GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Monday 6 April 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 THIRTEEN)

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) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
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(In the absence of the jury)

THE CORONER: I understand Mr Townsend has been delayed but I thought I would come in and see if there is anything we can achieve before he gets or instead of him being here and if not I will go out again

MR LEIPER: There is nothing I seek to raise.

B

MS BALLARD: Nothing sir,

THE CORONER: That is that then. He is due now'ish, so I will give him a couple of minutes to compose himself and then we will continue.

(Short adjournment)

C

MR TOWNSEND: Sir, can I apologise, there was a problem on the railways.

THE CORONER: So I understand. I just watched Judge Marsden coming in.

MR TOWNSEND: He was on the same train as I was. We discussed our misery jointly.

D

THE CORONER: We will have the jury now, please. Mr Townsend, I asked other counsel if there was anything they wanted to raise before the jury came in: is there anything you want to raise?

MR TOWNSEND: No, thank you, sir.

(The jury entered)

E

THE CORONER: Good morning, welcome back. Dr Wilcock, please.

ANDREW WILCOCK, Sworn

THE CORONER: (To the witness) Would you give the court your full name and your qualifications, please?

F

A Dr Andrew Wilcock, MBChB, FRCP, BM.

Q And your current position?

A Clinical reader in palliative medicine and medical oncology at the University of Nottingham and Nottingham University Hospitals NHS Trust.

G

Q Doctor, let me just clarify: this is a Coroner's court so it is not a court like any other, dealing with blame or culpability. The Coroners' Act specifically says I must not do that, so we are looking facts surrounding death and not if anyone was at fault. The position is that if I find myself being led to questions of culpability I will stop questioning and so we will avoid that.

Can we start with Leslie Pittock, please? All these cases you looked at cold because you were only going through the paperwork; you did not see any of the bodies?

H

A No.

Q Was the paperwork supplied to you by the police?
A Yes.

Q The opinions that you formed are from the hospital notes, hospital records and statements that were sent to you?
A Yes.

Q Take me through Mr Pittock, please? What did you find with him?
A If I may read from my report?

Q Yes, please do.
A I found Mr Pittock to be a frail, 82 year old man who was admitted to Norbury ward, Gosport War Memorial Hospital, due to depression. He was withdrawn, agitated and irritable and required the help of two others to mobilise. Despite this admission and the reduction or discontinuation of some of his medication, his low mood and poor mobility persisted. He developed a chest infection and urinary retention. After about three weeks in hospital his condition remained poor and he started to develop pressure sores. He was referred to Dr Lord for a medical view and was subsequently transferred to Dryad Ward.

During his admission to Dryad Ward ---

THE CORONER: Can I stop you there? The comments you make with regards his medication, you felt that was over-prescribed at that point, did you?
A Not at that point, no.

Q Was it appropriate?
A It seemed appropriate, yes.

During his admission on Dryad Ward his condition continued to deteriorate. There was a lack of adequate note-keeping and as such a lack of documented assessment of his condition. Some of the drugs that were prescribed were difficult to justify and ..(inaudible).. in the dose range in which they were prescribed. If pain was a problem it was not recorded or assessed.

As he deteriorated the dose of the drugs that he was administered in the syringe driver in my opinion exceeded that which was generally considered an appropriate starting dose based on his existing ... As he deteriorated further he became tense and agitated. There was no clear assessment of why this might be or apparent consideration that the drugs may have been contributing to this and his dose of diamorphine was increased.

There was a comment in the notes that at one point his respiratory rate was six, which to me at least seems a relatively low level of respiratory rate given that this man was likely to be ..(inaudible).. of bronchopneumonia, and that is an indication that the diamorphine may well have been excessive to his needs at that time. In my opinion, however, he was naturally coming to the end of his life and the bronchopneumonia was likely to be a terminal event, albeit that he is likely to have received doses of diamorphine which were likely to be excessive to his requirements.

THE CORONER: Excessive to his requirements or having a negative effect?

