I think it would be more sensible therefore to read that statement at some point next week. It is a short statement from the person who is now the Director of Corporate Affairs at the Hampshire Trust. So it is not frankly going to matter hugely when that statement gets read to you, and so perhaps you will just allow us time to consider other matters.

Now, can I raise two other matters; first of all, in relation to the chronologies. "We" I was going to say, but really Mr Fitzgerald has done a great deal of work and he has provided copies of all of the new improved chronologies to the defence, and Mr Jenkins has also been doing a good amount of work on those. We have been provided back with copies annotated by Mr Jenkins, and in respect of those we have been able to produce final versions, which I think are now copied up, for Patient A, H, K and I think it is I. I am very grateful indeed to the Panel Secretary, who has also assisted, and the reprographic department here. It means, of course, that we are still shy of many more chronologies. I gather that by the end of this evening a total of ten will be able to be copied up, and so we will be doing two over the weekend. I can only apologise, but, as you will have seen with the one that I think you have been given, they are very detailed indeed, they all have to be checked and it has just taken time to do it. So we can provide you with the chronologies for A, H, K and I now, and we are happy if you want to have a separate bundle for those and peruse those this afternoon. It is a matter entirely for the Panel.

Can I raise the issue again of whether you wish to receive Professor Ford's reports.

THE CHAIRMAN: Yes. Before you do, can we just finish with these chronologies. I had understood that both parties wished us to have read the revised chronologies before we started on the expert.

MR KARK: Well, can I say this: I think in a perfect world that probably would have happened, but the reality is that Professor Ford has some evidence to give of a general nature in any event. We will obviously have breaks in his evidence. I think certainly before he deals with each particular patient, which – the way that I was going to introduce his evidence was obviously to deal with his general comments first about the nature of the drugs that have been used, syringe drivers, hydration and all the rest, and then turn to the individual patients and just run through from A through L. So there will be time, I suspect, during the course of that process for you to have an opportunity at least of looking at the chronologies, if not studying them in great detail. By the time we come to Professor Ford being cross-examined we will have had, I suspect, two days in the middle of next week, on one of which you will have reading time, where you will have an opportunity of spending rather longer on the chronologies. So I would not wish to delay calling Professor Ford on Monday morning if at all possible, because otherwise I think we are going to get into---

THE CHAIRMAN: I think that is understood, and if Mr Langdale is happy with that approach---

MR LANGDALE: Sir, I entirely agree. I do not think it is going to create any difficulties for the Panel because Professor Ford will be taking no doubt the chronological history of the patient he is dealing with at any particular time in order to set the context for his own views. So I do not see any problem with that. I think the other thing that was thought to be a sensible course to take was so that the Panel, before Professor Ford gave his evidence, would have in mind the statements made by Dr Barton about nine patients, I think it is, but I think my learned friend Mr Kark and I agreed there is no difficulty about that not being done prior to Professor Ford giving his evidence in-chief. The important thing is that the Panel would have had an opportunity to read Dr Barton's statements before I cross-examine, because obviously I will be raising matters contained in them with Professor Ford. Professor Ford, of course, will have seen them. He saw them ages ago.

THE CHAIRMAN: Yes. So might that opportunity for the Panel be on the Wednesday, when we are clear that there will not be a---

MR LANGDALE: There is room for manoeuvre on that, I am sure. I think Mr Kark agrees with that sentiment.

MR KARK: Certainly. Those are in fact ready now, so those could be handed up this afternoon. They are not particularly lengthy. I re-read them the other evening, and I think it is probably about two hours reading, something like that. It is not an enormous amount of reading. So although they each look quite fulsome, the beginning few pages, once you have read it, is the same pretty much, I think, for the rest of them.

MR LANGDALE: May I just mention one other thing. Maybe I am misjudging it, but, quite frankly, reading a whole series of statements about different patients makes for a pretty indigestible process. They are not very long, but it may be that the Panel will find it easier to somehow deal with them one by one. We have all had the experience of sometimes forgetting what it was that ever brought the patient into hospital in the first place. That kind of thing---

THE CHAIRMAN: Especially with the speed we have been going at.

