GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Thursday 26 March 2009

The Guildhall,
Guildhall Square,
Portsmouth,
PO1 2AJ

BEFORE:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY SEVEN)

MR ALAN JENKINS QC, instructed by ??, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by ??, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09 by), appeared on behalf of the Wilson family.

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(In the absence of the waiting jury)

THE CORONER: Good morning. Do sit down, please. Mr Leiper, good morning. You are on your feet.

MR LEIPER: I am ready, sir. Albeit extremely briefly, instructions in relation to witness list: the families are quite happy that that should go before the jury.

THE CORONER: Excellent. Then thank you very much indeed. Thank you for doing that. I am grateful. If the jury might have a copy of it, I would be grateful. Anything else? Right.

Mr Sadd, I think the only point I was going to raise was, I was going to call Mr Wilson first, Mr Ian Wilson. Mr Neil Wilson, I am more than happy to take his statement under rule 37 and, if you want to reserve your position for the future, I am happy that you should do that but making progress with Mr Wilson this morning.

MR SADD: Sir, that we understand totally. May I take, as it were, advice about Neil Wilson's statement?

THE CORONER: Certainly.

MR SADD: Thank you.

THE CORONER: If we could get the jury in, please.

I understand the Cunningham figures are now agreed as postage. They are correct.

MALE SPEAKER: The one query was I think the hiazine start date was incorrect. The 21st and 22nd September should have been deleted.

THE CORONER: I have got the 23rd as being the first date.

MALE SPEAKER: The 23rd is the starting date for the hiazine.

THE CORONER: That has been amended.

MALE SPEAKER: That has been amended. I am most grateful. Thank you.

(In the presence of the waiting jury)

THE CORONER: Good morning, ladies and gentlemen. Are you ready? Mr Ian Wilson, please.

MR IAN WILSON, Sworn
Examined by THE CORONER

THE CORONER: You are Ian Alistair Wilson?
A Yes.

Q Robert Colwell Wilson was your Dad?
A Yes.

Q And it's about him that we have heard, and Professor Black gave some evidence yesterday and the day before about Dad.
A Yes.

Q Do you want to tell me about him in your own words, or do you want to go through the statement? How do you want to deal with it?
A It's probably easier for me to say it in my own words.

Q Yes, please do.
A I've got some notes here that help me along. My Dad was 74 years old. As a child, he was... as I grew up he was ex-Navy. He'd done 27 years in the Navy. He came out as a CPO TASI and really his life was the Navy. I think we were all born in between leaves and I'm the middle one of seven. I've got three older than me, three younger than me. I wouldn't call us a close family; being a big family, we've always fought, and we're now spread across the world.

Q I think Neil's in Bahrain and it was he that we were talking about the other day, isn't it?
A Yeah. I've also got a sister in Los Angeles.

Q Right.
A We're all spread around. We've worked out that we actually get on better as a family if we...

Q If you don't see each other?
A If we've got distance between us.

Q We understand that.
A My Mum and Dad were married for 32 years. We lived together in Fareham and I suppose Neil, my younger brother, was probably my Dad's favourite, and I was probably my Dad's least favourite. That probably had a lot to do with the fact that I was a bit of a "toe rag" when I was younger and unfortunately used to drag my little brother along with me. As we grew up, Neil went and joined the Army and that made my Dad immensely proud, the fact that he'd followed in my Dad's footsteps into the service, and it had kept him out of trouble, unlike me. But my Dad and I had a good relationship. It was up and down. He was very, very strict. He ran us at home as though we were on board ship.

After 32 years my Mum and Dad got divorced. My Mum instigated the divorce and my Dad took it very, very badly. For that matter, so did I. I was probably more upset than most of the other kids in the family at that time. I spent a lot of time with my Dad. After he came out of the Navy he was a coach driver, bus driver, and I used to go all round the country with him, and I did actually spend a lot of time with him as I was growing up. They got divorced, I think, early Eighties – I can't exactly remember the year – and my Dad moved to Sarisbury Green and he moved into lodgings with an old Polish war somebody or other. They had a lot in common. They could talk war and they were quite happy and it seemed that my Dad had quite a nice little thing going. He was quite happy.

My Dad for the whole of my life was an alcoholic. He probably wouldn't admit it for that long but the chances are all the time that he was in the Navy and afterwards... My Dad was Scottish. He was very, very proud of his Scottish roots and he used to say, "Navy, Scottish, chances are I'm going to drink" and he certainly did. He had a very, very broad Scottish accent and he never lost that, and sometimes it made it very, very difficult to understand him. He was also deaf in one ear. That was due to something that had happened in the War. He saw active service during World War II and also in D-Day. He was on the D-Day landings. He was a bit of a hero to us. He was a bit of a hero actually.

I lost the thread there.

Q Deaf in one ear.
A Yes.

Q Had his lodgings in Sarisbury Green with the Polish...
A He was totally deaf in one ear and it was to do with when he was in the Navy. We used to think it was just selective hearing; when he didn't want to hear something from us, he'd turn his deaf ear to us but it was no ifs or buts: if we spoke into the wrong ear, he couldn't hear a thing.

Life went on and he met somebody else. He never got over my Mum. My Mum was the love of his life and right up until the last days of his life he always hoped there was a chance he'd get back with my Mum. He met somebody else. She was a barmaid at the local pub where he was drinking and I suppose it was an easy relationship. I think she probably felt threatened by us kids. Seven of us is a lot to put up with, especially when we were all much the same. I didn't like her at all. She didn't like me. Over the years that he was with her – and he was with her for quite a few years. He married her. He didn't tell any of us except my brother Neil that he was getting married. I wouldn't have turned up at the wedding anyway, unfortunately, I disliked her that much. But at the end of the day, she looked after him. She fed him. He seemed to have a fairly nice life and after a few years they moved up to Sarisbury Green, further into the village, and it was much nearer to the club where my Dad drank – in fact, about 200 yards from the club. That really became my Dad's life. He got up in the morning, he'd have some breakfast, he'd wander down the club, he'd wander back from the club half two, three o'clock in the afternoon. If he felt like it, he may go down in the evening, he may not, but my Dad revolved around the club and alcohol.

Q What did he drink? What was his tipple?
A He did used to drink beer, and then he went off the beer and in the last few years he was on Wood's Rum and his last tipple was whisky. That was basically their life. I had a major row with his wife and I was banned from going up to the house. She didn't want me anywhere in the house. It suited me. I used to see my Dad down at the club. We were all well known down at the club. Everybody in the club knew we were Jock's. "Jock's kids" they called us, and that was basically life as it went, until 1997, when he was admitted into hospital. I'm not 100 per cent sure what he was admitted in for other than I know he had had a fall but while he was in in 1997 a lot of tests were done on him and a lot of it was to do with his alcohol.

Q Yes, the liver damage that Professor Black referred to.
A Yes, yes. I can't remember exactly how long he was in the hospital at that time but we all went in and visited him, although my Mum didn't go and visit him at that stage. When

he came out of hospital at that time he'd been told that he had to do something seriously about his drinking and his compromise to that was that was when he went from Wood's Rum to whisky. Some compromise!

Q Yes, obviously.
A That would have taken us up to 1998. The fact that Gill didn't tell us that he was in hospital in 1997 caused one huge row with all of us. She said it had nothing to do with us and we made it very, very clear to her that he was our Dad and it had everything to do with us, and we expected her, if it happened again, to immediately let us know.

Unfortunately, in 1998 his wife was down in Cornwall on holiday. My Dad had just received a pay-out, a compensation pay-out because of his deafness from the Navy, and I think he ended up with £20,000 plus. Gill, his wife, used to disappear off all over the place on booze cruises and weekends away, and one of the downsides about that was that there was always, always bottles of spirits around at his house. Always. There was huge amounts of spirits around at his house.

In 1998, September, Gill was away down in Cornwall, and I think she'd been away for four or five days and my Dad was fending for himself. My Dad's way of fending for himself was half a bottle of whisky when he got up for breakfast, down to the club, a few whiskys down the club, back home, crash out. He didn't bother with eating. He might have fed the cat but that was about it, and for four or five days that would have been my Dad. He was so regular at the club that you could almost set your clock by him, and one morning he hadn't turned up at the club and Harry, the steward, had decided to wander up the road to make sure he was all right. Harry found him – I'm not sure how, whether the back door was open or whether Harry had a key or whatever, but Harry went into the house and I know that Harry found him, and I believe that he'd fallen over by the side of his bed, but he hadn't been able to get himself up. My Dad had put on a huge amount of weight in his latter years. When he was younger he was very, very fit and active. He could always catch up with me, that's for sure. But as he got on he'd put on a lot of weight and he wasn't very fit at all.

Q Was he centrally obese? Was he big tum, big chest?
A Yes, yeah. He just generally put on a lot of weight. His only exercise was to walk 200 yards to the club and stagger 200 yards back, or 400 yards back.

Harry had called the ambulance and he was taken over to the QA. Harry knew that his wife was down in Cornwall and I presume that Harry must have given the hospital her contacts, because I know the hospital were in contact with her. I believe that had Gill been at home that he would have been discharged, because he refused to have the operation, that he would have been discharged back out of the hospital but, because she refused to come back up from Cornwall, he was kept in and it was then obviously the following day that they realised that there was more problems with him.

Q My understanding of Professor Black's evidence was that your Dad refused any surgical intervention on admission – yes?
A Yes.

Q And it wasn't until his condition had deteriorated to such an extent that he might have had the operation that they couldn't do it at that point. That was not quite rightly put, but you know what I mean.

A Yes. By the time he was saying "yes", they were saying "no" because he'd deteriorated.

Q So when do you first become aware that Dad's in hospital?
A I think he'd been in there a week, and I'm not 100 per cent sure who out of me and Neil first found out but Neil and I both found out from Harry. I'd gone down to the club and I think Neil might have phoned Harry, or Harry had phoned Neil, but it was Harry that let us know that my Dad was in hospital again. I went up to the hospital and I think, as far as I was aware, I was the very first one to see him up there.

Q What did you find when you got there?
A I was totally shocked when I saw him. I couldn't believe the state of him, how he looked, and, to be honest, if he had died then, I wouldn't have been surprised.

Q What was wrong with him? What was so shocking about him?
A Well, he was laid in his bed. I'd never seen my Dad looking so bad. He had no energy. He didn't want to do anything. He almost had no life in him. He just lay there and he didn't really want to talk. He didn't want to do anything. He wasn't eating, he wasn't taking liquids, and I was really, really worried. At that point I done two things. I phoned other members of the family to let them know that he was there and how bad he was, and that everybody ought to get in there, and I spoke to nursing and medical staff. I spoke to the doctor up there, and I can't remember, for the life of me, what the doctor's name was, and I asked him straight out was my Dad going to die, and he said that the problems that my Dad had weren't in themselves life-threatening. He'd had a nasty fall and he had a very painful and serious fracture. That was when he told me that my Dad had refused the operation and that's when he also told me that now my Dad was too ill to have the operation. Then he said about his other problems, i.e. the alcohol, the problems that the alcohol had brought on. I didn't know what all those problems were at the time but I knew they were all related to the fact that my Dad was an alcoholic.

The doctor said that none of those things were actually life-threatening but that in my Dad's case, because of the way he was, some of the things that he'd said to the nurses, what sometimes happens in older people is they give up the will to live, and he said that in this case he suggested that's probably what it was with my Dad. He'd had enough and he was ready to give it up. That didn't ring very true with me because my Dad was a fighter; always had been. Coming from the Gorbals and round the Gorbals, he had to be a fighter. My Dad was always, you know, he was a strong fighter.

When we were younger and we lived at home, my Mum and Dad had lots and lots of ups and downs, and my Dad, because he was so strict, certainly with us older children rather than the younger ones, my Mum always used to throw at him all the time in rows that he'd turn us kids against him and he would die a sad and lonely old man, and that's what I saw there. I saw a sad and lonely old man. The hospital said he'd given up the will to live.

Q But you were there for him.
A I'd only just got there. He'd been there for a week with absolutely no-one around him. So for a week, the first week he was there, there's no ifs or buts, to his way of thinking, I would think that he saw my Mum's prophecy coming true.

Q Right.
A None of his kids were there, his wife wasn't there, neither of his wives were there, his ex-wife nor his present wife. He was to all intents and purposes a sad and lonely old man.

Q So it was affecting for you.
A Yes, it was.

B Q A very difficult situation.
A I mean, I was heartbroken. I was gutted. I don't really know how to explain. I was devastated. This was my Dad. The last thing I wanted to do was to lose him. I suppose, at the end of the day, we all take our parents for granted until all of a sudden you see them there in front of you, and it, you know, it's all there.

C Over the course of the next week, I suppose, we were all in to see him. I say we were all in to see him; Neil was in to see him, I was in there virtually every day, my younger sister Tracey was in there virtually every day, my sister Karen came over from the Isle of Wight to see him. She was there on and off. My brother from Bournemouth, he also came up, and he hadn't seen my Dad in years, and the one thing that really, really picked my Dad up was my Mum went in and saw him.

D My Dad started responding. He started taking food and drink. He was much more alert, he was much more involved. Instead of being laid in bed most days, he was either sat on the bed or sat in a chair alongside the bed. They tried to keep him in the chair alongside the bed so he could raise his arm and keep his arm in a set place, because obviously that was still painful for him. But over the course of the next week, eight, nine days, the improvement in him was immense. As I say, he was eating again, he was drinking, taking fluids, he was... the nurses knew he was getting better because he was back-chatting them, which he hadn't done. He was arguing back with them all the time – not in an aggressive way but it was argumentative E banter between them, and he seemed to be getting back to himself again.

The QA, all the nursing staff and the doctors up there were very, very helpful. There was always someone to talk to and they were always happy to talk, willing to talk. The nursing staff and the – I don't know what you call them – like the auxiliary staff, the cleaners and all those sort of people, they were talking to us all about how my Dad had responded, and it seemed that it had been an awful lot to do with the fact that he had his family around him F again. Also, he was on medication which was by now taking effect for his liver and whatever else he was on. So obviously that was all starting to take effect on him as well. As I said, he was eating, so that was also having an effect, and the QA was very, very aware of the friction between my Mum's – for want of a better way of describing it, my Mum's side of the family and his ex-wife.

G Q No, your Mum's family and his current wife.
A Yes, my Mum's – yes. The hospital was very aware of friction there and they made a point of always telling us, both sides, what was going on with my Dad, so there was no arguments or fights. I can't remember Gill being up there very much at that time. Certainly when I was up there I don't remember seeing her at all – maybe once. I know that Neil was up there all the time. Neil had problems of his own. He'd just had or his wife had just had a premature baby and he was dashing between St Mary's and the QA, and working as well. Social Services got involved because they wanted to technically move my Dad out of the QA. H He had got to the bit where he didn't need to be in the QA but his wife had refused to have

him at home. She said she couldn't cope and so he wasn't going home. That really did distress my Dad, because he didn't want to go into a nursing home, and the main reason he didn't want to go into a nursing home is because his wife and stepdaughter both worked in nursing homes and he listened to their stories. He just didn't want to go into a nursing home.

At one stage my Mum had volunteered to me and my two brothers to have him home and we talked around that. We said that it was better for her not to.

Q Yes, it's a difficult decision, isn't it? It's the "what if?" decision, isn't it?
A Yes, but we decided that it was probably better for my Mum not for my Dad to go there, and so we talked her out of it. It was then decided that he was too well to go to a nursing home and there was questions over funding of a nursing home because he had got that much better. We talked about funding and Social Services, who mainly talked to my brother Logan and my brother Neil, were looking for a care home/rest home that was primarily ex-Navy so that he could go into an environment that he was comfortable with. In the mean time it was suggested that he was moved to St Christopher's Hospital in Fareham and, as far as I was aware, that's what was going to happen.

On the night before he was moved from the QA I went up to the QA to see him. My brother Neil was there and the ward was in a bit of a riotous state. Neil was telling jokes out of the *Sunday Sport* and my Dad and a few of these other old chaps, they were having a right old field day up there. I was then told that my Dad wasn't going to St Christopher's, that he was being moved to the War Memorial, because it was easier for people to get to it. Well, in actual fact it was only easier for me to get to it because I'm the only one that lives in Gosport. So for me, I thought well, that's really handy for me. His wife had to come over from Sarisbury Green, so it was difficult for her but he was being moved the War Memorial the following day. When I left him that night he was sat up in bed, he was chatting, he was talking, he had been eating sweets, he had been drinking and he'd generally been quite happy, and he was fairly content that he had to move to the War Memorial. The one thing he was concerned about was my Dad hated travelling. Even though he'd been a coach driver and a bus driver for many, many years, he hated being driven by anybody else.