A This is where it is difficult to separate out. I think from a review of the notes there is no doubt that he was naturally coming to the end of his life and was naturally dying as a result of a bronchopneumonia. Alongside that, however, there were indications from the notes, possibly because of his increased agitation and possibly because of the reduced respiratory rate that the doses of diamorphine he was administered were excessive to his requirements.

B Q That goes back to the original point, does it not? Did it have a negative effect on him or is it just a neutral factor for him?
A If there is a negative effect the implication, from my point of view is difficult to judge. If it led to a shortening of his life it may be a matter of hours to a small number of days.

C Q And it was palliative care?
A I would not say it was good palliative care but his symptoms would have been palliated with appropriate drugs but not inappropriate dosage, in my opinion.

Q What would be the effect of an over-dosage?
A If someone was given too much opioid they become increasingly drowsy; they may be nauseated; they may become confused and as the sedation increases their respiratory rate may become depressed, and it is the respiratory depression that would ultimately lead to
D death.

THE CORONER: What order are we going in? Shall we start with Mr Jenkins?

MR JENKINS: We can.

THE CORONER: It would seem to be appropriate.

E

Cross-examined by MR JENKINS

Q This was a man coming to the end of his life?
A I believe so, yes.

Q What you have seen are records that were not as full as you might typically see for
F someone nursed in hospital.
A No.

Q You understand that so far as the medical ... was concerned, that was extremely limited at the Gosport War Memorial Hospital?
A Yes.

G Q If doctors had more time with their patients one would hope to see a full explanation in the medical records as to each decision which is made in the management of the patient?
A Time is an elastic phenomena, and I think if you are acting and working in accordance with the General Medical Council guidelines then I think an attempt should be made to document your decisions and document treatments given.

H

Q I agree but if a doctor does not manage to make time elastic, as you have suggested, there will be things that perhaps could be done and perhaps will not be done, there is not enough time.
A It is a circular argument.

Q I do not understand the circulatory or the elasticity. If you want to explain them please do.
A I think being busy, a lot of people can claim to be busy but that does devolve you from actually doing a good job and if part of doing a good job is actually recording and documenting then that has to be part of the work.

Q The fact is that the notes do not give a full explanation for some of the decisions that were made, you agree?
A Yes, but again, the lack of documentation – the Coroner in Nottingham will say if it is not documented then it did not happen, full stop.

Q That is a proposition that can be advanced but there is no way of judging whether it is right or not?
A I think the difficulty with a lack of documentation is on the one hand it makes it difficult to unpick what happened here, okay, but equally it does not defend what happened here. There is no defence; there is no justification; there is no obvious understanding of why certain drugs were given; why certain doses were adjusted in the way they were.

MR JENKINS: I understand. No-one is here to justify or defend anybody. We are here to find out how various individuals came about their death. This is not the General Medical Council. It is not a court and we are not here to make any judgments.

THE CORONER: I think the answer is that, yes, we are here to make judgments but not of people but of circumstances.

MR JENKINS: So far as the administration of any medicine is concerned, obviously there has to be a decision to prescribe it and then there has to be someone giving it to the patient.
A Yes.

Q The evidence that the jury has heard is that nursing staff would not give medication to a patient if they thought it was not appropriate and that would be usual in medicine, would you agree?
A My understanding is that as the doctor who prescribes the drugs you retain overall responsibility for that prescription. It is your duty to ensure that that prescription is used appropriately.

Q I was asking you about the nursing staff. Do you want to answer the question I asked?
A I find it very difficult to understand how the prescription as it is written gives clear guidance to the nursing staff, because the prescriptions of many of these drugs is in a wide range, with no explicit instruction anywhere on that prescribing chart as to how those drugs should be used, of what days they should be started, in what combination and on whose decision.

Q The evidence we have heard – I am waiting for ..(inaudible).. – the evidence we have heard is that there was an extremely good understanding between the doctor and the nursing staff and that if there was to be any change in the administration of the medicine that would be discussed between the doctor and the nursing staff. The doctor would receive feedback as to how the patient was responding and if it was felt appropriate that the level of medication should be increased or changed in any way it would be discussed and authority would be given for the change in dose: do you understand? That is what we have heard.
A Okay.