MR LANGDALE: ---arises terribly easily, and I am as burdened by that as anybody. So whatever is appropriate for the Panel, but I simply wonder whether one might be able to break it up in a way. The other thing is, and this is not meant as something to prevent the Panel reading the statements of Dr Barton when they are provided, but my learned friend Mr Jenkins, and I am very grateful to him for doing this, is proposing to provide a single sheet for those statements so that it is very easy to see, when Dr Barton says, "I saw him on 8 December and my note reads", to give you a reference, and all of us a reference, to the page in the files of what it is that Dr Barton was in fact referring to at the time she made her statements. The documents were not in the shape and form that they are now. Again, I repeat, it is entirely a matter for the Panel.

THE CHAIRMAN: I think anything that assists the Panel in navigating its way through what is by any standards a very large amount of paper, particularly in the light of the fact that we have gone through very much faster than normally happens in a case of this length, and, I mean, Mr Jenkins alluded to it yesterday, it is difficult for the most attentive and assiduous Panel to balance in their heads all of these things without having some sort of a break or structure, so any structure you can give us is going to help enormously. It may be, Mr Kark, that the way to do it would be as those structures become available for individual patients, as it were, that is when we are given the statements.

MR KARK: It is equally difficult for the most attentive of barristers. What we might want to do, once we get to the patients with Professor Ford, is to take a break between each patient, possibly not a very long one, but we might do just so that we can re-focus, as it were, on the medical---

THE CHAIRMAN: I am sure that the Panel would find that enormously helpful, so that we are re-focusing each time rather than just running straight through. If that is going to be possible, I think we would welcome it.

MR KARK: Can I then turn to the next issue, and it is really, rather than making an application, to make an inquiry in a sense. You remember that towards the beginning of this case I made an application to you to receive Professor Ford's reports in advance so that you have in mind in advance what he was going to say about each patient, so that when you were listening to the various pieces of evidence you knew what the expert opinion was, and you rejected that application, and I have no qualms with that at all. The point now comes when Professor Ford is about to give evidence, and he is going to be working through his reports, and unless he is stopped, or I am stopped from doing so, I am going to be asking him to have these reports in front of him and I am going to take him through them, because there is no other way of doing it with a case of this complexity and size. Now, it is very much a matter for the Panel whether they feel that they would be assisted, certainly in respect of not necessarily the general report that he has done, but the reports that he has prepared in relation to each individual patient, the Panel would be assisted by having those reports at least at the time of him giving evidence, or we would suggest if you are going to have them at all you ought to have them in advance. It is simply to assist you following his evidence. It gives the GMC no particular advantage because I will be going through the report with him, you will be getting it on the transcript. It may mean, I have to say, that if you were to take that course I could be rather shorter with him, because he will effectively affirm that the reports are his and either he still agrees with the conclusions or he does not agree with the conclusions. I cannot say that it will avoid me having to deal with at least some of the material in each report, partly because there is a public element to these proceedings and it is important that the public know what evidence you are receiving, but it would undoubtedly make the process shorter. So I simply raise that as an inquiry, whether you feel at this stage it would be helpful to have those reports from Professor Ford.

THE CHAIRMAN: I think the key phrase is "at this stage". At the earlier time we did agree that it perhaps would be best if we did not have that information, but when we are at the stage when the evidence of the professor is about to be adduced, particularly because by definition it is going to be long and it refers to a number of different patients, as I said earlier, anything that assists us to navigate is enormously useful. This is a very experienced Panel. Every one of them have been on many long cases in the past, and on

many long cases this would be the time when Panels would be most receptive, shall I say, to receiving those. I might also say that on a number of recent long cases in which I have been involved it has been a time when the defence have themselves said, "Well, we are happy for you to see his in advance, but if it is going to be assisting to know where the issues are, will you see the defence report at the same time?" Now, it may be that you would not wish that or that Mr Langdale would not wish that.

MR KARK: I can give an answer to that straightaway: we would have no objection, obviously on the basis that the defence expert is going to be called. We have now been provided with an expert report, and we would have no objection to you having that in advance at the same time as Professor Ford's reports.

THE CHAIRMAN: Would you have a view on that one way or the other, Mr Langdale?

MR LANGDALE: I do most certainly have a view. My learned friend charmingly says this is simply an invitation to the Panel to see if it would assist. He is in fact applying to put this report in to the Panel. The Panel has already heard the application, and I am not going to repeat the nature of the objections I had at that stage. This is something very different to assisting the Panel in the way that we have been trying to do with various documents that have been produced – documents which I stress are non-contentious. This is an utterly different matter. This is a contentious document. This is in effect the GMC's case against Dr Barton.