On the morning that he got transferred, we hadn't actually been able to confirm the exact times but it would appear that he was picked up from the QA some time just after ten o'clock in the morning, and he was picked up not by an ambulance, not by paramedics; he wasn't that ill. He was placed into passenger transport to transfer, and I think he got to the War Memorial just after two... It was either just before two o'clock or just after two o'clock. It went everywhere. This transport went everywhere. I went to St Mary's, it went to St Christopher's.

Q It wasn't a single transfer.
A No.

Q It was a general bus.
A Yes, and he travelled on that with his wife Gill. I told him the day before, the evening before, when I saw him, that I wouldn't be in to the War Memorial the following day. I'd leave him to settle in and I'd be in the following day after that. I now know that the date I'm talking about was, I saw him on the 13th, he got transferred on the 14th and I'd arranged that I'd go into the War Memorial on the 15th. When I got to the War Memorial on the 15th – I

can't remember the exact time but I think I'd been at work, so I would presume that it would be around about late afternoon, teatime-ish time that I went in there.

Q Can I stop you for just a second because I've lost my table. (Pause) Has anyone got a spare one? (Same handed) Thanks very much. Sorry. You see him on the 15th?
A Yes.

B Q Yes.
A When I went in on the 15th I was horrified. I was absolutely horrified. He was back the way he was. He was worse than he was. He was laid on the bed. He was unable to move. He could hardly speak, and I just couldn't believe the decline in him. Gill was there, his wife, and I said to her, "What happened?" and she said, "Well, he didn't travel down very well. He was four hours or three and a half hours on the transport. You know what your Dad's like" and blah, blah, blah, and she said, "But I've been told that he's seriously ill and
C that he's going to die" and I said, "Well, that's not what they said at the QA. Who told you that?" and she said, "The sister." So I asked to see the sister and I was told that she wasn't available. I asked to see the doctor and I was told that she only comes in once a day, in the mornings. I must admit that at that time probably my emotions got the better of me and I kicked off a little bit, and I was told that, by a nurse, I don't know who the nurse was, that I wasn't the...

D Q Next of kin?
A No. I can't think what word it was. I wasn't the something family member. I can't think what word it is I'm thinking of.

MALE SPEAKER: "Designated" perhaps?
A Designated family member. Thank you very much. I wasn't the designated family member, that Gill was the designated family member and the nurses and doctors would talk
E to her and it was down to her to pass the information on to the rest of us. I pointed out that she was an alcoholic and hated me and blah, blah, blah and, as I say, I kicked off. I was threatened with being ejected from the hospital and arrested if I kicked off again. I went home. There was no point in staying there. I didn't want to be arrested. I didn't want all that. I went home and I spoke to other members of the family, my brothers and sisters, and I believe that my sister Karen was also spoken to by the nurses and they accepted Karen, the one that lived on the Isle of Wight, as a designated family member. At that time Neil wasn't
F able to get over there because his daughter was in an incubator. He had had a daughter born, I think, three months early and weighed less than two pounds and so he was dodging his time in between St Mary's incubator with his daughter and my Dad. So I believe Karen was also made the designated family member at the War Memorial, even though she'd had no real dealings up at the QA. I was totally, totally excluded. I couldn't even get a nurse to talk to me.

G Before I left on the 15th I leant down to give my Dad a cuddle and he spoke the very last words to me, and he said, "Help me, son. They're killing me" and I said, "No, they're not, Dad. They're trying to do the best for you" and I left him there.

When I went in the following day he was in a coma. That's the only way I can describe it. he had a... Yeah, he had the syringe driver in by then, and I wanted to know what that was all about and nobody would tell me. Gill didn't really know what it was all about. She thought
H it was for pain killer, for pain relief. The thing is, up at the QA my Dad... My Dad was anti

drugs. All his life he was anti drugs. He was anti any drugs. He just didn't do drugs. Well, as far as he was concerned, alcohol wasn't a drug. He was really, really anti drugs and up at the QA he was refusing paracetamol, which is what was the only pain killer or pain relief that was written up for him, and he was refusing pain killer, re paracetamol, and now all of a sudden here he was at the War Memorial on some sort of drip machine pouring pain killers into him, and he was there in a coma.

B My brother Neil phoned my sister Lesley in Los Angeles and told her she'd better get over here because he wasn't going to last. My sister immediately arranged flights to Heathrow, Neil went to Heathrow to pick her up, and I think she arrived on the Saturday, which would be the 17th. I can't exactly remember what time she turned up but I know it was some time in the afternoon, mid-afternoon, late afternoon. My Dad had been moved into a small private room and every so often nurses would come, and we were there, his wife Gill was there, his stepdaughter Debbie was there, I was there, Karen was there, Tracey was there. I'm not sure C whether my brother Logan was there or not at that time. No, I don't think he was. And my Mum had been in to see him as well.

Each time the nurses came, they said to make him comfortable, they insisted that we all left the room and the room was shut, and they'd go in there and make him comfortable, and then we'd be allowed to go back in. On the evening that my sister got there from Los Angeles, I was there when Lesley turned up and then I went home and I think Tracey went home and I D believe that we just at that time left Lesley and Karen there, and I think Gill and Debbie were there but I think they then left to go home as well.

Q Is Lesley a male or female Lesley?
A Female. My sister Lesley. So Lesley and Karen were there, and we then got a phone call later in the evening, late in the evening, quarter to twelve, twelve o'clock, to say that my Dad had died and that we could go into the hospital to see him. I went to the War Memorial E and I think then my brother Logan was there, Neil was there, I think we were all there in actual fact. I'm not sure whether my youngest brother David was there or not at that time. Also, I believe that Gillian, his wife, and Debbie had also got there.

We stayed with my Dad – I don't know – for a while and then we all left the hospital. We went round to my house, because I lived in Gosport. I was the nearest one. I say we all went to my house. Logan didn't come to my house. It was myself, Neil, Tracey, Lesley and Karen F went to my house. We sat and talked for a while about what had happened and what we had to do now, and it was decided that we wouldn't do anything at all until we all met up the following day at lunchtime and we'd decide what we had to do now about my Dad. We all knew that we didn't want his wife to take control because she'd have excluded us.

It was arranged that we all get together the following afternoon. I can't remember whether we were going to meet at the hospital or whether it was going to be... I think it was going to G be arranged by phone call where we were going to meet but Tracey and I, my younger sister, we never heard anything, and the next thing I heard was that Neil and Karen and Lesley had been into the hospital and they'd arranged the death certificate and they'd arranged that he was being cremated and they'd arranged for a funeral director, and Tracey and I really kicked off over it because we'd been excluded.

That was my Dad died.

H

Q Is it fair to say that, because of your reaction at Gosport and your kicking off, that they marginalised you, they pushed you to one side, they wouldn't take you as a person to whom they should be speaking? Was that one of the reasons?
A No. The reason I kicked off is because they excluded me. They didn't exclude me because I kicked off; I kicked off because they excluded me.

Q You were excluded because you were not the designated person.
A Yes.

Q And because there was clearly a conflict between you and Gill, his wife?
A Yes. But at that time they weren't aware of the conflict between Gill and I. When I first turned up at the War Memorial, I asked to see somebody and I was told straight away that I wasn't the designated person. I then went and spoke to Gill and she told me about this designated person, and that's when she told me that the sister had told her that my Dad was seriously ill and he'd be dead in four days, which in fact he was.

Q I think Professor Black certainly confirmed your Dad was very ill and that he had an overwhelming problem, perhaps not in the way that he understood or believed but that wasn't evident to you when you saw your Dad?
A No.

Q Before the transfer to Gosport.
A No, and up at the QA I had been told by the doctor that his... what he had wrong with him, none of it was life-threatening, and that was right at the very beginning, when my Dad looked really, really bad. So by the time he'd actually recuperated a bit, by the time the medication had kicked in, then no, there was no way I was expecting then for him to die, and I wouldn't have put his illnesses down as being life-threatening then.

Q All right. Thank you for that, which I'm sure has been very painful. Is there anything else you want to tell me?
A I don't know. No. I think I've probably covered most of it, as far as I can remember.

THE CORONER: All right. Thank you very much indeed. Any questions from anyone?

MALE SPEAKER: No, thank you.

Examined by MR JENKINS

MR JENKINS: I'm going to ask you some questions on behalf of Dr Barton. Not many. You are clearly still working through some issues about your own relationship with your father.
A No.

Q Did you say you were the black sheep?
A No, I didn't. If you want to put words into my mouth...

THE CORONER: I think how you put it was that you were saying that Neil was the favourite and you were probably the least favourite.
A Yes. Neil was the favourite.

Q That's how you put it in your evidence. Is that fair?
A Yes.

MR JENKINS: Don't let me put words in your mouth, if you don't like the question...
A I won't.

MR JENKINS: ...you must answer. All right?

B

THE CORONER: Mr Wilson and I are old friends. He won't let you get away with anything, if that's any help.

MR JENKINS: I am sure the jury got the same impression. I don't want to ask about family relationships but I think that there were a number of people who were going to see your father at the War Memorial Hospital. You are one of seven. Your mother went to see him as
C well. His wife went to see him too, and his wife's daughter?
A Mm-hmm.

Q Were there ten people going to see him?
A Not all at once.

Q No, I understand that.
D A But yes, over the course of the four days that he was there, yes, we were all in at different times.

Q I understand. I think, in addition to the alcohol that you told us about, your father had been a smoker.
A Yes.

E Q Had he smoked 80 a day?
A Yeah, probably at one time, yeah. He was a heavy drinker, heavy smoker.

Q Yes, and you've told us as well that he wasn't very good at eating, certainly whilst he was living in the last year or two of his life.
A No, what I said was that when he was living on his own, while Gill was away, he wasn't very good at eating. He neglected himself. He'd drink rather than eat. If it came
F down to my Dad having to prepare himself something to eat and open a bottle, my Dad would open a bottle.

Q I understand.
A When Gill was there, she fed him and he would eat. As for smoking, he had actually given up 16 years before he died.

G Q Well, you know what the medical records say: his wife was suggesting that he doesn't really eat at home during the daytime. Are you in a position to contradict that?
A No, because I wasn't there but I know that he always had a good appetite. It was pure laziness that when he was on his own he couldn't be arsed to do it for himself.

MR JENKINS: You know that when he arrived in hospital having broken his arm the
H dieticians were involved, there was real concern.

THE CORONER: Are you talking of the QA?

MR JENKINS: Yes. There was real concern that he really hadn't been getting adequate nutrition.

A For the five days previously all he'd had was probably rum or whisky, so...

Q I'm not talking over the previous few days.

A No.

Q But over the long term.

A I wouldn't say that over the long term, because I haven't seen that in his medical notes. I would say that yes, he didn't eat a perfect diet. He ate what he liked. It probably wasn't a perfect diet. It certainly wasn't five veg a day.

Q You know that in October, the month he was to die, he was seen by a psychiatrist, Dr Lijnad(?), and whilst he might have been bright when you saw him, to the psychiatrist he was certainly suggesting that he saw no point in living.

A Mm-hmm. I think the psychiatrist saw him in the first eight or nine days.

Q She saw him on 8 October.

A The 8 October, so he'd been in hospital ten days.

Q Ten days before he died. I think he went into hospital at the end of September, and you know as well that the psychiatrist was suggesting that he may have dementia or early Alzheimer's.

A It had been suggested but I don't think there was any proof as such, and I don't think he'd been tested in any way for it. It was just a suggestion that she had put forward.

Q Yes, but a psychiatrist was suggesting it.

A Yes, yes.

Q Not someone who was ignorant.

A No, no. She was looking. There's no doubt about it. She gave him a good investigation. She looked well into it, and yes, there's no doubt about it; at that time he had told her that he saw no point in going on.

Q And we know the extent of his liver disease. We know that there was discussion of renal failure, kidney failure, as well.

A I believe that that was all dealt with with the medication that he was on.

Q So are you saying that there wasn't a problem with kidney failure or what?

A No, I'm not saying there wasn't a problem but I believe it was under control with the medication that he was on at the QA. I think even Dr Black, Professor Black, said that as well.

THE CORONER: I think what Professor Black said was that it wasn't going to get better and all you could hope for was to control it. I think that's where he was coming from.

A Yes, and the drugs, as far as I was aware, the drugs that he was on was controlling it.

MR JENKINS: And you know that the view at the Gosport War Memorial Hospital, because of his fluid overload, was that his heart wasn't working effectively. He had congestive cardiac failure.
A No, I don't know that because nobody at the Gosport War Memorial ever talked to me. So no, I don't know that.

Q You were one of ten that they may have been talking to.
A We've heard so far that the nurses and the doctors were bending over backwards and really caring and, you know, they weren't. Otherwise they may have found the time to have talked to us.

Q Well, what you know is that this was a ward which had very little doctor input.
A Mmm. Terrible really.

Q That may be right. I'm just inviting you to consider the facts.
A I know that. I tried to see a doctor. Believe you me, I tried to see a doctor there, and I couldn't, so I knew there wasn't very many doctors around.

Q Yes, and what you have told us is that there was a stage when you saw your father, and he was on a syringe driver.
A Yes.

Q We know he wasn't put on the syringe driver until 16 October.
A Mm-hmm.

THE CORONER: That was the first day you saw him after he'd been transferred, the 16th.
A No, I saw him on the 15th.

Q Sorry.
A I then saw him on the 16th. I then saw him on the 17th.

MR JENKINS: I just want to talk about the syringe driver. We know that that was instituted on the 16th and that was after Dr Napman(?) had seen your Dad.
A Mm-hmm.

Q And you know that Dr Napman was writing in the notes that there may have been a myocardial infarction, a heart attack.
A Ah, but we also know that there was no assessment done on my Dad when he went into the War Memorial.

Q We don't know that at all because we haven't heard from Dr Barton.
A Well, I think we have heard because I think we heard that from Professor Black.

THE CORONER: No, that actually is going to be one of the issues that we've got to deal with, and that is, it may not be documented but did it happen? That's the problem that Professor Black referred to time and time again. You know, "Well, I couldn't find any record of it."
A Surely, it if happened, it would have been made a note of.

Q Well...
A Other things were made a note of so surely....

Q I've got an open mind about it at the moment.
A OK, well...

Q Not empty but it's open.
A I'd have to say that I don't think he was assessed when he went into the War Memorial.

MR JENKINS: You can say what you like, Mr Wilson, but you weren't there on the 14th, were you?
A No, I wasn't.

Q What we know is that the doctor wrote "CCF" meaning a congestive cardiac failure as part of the entry that she wrote. What we know is that she wrote him up for a large number of drugs. Yes? We will hear from her in due course. I'm just asking you about the evidence that you are able to give rather than speculation that you are wont to engage in.
A No, I don't. I want the truth.

Q Yes.
A That's all I've ever been here for.

Q Then let's get it through the evidence. All right? What we know is that your father was put on a syringe driver and on the 16th, after he had been seen by Dr Napman, after Dr Napman had written "Query, silent MI," meaning had your father had a heart attack. Also, "Query, deterioration liver function." That's what Dr Napman has put in the medical records on his assessment of your father on the 16th, and it was after that that your father was put on a syringe driver. Yes?
A I...

THE CORONER: Well, that's what the notes say.
A I've got to assume that that's right.

Q You don't argue with that presumably.
A Yes.

MR JENKINS: And we know that Dr Peters saw your father as well two days later.
A Mm-hmm.

Q It may be that you didn't speak to any of the doctors but the doctors were certainly there assessing or seeing your father, writing him up for various forms of medication, changing prescriptions in one or two cases.
A Well, they changed it all.

Q Pardon?
A They changed it all.

Q His condition changed, didn't it?
A Well, yeah, that's where we differ because I think that it's down to the drugs that his condition changed.

Q Just what the records say on the 16th---
A I'm going by his records on the 13th. His records on the 13th say, there's no ifs or buts here, he got a lot better than he was.

Q Yes. You've told us---
A Nobody is saying he was perfect.

Q No.
A But then on the 14th he starts going immediately downhill again, on the 15th he's in a coma and on the 16th he's on a syringe driver.

Q Yes, but you told us what your stepmother's comment was about the transfer.
A So the transfer killed him?

Q Well, I'm not speculating, Mr Wilson. I'm just dealing with the evidence.
A OK. I would say that when he turned up, having transferred, my Dad would have been agitated. He would have been bloody annoyed but I don't think it would have killed him.

Q On the 16th the note is to this effect: "decline overnight with shortness of breath". There are other entries about the swelling, a lot of swelling in his arms and legs, "question mark silent myocardial infarction", a heart attack, "question mark, deterioration liver function."
A He had all the swelling up at the QA and I think they were dealing with it with drugs.

Q And there was then, on the days that followed, a further rapid deterioration noted by other practitioners.
A Mm-hmm.

Q You are not saying that didn't happen?
A No, no, but how much diamorphine had he had by that time?

Q Well, we've heard the evidence.
A You know, and...

Q Can I just ask? You suggested that your father said, "They're killing me."
A Yes.