Q You are used, I think, to a situation where the doctor prescribes medication which the patient may need at that time, not at some future time?
A What I am used to seeing, both in the hospice and in the hospitals is the use of medication to be given if required. When it is unclear what a patient's requirements might be it is far more usual and much safer to actually prescribe small doses of diamorphine, Midazolam or hyoscine to be used if required. That allows the patient who you may or may not know is going to need these drugs to have them always readily available and so it is the needs of the patient that drives their use. It may be that that patient only needs one dose in 24 hours of that particular drug for a particular symptom, but that allows you to judge what their needs are and their likely dose requirement based on the use of those drugs. For arguments sake, if they are using it two or more times a day they would require a regular dose, that informs you what the regular dose should be.

Q Right.
A I think there is a common theme here, I think that opportunity was never afforded to patients. It was usually a syringe driver with a wide range of dose of diamorphine and whatever other drugs.

MR JENKINS: What we have heard is that the consultants were content with what was happening, namely that for drugs to be given via a syringe driver there might be a wide range of prescribing; the consultants knew about it; the sister on the ward knew about it and the clinical assistant knew about it as well, yes?

THE CORONER: I think Mr Jenkins is actually telling you it comes from the evidence we have heard.

MR JENKINS: (To the witness) Would you say that that is an unusual practice?
A From my experience, yes.

Q We know that Dr Reid, who was the medical director locally, was one of the consultants, and he was content that this practice should continue as well, so there is no issue about whether it was followed, and the hierarchy was aware of it, but what we have heard is that the circumstances in which the resources were allocated were such that this was felt to be an appropriate way of dealing with prescribing. The question I asked you some time ago was that nursing staff, if they are to administer medication, should refrain from doing so if they think that the medication is inappropriate for that patient at that time?
A Nurses will have their own set of responsibilities.

Q Yes but that is what we have heard and we have heard from the nursing staff, or certainly a number of members of the nursing staff, that they were mindful of those

responsibilities and if they had had any concerns for the given patient they would not have given the medication that was in fact given: do you follow?
A Uh-huh.

Q What has been said that if they had had any concerns they would have declined to give it and would have made a note that they had declined and why they had declined in the medical records. So the fact that patients were receiving the medication you have seen in the records, it follows that the nursing staff were of the state of mind that it was appropriate for the patient, given their symptoms; it follows from the evidence we have heard that the prescribing doctor considered it to be appropriate for the patient and their symptoms, and for those cases where there were ward rounds by the consultant, in Dr Reid's case we heard every week, it follows that the consultant too would have been of the state of mind that the prescribing was appropriate? That is the evidence we have heard in fact, and I will come back to the point that you raised: what you said is if it is not documented it did not happen, yes?
A That is the view of the Coroner in Nottingham, yes.

Q That may be right, he is hundreds of miles away and we are going to leave him in Nottingham for these purposes, all right? If a drug is administered to a patient and it is pain relief that is being administered, the fact that no-one has written that the patient is in pain does not mean that the patient was not in pain, does it? It may mean that in Nottingham but it does not mean that in truth?
A It may also mean that they have a pain for which opioids are not appropriate, so, do you see what I mean? We can discuss this at length but what you need to know is if people are in pain what the cause of the pain is, and only by understanding what the cause of the pain is do you know whether you are appropriately treating it.

MR JENKINS: What you have agreed with me about there is that if it is not recorded if someone is in pain but that they are given analgesic pain relief, the fact that it is not written down there in pen does not mean they are not in pain?

THE CORONER: But what it does mean that it is impossible for you to make a judgment on that in the absence of the note? I think that is really where we are, is it not?
A Yes.

THE CORONER: I think that is the difficulty we have had throughout this ---

MR JENKINS: Indeed.

THE CORONER: --- how does one take any view of it if it is not there.

MR JENKINS: Yes. (To the witness) I come back to the Coroner's first question really of you, all you have seen are records with regards to these patients?
A Uh-huh.