Not only do the objections, which I think the Panel found were made out, stand as they did at the outset, nothing has changed as to whether this should properly be received because we have now reached the stage that we have, but any changes that have taken place since this matter was first raised before the Panel are in fact further indications as to why the Panel should not have the reports of the expert.

There is no problem at all, in my submission, created for the Panel by not having the report of Professor Ford. The Panel is going to be deciding the case on the evidence of Professor Ford. The report is not the evidence. Indeed, slightly alarmingly my learned friend seemed to be suggesting that in order to shorten proceedings he would give you the report and just ask Professor Ford about certain bits of it, which really, with the greatest of respect, simply is not a sensible way of proceeding from anybody's point of view, and I would certainly have the strongest possible objection if that is what he was proposing to do.

What has changed from the time that this application was first made is that it has been absolutely apparent that the Panel are well able to keep their own relevant notes. There has already been some quite difficult and detailed evidence, for example from Dr Reid. There has been no difficulty, so far as the Panel has been concerned, in terms of keeping track of his evidence, making whatever notes are necessary for the Panel to remind themselves of what they need to ask about, or anything of the kind. The Panel, in any event, receives every day a transcript of the previous day's evidence, and I have no doubt that has been of assistance in determining what particular bits of evidence need further explanation or scrutiny by the Panel.

A It is going to be absolutely the case with Professor Ford, whose evidence in chief is going to take I would have thought certainly two days that the Panel is going to have ample opportunity to consider what it needs in terms of a record of what has taken place.

The important thing, it seems to me, not only as a matter of common sense but also so that justice can be seen to be done, is that the Panel makes it clear it is focusing on the evidence it hears. There is no difficulty about the reception of that evidence. There is no B difficulty about my learned friend adducing his evidence. The thing that does assist the Panel in terms of following Professor Ford's evidence, and I suspect will also assist Professor Ford, is that you have the detailed history of what happened with regard to each patient in the way that has already been set out in advance, as it were, and you know the general nature of it. I must say, I found it of enormous assistance to have something of that kind and of enormous assistance when considering what Professor Ford says in his report, even from our point of view.

C

The disadvantages for the Panel of having this material in front of it is that it is not his evidence, number one; number two, the way in which Professor Ford's report is set out, and this is not a criticism of him for a single second, is that it is not chronological; it is a mix. He will set out the history with regard to the medical notes and then set out a section setting out the history in terms of the nursing notes. One literally does have to turn the pages backwards and forwards to try and get the chronological picture. D I presume Professor Ford, when my learned friend takes him though his evidence, is going to be dealing with it chronologically. The key thing is the chronologies that are going to be provided to you.

The other disadvantage is that the report contains comments and statements which may well not be borne out in terms of the evidence the Panel has heard, that may well not be borne out in the course of Professor Ford's evidence. This is an important further reason E in my submission: the report contains some repetitious material – again this is not a criticism of Professor Ford – and indeed it contains a number of repeats of the same opinion. In some cases there are two reports produced by Professor Ford – again, not his fault because he was asked to look at some patients at a certain time back in December of 2001 and then produce a final report.

May I just indicate, just by way of example, just taking Patient H, Mr Wilson, Professor F Ford was asked to produce a report in December of 2001 and he produced a five-page report setting out various matters and giving his opinion about certain aspects of the matter. Professor Ford does not always use the same expressions when he is talking about the same thing. It is not going to be of assistance for the Panel to have a document which describes the same event with different adjectives or appellations made by the same witness, because it is going to distract the Panel from concentrating on what the evidence is from Professor Ford. Perhaps creating even more of a problem is that he then G produced – again none of this is a criticism of Professor Ford at all – later on, rather more recently, a further report about the same patient, on this occasion five pages, repeating very much the same sort of thing but very often using different expressions – the sort of thing that may trouble a lawyer and a lawyer may have to deal with in the course of his evidence but should not be before the Panel because he may not say that and he may not say it in the same way. Far from shortening proceedings, in my respectful submission, it is going to lengthen them.