Q When did he say that? What date?
A That would be on the 15th.

Q Did you tell the police that?
A Yes.

Q You did?
A Yes, and the police... My statement with the police is well documented that I do not agree with my police statement because they've missed so much out. My statement is also absolutely well documented with the GMC, because I've said that is not my statement; it's not a complete statement of what I gave to the police.

Q Did you sign it?
A Yes, and there was a lot of controversy over the statement being taken. I had originally when the police said they were going to take a statement from me, I volunteered to go to Fareham Police Station or Gosport Police Station, where it could be done in a police interview room and recorded, because I wanted a copy of the interview. I've got---

THE CORONER: May I stop you for just a second? I don't mean to interrupt save to say it is probably not a relevant line of questioning for me. You say that Dad said to you on 15 October that they were killing him. He doesn't go on to the syringe driver until the 16th, which is the following day.
A No.

Q So he's suggesting that the day after admission effectively.
A Yes.

THE CORONER: Sorry, Mr Jenkins.

MR JENKINS: That's all right.

THE CORONER: I'm not sure you're leading me in a direction I want to go in anyway.

MR JENKINS: I just want to ask. You say this. "The last thing I remember Dad say to me was 'Help me.'"
A "Help me. They're killing me."

Q Well, it doesn't say that in the statement.
A No, and, as I've just explained, when the police came to my house, I had to sign. They totally refused to do the statement at the police station under recorded conditions. I wanted a copy of the tape. They said no, they wouldn't do it. I then said that I was going to record their conversation when they came to my house and I had to sign a declaration with the officer that came, the two officers that came to my house to agree that I wasn't covertly recording the conversation. I then asked for a copy of the statement, which I did eventually receive, and there was omissions from the statement. That's not the only thing that's missing out of the statement. There was other omissions from it, but I have made it very, very clear to both Hampshire Constabulary and the GMC that I'm not happy with that being my statement and it's not a complete statement.

Q Well, there we are. All I've got is the signed statement which you've signed as a true to the best of your knowledge and belief.
A No, what you've actually got I think is a typed copy of a transcript of a statement.

Q No, I've got a statement which says, "The last thing I remember Dad saying to me was 'Help me.'"
A "They're killing me."

Q And you say, "I said, 'I can't, Dad. You're in the best place.'" Was that said?
A No.

Q It wasn't said at all?
A What was said was, my Dad said to me... These are the very last words that my Dad said to me. Do you honestly think that I want to be sat hearing this? For ten years I've wanted to put this all to bed. This is my Dad we're talking about. Do you honestly think that I want to be here doing this? Put yourself in my position. Would you like that to be your Dad's last words to you?

MR JENKINS: I'm afraid it is often unwise for witnesses to ask questions because it invites sometimes an answer.

THE CORONER: Please don't give one.

MR JENKINS: Thank you, Mr Wilson.

Examined by MR SADD

MR SADD: Mr Wilson, you've been taken to the facts, you've been taken to the evidence and I'm going to do the same with you now, but I wonder if you could be given a bundle of the medical records, please.

THE CORONER: Which ones? What page do you want?

MR SADD: It's essentially 1-200, so the first volume.

Q Can I just deal with things slightly in reverse? Were you aware of your father's renal problems, that is, kidney problems?
A No, I didn't know exactly what all his problems were. I just knew that he had multiple problems; it wasn't just the fracture in his shoulder that was the problem. I knew there was other problems with him.

Q The jury will be hearing in due course from a Dr Wilcock and Dr Wilcock's conclusion so far as the renal failure is concerned is that his renal impairment at Queen Alexandra Hospital – this is page 36 of the report, sir – had resolved completely with appropriate therapy on transfer. Were you aware of that?
A As I say, I was under the impression that his renal problem had been... The drugs that... I was under the impression that the drugs that they'd given him at the QA were having the desired effect and they'd done what they were supposed to do or they were doing what they were supposed to be doing.

Q Thank you, Mr Wilson. I'm now going to take you to a variety of notes, some of them Social Service notes or social worker's notes, nursing notes, dietician notes, and I'd like you first to go to page 18 and, as has been correctly pointed out to you by Mr Jenkins, what we have in the documents is a record made contemporaneously, that is, at the time of this passage in your father's life and, sadly, his death. So if you go to page 18, please, the entry we have for 8 October, which is the same date as you had from Mr Jenkins of the assessment made by the psychiatrist. Can I just read this passage to you: "Seen by occupational

therapy" – this is four lines down the page – "refusing to wash for second day running. Come back tomorrow." His quote. "Assessment rebooked for tomorrow" and then "Neil Howard rang and stated that he will speak with Sandy Boring" – I think it is – "about problems of trying to get an OT report. I stated that he was no longer requiring an acute bed and we need to move him as soon as possible to a nursing home. Neil will call back. I suggested that family could be given information so that they could at least start looking for suitable home until arm has recovered. He is at risk of self-injury and very, very oedematous and at risk of breakdown due to low albumen."

That entry there, does that accord with your memory of what was going on at about that time? This is, he is at the Queen Alexandra. He has been there ten days.
A Yes. Yes, this is when they actually said that he'd actually got better and he was too better to go into the nursing home.

Q Let's read on because, just to be entirely accurate, and along with what Mr Jenkins put to you, if we look at the bottom of the page, we can see that on that day he's also seen by Dr Lusnat(?) and you have been taken to her conclusions about your father's mental condition at the time. All right? If we turn over the page, please, to page 19, again, I'm going to read this to you and invite you to comment in a moment. It's two lines down. 8 October. "Mrs Wilson phoned to say that she would not be in to visit today. I asked her if she'd heard from Social Services today and she said that she had not. I informed her that we are trying to sort out discharge to a rest or nursing home, whichever is deemed appropriate. She stated that she did not want her husband to go into a home and that he didn't want this either. I asked if she would be in tomorrow but she said that she is busy all day. I've given her Social Services' phone number, asked her to contact them first thing tomorrow because we need to get the situation sorted out. She said that she would," and then we look for 9 October, the next entry: "Margaret Jackson rang, social worker, and would contact wife this morning re placement. If they adamantly refuse, then continuing care might be only alternative until healed because Robert is at risk." Again, does that accord with your recollection of what was going on?
A Yes.

Q Can we then go, please, to page 21 of the notes? Looking at the top of the page, reading from the top of the page, if I may, Mr Wilson, "12 October 1998, 12.30, tried to put Mr. Wilson's name forward for a continuing care bed but not accepted because the Barthel score was too high at 7. Phoned social worker but she was not there. Later on in the day social worker rang back. They cannot accept Mr Wilson for convalescent bed because at 7 his Barthel is too low. Question appropriate for rehab. Seen by Dr Grieves(?). To review on doctor's round tomorrow." And then we have 13 October: "Reviewed by medical team. Continues to require special medical nursing care as oedamatous limb is at high risk of breakdown. This is due to oedema secondary to cardiac failure, low protein, also high risk of self-neglect and injury. Need to have 24-hour hospital care until healed." Then just below that we read: "13 October, seen by dietician. Please continue with high protein diet of milk shakes, encourage dietary supplement drinks. Will arrange dietetic follow up at St Christopher's." Does that accord with your memory of an assumption that he might have been going to St Christopher's?
A Yes, it does. That's exactly it. We were under the impression that he was going to St Christopher's.

Q Thank you, and if we now turn, please, to page 34, and starting at the bottom of page 33, these I take to be the nursing notes. 8 October 1998. We know that is the date of the psychiatrist's assessment. "No problems communicating. Very adamant in opinions this morning. Fluid chart maintained although eating well. Arm and cuff in situ. Arm remaining swollen although less---

THE CORONER: "Elbow and cuff" it says.

MR SADD: Sorry. Did I leave out "elbow"? My mistake. Sorry, sir. Thank you. "Elbow and cuff in situ. Arm remaining swollen although less today. Refused wash. Was absolutely adamant. There was no convincing Robert this morning. Felt he'd been washed too many times and in the war he had a wash only twice weekly. Hair brushed. Bioclusive renewed to arm. Catheter draining. Some discharge. Very chatty and funny." 8 October, continuing there, "Communications quite good. Cooperative late morning after initial reluctance to partake in care earlier. Hand remains very red and oedamatous." Then there are further issues about "ankles very oedamatous and tender. Appetite variable. No complaints of nausea. Inappropriate diet. Patient prefers to snack but will..." I'm sorry. I can't read that. And reference to the catheter there. And then we have p.m. on the 8th. "Sat out for most of the afternoon but was very tired and needed to rest in bed by the end of the afternoon. Remains oedematous" I think I'm going to take again. "Catheter draining a small amount. Paracetamol given as prescribed. Over the course of the night communicated quite well although varies according to mood." If we go, please, over the page to 9 October, at ten o'clock he is given a shave. He declined any further care. "Still talking about going home. P.m. Bob had visitors all afternoon. Chatty and appears well." And if we go, please, to the 10th, we see that "Robert reports a good night's sleep." On the 11th, on the same page...

THE CORONER: What does the "B.O." stand for?

MR SADD: "Bowels open." 11 October, "Communicating well. As required codydramol. Now prescribed although no extra analgesia required overnight. Assisted into bed. Aware and sat out in chair for about one hour and then returned to bed. Bottles feeds with minimal assistance." Again on the 11th, "No problems with communication. Robert is a bit clearer with speech, a good diet taken. Pain remains quite bad in his left arm." Sorry, that's turning over the page. "Assistance given with hygiene needs. Robert managed to shave himself. Transferring much better today" and "p.m. transferring much better this afternoon. Eating and drinking well. Overnight" – that's overnight of the 11th to 12th – "drinking well, supporting position, appears comfortable with regular analgesia. Restless night. Has sat out in chair for long periods." It refers there to incontinence. On 12 October, "Good breakfast taken. Remains in a lot of pain when being cared for. Hygiene needs met. States that night staff washed lower half. Overnight no complaints of nausea. Drinking well. Arm, hand and feet remain swollen. Very uncomfortable. Restless overnight. Some time spent in chair." On the 13th there is the reference to the weight having gone up which we cited yesterday. "Refused to change clothes. Diet taken is fair. Arm supported on a pillow. Wash given. Bioclusive applied to right foot. Legs elevated on a stool. In a good mood this a.m." And finally page 37, please, Mr Wilson. "For discharge to Dryad Ward tomorrow. Has remained on his bed all p.m. No complaints of any pain. Passing urine independently using the bottle." Reference to when his bowels were last open and then it says, "Robert had a peaceful night, slept well. No complaints of pain." Does that accord with your memory of the lead-up to your father's transfer to Dryad Ward?

A Yes.

MR SADD: Thank you, Mr Wilson.

THE CORONER: Ladies and gentlemen, is there anything you want to ask? Thank you very much indeed. Mr Wilson, thanks very much indeed. I really am grateful to you.
A Thank you.

(The witness withdrew)

THE CORONER: Right. I think we will have a break for five minutes. Then we can change witnesses and you can stretch your legs.

MR JENKINS: Can I give you a document you may not have seen? It is a general statement from Dr Barton.

THE CORONER: Thank you.

(Adjourned for a short time)

DR JANE BARTON, Sworn
Examined by THE CORONER

THE CORONER: You are Dr Jane Barton?
A I am.

Q Do you want to sit down?
A No, thank you.

Q Dr Barton, let me tell you that I need to warn you. I need to give you a warning that you are not obliged to answer any of my questions if they are going to compromise you in any future proceedings. Whether you give evidence to me is a matter for you if there is likely to be any question of that compromising you in those proceedings. The choice of giving evidence is entirely yours, on advice, and I presume you have taken that advice.
A Thank you.

THE CORONER: Mr Jenkins, is that all right?

MR JENKINS: Yes.

THE CORONER: Thank you. Then tell me about your job.
A Would you like me to read my…

Q Is that the easiest thing to do? It probably is. Yes, go on.
A I am Dr Jane Barton of the Forton Medical Centre, Whites Place, Gosport, Hampshire. I am a registered medical practitioner and qualified in 1972 at Oxford University with the degrees MA BM BCh. I joined my present GP practice in January 1980, initially as an assistant for three months and then a minimum full-time partner. As a general practitioner I had a minimum full-time commitment. I had approximately 1,500 patients on my list. I worked eight general practice surgery sessions weekly and carried out house calls on my own

patients, and I conducted half the out of hours on call responsibilities of my partners, with one night in ten and one weekend quarterly on duty for the whole practice. In addition to my general practice duties I took up the post of a sole clinical assistant in Elderly Medicine at the Gosport War Memorial Hospital in 1988. The Gosport War Memorial Hospital was a cottage hospital. It had 48 long-stay beds and was originally on three separate sites, and was resourced, designed and staffed to provide continuing care for long-stay elderly patients. The position of clinical assistant was a junior, part-time appointment. Initially the position was for four sessions a week, one of which was allocated to my partners to provide out of hours cover. This was later increased, so that by 1998 the healthcare trust had allocated me five clinical assistant sessions, of which one and a half were now given to my partners in the GP practice for the out-of-hours aspect of the post. I was therefore expected to carry out my day-to-day responsibilities in this post in effect within three and a half sessions each week. This was, of course, in addition to my GP responsibilities.

By 1998 I was working on two of the wards at the hospital, Daedalus and Dryad wards. The two wards had a total of 48 beds. About eight of the beds on Daedalus were for slow-stream stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients. Two consultants in elderly medicine were responsible for each of the wards. Dr Alfia Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both consultants however had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord, for example, was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital conducting out-patients on Thursday, when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998, followed immediately thereafter by maternity leave, so that she did not return to work until February 1999. In spite of the considerable workload, the trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover but the reality was that, given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. For much of 1998 therefore I had no effective consultant support on one of the two wards for which I had responsibilities, with the consultant role on the other ward already being limited.

At the time of my resignation from the Gosport War Memorial Hospital in April 2000 there were two Elderly Medicine consultants covering the wards and providing a weekly ward round. The consultant nominally in charge of Dryad was also Clinical Director for the trust as well as his other extensive clinical commitments in two other hospitals and was not always available to provide the weekly service.

In carrying out my duties as clinical assistant, I would arrive at the hospital each morning when it opened at about 7.30. I would visit both Daedalus and Dryad wards, reviewing patients and liaising with staff, before I then commenced my general practitioner responsibilities at 9 a.m. I would return to the hospital virtually every lunchtime. New patients, of whom there were about five each week, would usually arrive before lunchtime and I would admit patients, write up charts and see relatives. Quite often, in particular if I was the duty doctor, I would return to the hospital after GP surgery hours at about 7 p.m.

I was concerned to make myself available to relatives, who were not usually able to see me in the course of their working day. This became a very important time commitment in the job. I would also attend the Daedalus ward round on Mondays with Dr Lord but was unable to attend the round for stroke patients on Thursdays.

I was also concerned to make myself available even outside those hours when I was in attendance at the hospital. The nursing staff would therefore ring me either at home or in my surgery to discuss developments or problems with particular patients. In the event that medication was to be increased, even within a range of medication already prescribed by me, it would be usual for the nursing staff either to inform me of the fact that they considered it necessary to make such a change or they would inform me shortly thereafter of the fact that the increase had been made.

When I took up the post first, the level of dependency of patients was relatively low. In general, the patients did not have major medical needs. An analogy now would be to a nursing home. However, over time that position changed very considerably. Patients who were increasingly dependent would be admitted to the wards so that in time, and certainly by 1998, many of the patients were profoundly dependent, with minimal Barthel scores. There was in consequence a considerable increase in the medical and nursing input required to care for such patients. Further, in 1998, as an example, the bed occupancy was about 80 per cent. However, the trust was concerned to increase that still further and it then rose to approximately 90 per cent. There would therefore be as many as 40 or more patients to be seen and/or reviewed by me when I attended each day. There was no increase in nursing staff, support staff, occupational therapy and physiotherapy, and no support from Social Services to assist with the increase in patients and the increase in dependency and medical needs. On a day by day basis mine was the only medical input.

Part of the list of duties laid down for me as clinical assistant was to be responsible for the day to day medical management of patients. My work involved looking after a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. The vast majority had undergone treatment in the acute sector and were transferred to our care for rehabilitation, continuing care or palliative care after their acute management was completed. A major group of these patients were suffering from end-stage dementia as well as major organ failure such as renal failure. A lot of my time would be spent attempting to forge a relationship with families and helping them come to terms with the approaching death of a loved one. This aspect of the job was often not helped by unrealistic expectations of the level of rehabilitation available at our cottage hospital or possible in these individual patients and difficult dynamics within families. The act of transferring such frail patients also further compromised their condition, sometimes irreversibly.