Q You have not seen the patients themselves, quite obviously; you have not spoken to any of the nursing or medical staff who treated these patients, I do not think.
A No.

Q So you are trying to piece together from what may be incomplete or inadequate notes what actually happen, and you appear, if I may say, that you appear to have come into this exercise with the mind-set that if it is not recorded then it did not happen.
A I come into on that because you talked about documentation. My view here, and what I have attempted to do is to actually provide a very fair overview of the situation as I have understood it from the notes, and I have been asked for my opinion and that is what I have done. I have looked very carefully at all the different pieces of evidence that were available to me in coming to the conclusions I have come to.

MR JENKINS: I understand but the evidence that has been available to you, you have told us, was very limited: you have not spoken to anyone, you have not seen the patient and you have formed the view that the records are inadequate or incomplete, so you have seen very little.

THE CORONER: He has seen everything there is that is available now, and there would have been a lot more available with full medical notes.

MR JENKINS: Thank you. That is all I ask.

THE CORONER: Mr Townsend?

Cross-examined by MR TOWNSEND

Q Just one point to clarify, Dr Wilcock. The decision as to where to prescribe, for example, the diamorphine at what level, 10, 20, 30 milligrams, whatever it is, is a medical and not a nursing decision, is it not? In other words, it is a decision for the doctors, not the nurses?
A In terms of prescribing such drugs it would be a decision for the doctors.

Q A doctor would discuss matters with the nurses who have the day-to-day view of the patient, correct, in deciding what level to administer it at?
A Yes, but what is drummed home in terms of safe prescribing is that that prescription of itself should be clear and not open to misinterpretation.

Q Yes, I accept that. So the final decision as to what dose to give rests with the doctor?
A In my view, yes.

MR TOWNSEND: Thank you.

THE CORONER: Ms Ballard?

MS BALLARD: No questions, thank you.

THE CORONER: Mr Leiper?

Cross-examined by MR LEIPER

Q Dr Wilcock, I ask questions on behalf of a number of families but not Mr Pittock but you have given evidence during the course of this morning about some common themes you have identified in these cases and I just wanted to pick up on that. The common theme I think you specifically mentioned was in relation to the prescription of the amounts of

diamorphine and the absence of an analysis as to how that was affecting the different patients, is that the common theme you are referring to?

A The common theme I was referring to I think is that there is lack of the ability to give intermittently small doses of either the diamorphine, the diazepam or hyoscine which could be prescribed proactively and actually is seen as good practice to prescribe small doses to be available intermittently so it gets you around the situation where if there is not a doctor immediately to hand that patient can receive the drugs that they require, but this is about using a safe dose of all those drugs, which again it allows you to assess what that patient needs; it allows you to assess the doses of those drugs that patient is likely to need and it allows you to assess the need to commence those drugs then on a regular basis, which, typically may well be within a syringe driver and so in that way you have identified that the patient needs those drugs, you have identified that the likely dosage that patient is likely to at least require on starting those drugs and their need for it regularly. The theme in many of these cases is that it is straight to syringe driver or there is a dose range given in a syringe driver that is difficult to justify, whereas by allowing these intermittent doses to be used as necessary it helps you to inform any further dose increments necessary in the syringe driver. Let us say a patient is poorly symptom controlled, they may need those drugs even up to every hour, certainly every four hours, and so you would reassess that patient and then adjust their dose in the syringe driver accordingly. And so I think one of the reasons that we are all standing here today is that there has been this missing piece of that particular jigsaw, knowing for certain that the patients required those drugs in those doses and using these intermittent doses subcutaneously would allow everybody concerned to be much more content that the doses were required and the doses given were necessary.

Q So this is a matter which is not dependent on the absence of notes; as a matter of good practice what should happen is that one begins with a smaller amount and sees whether or not that is effective ---

A Yes.

Q --- in dealing with the patient's needs?