H

These are closely typed reports. Just by way of illustration, he says in respect of simply the second report with regard to Patient H the prescription of diamorphine and midazolam was inappropriate and unjustified. The Panel know that because they know that from what Mr Kark said by way of opening. He says that again in the same paragraph. He says it twice more in later paragraphs. So you are getting it a further five times I think in various paragraphs, saying exactly the same thing. It cannot assist the Panel, or indeed any tribunal, to have a repetition of the same material when the Panel is not going to find it impossible, difficult or in any way a problem following Professor Ford's evidence. You now know much more about the case than you knew at the start and it is simply going to add to your work, in my submission, run the risk of giving the reports a prominence they do not deserve because they are not evidence and, far from agreeing with my learned friend's assertion that this is likely to shorten his presentation of the case, I just do not see that happening.

These objections are serious objections and it seems to me everything the Panel has been faced with in terms of the work that it has had to do already and the changes that have taken place indicate that it is simply not necessary, and indeed is a distraction for you to have in front of you.

THE CHAIRMAN: Thank you very much, Mr Langdale.

Mr Kark, I think it is clear from what Mr Langdale has said that your charming invitation really is an application.

MR KARK: I think we can certainly see there is objection to it, whatever it is, but I do not entirely accept that it is not a sensible way forward. This is how it is done in all civil proceedings, I believe, that an expert report will be produced and the expert will turn up to confirm that that is his report and then be cross-examined on it.

MR LANGDALE: I am sorry to interrupt. One thing I should have made clear, in case there is any confusion, and I should have said it: I have no objection at all of course to Professor Ford having his reports in front of him. He has got to have them in front of him.

MR KARK: I will only remind you that this is the same afternoon where it is being suggested that you would have the advantages of reading Dr Barton's statements in advance so that you know where the issues lie in advance of hearing presumably Dr Barton's evidence, and it is not so very different from hearing from Professor Ford and knowing what he has said in advance.

I really do leave it – I am not going to pursue this strenuously – as an invitation, call it an application if you will, to the Panel to consider the pros and cons.

MR LANGDALE: May I just add one thing in relation to what my learned friend has just said, and I am sure your Legal Assessor will advise you in the same way: the statements of Dr Barton are being put in by Mr Kark as part of his case; they are not being put in by the defence as some kind of "would you look at this in advance, please, members of the Panel, so that you know what our case is". He is putting them in as part of his case.

THE CHAIRMAN: Presumably, Mr Kark, you have therefore had the opportunity to put them in at the time that you wish. Without prejudging the views of my colleagues, if the Panel were to say that the application, or whatever it is, is not successful, you would have the discretion as to the time at which you put in the documents which you are adducing?

MR KARK: I would but I would still try and behave sensibly and make sure that you got them at a time when it is going to be most helpful to you.

THE CHAIRMAN: Would you therefore agree with Mr Langdale that it would be most helpful to the Panel to have that information in advance?

MR KARK: Yes. You will remember, if I may be allowed just to remind you, when I opened this case, I did describe those statements, and I am sure Mr Langdale would agree with this, in a technical legal sense: those are known as self-serving statements. They were prepared by Dr Barton one expects with her lawyers and so they are not the same as evidence under cross-examination. Should the event arise that Dr Barton were not to give evidence in support of those statements, then we would have more to say to you about how you should treat that evidence.

Having said all of that, given that that was her response to the police interviews, although she did not allow herself to be questioned in the sense that she did not answer police questions, we do think it is appropriate for you to have those and we have no objection to you reading those in advance of hearing from Professor Ford so that in relation at least to those patients you know where the battle lines are.

THE CHAIRMAN: That is a very helpful indication. Thank you.

Mr Langdale, I am going to ask the Legal Assessor now whether he has anything to add to his earlier advice and whether he wishes to repeat any of that earlier advice.

THE LEGAL ASSESSOR: Mr Chairman, I last advised the Panel in relation to the reports of Professor Ford on the second day of this hearing, 9 June, and the issue now raises its head again.

I advise that this should be treated as a renewed application by the General Medical Council. I advise you that you should read the skeleton arguments submitted by counsel on 9 June; it will not take very long. You should then read my advice set out on what I believe is page 20 of Day 2 of the transcripts and you should then read the Panel's own earlier determination on the issue.

Having looked at all that, you should then look at matters afresh today, but asking yourself what, if anything, has changed, particularly with the passage of time, since your determination of 9 June 2009.

You will bear in mind the following points, and I will deal with them briefly. First, as is apparent from the earlier advice, this is not an application that the reports should go in as evidence, and that still means, in my view, that Rule 50 of the Old Rules does not apply and Mr Kark conceded on the last occasion that that may indeed be the case.