In carrying out my work I relied on a team of nurses, both trained and untrained, to support the work I did. Between us all we tried to offer a level of freedom from pain, physical discomfort, unpleasant symptoms and mental distress, which is difficult to offer in an acute setting and is more allied to palliative care. Over the 12 years in which I was in post I believe I was able to establish a very good working relationship with the nursing staff at the hospital. I found them to be responsible and caring. They were experienced, as I think I myself became, in caring for elderly, dependent patients. I felt able to place a significant measure of trust in the nursing staff.

Over the period in which I was in post there was only a marginal increase in the number of nursing staff, with the significant number of patients and the considerable increase in dependency over the period, the nurses too were faced with an excessive workload.

The picture therefore that was emerging, at least by 1998, at the hospital was one in which there had been a marked increase in the dependency of the patients and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on me were very considerable, given that I was expected to deliver this significant volume of care within a mere three and a half sessions each week. I raised this matter with management, albeit verbally, saying that I could not manage this level of care for the number of patients but the reality was there was no-one else to do it. In due course I felt unable to continue. I resigned from my post in 2000.

It may be of some significance that my position was then replaced not with another part-time clinical assistant but a full-time staff grade. Indeed, my present understanding is this post may be increased to two full-time positions and is a clear reflection of the very considerable demands upon me at the relevant time, when I was struggling to cope with the care of patients. In addition, the consultant cover to the two wards was increased to ten sessions per week in 2000. In 1998 I had tried to raise the issue with trust management but there was no-one else to do the job. I could have said that I could not do the job any more and walked away, resigning my position at that time. However, I felt obliged to remain to support my colleagues and, more particularly, to care for my patients. I felt that if I left, I would be letting down the nursing staff with whom I had worked for 12 years and letting down the patients, many of whom were in my practice and part of my own community. In reality, I was trying to do my best in the most trying of circumstances. I continued to express my concern to trust management but to no avail, and eventually I felt compelled to resign in April 2000.

In caring for patients on a day to day basis therefore I was left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see but potentially neglecting others. In the circumstances, I attended to my patients and I readily accept that my note keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point. Of necessity, they were sparse. The constraints on the nursing staff meant they too had the same problem: to tend to the patients, keeping them clean, feeding them and attending to their other nursing needs, or to write detailed notes.

Similarly, in relation to prescribing I felt obliged to adopt a policy of proactive prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance particularly out of hours. It was a practice adopted out of necessity but one in which I had trust and confidence in the nurses who would be acting on my prescripts, and indeed, in which the nurses would routinely liaise with me as and when increases in medication were made, even within the authority of the prescription.

I accept that this would not be necessary in a teaching hospital or even a big district general hospital, where a professor or consultant in geriatrics would have a plethora of junior staff.

Somebody will either be on the end of a bleep or be available on the ward to write up or review a prescription for opiates. It also may be of some significance that prescriptions of this nature by me were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, I am very anxious to emphasize that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload and she did what she could, given the constraints upon her.

Q Thank you. We are looking at this generically now and your practice normally would be to be in the hospital at half past seven in the morning. You would be in surgery then at what time?
A Quarter to nine, nine o'clock.

Q So about an hour...
A An hour and a quarter.

Q What would you be doing during that time? That's not a facetious question in any way at all; apart from having a nervous breakdown, what actually were you doing?
A I arrived first on Dryad Ward, where I liaised with either the sister or the senior staff nurse on duty, who would be coming to the end of her report with the night staff, so I would be able to hear that finishing, and I would walk through the ward with her, seeing all the patients. I would ask relevant questions of each of the patients: "How are you today?" I would ask about their bowels, their night they had had, the medication they were having, any problems the nurses were having.

Q That must have been a fairly quick spin through the ward in order to do the number of patients that you had to see.
A They did not all require the same degree of attention if their condition was stable and nothing was changing.

Q When you had done that, was there any writing up done or was it just a ward round and you would only write up whatever was necessary at that point?
A I fear that I would only write up what was necessary at that time.

Q When patients were admitted, did you see them?
A Generally, as you heard in the case of Mr Wilson, they didn't arrive on the hospital transport until lunchtime, so I would be informed at the surgery that somebody had arrived and I would come back to the hospital to clerk them in.

Q When you clerked them in, that was a full clerking, was it?
A Mm-hmm. Yes.

Q And the prescription that was written up for them at that time, that would be done by you there and then?
A Based on the notes that had hopefully come with the patient, so that I could reflect what they were already having and any additions that I needed to make.

Q I think it was said by Mrs Barrett that there were occasions when the notes didn't arrive with the patients. She said it was rare but it did happen. In that event, how would you handle that?
A I would ask the nurses to contact the ward from which the patient had come and get a report of what they had actually been sent down on. Sometimes they would arrive with their medication but no paperwork; sometimes paperwork, no medication.

Q So you would clerk them in at the first available opportunity once they had arrived?
A Yes.

Q The condition of the patients – and I don't wish to be indelicate in any way at all – was in fact reducing; it was deteriorating over the years, that the degree of dependency was increasing. The Barthel scores were fairly grim latterly.
A Yes.

Q And perhaps not the type of patient that the unit had been set up to cope with.
A Yes.

Q Reference was made to bed-blocking and questions of pressure being put on by Haslar and QA.
A Yes.

Q Did you experience that or was that a nursing staff problem?
A That wasn't my problem. It was a problem for management of the nursing staff and the nursing staff to deal with. If I was told somebody was arriving from somewhere, I would clerk them in. It wasn't my job to refuse to take them or...

Q I don't think that's what I'm suggesting. I think what I am trying to pick up is the increased demands on you and the pressures on Gosport at that time, and that clearly seems to be a pressure.
A Yes, there was an enormous pressure, particularly as I felt that every patient being transferred deserved to be clerked in on that same day, not to be left until the next day or something like that. They needed to be seen when they arrived, and assessed when they arrived.

THE CORONER: Right. How do you want to deal with this? I would suggest that if we pick this point up now, and then we can move on to the specifics. Are there any generic questions at this point?

MR LEIPER: Sir, you will know that I represent a number of families and Dr Barton is not giving evidence in relation to any particular family today. In the circumstances, I think---

THE CORONER: Well, she will today but not at this moment.

MR LEIPER: And not in relation to any of the families that I represent. In the circumstances, I do not think it appropriate to ask Dr Barton any questions in the course of today.

THE CORONER: All right. Thank you.

Examined by MR TOWNSEND

MR TOWNSEND: Yes, just two matters. Dr Barton, as you have stated in your statement, you had a good working relationship with the nurses on the ward – correct?
A I did.

Q You decided to institute what you've described as the "proactive" system of prescriptions to cover a range – correct?
A I did.

Q And you've told us that the nurses would liaise with you within that range if they were making changes?
A They did.

Q In broad terms, would this be fair: the working relationship was good and the nurses appeared to you to be acting appropriately within the authority of the prescriptions?
A Entirely.

MR TOWNSEND: Thank you very much.

MR SADD: Sir, to a much lesser extent, I am in the same position as Mr Leiper, so I will wait, if I may, until Mr Wilson's case arises.

THE CORONER: Thank you.

MR JENKINS: Can I just raise a very few?

THE CORONER: I was actually going to go to the jury first and then invite you back at that stage, which I think is probably appropriate for you, isn't it?

MR JENKINS: Fine.

THE CORONER: Yes?

Questioned by THE JURY

A MEMBER OF THE JURY: You said about clerking a patient in. What sort of time frame does that take, to clerk a patient in?
A Twenty to thirty minutes.

Q You said you were getting about five new patients a week?
A Yes.

A MEMBER OF THE JURY: You also said you were contractually obligated for three and a half sessions a week. When you went back in the afternoons or lunchtimes and then the evenings, was that part of your contract or was that you...
A I wanted to do it. I needed to do it. It wasn't part of the contract, no.

A MEMBER OF THE JURY: How long is the session? Three sessions of how many hours?

A It's approximately three hours. So that you had an hour and a quarter every morning, every weekday morning I had a three- to four-hour ward round once a week, and the lunchtime visits and evening visits if families requested to be seen.

Examined by MR JENKINS

MR JENKINS: It is not a district general hospital or a teaching hospital?
A It's not.

Q Were there other doctors on site?
A No.

Q Cardiologists? Urologists?
A No.

Q That you could call on to ask for a second opinion about a patient if you needed it.
A No.

THE CORONER: Whilst you say they were not on site, were they available to you at a distance?
A In theory, I had a duty geriatric consultant on the end of a phone, so that if I had a particular problem that I felt I couldn't deal with, I could ring somebody and ask for their advice.

Q But that was a phone contact.
A It was a phone contact. They would not be on the peninsular. They would not be in the hospital.

MR JENKINS: What about equipment? Could you put a patient on an ECG machine to record their heart rate?
A We didn't have an ECG machine at that time. We didn't have intravenous facilities. We didn't have a defibrillator at that time.

Q That is electric paddles to shock someone back into normal heart rate.
A Nothing like that.

Q If you had had an ECG trace on a patient, was there anyone on site who could read it?
A Interpret it?

Q Yes.
A No.

Q You have told us that you would be once a week, alternate weeks, on a ward round with a consultant for that ward, Dr Lord or Dr Tandy and subsequently Dr Reid. We know there were gaps occasionally when they couldn't attend or when another doctor came in their place. What would a ward round involve?
A That was a walk around the ward with the notes trolley and the senior nursing staff, discussing more fully each patient and the progress, treatment options, and what was going to happen next. So that was 20 minutes with each patient.

Q So we know one ward had 20-odd beds, the other had 24, I think.
A It was quite a long session.

Q That would be the whole afternoon.
A Oh yes.

Q And during the ward round, what would the consultant know about the history of the patient, the treatment they were on, the medication that was being prescribed?
A Only what the staff nurse and I told her, and, of course, their reading of the hospital notes they had in front of them.

Q I see. So the consultant would have the clinical entries that you had written or the nursing staff had written, and they would be aware of the medication that the patient had had prescribed for them.
A Yes. The drug chart would be there with the notes.

Q So far as the medical records that you were making and the nurses were making, was any concern ever expressed by a consultant as to the adequacy of them or the amount of detail?
A No.

Q We have heard of this practice of prescribing medication in advance, prescribing either at a time when the patient didn't need strong opiates, a syringe driver perhaps, or diamorphine, or prescribing when they did need that but prescribing at a range where they didn't need the upper end of the range.
A Yes.

Q Were the consultants and the nursing staff well aware of that as a practice?
A Well aware.

Q We heard Sister Joynes(?) a week ago tell us that that was a practice that was discussed.
A Yes.

Q And it was embarked upon because that was a means to ensure that patients could receive appropriate pain relief if it was necessary to administer that pain relief.
A Yes.

Q If there was a weekend, for each weekend, would there be a doctor attending routinely on either ward at all?
A It varied. One or two of my partners, I gather, would pop in and check with each of the wards whether there were any problems or anything needed doing, but if they weren't on duty, there was no routine presence at the weekend.

THE CORONER: I was under the impression that it was your practice that was contracted to provide the out of hours care for Gosport.
A And their understanding of providing out of hours care was that they would attend if asked.

Q I see. So there was no routine presence?
A No.

THE CORONER: I am sorry, Mr Jenkins.

MR JENKINS: So if they were called, because they were on call, part of your allotment, your contractual duties...
A ...was for someone to attend.

Q But that would be to attend to see a specific patient for a specific reason the nurses raised.
A Yes.

Q Again, you weren't at the hospital except for a few hours each weekday, a couple of hours each weekday. Where did your information on the patients come from? Where did you get the information about how the patients were doing?
A From the nursing staff.

Q Again, we heard Professor Black make the observation that the nursing staff were key. Do you agree with him?
A Totally.

THE CORONER: You are presumably getting a snapshot when you are looking at the patients. The nursing staff are seeing them 24 hours a day; you are actually looking at a snapshot effectively.
A Totally reliant on their impressions over dealing with the patient for 24 hours.

MR JENKINS: Can I ask, was there any involvement of a pharmacist or pharmacy?
A We did have a weekly visit from a pharmacist from Queen Alexandra, who came to check prescriptions and presumably refill the pharmacy that we held on the site at that time. So she would come on to each of the wards and check the prescription sheets and check that everything was in order.

Q And again, in that regard, were any concerns expressed as to the way in which prescribing was carried out?
A None.

Q Lastly, you have touched upon it, but what was the reason for your resignation in April 2000?
A There was a serious bed crisis in the acute trust sector and, as one of the clinical assistants, I received a letter from the Department of Geriatrics suggesting that our beds were under-utilised and that we should try and put more patients in them to relieve the bed crisis, because no routine surgery was going on at that particular time in the acute trust because of bed blocking, and I felt a bit aggrieved about this because of the workload that we were carrying out compared with some of the other community hospitals, and I wrote a letter back to the Medical Director stating that. There was then a further letter saying that no, no, we must try harder, and at that point I decided that the time had come to resign.

THE CORONER: I think it was said that there had been some 80 per cent occupancy but that had risen to 90 per cent, which is a clear indication of the increased demand, isn't it? The trust was looking for more than that.

MR JENKINS: I think it is fair to you that I actually give you the letters and invite you to look at them. (Same handed to the witness)

A The first one is written by the Director of Medicine for Elderly People and it's dated 16 February 2000.

> "Dear colleague,
>
> The bed crisis at Queen Alexandra Hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all..."

THE CORONER: Can I ask you, if you are going to read it, to read it in a flat voice?

A Sorry.

Q It is just that it is very interesting that one can put emotion into it, which is one of the things we don't do. I mean, I am more than happy to read it but it is a bland letter rather than the emotion perhaps that you are feeling.

A

> "The bed crisis at Queen Alexandra Hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in Elderly Medicine as efficiently as possible. There has been some under-utilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post-acute patients. A policy offering guidance is enclosed. We shall trial the flexible use of the beds for a few weeks and I should be happy to co-ordinate any comments."

MR JENKINS: What does "post-acute" mean?

A Very much less stable medically than continuing care patients.

THE CORONER: Was it Mrs Barrett that was referring to patients being transferred too soon and they were having increasing difficulty? Is that what we are talking about?

A Exactly.

MR JENKINS: Did you write back?

A I wrote back on 22 February 2000:

> "I was very disappointed and also quite concerned to be shown a letter from yourself dated 16 February on the subject of the bed crisis at Queen Alexandra and addressed to various ward managers and sisters. Less than a month after I wrote a letter to the Clinical Director expressing my concerns about the situation in our continuing care unit I find that we are being asked to take on an even higher risk category of patient. These post-acute patients have a right to expect a certain standard of medical care, appropriate levels of therapy and supervision, and appropriate out of hours cover during this period of time in hospital. I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards, and the other consultant cannot be expected to provide anything other than fire-fighting

support during this time. As a result, I am unable to do the clinical assistant job to a safe and acceptable standard, which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my staff are subjected to ever-increasing pressures from patients and relatives, causing stress and sickness levels to rise. I would also question the term 'under-utilisation' in a unit which is handling approximately 40 per cent of the continuing care done by Elderly Services at this time."

B

THE CORONER: That is 2000, which really is just the year after or less than a few months after the end of the period that we are looking at.
A Yes.

MR JENKINS: For how long had that pressure been building up?
A Two, three years.

C

MR JENKINS: Sir, thank you. Those are the only questions I have at this time.

Examined by THE CORONER

THE CORONER: Right, thank you. Do you want to start at the beginning. Mr Pittock, please.
D A It is apparent from Mr Pittock's medical records that he was 83 years of age and had been suffering from depression since his fifties. Mr Pittock had been living in a residential home, Hazeldene, and had also been an in-patient at the Knowle Hospital, where he had received electroconvulsive therapy as treatment for severe depression. Having returned to Hazeldene early in 1995, it is recorded that by September that year Mr Pittock had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the Gosport War
E Memorial Hospital, having been seen at Hazeldene by a community psychiatric nurse in September 1995. The note of the CPN for 1 September 1995 records that she had been asked to review Mr Pittock's mood and behaviour. She said that he had lost 1 stone 2 lb in two months and appeared physically frailer, anxious, and had fallen at times. She recorded the drug regime at that time and her view that the best course of action was to arrange an admission to Mulberry Ward for assessment of the regime and to provide interim intensive support for Mr Pittock.

F

From Mr Pittock's records, it appears he was then admitted to Mulberry Ward on 14 September 1995 under the care of consultant in old age psychiatry Dr Vicky Banks. Mulberry Ward is the long-stay ward elderly mental health ward at the Gosport War Memorial Hospital. On admission, it was recorded that there had been a deterioration of Mr Pittock's mood and physical capabilities over recent months. While on Mulberry Ward Mr Pittock's depression was treated with lithium, sertraline, and he also received diazepam
G and thioridazine.

Mr Pittock was then discharged from Gosport War Memorial on 24 October 1995. The subsequent discharge letter to Mr Pittock's GP from Dr Rosie Bailey, registrar to Dr Banks, stated that Mr Pittock had scored 8 out of 10 on a mental health score and that he had been offered ECT for his depression but had turned it down as it had not been very effective previously. Dr Bailey referred to his frail physical condition but said that his mood had

H

improved quite a bit during his admission and he seemed to have more energy. He was apparently to be followed up as a day patient.