A Yes. So more recently you can be in a situation where you are dealing with an elderly frail patient, you are uncertain of what is likely to happen with them, they may well be going on to deteriorate and die, it may be that there are some medical issues that could be addressed to improve their situation. It is not unusual to be in that sort of uncertain area, and in that respect it is not unreasonable to prescribe people small doses of diamorphine, Midazolam and hyoscine to be used if necessary, and, again that is something that certainly when people are considered to be dying more recently the Liverpool Care of the Dying Pathway has been promoted and good practice, and one of the elements of good practice is this pre-emptive prescribing but it has always been in the context of small individual doses rather than pre-emptive prescribing of a syringe driver with a wide dose range.

Q So you can comment on the adequacy of what was done in these circumstances, notwithstanding the absence of records from the clinical assistant.

A I guess to a certain degree, but what you are also left with saying is that without these intermittent doses you are left not being able to say with any certainty that the doses that were started in the driver or subsequently achieved in the driver were justified, and what I mean by that is if the patient ended up having four or five extra doses because their symptoms were not controlled that justifies that the next time their syringe driver is changed a much bigger dose was put in because their symptoms clearly were not controlled. What we have here is an absence of any guide like that that would reassure us all that appropriate doses were given.

Q What is the danger of that?
A Well, the danger of that is again that the doses that are used are not informed, they are not based on what the patient's likely needs are and, again, as I have described, if you are giving people more opioids that are required then it is drowsiness, maybe nausea, confusion, respiratory depression, death.

B Q And those are all well recognised?
A Yes.

MR LEIPER: So does it follow that if you do not follow the route in relation to prescribing that you have described you may well be running a risk of death which is unjustified in the circumstances?

C THE CORONER: Surely that is ..(inaudible).. is it not?
A Again, it is my – people have looked at opioids and they have seen opioids as some dangerous drug, okay. Now some people say there is no such thing as a dangerous car, only dangerous drivers and it is a similar with morphine. Morphine if used appropriately is a very safe drug. It is when it is used inappropriately you run the risk of unacceptable side effects or more serious side effects. There are people that might have a view, and, again, drawing an analogy with diabetes, this person is diabetic, therefore they need insulin and because they
D are diabetic the more insulin they have that must be better for them, and some people may have a similar view to opioids, if somebody is dying then the more morphine they get the better because they are dying, are they not? And in people with diabetes and insulin you have to titrate that dose carefully in order to achieve the required outcome without causing excessive side-effects or problems and obviously a dose of insulin which is way excessive to a person's needs can kill them, and I think it is a similar analogy with morphine. Morphine is
E a good drug, it is indicated for a number of reasons why people are dying that that is not to say that you can just give as much as you like and the more you give the better it is, it is a matter of saying "I am titrating the dose according to the patient's needs in order to get the positive benefit of it without running the risk of negative side effects or more serious side-effects".

Q That, as far as you are concerned, is that what should happen?
A Yes. Like any drug it should be titrated to achieve an effect and to minimise side-
F effects.

MR LEIPER: You have been told that a Dr Reid, who was the clinical assistant's supervisor in this case, approved some of the practice of anticipatory prescribing, does that make any difference to your view, and I should ---

G THE CORONER: (To the witness) I do not think that is what you are critical of, is it – forgive me, Mr Leiper – I think what you were saying is that that is in order but to a far more limited prescription range?
A Yes. Pre-emptive prescribing of syringe drivers in a wide dose range is not something I have experienced. Pre-emptive prescribing of small doses of diamorphine, Midazolam, these other drugs is and is seen as good practice.

H MR LEIPER: But anticipatory prescribing of a range of diamorphine between 20mgs and 200 mgs that would be outside of your experience of that which is recognised as acceptable?

A I would say that, sure, in any of my practice.

Q Does it follow that it is outside of the range of what you recognise as acceptable clinical practice?
A Yes.

Q So the fact that the clinical assistant's supervisor may have approved what was happening does not alter your view in relation to that?
A No.

Q And the fact that nursing staff may not have raised concerns in relation to that as a practice, that does not alter your view?
A Not in terms of my experience, no.