Secondly, the new chronologies that have been prepared, and you have one already, are,

as I understand it, fully factual and uncontroversial and will not incorporate the GMC's specific criticisms of Dr Barton as you suggested in the final paragraph of your earlier determination. I understand, I hasten to add, that that was considered carefully but was not felt to be possible. Obviously you will be able to write notes of Professor Ford's evidence on the relevant pages of the new chronologies.

The defence view remains that the admission of the reports, even if not by way of evidence, would remain prejudicial. They are based, it is said by the defence, on partial or defective statements or statements which differ from later oral evidence and the defence state that the passing of time does not diminish that prejudice.

Attempts have been made to edit matters into a satisfactory form but that has not been possible.

We are all, I am sure, anxious that the Panel should be properly assisted as much as possible. It might be that the provision of reports shortly prior to Professor Ford giving evidence might assist the Panel in understanding his evidence better when he comes to give it. After all, the Panel has now heard much, if not all, of the nursing evidence in the case and, subject always to the question of memory, it would be able to look at the reference to the nurses' evidence in Professor Ford's reports in the light of the evidence that they actually gave.

On the other hand, it does not necessarily assist a panel to be given a very large amount of material which it is forbidden to rely upon as evidence. It is possible that such a course would in fact not assist the Panel and that it would actually be muddling, because the Panel would have to constantly bear in mind that Professor Ford's opinion might now be very different from that set out in the earlier reports, and furthermore the Panel would have still to perform the disentangling exercise I referred to in my earlier advice.

You should also consider whether the reception of Professor Ford's evidence will be made easier for you, even if you do not have the reports, by it being led chronologically and in relation to each patient in turn.

Mr Chairman, I am sure that the parties will have done all they can to assist the Panel by reaching agreement as to editing by the removal of any material which could conceivably be prejudicial or which is inconsistent. Unfortunately, that has not proved possible.

Whether fortunately or unfortunately, the situation is not that the Panel may take whatever course it would find most helpful. The mere fact that Professor Ford is about to give evidence does not of itself alter the fact that we are all constrained by the state of the law. I refer the Panel to my earlier advice, which remains that I am not able to point the Panel to any clear legal authority which would entitle the Panel to override the objections of the defence and receive the reports at this stage. I therefore cannot advise the Panel that you are able to require the reports to be produced to you, contrary to the wishes of the defence.

I advise that the Panel should go into camera to consider this matter now.

THE CHAIRMAN: Thank you, Legal Assessor.

Mr Langdale, do you have any observations on the advice just tendered?

MR LANGDALE: None, thank you.

THE CHAIRMAN: Mr Kark, do you have any observations?

MR KARK: No.

THE CHAIRMAN: The Panel will go into camera and we will call you back as soon as we possibly can. Thank you.

PARTIES THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

PARTIES HAVING BEEN READMITTED

D E C I S I O N

THE CHAIRMAN: The Panel has received what it regards as a renewed application from Mr Kark for the Panel to receive copies of the expert's report or reports in advance of the expert giving his evidence. The Panel has considered whether the passage of time has raised any fresh considerations which require us to depart from our earlier decision. We have concluded that there are no such fresh considerations which require us to depart from that decision.

We have concluded, as before, that in the absence of consent from Mr Langdale on behalf of Dr Barton it would not be appropriate for us to receive the reports at this stage. The Panel therefore rejects the application. We do, of course, note that in one area at least things have changed; that is that, due to the diligence of Mr Fitzgerald and Mr Jenkins, the Panel will be furnished with the upgraded chronology, if I can put it that way, that we asked for at the time of our previous determination on this matter. We are confident that will assist us greatly.

MR KARK: Mr Fitzgerald is now back in the Court of Appeal where he was this morning. He will be continuing with the chronologies this afternoon. As I say, we hope to have them available to you as close as possible to Monday morning. If you are content to receive those which are ready, I think they are sitting on the desk behind you.

THE CHAIRMAN: Absolutely. It will enable the Panel, some of whom have long train journeys, to use the time to good effect, if you are content for us to do so.

MR KARK: An enjoyable use of time before the weekend starts!

THE CHAIRMAN: Those are chronologies for A, H, L and Patient I.

MR KARK: Yes. That is all that we have for you today.

THE CHAIRMAN: Thank you.

MR KARK: We will be starting on Monday at 10 o'clock with the Professor Ford.

(The Panel adjourned until 10.00 a.m. on Monday 6 July 2009)