Mr Pittock was then readmitted to Mulberry Ward from Hazeldene on 13 December 1995. The nursing staff at the residential home were said to have found it increasingly difficult to manage him as he had become both physically and verbally aggressive. On 20 December his physical condition was described as poor and he later developed a chest infection and areas of pressure ulceration. With his condition remaining poor, Dr Bailey wrote a note on 2 January 1996 requesting Dr Alfia Lord, consultant geriatrician, to see Mr Pittock. In her note Dr Bailey said that on admission Mr Pittock's mobility had initially deteriorated rapidly and he had developed a chest infection. She reported that his chest was now clearing but he remained bedbound, expressing a wish to die. The following day Mr Pittock was said to be deteriorating.

Dr Lord then undertook an assessment on 4 January. In Mr Pittock's records she said she would be happy to take Mr Pittock to a long-stay bed at the hospital. Recording the position at this time when then formally writing to Dr Banks on 8 January, Dr Lord said she noted he had suffered from a chronic resistant depression and long courses of ECT in the past had not been effective. He had recovered from a recent chest infection but was completely dependent, with a Barthel score of zero. His urinary catheter was bypassing and he had ulceration of the left buttock and hip. He had hypoprotenemia, with an albumin of 27 and was eating very little, although he would drink moderate amounts with encouragement. She felt he would need high-protein drinks as well as a bladder wash-out but overall felt his prognosis was poor and would be happy to arrange transfer to Dryad on 5 January. She gathered that Mrs Pittock was also aware of his poor prognosis.

In noting that his prognosis was poor, I believe that Dr Lord felt that Mr Pittock was unlikely to get better and, sadly, he was not likely to live for a significant period. Accordingly, Mr Pittock was admitted to Dryad Ward the following day, 5 January, though under the care of consultant geriatrician Dr Jane Tandy, and I undertook his assessment. Unfortunately, given the very considerable interval of time, I now have no real recollection of Mr Pittock but my admission note in his records reads as follows: "5.1.96 transfer to Dryad Ward from Mulberry. Present problem: immobility, depression, broken sacrum, small superficial areas, ankle, dry lesion left ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself. Longstanding depression. On lithium and sertraline. I also prescribed medication for Mr Pittock, continuing the sertraline, lithium, diazepam and thyroxine, which had been given on his stay on Mulberry Ward, together with Daktacort cream for his pressure sores. I believe I would have seen Mr Pittock each weekday when on duty at the hospital. 5 January 1996 being a Friday, I would have seen him again on 8 January and reviewed has condition. I have not made a note but anticipate his condition may have been essentially unchanged.

Q Would it have been your practice that, if there had been a significant change, you would have noted that?

A I would have attempted to note that had there been a significant change. I didn't always succeed. I saw Mr Pittock again on Tuesday 9 January and made the following entry in his notes: "Painful right hand. Held inflection. Try Arthrotec. Also increasing anxiety and agitation. Query sufficient diazepam. Query needs opiates." The nursing note for 9 January documents that Mr Pittock had taken a small amount of diet. He was noted to be very sweaty that morning but apyrexial, no temperature. He stated that he had generalised

pain, and it was noted that he would be seen by me that morning. The prescription chart shows that I prescribed Arthrotec, which would have been for the pain in Mr Pittock's hands, as recorded by me in the notes. The prescription is in fact dated for the previous day. I do not know if the date is in error or I had prescribed and seen him the previous day and made a substantive note the following day. In any event, on 9 January I noted that Mr Pittock had increased anxiety and agitation and raised the possibility it might be necessary to increase the diazepam and prescribe opiates.

I would have been conscious that a ward round with Dr Tandy was to take place the following day and that a change in medication could sensibly be considered then. The notes show that Dr Tandy and I then saw Mr Pittock the following day, 10 January. Dr Tandy noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero and he would eat and drink. She wrote that Mr Pittock was for TLC, tender loving care. This indicated that Dr Tandy effectively agreed with Dr Lord's assessment and felt Mr Pittock was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Mr Pittock's wife, who had agreed that in view of his very poor condition this was appropriate.

The nursing note for the same day confirmed that we had seen Mr Pittock and that his condition remained poor, with Mrs Pittock being aware of this. The prescription chart shows that I prescribed Oramorph for Mr Pittock the same day, no doubt in consequence of liaison with Dr Tandy at the time of the ward round. This would have been for relief of pain, anxiety and distress. The dose is recorded as 2.5 ml in what is a 10 mg in 5 ml ratio four-hourly. The regime was written up for doses at 6 a.m., 10 a.m., 2 p.m. and 6 p.m. It appears that I also proactively wrote up a prescription for diamorphine in a dose range of 40-80 mg subcutaneously over 24 hours, together with 200-400 micrograms of hiazine and 20-40 mg of midazolam via the same route. I anticipate we were concerned that the Oramorph might be insufficient and that further medication should be available just in case he needed it.

Sister Hamblin recorded in the nursing notes the same day that Mrs Pittock was seen and was aware of her husband's poor condition. He was to occupy a long-stay bed. It was clear his condition was such that he would not recover. In essence, all that could be given was palliative care, with his death expected shortly.

I anticipate that I would have seen Mr Pittock again the following day. Although I did not make a clinical entry in Mr Pittock's records I wrote up a further prescription chart for the various medications Mr Pittock was then receiving. In addition, I increased the Oramorph available for Mr Pittock's pain, anxiety and distress by adding an evening dose of 5 ml to the four daily dose to tide Mr Pittock overnight. I also provided a further prescription for hiazine, diamorphine and midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day. I would have been concerned that although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. The sertraline and lithium were discontinued from this point given Mr Pittock's poor condition.

I anticipate I would have seen Mr Pittock on the Friday morning but would then have been away from the hospital over the weekend. I returned on the morning of Monday 15 January and would have reviewed all the patients on both Dryad and Daedalus ward in the usual way, including Mr Pittock. I believe I may have been told his condition had deteriorated

considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Mr Pittock's notes, I anticipate due to lack of time, but the nursing note indicates that I saw Mr Pittock and that 80 mg of diamorphine, 60 of midazolam and 400 micrograms of hiazine over 24 hours were commenced subcutaneously via syringe driver at 8.25 that morning.

B The previous medication, including the Oramorph, was clearly insufficient in relieving Mr Pittock's condition. He had been transferred to the ward in a poorly condition and had been considered by consultants at about that time to be in terminal decline. Dr Tandy in particular had noted he should have TLC, in other words, palliative care, in circumstances in which he was clearly dying. Since then Mr Pittock had deteriorated yet further. My concern therefore was to ensure he did not suffer anxiety, pain and mental agitation as he died. I believe my assessment of Mr Pittock's condition at that time was also that he was in
C terminal decline.

I tried to judge the medication, including the increase in the level of opiates, to ensure there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver. This had to take account of the fact that the lithium and sertraline, with their additional sedative effects, had previously been discontinued and that he would have
D developed some tolerance to the oral regime. Although the nursing notes suggest that Mr Pittock continued to deteriorate, his pulse was noted to be stronger and regular, and he was said to be comfortable during the night.

The notes continue that the following day, 16 January, Mr Pittock's condition remained very poor and there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the previous day had been largely successful in
E relieving Mr Pittock's condition but not entirely. At the same time, it would have seemed that Mr Pittock's pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I had felt appropriate. In view of the agitation, I decided to add between 5 and 10 mg of haliperodol to the syringe driver, with 5 mg being given at that time. The fact that I saw Mr Pittock and prescribed is recorded in the nursing notes but, again, I anticipate my commitments in tending to patients at that time meant I did not have an opportunity to make an entry in Mr Pittock's notes.

F

Mr Pittock's daughter apparently visited later that day and was said now to be aware of her father's poorly condition. I believe I saw Mr Pittock again the following morning, 17 January. It appears from the nursing notes that Mr Pittock was tense and agitated, and so I decided to increase the level of his medication. I wrote a further prescription for 120 mg of diamorphine, noted by me on the drug chart to have been at about 8.30. This was with the specific aim of relieving the agitation and from concern that, as Mr Pittock would be
G becoming inured to the medication and tolerant of it, so he might experience further agitation and the pain and distress might return. I also increased the haliperodol to 10 mg and the hiazine to 600 micrograms, the latter to dry the secretions on his chest, suction being required that morning.

I returned to review Mr Pittock in the early afternoon. The nursing note suggests that the medication was revised at that stage and it is possible that the changes I had recorded earlier
H were instituted at about this time.

Unfortunately, Mr Pittock seems to have appeared to have deteriorated further that evening. He was, however, said by Sister Hamblin now to be settled and aware of when he was being attended to. My inference was that the increase in the medication had not seemingly caused Mr Pittock to be excessively sedated.

I believe I saw Mr Pittock again the following morning, Thursday 18 January. The nursing note indicates that his poorly condition continues to deteriorate. I made an entry in his records on this occasion as follows: "18 January 1996, further deterioration. Subcutaneous analgesia continues. Difficulty controlling symptoms. Try Nozinan." I believe from my note that Mr Pittock's agitation had returned and we were having difficulty controlling his symptoms. I therefore increased the haliperodol to 20 mg and decided to add 50 mg of Nozinan to the syringe driver to run over 24 hours, Nozinan being an antipsychotic used also in palliative care for pain and severe restlessness.

The nursing note states that he appeared comfortable in between attentions, from which I would infer that he had adequate relief from symptoms, but he would experience pain, distress and agitation when receiving care, such as being turned, that being necessary to prevent the further development of bed sores. Later that day a marked deterioration in Mr Pittock's condition was noted by the nurses. Clearly, his condition continued to deteriorate given the fact that he was in the process of dying. His breathing was noted to be intermittent and his colour poor.

I would not have been on duty over the weekend and it appears that one of my GP partners, Dr Michael Brigg, was available. The records show that on Saturday 20 January he was consulted about Mr Pittock and he advised that the Nozinan should be increased to 100 mg and the haliperodol discontinued. My expectation is that Dr Brigg would have been advised of Mr Pittock's condition and the drug regime; the only modification being in the antipsychotic medication it would seem that Dr Brigg did not consider the general regime to be inappropriate in view of Mr Pittock's condition. Dr Brigg specifically recorded in the notes that Mr Pittock's notes that Mr Pittock had been unsettled on haliperodol, that it should be discontinued and changed to a higher dose of Nozinan.

It seems that Dr Brigg then saw Mr Pittock the following day. He has made a record in the notes of 21 January in addition to the entry for the verbal advice given the previous day. Mr Brigg noted that Mr Pittock was much more settled, with quiet breathing and a respiratory rate of six breaths per minute. Dr Brigg said he was not distressed and stated "Continue". Again, it would seem that Dr Brigg did not disagree with the overall medication which was being administered in view of Mr Pittock's condition.

I would have seen Mr Pittock again on the Monday morning, 22 January. I have not made a note but the nursing records indicate that Mr Pittock was poorly but peaceful. I would have seen Mr Pittock again on 23 January, when again it was said by the nurses that his poorly condition remained unchanged and he remained peaceful. In view of the fact that the medication was apparently relieving his symptoms, it was not necessary to alter either the nature or the amounts being given. Sadly, in the early hours of 24 January Mr Pittock deteriorated suddenly and he died at 1.45 a.m.

Q One of the problems that we all have in looking at these things is that death isn't optional, that life is finite. The two things that are certain in this life are death and taxation, it

is said. There is a difficulty in looking at any kind of palliative care in almost the resignation of saying this is a life coming to an end, but that's the situation that you and those in Gosport dealing with palliative care were coping with.
A Yes.

Q That was the job, wasn't it?
A Yes.

Q The view that one might take, and I was concerned with Mr Pittock at the starting level of the analgesia, and if you look at your paragraph 21, "I proactively wrote up a prescription for diamorphine at a dose of 40-80 mg subcut." The view taken by Professor Black was that that was considerably higher than he would have started off. Would that have been necessary for Mr Pittock? Was that how you assessed the situation?
A Yes, it was necessary.

Q It was your "hands-on" with Mr Pittock that led you to believe that and I think Professor Black is quite clear in saying that he wasn't the man with the patient in front of him.
A Yes.

Q You were the person.
A Yes.

Q Would you, as a matter of course, start off at that level or would you go lower than that?
A For somebody who was totally opiate-naïve and hadn't been on the amount of antipsychotic medication that Mr Pittock had been on, I would routinely consider 20 mg of diamorphine over 24 hours. For Mr Pittock I felt that, with his previous psychotic medication still in his system, he would not respond to 20 and possibly not even to 40.

Q Which is presumably why you wrote up the dose to go beyond that.
A Yes, and that was proved by his response to the medications over the first couple of days.

Q The diamorphine would cope with the agitation and anxiety, and I think Professor Black was quite clear about that, that it wasn't just pain relief but that it was the drug of choice for these cases. Would that be right?
A It would, but I felt in his particular case that we couldn't rely on just going higher and higher with the diamorphine. We had to have some help from the Nozinan, the haliperodol first and the Nozinan, judging by the degree of agitation he had. I wouldn't have just increased the diamorphine and increased it.

Q What would be the effect of that?
A Of just increasing the diamorphine?

Q Yes.
A It probably would have relieved his symptoms but it would have been worrying, increasing the level of opiate administration.

Q Ultimately it would kill him?
A The end result was going to be the same.

Q But what you have done is to change the cocktail, as it were.
A Yes.

Q Change the balance of drugs.
A Yes.

B Q As being an appropriate way of treating…
A …his particular symptoms, yes.

Q And I think we will find as we go through all these cases that it is the change of the cocktail and it is not just a routine increase.
A No.

C Q So at each decision-making process, each review, you are considering this not exactly from square one but taking it back to a base level to reconsider.
A Yes.

THE CORONER: Thank you. Who is going first?

MS BALLARD: No questions.

D

MR LEIPER: No questions, sir, thank you.

THE CORONER: Mr Sadd, anything you want to ask?

MR SADD: No, thank you, sir.

E THE CORONER: Ladies and gentlemen, anything you want to ask? Mr Jenkins?

MR JENKINS: No, thank you.

Examined by THE CORONER

THE CORONER: OK. Can we move on then to Lavender then, please?
F A Mrs Lavender, aged 83, was transferred to Daedalus Ward at Gosport War Memorial Hospital on 22 February 1996 under the care of consultant geriatrician Dr Alfia Lord. Her past medical history was of diabetes for over 40 years and she had been registered blind since 1988. She had apparently lived alone since the death of her husband and had a son living in Warsash who would do her shopping. She had fallen down the stairs at home two weeks previously and been admitted to a medical bed in the Royal Naval Hospital Haslar with general weakness and immobility.

G

She was referred to Dr Jane Tandy, consultant geriatrician at Portsmouth Healthcare Trust, by her consultant physician, Surgeon Commander Taylor, although I do not have the benefit of the referral letter nor any of her Haslar notes. Dr Tandy had seen her on ward A4 at Haslar and dictated a letter to Surgeon Commander Taylor on 16 February 1996. Dr Tandy had recorded that she had examined Mrs Lavender. She felt the most likely problem was a brainstem stroke which led to the fall. In addition, she had noted that Mrs Lavender had
H insulin dependent diabetes mellitus, was registered blind, was now immobile and had atrial

fibrillation. There was weakness in both hands and Mrs Lavender had been unable to stand, although was able to do so with physios. She was a bit battered and had pain across her shoulders and down her arms. She still required two people to transfer her. She had longstanding stress incontinence and mild iron deficiency anaemia. Dr Tandy had confirmed the atrial fibrillation on examination. She had no murmurs. She had made mention of further investigation of her iron deficiency anaemia and her stroke but had agreed to take her over to Daedalus Ward for rehab as soon as possible.

B

To assist with the transfer, one of the nursing staff on ward A4 completed a nursing referral form on 21 February recording that Mrs Lavender's main problem was now immobility. She confirmed the pain in the arms and shoulders and recorded that Mrs Lavender had ulcers on both legs. At that stage all pressure areas were said to be intact, although her buttocks were very red. The referral form also set out the various medications Mrs Lavender was receiving at the time of discharge to Gosport War Memorial Hospital.

C

I then admitted Mrs Lavender to Daedalus Ward the following day. Unfortunately, given the very considerable interval of time, I now have no real recollection of Mrs Lavender but my entry in her records for the assessment on her admission reads as follows: "22 February 1996, transferred to Daedalus Ward, Gosport War Memorial Hospital. Past medical history: fall at home, top to bottom of stairs. Laceration on head. Leg ulcers. Severe incontinence. Needs a catheter. Insulin-dependent diabetes mellitus. Needs mixtard insulin twice daily. Regular
D series of blood sugars. Transfers with two. Incontinent of urine. Help to feed and dress. Barthel 2. Assess general mobility. Query suitable rest home if home found for cat."