THE CORONER: Can I just be clear on that? The nursing staff were not giving a view of the proactive prescription from 20 to 200, or that is not the view that they were giving. They were saying that they would start at whatever it was and nobody actually criticised the prescription of 20 to 200, in the nursing staff.

MR LEIPER: Correct, yes.

THE CORONER: It was not within their remit at that point ---

MR LEIPER: No.

THE CORONER: I think the point that was put to them was if they had been told to go straight to the 200 they would not have done that, that is what they all said.

MR LEIPER: Yes.

THE CORONER: But nobody was critical of the range. I think I am right on that, am I not?

MR LEIPER: Yes. Thank you sir, that was a very helpful résumé, if I may say so. (To the witness) You have been told that the nursing staff, when administering that which had been prescribed raised no concerns and had they had concerns when administering that which had been prescribed, again they raised no concerns, that is what has been put to you. In the light of the absence of concerns being raised by nursing staff who appear to be acting in accordance with a doctor's overall instructions, does that cause you to change your view as to the acceptability of this practice?
A No.

MR LEIPER: Thank you.

THE CORONER: I think the final word for Mr Pittock is the cause of death was given as bronchopneumonia. When Professor Black gave evidence he said 1(a) sepsis, 1(b) chest infection, 1(c) drug induced Parkinsonism and 2 severe depression. I think you plumb for bronchopneumonia, do you not?
A Yes.

Q As a straight encapsulating cause of death?

A Yes.

THE CORONER: Ladies and gentlemen, is there anything you want to ask? (Nothing) Right, can we look at Mrs Lavender, please?

A An abridged summary of my conclusions: Mrs Lavender was a frail, 83 year old with significant medical problems. She was admitted to the Royal Naval Hospital Haslar in Gosport following a fall down her stairs, following which she found it difficult to walk and move her hands and wrists. She complained of pain across her shoulders and down her arms. Low blood sugar was considered a possible cause for her fall. She was seen by Dr Tandy 11 days later, who documented some improvement in her mobility and abnormal neurological findings. The conclusion was that Mrs Lavender had suffered a brain stem stroke and she was transferred to Gosport War Memorial Hospital for rehabilitation. Again there was a failure to keep clear accurate and contemporaneous patient records and there was lack of documented assessment of Mrs Lavender's condition, in particular her pain. There were certain symptoms and signs that warranted an examination that were not acted upon. During the course of her stay it was found that she had an increasing white cell count which could be a feature of infection. Her blood sugars were going up, as were her insulin requirements, and again that can occur with an infection. She had increasing back pain. She went into urinary retention and had faecal incontinence, all of which could indicate damages to the nerves. She was then prescribed morphine, despite a lack of assessment of this particular pain, and the dose of morphine was increased, which may well have been excessive. The possible role this may have had in her deterioration did not appear to have been considered and ultimately she was prescribed doses of diamorphine and Midazolam which were excessive for her needs.

THE CORONER: Professor Black took us to the question of cervical cord injury, and I think you considered that with this lady: what was your view of that? There was no particular assessment done but she had pain in all four quarters.

A Yes. Again, I am not an expert in orthopaedic and trauma. It looks as though they examined her cervical spine when she presented after the fall and I think in the notes, if I remember correctly it said "Full range of movement" or something like that. If there was a significant trauma to the neck you would expect some sort of symptoms immediately after the fall. However, that may not necessarily be the case, and certainly with her neurological findings I think what should have happened is that she should certainly have had an x-ray of the neck and it does not look as though that happened. Certainly over the course of time, if there was trauma you would anticipate that any injury or damage caused by the trauma would progressively improve, and so the pain if anything should have been progressively improving. The fact that the pain seemed to be either persistent or getting worse to me as a doctor would suggest you need to try and ask the question why? Why is it getting worse and we are that much further away from the injury? The fact that she had certain neurology would make me think about the neck, so I think an x-ray of the neck would have been very reasonable – a neurological examination, documented neurological examination would have been very reasonable.