The nurse apparently recorded that Mrs Lavender had a Barthel score of 4 but the difference with my assessment is of no real significance. Mrs Lavender was clearly profoundly dependent. A Waterlow pressure sore on admission was recorded at 21, a score of 20 or more being very high risk. Mrs Lavender's prognosis in view of her condition – being blind,
E diabetic, with a brainstem stroke and being immobile – was not good, but the hope was that we might be able to rehabilitate her.

Following the information in the referral form in relation to Mrs Lavender's medication, I prescribed digoxin for her atrial fibrillation, co-amilofruse, a furosemide and amiloride combination, for congestive cardiac failure, insulin mixtard for her diabetes to be given in the morning if the blood sugar was above 10 and the same medication at night at a slightly
F different dose, again, if her blood sugar was above 10. I also prescribed ferrous sulphate for her anaemia, beclomethasone as an asthma preventer, and salbutamol as an asthma reliever.

I do not know now if Mrs Lavender was receiving pain-relieving medication whilst at Haslar but, in view of the pain she was experiencing on admission, I also prescribed dihydrocodeine, two 30 mg tablets four times a day.

G

I saw Mrs Lavender again the following day, probably in the morning, and would have reviewed her condition again. My note on this occasion reads as follows: "23 February 1996. Catheterised last night. 500 ml residue. Blood and protein. Tri-methoprim." The nursing note for the previous day in fact recorded that 750 ml of urine had been catheterised but the important feature was that the subsequent urine test revealed the presence of blood and protein in the urine, suggestive of a urinary tract infection. I therefore prescribed an appropriate antibiotic, Tri-methoprim, on a precautionary basis in case of infection. Bloods
H had been taken on 22 February and the nursing notes for the following day suggest that the

platelet level was found to be abnormal and that the blood sample was too small. I was apparently informed of this and was to review the position in the morning.

The nursing notes record that I did see Mrs Lavender again the following morning, Saturday 24 February, and that her pain was not controlled by the dihydrocodeine. The nursing notes show that she had a red and broken sacrum. I therefore prescribed morphine sulphate, 10 mg twice a day in addition to the dihydrocodeine. Although I did not normally see patients at the War Memorial over weekends when others were usually on duty, I may have been on duty the previous night and would have been concerned to attend to Mrs Lavender if she was in pain at the time.

The nursing notes suggest that in consequence of the morphine sulphate Mrs Lavender had a comfortable night but had deteriorated again by the following evening. It was said that she appeared to be in more pain, screaming "My back!" when moved, although she was uncomplaining when not. Mrs Lavender's son apparently wanted to see me. The nursing notes also indicate that the sacral area was now weak and blistered and that there were red sore and broken areas.

I would have reviewed Mrs Lavender's condition again on the Monday morning, 26 February. In view of the fact that the previous dosage of morphine sulphate had become insufficient for Mrs Lake's pain, I increased the dose to 20 mg twice a day, again, with the dihydrocodeine continuing. I believe Mrs Lavender's bottom was very sore and I was concerned that she should have a Pegasus mattress in the hope of reducing pressure sores. I was probably made aware of the fact that Mrs Lavender's son wanted to see me and arranged to return to the War Memorial at 2 p.m. for that purpose. The nursing notes record that I saw Mr Lavender and his wife at the hospital that afternoon. I have no recollection of this meeting but I anticipate he was understandably concerned at the fact his mother had been suffering pain over the weekend. I think that by this stage Mrs Lavender's appetite was very poor. I would have explained that pain relief was becoming more difficult, that there was skin breakdown and his mother was deteriorating.

Sadly, it is the case that in elderly frail people with pre-existing illness such as Mrs Lavender significant events such as a major fall, with transfer to one hospital and then another, can in themselves have a very serious deleterious effect on their health, leading to death. It may be the case that in the circumstances I indicated to Mrs Lavender's son that his mother might be dying, this simply being a feature of what can happen to elderly people in such circumstances, with the trauma of stroke, major fall and transfer from one hospital to another. I believe I would have discussed the options for pain relief with Mrs Lavender's son and probably explained it might be necessary to use a syringe driver and administer diamorphine if the pain continued to be inadequately controlled.

I think I would have explained that it was possible the administration of proper pain relieving medication might have the incidental and undesired effect of hastening death. I believe Mrs Lavender's son was concerned that his mother should have adequate, proper pain relief, including medication administered by a syringe driver if necessary, so that his mother was free from pain. In any event, my note for 26 February in Mrs Lavender's notes reads as follows: "26 February 1996. Not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute subcutaneous analgesia if necessary."

I think that following my discussion with Mrs Lavender's son I wrote up a proactive prescription for further pain relief should Mrs Lavender experience uncontrolled pain when I was not immediately available. I prescribed diamorphine in a dose range of 80-160 mg together with midazolam 40-80 mg and hiazine 400-600 micrograms. I would have anticipated the nursing staff would contact me in such an event so that I could then have authorised administration as necessary within that dose range. I believe I would have seen Mrs Lavender again the following morning although I have not made an entry in her records. B The nursing notes record that bloods were taken. An area I believe on Mrs Lavender's sacrum was now said to be blackened and blistered.

I would have seen Mrs Lavender again the following day, 28 February, but again, I did not make an entry in her notes on this occasion. The nursing notes show that the black areas on the sacrum were covered with inodine. It appears over the period 26-28 February Mrs Lavender had required no insulin in the morning and 20 units in the evening, suggesting C poor nutritional intake.

Again, although I do not believe I had an opportunity to note it, I would have seen Mrs Lavender on 29 February and 1 March to review her condition. Sadly, I think she was slowly deteriorating over this period. The nursing notes suggest on 29 February Mrs Lavender's blood sugar was elevated and that I was contacted, ordering a quick-acting insulin to be administered. I would not then have seen her until the following Monday, D 4 March.

Unfortunately, Mrs Lavender was again suffering pain by 4 March. The drug chart and the nursing notes show that I therefore increased the morphine sulphate in the form of Oramorph slow release tablets to 30 mg twice a day. I think the dihydrocodeine was still continued at this stage.

E I would have reviewed Mrs Lavender again the following morning and it was clear that pain relief was again inadequate. The nursing notes record that Mrs Lavender's pain was now uncontrolled. She had had a very poor night and was said to be distressed. She was now not eating or drinking and had deteriorated over the last few days. In the circumstances, I felt it was necessary now to set up subcutaneous analgesic via syringe driver and to administer diamorphine together with midazolam in order to relieve Mrs Lavender's pain and distress. I recorded the medication on her drug chart, with the diamorphine in the range of 100-200 mg F over 24 hours, midazolam 40-80 and hiazine at 400-800 micrograms. The syringe driver was set up at 9.30 that morning with the diamorphine and the midazolam at the lowest end of the range, 100 mg and 40 mg respectively. It was not necessary to administer hiazine at that stage as there were no secretions.

I considered these doses appropriate in view of the fact Mrs Lavender's pain was now uncontrolled and she was reported to be in distress. In spite of the previous increases, it had G become necessary to increase the medication still further. A further reasonable increase to the level prescribed by me was now necessary to ensure that Mrs Lavender was free from pain and distress in circumstances in which it was clear she had continued to deteriorate and was now likely to be dying. This medication was given solely with the aim of relieving that pain and distress. My note on this occasion in Mrs Lavender's medical records reads as follows: "5.3.96. Has deteriorated over last few days. Not eating or drinking. In some pain therefore start subcutaneous analgesia. Let family know." As suggested in my note and H confirmed by the nursing records, Mrs Lavender's son was contacted by telephone and the

situation explained to him. The medication appears to have been successful in relieving the pain and distress. The following day the nursing notes indicate the pain was well controlled and the syringe driver was renewed at 9.45 a.m. I reviewed Mrs Lavender again that morning and my note reads as follows: "6.3.96 further deterioration. Subcutaneous analgesia commenced. Comfortable and peaceful. I am happy for nursing staff to confirm death." As indicated, Mrs Lavender was now comfortable and peaceful. It was apparent the medication had been successful in relieving the significant pain and distress which she had suffered. Aware that she was dying, I indicated I was happy for nursing staff to confirm death and it would not be necessary for a duty doctor to be asked to attend for this purpose. It appears that Mrs Lavender died in the course of the evening of 6 March and she was found to have passed away peacefully shortly before 9.30 p.m.

Q Thank you. You heard what Professor Black said in his opinion was the difficulty with this lady, that she had the high cord injury from the trauma. Did that surprise you?
A Yes.

Q It seems to be out of kilter with everything, doesn't it?
A Yes.

Q But she's effectively weak in all four quarters, isn't she? She's not one-sided, from the notes that we read.
A Dr Tandy is an expert in strokes and when she said that Mrs Lavender had suffered a brainstem stroke, I assumed that by that she meant that the picture would not necessarily be one side or the other but could be a generalised weakness.

Q But you had no reason to query that?
A I had no reason to query it. It would not have altered my management of Mrs Lavender one jot.

Q I think that's right. The significance of it is perhaps limited but I just was very surprised that he took that view on what we have seen, but that clearly is his opinion of it and one would say fine; we are long after the event and after the trauma of the fall down the full flight of stairs, one would presume that the appropriate examination had been undertaken when she was admitted to QA.
A Haslar.

Q Haslar, sorry.
A I didn't have the benefit of the Haslar notes.

Q No. He said you can order an X-ray but is it actually done? (Are you hovering? It is difficult to tell really.) She was admitted with a Barthel of 4 to Gosport. She is clearly highly dependent and that doesn't improve in any way, and there is a significant deterioration in her condition and it's almost depressing that each entry is "significant deterioration", and again, you look at the medication and you seem to be adjusting that to cope with her obvious pain.
A Yes.

Q The nursing staff clearly are giving indications that she is calling out and she is in difficulty, and the sores from which she was suffering would cause her great pain.
A They would.

Q You certainly take the view that the prescription that you wrote up for her was appropriate.
A I do.

Q The nursing staff moved that on by administering it as and when required.
A They did.

Q I'm just trying to think of the practicalities of it, because they would see what was going on. Would they as a matter of course contact you before increasing dosage?
A Yes. If I was available, they would.

Q And if they couldn't, then they would tell you after the event?
A Yes.

Q But it was within the range that had been written up.
A Certainly.

THE CORONER: OK. Thank you. Anybody?

MS BALLARD: No thank you, sir.

MALE SPEAKER: No thank you, sir.

Questioned by THE JURY

A MEMBER OF THE JURY: If Haslar had picked up the broken neck, if it was, from Professor Black, would she have stayed at Haslar?
A I'm sorry. I can't answer that.

THE CORONER: I think what Professor Black said was that there wasn't anything they could do for her, that the options were surgery, which would have been potentially disastrous, or very protracted bed rest, the effects of which would have been disastrous. I don't think the prognosis was any different. It was just the fundamental condition may have been treated differently but the---

A MEMBER OF THE JURY: (Inaudible) removed (inaudible). That's what I was thinking of.

THE CORONER: She wouldn't have stayed in Haslar because it was going to be a long-term bed. I say that as being my view of it. Don't take that as evidence but it's more likely than not.

Examined by MR JENKINS

MR JENKINS: Just very briefly, at the 22nd or so, who would have seen Mrs Lavender after she fell down the stairs? If she was taken by ambulance to the hospital---
A She would have been seen presumably by an SHO in the A&E department and transferred into a medical bed.

Q To get into a medical bed there has to be someone admitting you to a medical bed.
A Yes.

Q That is either by referral by a GP.
A Yes.

Q Or by admission through Accident & Emergency.
A Yes.

Q So there is a doctor before she gets to hospital.
A Or as she arrives.

Q Before she gets to the medical bed that is doing some kind of assessment.
A Yes.

Q If she is coming by ambulance, would you expect paramedics to undertake an assessment as well?
A Yes.

Q Once she is on the medical bed – and we have heard Surgeon Commander Taylor referred to – would one expect some kind of investigation to find out what her medical problems were?
A Yes.

Q I think Professor Black told us about an x-ray. One was ordered. He's not seen one. There's reference in the letter that you have read out to physiotherapists helping Mrs Lavender.
A Yes.

Q I don't know – would you expect physiotherapists to be able to form a view about...

THE CORONER: Is this the hour of weakness that you are talking about?
A No, this is the Haslar.

MR JENKINS: This is the Haslar.
A I would have been very alarmed retrospectively if I had been standing a patient with a potentially unstable fracture and encouraging them to walk. That is pure speculation.

Q Again, Professor Black is the only person who we are dealing with who didn't see the patient. All the others did. Dr Tandy plainly did see the patient.
A She did.

Q And it was a brainstem stroke...
A In her opinion.

Q ...that she thought she was seeing. Can I just deal with Mr Lavender. He was the first witness the jury heard from last week.
A Yes.

Q His recollection was that he had several conversations with you whilst his mother was being cared for at the War Memorial.
A Yes.

Q Does that sound right? You refer to one, certainly, in the statement you have read out.
A Yes.

Q Might it be that there were more conversations with family members than you have recorded? You have recorded one here. He says several.
A Entirely possible.

Q He recalled two things from those several conversations. One is you saying that they would have to get rid of the cat, and you've put that in your note that you've read out to us. We don't need to spend much time on the cat but we will recall that this was a feral cat that didn't get on with other people but got on very well with Mrs Lavender and she was very worried about it.
A And it caused concern to the nursing staff. There was talk about would somebody adopt the cat, somebody amongst the nursing staff. I didn't volunteer to do that, I must confess.

Q No, but again, your entry in the note was "Query suitable rest home if home found for cat."
A Yes.

Q That is something that you were discussing with the son.
A Mr Lavender, yes.

Q He also told us that you said that his mother was going to die. That was your view at some stage, plainly.
A Yes. Perhaps not exactly in those words.

Q But again, if it is the view of the medical practitioners that a patient is dying, do you have a duty to be honest with the relatives?
A Yes.

MR JENKINS: Thank you.

THE CORONER: Good. Thank you very much.

(Luncheon adjournment)

(In the absence of the waiting jury)

MR JENKINS: I have been asked by others for copies of the letters that Dr Barton read out. Copies have been made and it occurred to me you might like a copy.

THE CORONER: That is very nice of you. Thank you. Yes, please. (Same handed in) The jury, please. Will tomorrow be all right for Beverley Turnbull and Mr Farthing?

MALE SPEAKER: Sir, yes.

MALE SPEAKER: Yes.

THE CORONER: Good, excellent.

MALE SPEAKER: Sir, those are the only two live witnesses tomorrow, are they not?

THE CORONER: Yes. We might pick up some rule 37s depending on where we are. I need to be away at a reasonable hour tomorrow afternoon because I have a logistical difficulty, so certainly away from here at quarter to four at the very latest, if that's all right.

MALE SPEAKER: Very good, sir.

(The jury came into court)

THE CORONER: Are we refreshed, ready for the afternoon?

A MEMBER OF THE JURY: We are.

Examined by THE CORONER

THE CORONER: Good. Dr Barton, please can we move to Mrs Service, please.
A Mrs Helena Service was 99. From her medical records it is apparent that in 1981 she had a partial gastrectomy and cholecystectomy for what appeared initially to be a malignant stomach ulcer but on histology this turned out to be benign. An x-ray report in October 1984 revealed that her heart was enlarged and she was admitted in December of that year to St Mary's Hospital with a right-sided cerebrovascular accident and left-sided hemiparesis in consequence.

Q That is a right-sided stroke, left-sided paresis.
A Following extensive physiotherapy she made a very good recovery and was discharged home. In August 1987 she was admitted to hospital having sustained rib fractures after a fall at home. She was noted to be in controlled atrial fibrillation but at that time there were no signs of cardiac failure. Chest x-ray again confirmed enlargement of the heart. In December 1992 Mrs Service was admitted to the Queen Alexandra Hospital having suffered another cerebrovascular accident. She had a left hemiparesis but again appears to have made a good improvement and was discharged.

Following a request by her general practitioner, Mrs Service was then seen by Dr Alfia Lord by way of a domiciliary visit on 9 January 1995. The letter from her GP in this regard shows that Mrs Service had been increasingly short of breath over the preceding two weeks in spite of an increase in diuretic medication she was receiving and also had pitting oedema to her knees. Her GP suspected that she might need an ACE inhibitor. The pro forma domiciliary visit record for Dr Lord appears to indicate the GP's view that Mrs Service was in heart failure. Dr Lord then carried out a domiciliary assessment on 10 January, writing to her GP on 13 January 1995. Dr Lord observed that Mrs Service's pulse was irregular, she had a pansystolic murmur at the apex of her heart that radiated towards the axilla, and she agreed that Mrs Service had congestive cardiac failure due to mitral regurgitation and possible atrial fibrillation.

Dr Lord felt that her diuretic should be increased in the first instance to 80 mg of furosemide daily. She did not feel that ACE inhibitor should be started immediately as there was a need to ensure that her renal function was normal first. Dr Lord had apparently made arrangements for monitoring that with the proprietor of the rest home at which Mrs Service was a resident.

Subsequently renal function was established to be normal. Mrs Service apparently remained breathless on exertion and her mobility was said to be quite limited. In her report to Mrs Service's GP Dr Lord stated on 17 January 1995 that she was arranging for her to be admitted to the Queen Alexandra hospital for an ACE inhibitor to be commenced. On examination in hospital Mrs Service was said to be peripherally cyanosed and dyspnoeic on minimal exertion. Atrial fibrillation, jugular venous pressure which elevated to her ears and a mitral regurgitant murmur that radiated to the axilla were also noted. She was given a trial of an ACE inhibitor, being started on lisinopril, in addition to her 80 mg of furosemide daily and was subsequently discharged on 25 January 1995.

Mrs Service was admitted to hospital again the following year. She was complaining of pain in the wrist and was thought to have been hitting her wrists against the wall persistently. A diagnosis of gout was made. Unfortunately, in May 1997 Mrs Service deteriorated and the residential home became unable to cope with her needs. A care plan for 12 May 1997 recorded that her GP, Dr Rees, had visited and she had diagnosed her as being in heart failure. At that stage Mrs Service was described as "very poorly". Admission was arranged to the Queen Alexandra Hospital. In her referral letter Dr Rees indicated that Mrs Service had recently developed a urinary tract infection which had responded initially to antibiotics but Mrs Service had now become increasingly short of breath, confused and disoriented.

On admission to the Queen Alexandra Hospital Mrs Service was found to have atrial fibrillation and a possibility of chest infection. Bronchial pneumonia was also raised. It was felt that there was evidence of left ventricular failure. An ECG was performance which showed Q waves inferiorly, consistent with ischaemia, and a chest x-ray showed patchy consolidation consistent with the pneumonia. Mrs Service was treated aggressively with antibiotics and fluids and her atrial fibrillation was controlled with digoxin. The senior registrar reviewed Mrs Service following admission, confirming the impression of left ventricular failure and noted that she was not for 555, meaning that her condition was such that she was not suitable for resuscitation.

Mrs Service's condition improved a little over the following days. It seems that the nursing staff contacted the rest home on 22 May 1997 and were informed that she needed to be able to transfer with the assistance of one person in order to return to the home. Referral to Social Services would therefore have been necessary in case a nursing home was required.

Mrs Service's antibiotics were completed on 23 May 1997 and the intravenous fluids were to be discontinued.

The following day she then developed a floppy left hand and became unaware of the hand, with reduced tone, giving the impression of a cerebrovascular accident or a transient ischaemic accident. It appears then that the rest home declined to take Mrs Service back as she was unable to wait there and had a left-sided weakness. A referral was then made to Social Services on 27 May 1997 by the senior registrar on the ward round. At this point Mrs Service's Barthel was 4 and Social Services apparently indicated that she had to be

referred to Elderly Services as she was too dependent for them to place. In consequence of this, it appears that Mrs Service was then referred back to the geriatricians. Consequent on that referral, Mrs Service was seen by Dr Ashbal, locum geriatrician, on 29 May 1997. Dr Ashbal noted that there had been a further episode of left ventricular failure and she was still congested, by which I anticipate he meant she was still in congestive cardiac failure, although he noted that she was better. His entry in the notes for 29 May indicates that he was to transfer Mrs Service to the Gosport War Memorial Hospital.

Mrs Service then remained at the Queen Alexandra Hospital waiting for a bed to become available at the Gosport War Memorial Hospital. The fact that immediate transfer was not possible is probably an indication that there was very high bed occupancy at Gosport War Memorial Hospital at that time. An entry for a ward round on 2 June 1997 indicates that a bed was still awaited and Mrs Service was said to be well. The nursing records however suggest a rather different picture, of Mrs Service being dyspnoeic, short of breath on exertion, a condition which had persisted throughout her stay in the hospital. The night staff on 2 June recorded that there were no signs of confusion but Mrs Service was said to be very demanding overnight, shouting out constantly. Mrs Service was then transferred to Gosport War Memorial Hospital the following day, 3 June.

MR JENKINS: Sir, forgive me for interrupting. On the large sheet that the jury have I think the date is put as '99. It should be '97.

THE CORONER: Oh, yes. Sorry. Column date W.

MS BALLARD: (Inaudible)

THE CORONER: It is all right. They are on the ball! Do go on, please.
A Mrs Service was then transferred to Gosport War Memorial Hospital the following day, 3 June. She was recorded as being 99 years old with atrial fibrillation and confusion. Medication on transfer consisted of Mellaril 25 mg at night, lisinopril 2.5 mg twice daily, bumetanide 1 mg once a day, aspirin 75 mg once a day, allopurinol 100 mg at night and digoxin 125 micrograms once a day. My expectation is that Mrs Service would have been transferred from the ward at the Queen Alexandra Hospital to the transfer lounge, waiting there till it was possible to bring her to Gosport.

Q What is the transfer lounge?
A Patients were taken from their beds very early in the morning and went to this room to wait for their transport.

Q Transit?
A Transit lounge.

Q Right.
A Yes. This would understandably have been a very stressful experience for an elderly lady suffering with heart failure. In any event, on arrival I carried out an assessment and my record in her notes reads as follows: "3 June 1997, transfer to Dryad Ward. Recent admission 17.05.97. Confusion. Off legs. Upper respiratory tract infection. Non-insulin dependent diabetes mellitus. Congestive cardiac failure. Gout. Came from a rest home. On examination slightly breathless, plethoric lady. Heart sounds 1 and 2 plus gallop. Bases

clear. Ankles tick, tick. Needs palliative care if necessary. I am happy for nursing staff to confirm death."

As my note indicates, Mrs Service was now no longer able to mobilise, hence the reference "off legs", and she was confused. I recorded the fact that she was a non-insulin dependent diabetic and that she had had an upper respiratory tract infection. I also recorded that she was in congestive cardiac failure. My note indicates that I undertook examination recording that she was breathless and plethoric, by which I meant that she had purple/blue colouring of the extremities indicating cyanosis consequent on her heart failure. I listened to her heart sounds. I was able to hear a gallop, a third heart sound, indicating that the heart was struggling to cope and that she was clearly in heart failure.

In my view, Mrs Service was very unwell. I believed she was probably dying and might well die shortly. She had probably reached the stage of multi-system failure. Blood test results revealed a high sodium level, probably brought about by dehydration due to her powerful diuretics, which were vital in treating her heart failure. She had low potassium and high urea and creatinine levels. At the time of my assessment I considered Mrs Service would have been more appropriate for care at the Queen Alexandra Hospital but a return transfer in an ambulance was probably not in her best interests. She had probably deteriorated consequent upon the transfer to the Gosport War Memorial Hospital and would have deteriorated further through a transfer back to the Queen Alexandra Hospital. No doubt her bed there would have been allocated to another patient and she might well have had to wait on a trolley while another bed was found. In all the circumstances, we had to do the best we could to care for her.

Having assessed Mrs Service, I then wrote up appropriate medication on her drugs chart. Concerned that she was in congestive cardiac failure, I recorded her PRN as required prescription for 5-10 mg of diamorphine to be administered intramuscularly. I prescribed bumetanide 1 mg once a day as a diuretic, lisinopril 2.5 mg twice a day for her heart failure, being the ACE inhibitor, allopurinol 100 mg daily for her gout, Lanoxin 125 micrograms daily for the atrial fibrillation and 75 mg daily of aspirin to help prevent a further cerebrovascular accident. In addition to that medication I also prepared a prescription for diamorphine 20-100 mg subcutaneously over 24 hours, hiazine 200-800 micrograms subcutaneously over 24 hours and midazolam 20-80 mg subcutaneously over the same period.

If Mrs Service's condition deteriorated and she developed pulmonary oedema consequent on the cardiac failure, the diamorphine would assist in relieving the pulmonary oedema. Pulmonary oedema can cause a sensation of drowning, which would be profoundly distressing for a dying patient in such circumstances. The diamorphine and midazolam would have the effect of relieving the significant distress and anxiety produced from that sensation with the hiazine being available to dry chest secretions.

A Barthel assessment carried out on 3 June revealed a zero score, indicating that Mrs Service was now totally dependent. The nursing records noted her admission and it was recorded that her buttocks were very red and sore with broken skin. A pressure-relieving Spenco mattress was made available.

The nursing records go on to indicate that overnight Mrs Service failed to settle and was very restless and agitated. Quite appropriately, 20 mg of midazolam was given via syringe driver

in accordance with my prescription. While ordinarily I believe the nursing staff would contact me when making use of such an anticipatory prescription, this would ordinarily be in the event of the provision of diamorphine. In the circumstances in which midazolam only was given and at this time, I anticipate the nursing staff properly administered the midazolam without further reference to me.

Sadly, it was felt the following morning that Mrs Service's condition had deteriorated overnight. She remained restless. The nursing notes record that she was seen by me the following morning and the syringe driver was recharged, this time with 20 mg of diamorphine and 40 mg of midazolam. Mrs Service's nephew was contacted to inform him of her poorly condition. Unfortunately, I have not made an entry of my assessment of Mrs Service on this occasion for reasons I have indicated previously, that I would simply have had no opportunity to do so through the need to attend to all my various patients. I anticipate that the agitation and restlessness observed overnight had been due to continuing cardiac failure and this deterioration was further apparent when I reviewed Mrs Service on the morning of 4 June. Given that she was in my view now terminally ill with heart failure and was distressed and agitated in consequence of that condition, it was in my view entirely appropriate to administer the diamorphine and midazolam in the hope of reducing the pulmonary oedema brought on by the heart failure and the distress and agitation from the drowning sensation of the pulmonary oedema.

Sadly, Mrs Service continued to deteriorate and she was recorded as having passed away at 3.45 on the morning of 5 June 1997. The diamorphine and midazolam were prescribed and in my view administered solely with the intention of relieving Mrs Service's agitation and distress, with the diamorphine having the additional beneficial effect of treating the pulmonary oedema from her heart failure.

Q Can I talk to you in general terms about the transferring of old people? Mrs Service is 99, and too often I have to deal with deaths resulting almost solely from the transfer of old people. They may be ill, they may have various conditions, but it has a very profound effect on them, doesn't it? It disorientates them, it makes them insecure and leaves them fairly vulnerable. This is in general terms. I was concerned that there was the prospect of transferring Mrs Service back to QA. That almost certainly would have been terminal, wouldn't it? She wouldn't have...

A She would possibly not have survived the journey.

Q No. It is all part of the decision-making machinery. You say in your statement latterly that she was now dying. I don't think any of Mrs Service's conditions were reversible, were they?

A None.

Q So we are talking of purely easing the path, as it were.

A Palliative care.

Q Yes. Right. OK, thank you for that. Anybody?

MS BALLARD: Nothing, thank you.

MALE SPEAKER: No thank you.

THE CORONER: Yes, Mr Sadd.

Examined by MR SADD

MR SADD: Dr Barton, just one point, and it really stems from your generic evidence this morning but it blends into what you said in this case. I think in this statement you draw a distinction between – and if I am being unfair, you must correct me – the assessment you make on Mrs Service's arrival into Dryad and subsequently, where you say you simply didn't have time so the notes aren't available or your recall of what happened subsequently isn't noted. Is that distinction a fair one, that you give a proper assessment---

THE CORONER: Do I understand it?

MR SADD: You give a proper assessment on transfer.
A Yes.

Q And that what we see in your statement here represents a paradigm of that, so that we know you've got...
A What's a paradigm?

Q "Paradigm" means a good example.
A My assessments subsequently would have been in with the nursing staff and I wrote the report based on what the nursing staff and I decided on subsequent ward rounds, although I did not put anything in writing in the medical notes.

Q No, that I understand, and you make that clear in your statement.
A There's nothing there that isn't in the nursing notes in my presence.

Q Sure. It's just by reference to paragraph 20 of the statement from which you've read, and of course, I haven't seen Mrs Service's medical records but you set out there, I suppose exhaustively, the note you made of her transfer, her condition and your examination.
A Yes.

Q And would we be entitled to take that as representative of what you would normally do on transfers of patients to Dryad?
A Yes.

MR SADD: Thank you.

THE CORONER: Ladies and gentlemen, anything you want to ask?

Questioned by THE JURY

A MEMBER OF THE JURY: Yes. What would be the time frame of a proper assessment of a patient after transfer? How long would it take you?
A Twenty to thirty minutes.

Q But you only had an hour and 15 minutes.
A Yes.

Q So that would obviously reflect on the time given to other patients.
A Yes, that assessment will have been done at a lunchtime, a special trip back to the ward to do that. The subsequent assessments that Mr Sadd was talking about would be done in the morning with the nurse in charge or the sister, going round and seeing all the patients.

Q So it would be a completely independent assessment. It wouldn't be a case of ticking off what somebody has previously diagnosed as being wrong with that patient. If somebody came across with, as you say, congestive heart failure or whatever, it wouldn't be a case of just assuming that that was what was wrong with them.
A You would examine them on that initial examination, yes.

Examined by MR JENKINS

MR JENKINS: Can we just do all that again, just so that we are all clear. In the morning on a weekday you will go round both wards. You will go round with nursing staff and you will do a review of all those patients that you need to know something about.
A Yes.

Q What we have heard is that it might be half an hour on one ward and you might have had 20 patients to review.
A Yes.

Q You then go and do the other ward.
A Yes.

Q If a patient is admitted, what you've told us is you would go back at lunchtime to clerk them in, as it is called.
A Yes.

Q And that process would take 20-30 minutes.
A Yes.

Q You would just be dealing with the one patient that you were clerking at that time.
A You would hope.

Q Although there may be other patients.
A Yes.

Q That you need to deal with when you are back at lunchtime.
A Yes.

Q Because something has changed.
A Yes.

Q When you are clerking in the patient – so they have just come to the ward and you are assessing them for the first time, you would have the patient, you would have records---
A Hopefully.

Q ---such as they were.
A Yes.

Q If there were records, you would have an indication of what previous doctors were regarding as the medical problems or the psychiatric problems with the patient.
A Yes.

Q If the consultant, Dr Lord, Dr Tandy, Dr Reid had agreed to the patient being transferred to the Gosport War Memorial, you would have a letter from the consultant, would you?
A Yes.

Q Indicating the basis upon which the patient was being accepted to the ward.
A Yes.

Q So you would have some background information. Over and above that you would have the patient, and what would you do by way of examination?
A Just a very basic systems examination.

Q And you were asked of this patient, the patient that you saw in 1997, at the beginning of June 1997, you have gone through a list of things, listening to heart sounds – bases clear?
A Means that there was no fluid actually at that moment in time at the bottom of her lungs.

Q So are you listening to the lungs with a stethoscope?
A Certainly.

Q As well as the heart?
A Certainly.

Q We know that the intensity of the work was to change over time before you resigned in 2000.
A Yes.

Q Would that level of assessment of patient, of examination, would that have gone on for the next three years?
A Yes.

MR JENKINS: Yes, thank you.

Examined by THE CORONER

THE CORONER: Thank you very much indeed. Unless there is anything else, Ruby Lake.
A Ruby Lake was admitted to the Gosport War Memorial Hospital on 18 August 1998. She had previously been admitted to the Royal Hospital Haslar on 5 August 1998 via Accident & Emergency after falling at home. She had a fractured left neck of femur and had undergone left semi-hemi arthroplasty. Mrs Lake had been diagnosed as suffering with mild hypertension as early as 1980 and had gone on to develop arthritis and gout. In 1988 a chest x-ray had revealed cardiomegaly, an enlarged heart. She had also suffered with leg ulceration and liposclerosis with soft tissue calcification. In September 1993 she was then admitted to the Queen Alexandra Hospital as an emergency, suffering with chest pain, and it appears that those caring for her considered that she had left ventricular failure of the heart and that she

had previously had a myocardial infarction. Mrs Lake was then discharged from hospital towards the end of September 1993 and after discharge was seen on 30 December by consultant geriatrician Dr Alfia Lord. Dr Lord wrote to Mrs Lake's GP on 30 September noting the diagnosis as left ventricular failure, controlled atrial fibrillation, aortic sclerosis, improving renal failure and osteoarthritis. She said Mrs Lake had done well since discharge. Mrs Lake returned to Dr Lord's clinic on 4 November 1993. Dr Lord's senior registrar felt that on examination she was reasonably well but noted elevated blood pressure and that she remained in atrial fibrillation, which was said to be controlled.

In August 1997 Mrs Lake was then referred by her general practitioner to Dr Barrett, consultant dermatologist at Gosport War Memorial Hospital. The GP noted that Mrs Lake had had terrible ulcers on her legs in the past. She now had a recurrent lesion on her lower leg which the practice nurse had been trying to heal but without success. This had been getting bigger and her GP, Dr North, was concerned to see Dr Barrett's assessment and advice. It seems that in due course Mrs Lake condition improved. She was reviewed by Dr Barrett at his dermatology clinic on 3 January 1998 and he wrote to Mrs Lake's GP several days later indicating that her right leg was looking very much better but said there was so much soft tissue calcification on the leg that there was likely to be further ulceration in the future.

In March 1998 Mrs Lake was referred by her GP once more to consultant rheumatologist Dr McRay(?) with further difficulties associated with her osteoarthritis. Dr McCray's senior registrar reported to the GP that Mrs Lake had had joint pains affecting her shoulder and her knees intermittently for 20 years. These apparently continued to trouble her, with difficulty standing and walking. Her main complaint at that point was apparently a lower left lumbar pain, which had been worse since a fall at Christmas. Following x-rays, Dr McRay then saw Mrs Lake again on 27 April 1998, noting that there were quite marked degenerative changes in the lower lumbar facet joints. She planned to arrange physiotherapy.

In June 1998 Mrs Lake was then admitted to Sultan Ward at the War Memorial Hospital with infected leg ulcers. It is not immediately clear to me when she was then discharged but her records show that on 5 August she was admitted to the Royal Hospital Haslar, having fallen. A fractured left neck of femur was diagnosed and, as I have indicated, an operation, a cemented hemi-arthroplasty, was then performed the same day. It appears that at some stage shortly after admission to hospital Mrs Lake was given 2.5 mg of diamorphine intravenously for pain relief. Mrs Lake had something of a stormy post-operative course in developing chest pain and pulmonary oedema, shortness of breath, diarrhoea and vomiting. By 10 August she was suspected to have a chest infection and it was thought that she might have suffered a myocardial infarction. She was also dehydrated.

On 12 August the registrar seems to have thought that Mrs Lake was much improved but she was developing sacral bed sores. The following day Dr Lord was asked to review her by Surgeon Captain Farquharson-Roberts. His house officer recorded in a note to Dr Lord in Mrs Lake's records that post-operative recovery had been slow, with periods of confusion and pulmonary oedema, though she had been an alert and well over the last two days. Dr Lord duly saw Mrs Lake the same day, noting in her records that she had a left bundle branch block and left ventricular failure which was improving. The left bundle branch block would have resulted in the electrical pulses to the left side of the heart being interrupted. In addition, Dr Lord noted that Mrs Lake had sick sinus syndrome with atrial fibrillation. This meant the heart was not transmitting electrical impulses properly and so was not beating

efficiently. Hence the reference to atrial fibrillation. Mrs Lake was said to be dehydrated but improving. She had bilateral buttock and leg ulcers and hypokalaemia, a low potassium level, together with normochromic anaemia. Mrs Lake had been suffering with diarrhoea and vomiting.

Dr Lord suggested that Mrs Lake should have a potassium supplement in the form of Slow K given that she was on digoxin, a cardiac glycoside which was being administered to reduce the oedema in view of the left ventricular failure. Dr Lord also noted that Mrs Lake should be hydrated orally and that stools should be sent for culture and sensitivity. She concluded her note by stating that it was difficult to know how much Mrs Lake would improve but that she would take her to an NHS continuing care bed at the Gosport War Memorial Hospital the following week. It was apparent from Dr Lord's note that she recognised that Mrs Lake might very well not recover and I anticipate from those circumstances, given her underlying condition, including heart failure, Mrs Lake might die.

Dr Lord then wrote to Surgeon Captain Farquharson-Roberts the following day recording her history and that the ECG showed atrial fibrillation and a variable interval indicating the sick sinus syndrome, with ischaemic heart disease and left ventricular failure also being problems. She noted that Mrs Lake's appetite was poor and she was eating and drinking small amounts. Dr Lord confirmed to Surgeon Captain Farquharson-Roberts that she was happy to arrange the transfer to the Gosport War Memorial Hospital, uncertain as to whether there would be a significant improvement. She said that overall Mrs Lake was frail and quite unwell at present. A Barthel assessment was conducted on 15 August giving a score of nine. Following on from Dr Lord's assessment, Mrs Lake was then duly admitted to the Gosport War Memorial Hospital on 18 August 1998. It is apparent from her records that I admitted her, although I am unable now at this remove of time to recall anything about her. In any event, my note in her records on this occasion reads as follows: "18.8.98 transferred to Dryad Ward. Continuing care. History of present complaint: fractured neck of femur left 5.8.98. Past medical history: angina, congestive cardiac failure. Catheterised. Transfers with two. Needs some help with activities of daily living. Barthel six. Get to know. Gentle rehabilitation. I am happy for nursing staff to confirm death."

As is apparent from my note, the history of present complaint was the fracture of the neck of femur which had occurred on 5 August. I also recorded the past medical history of angina and congestive cardiac failure, noting at this stage that Mrs Lake was catheterised, that she transferred with the assistance of two people and needed help with any activities of daily living. I noted a Barthel assessment of six, though I anticipate that would have been related by others rather than being a reflection of my own assessment at that stage. Clearly, Mrs Lake had a significant degree of dependence. My note also indicates I hoped that gentle rehabilitation could take place but I would have been aware that Mrs Lake was in a frail condition and quite unwell, as of course previously noted by Dr Lord. I was conscious that Mrs Lake might not recover, hence my note that I was happy for nursing staff to confirm death. Mrs Lake had had the trauma of a fractured neck of femur with a significant operation in consequence. She had heart failure and had possibly experienced another myocardial infarction. She had also just undergone the stress of a hospital transfer at the advanced age of 84. My note was designed to ensure that the nursing staff were aware that it was not necessary to call a doctor to attend to certify if death occurred out of hours, as I indicated previously.

Having assessed Mrs Lake, I then prescribed various medications for her, specifically digoxin administered to improve her cardiac output in view of the left ventricular failure, Slow K to maintain potassium in view of her previous dehydration, bumetanide, a diuretic, again for her congestive cardiac failure, and allopurinol for her gout. I also prescribed temazepam as required to assist sleeping. All of these medications previously had been prescribed at the Royal Hospital Haslar. In addition, I prescribed Oramorph for pain relief. I was concerned that Mrs Lake might very well require pain relief in view of the recent fracture and operation and in consequence of the sacral and leg ulcers. The Oramorph was in a 10 mg in 5 ml solution and at a dose range of 2.5-5 ml four-hourly. The records show that 5 mg of Oramorph was given at 2.15 p.m. and the nursing entry for that afternoon indicates that Mrs Lake seemed to have settled quite well and was fairly cheerful. Mrs Lake was then noted to have settled and slept well from 10 p.m. through to midnight but she apparently awoke very distressed and anxious, saying that she needed someone with her. A further 10 mg of Oramorph was given at 12.15 a.m. but apparently with little effect and Mrs Lake remained very anxious during the night and was confused at times.

Temazepam was available for the nursing staff to administer but they probably did not consider that appropriate and preferred the Oramorph in view of the fact that she was suffering from anxiety and distress, for which the Oramorph would be appropriate. Oramorph was also appropriate in view of Mrs Lake's history of congestive heart failure. Temazepam might have made Mrs Lake's heart failure worse and it is conceivable at this stage Mrs Lake was experiencing further heart failure.

I would have reviewed Mrs Lake again the following morning, 19 August. I believe that I was chairing a primary care group steering group meeting at the War Memorial Hospital starting at 12.30 p.m. so I would have seen Mrs Lake and all the other patients on the Dryad and Daedalus wards in advance of that. I have not made a specific entry of this in Mrs Lake's medical records and I anticipate I simply did not have an opportunity through excessive pressure of work for the reasons previously stated. I anticipate I was concerned that Mrs Lake's condition had deteriorated from her already frail and poorly state in view of the transfer and the difficulty she had had overnight. I believe I would have been concerned she might now be likely to die shortly and was anxious that she should have appropriate relief from the pain of her fractured hip and sacral ulcers and from her anxiety and distress, which had been apparent overnight. Opiates provided for that purpose would also assist in relieving the pulmonary oedema from congestive cardiac failure.

Accordingly, I prescribed diamorphine, 20-200 mg, hiazine 200-800 micrograms and medazalam 20-80 mg, all to be administered subcutaneously. It was of course my intention that these medications if necessary should be started at the bottom end of the dose range but increase was available within the prescription if that proved necessary. The nursing record shows that 11.50 a.m. on 19 August Mrs Lake complained of chest pains. The nurse specifically noted this was not radiating down the arm and was no worse on exertion. Mrs Lake's pulse was measured at 96 and she was noted to be grey round the mouth. Quite properly, a further 10 mg of Oramorph were given. The nursing record also indicates that the doctor was notified and my expectation is that I would have been informed of Mrs Lake's condition at about that time, and I would have been quite content that Oramorph should be given for the pain, although I have no recollection of events at this remove of time. There is no ECG available at the hospital and it would have been difficult to say if Mrs Lake had experienced another myocardial infarction but I anticipate there was increasing cardiac failure.

Unfortunately, it seems the Oramorph was not successful in relieving the pain over any prolonged period. A further nursing entry indicates that the pain was only relieved for a short period and Mrs Lake was said to be very anxious. Accordingly, the syringe driver was commenced with 20 mg of diamorphine and 20 mg of midazolam at 4 p.m. that afternoon. I do not know if I was informed of this at that time but, given the fact that Mrs Lake was still suffering with pain and was very anxious, institution of the diamorphine and midazolam at these levels was in my view entirely appropriate. By this stage, of course, Mrs Lake had received quantities of Oramorph which sadly had not been sufficient.

It appears that in consequence Mrs Lake had a comfortable night and did not suffer with distress and anxiety as she had the previous evening. The nursing entry records that she settled well, had a comfortable night and was drowsy but rousable the following morning. Unfortunately, it seems that Mrs Lake's condition was perceived to be deteriorating. The syringe driver was recharged at 10.10 a.m. on 20 August and in addition to the 20 mg of diamorphine and 20 mg midazolam, 400 micrograms of hiazine was added. The hiazine would have assisted in reducing the pulmonary oedema and secretions consequent on Mrs Lake's heart failure. The nursing record also indicates that Mrs Lake's family were informed of her condition, with her daughter being present. Again, I anticipate I would have reviewed Mrs Lake that morning but did not have an opportunity to note this in her records.

Over the course of the next night Mrs Lake's condition apparently continued to deteriorate. The nurses recorded that she remained very bubbly, with suction being attempted and it is likely that the hiazine which had been previously administered in consequence of those secretions. Mrs Lake was apparently distressed when turned and clearly, in spite of the fact that the diamorphine and midazolam were administered, they were not entirely successful in relieving Mrs Lake's distress. In view of the continuing distress it appears the driver was recharged at 7.35 the following morning, this time with 60 mg of diamorphine, 60 mg of midazolam and 800 mg of hiazine. I believe I would have reviewed Mrs Lake's condition again that morning, though whether this was before or after the recharging of the syringe driver I cannot say. It is possible that I was not informed of the increase at that point but would have arrived very shortly afterwards and reviewed Mrs Lake and would have been content that it was appropriate. Again, I was unable to make an entry in her records for the reasons previously stated.

Unfortunately, as evidenced by the nursing notes, Mrs Lake's condition continued to deteriorate. It is recorded that all care continued and that her family were present all afternoon. Sadly, she passed away at 6.25 p.m. The diamorphine, midazolam and hiazine were prescribed and in my view administered solely with the intention of relieving the pain, anxiety and stress which Mrs Lake was suffering in conjunction with her congestive cardiac failure.

THE CORONER: Thank you. Right. Mrs Mussle(?), is there anything you want to ask?

FEMALE SPEAKER: Could you just clarify for us: she went from 20 mg of the diamorphine to 60, but the record says that Nurse Turbritt has 40 drawn up and given but we can't find anywhere where the 40 is (inaudible). It says it was given at 16.55 on 20 August. But it seems to have jumped from 20 up to 60 (inaudible).

(Pause)

THE CORONER: Has anyone found it?

MALE SPEAKER: Not yet.

FEMALE SPEAKER: We've got it as two further entries in the book for 20 August and it's in Nurse Turbritt's statement but we can't find it and we can't find it in the nursing notes.

B

(Pause)

MR JENKINS: It's 394 and 395.

FEMALE SPEAKER: (Inaudible) That says 60.

C MR JENKINS: It does. Prescription (inaudible).

(Pause)

MR JENKINS: Professor Black; it's in his report at paragraph 5.16 on page 13. bottom of page 13.

D THE CORONER: 13 August diamorphine 20-200 mg subcut in 24 hrs, written up 20 mg started on 19 August, 20 mg started on 20 August then discarded, 40 mg started on 21 August.

MR JENKINS: No, I don't think that's right.
A No. 16.50 on 20 August previous syringe driver was discarded and 40 mg were put up. So it is in the same column but lower down.

E

MR JENKINS: I think you've misread Professor Black's sentence.

THE CORONER: Started on 20 August then discarded.
A You see it's written in red "discarded" at 16.50 p.m.

MR JENKINS: Can I read that? 20 mg started on the 19th, 20 mg started on the 20th, then
F discarded, and 40 mg started.

THE CORONER: Oh, I see.

MR JENKINS: On 21 August 60 mg started.

THE CORONER: Tricky, this English, isn't it?

G

MR JENKINS: It is where you put the punctuation that matters.

THE CORONER: Yes. So it's 20, 20 aborted, 40, then 60. Does that make sense?

FEMALE SPEAKER: Yes. The records show that 5 mg of Oramorph were given at 2.15. Was that the afternoon she arrived, on the 18th?

H

FEMALE SPEAKER: (Inaudible).
A 2.15 pm. On the afternoon of her arrival she was given 5 mg.

Q Yes. Was that after you had assessed her?
A Yes.

Q Because previously she had only been on paracetamol and codeine.
A Yes, and she was very restless and uncomfortable after the transfer and the assessment.

Q OK. Thank you. Another one. The day after her transfer she had chest pain. We know now no ECG machine was available there. Would consideration have been given to transferring her back for further investigation in Haslar or not?
A I don't think she would have survived the transfer in her frail and distressed state.

FEMALE SPEAKER: OK. Thank you.

THE CORONER: Anything else?

FEMALE SPEAKER: I do not think so.

THE CORONER: Anything? Ladies and gentlemen?

Questioned by THE JURY

A MEMBER OF THE JURY: Just one question, sir. When patients were obviously unfit for transfer and they arrived at your ward for assessment, as in the case of Helena Service, she was transferred for continuing care. After your assessment it was obviously palliative care, and also people with serious heart problems were transferred to the wards that had no ability to treat them apart from with drugs. Was that ever sent back the other way, so people who had initiated the transfer were asked questions why that happened?
A Perhaps we should have done.

THE CORONER: But there would be occasions, would there not, where patients were sent back to Haslar or QA if medical condition demanded that?
A No. There would have been a few.

Q Yes. The ones we are talking about today, Mrs Service, is not well enough to do that transfer.
A No.

Q But if she had been well enough.
A If she had been well enough, it's very unlikely she would have been on my ward.

Q That is right, isn't it?
A They were end of the line.

Q It is possible?
A It's possible, yes.

MR SADD: Sir, I'm slightly concerned by that exchange, because we've just had Dr Barton say "end of the line" – I know in reference to this particular individual but I just need to be clear on one issue, Dr Barton. You were asked by a member of the jury if on transfer from Queen Alexandra or Haslar to Dryad there was any re-transfer back. Did that ever occur in your knowledge?

A I can't remember very many. I'm sure it did happen on occasion.

MR SADD: Thank you.

THE CORONER: Right. I think that's probably all we can do this afternoon, unless anybody has anything they think we can do this afternoon. Thank you very much indeed, doctor. I will certainly take a view that we can discuss matters with Dr Barton for any future business, as it were.

MR JENKINS: You have promoted me to doctor and changed my surname. Jenkins. Forgive me. That we can discuss things with Dr Barton is pointed at me. I misunderstood.

THE CORONER: It makes a change for you to do it! It's normally my job. If we could start at ten in the morning. I actually think I would like to start with Beverley Turnbull tomorrow and then take you after that, Mr Farthing. Would that be terribly inconvenient?

MR FARTHING: Not at all.

THE CORONER: I have some more rule 37s that I can deal with tomorrow, although I thought those might be better dealt with on Monday. Let's see how far we get tomorrow. OK? Thank you very much indeed. Yes?

FEMALE SPAEKER: Can we just confirm that Ruby Lake will be Monday?

THE CORONER: Yes. We haven't rejigged that yet, if that's any help. OK. Thank you very much indeed.

(Adjourned until 10 a.m. the following day)