THE CORONER: The difficulty the jury will have is that from the beginning of next week they will have to alight on the cause of death; they will either accept the cause of death that has been given as CVA or on the evidence they will hear alight on another cause of death. As I say, Professor Black gave us the spinal cord injury as being a likely cause, because of the nature of the pain Mrs Lavender was suffering that it was continuing, it was not abating and, if anything, was getting worse, and he would say because of the absence of treatment to the high cord injury. That is the reason he gave us that cause of death as opposed to a CVA that

he said would probably have been one-sided. He would have looked to a one-sided lack of mobility or hemiparesis or something of that kind. With the lady having restriction throughout, and incontinence, he said it was probably a high cord injury: what would your view be of that?

A If there was a high cord injury it would almost, just through the nature of it, cause immobility, have contributed to the death. I think looking at the result in the nodes the white count was going up. Her insulin requirement was going up. Her sugars were going up and that often accompanies an infection. The other thing that was relevant was the platelet count, one of the cells in the blood stream was getting lower to quite a significant degree and the reason for that has not really been established and I do not think it will be able to be established but again it can be something that accompanies certain infections, so I suspect there was a sepsis or infection underlying her deterioration.

Q So CVA from the doctor, high cervical injury from Professor Black and sepsis from you.

A Yes.

THE CORONER: Has anybody got any questions arising from that?

MR JENKINS: Yes, sir.

<u>Cross-examined by MR JENKINS</u>

Q Mrs Lavender was seriously ill when she came to the War Memorial Hospital, I think, do you agree with that?

A I do not know if she was seriously ill at the time of transfer but clearly she became less well, did she not?

Q Professor Black has seen the same notes that you have and it was his view that she was entering the terminal phase of her life when she was admitted to the Gosport War Memorial Hospital and he expressed the view that it was likely she had several serious illnesses, which were probably unlikely to be reversible when she was admitted: do you agree with that?

A Well it depends on your view of if there is a potential sepsis there if there was a potential infection, that is obviously a medical complication that may be amenable to treatment.

Q Can I come back to one answer you gave to the gentleman at the end of this row, and you were saying that giving regular injections as required, that could be done and the dose could be changed and it could be done if there was not a doctor immediately to hand, that was something the nursing staff could do.

A If the doctor had prescribed small doses of either diamorphine, Midazolam, hyoscine, whichever drug, on the prescription it would be as required.

Q PRN?

A PRN, yes.

Q As required, but you did use the phrase "if there is not a doctor immediately to hand".

A Yes. If they are prescribed on the drug chart clearly then the nurses could administer those in accordance with that drug chart.

Q Did you have an image of the Gosport War Memorial Hospital and the two wards with which the jury are concerned that there was a doctor to hand most of the time?
A I have seen the job description for the clinical assistant and I have seen Dr Barton's comments on that job description. I can understand that there would not have been a doctor readily to hand but in accordance with the job description, if a patient required medical attention the job provided 24 hours a day/seven days a week medical care to Gosport War Memorial Hospital.

Q What we have heard as the evidence is that the doctor might be on the ward and do a ward round every second week, on a Monday afternoon, which may last three hours, but apart from that the doctor would do a ward round in the morning taking perhaps half an hour every weekday. She would come back to admit any new patients that had come in that day at lunchtime and she would come back to speak to relatives in the evening. So if we are looking at times when there might be a doctor immediately to hand, we are talking about six hours on the ward every second week: sorry, say two and a half/three hours a week, and a ward round every second week as well, for three hours? So for the 168 hours in every week there would be a doctor immediately to hand for five or six hours a week, which is not very much, I think you would agree?
A It is not very much but I think if you read the job description – again it goes back to that – the job description is fairly clear and my understanding is that this was not a time-limited post, that it was remunerated as a number of sessions which were nominal, likely to reflect the workload. The second or third line down on the job description is to provide 24 hour, seven days a week medical cover to the patients at Gosport War Memorial Hospital.

Q The evidence we have heard is that the clinical assistant was extremely busy when she was there, and we have heard that she was eager to be informed of how the patients were getting on, and certainly of any change in their condition. We know that she came back frequently to the hospital to deal with patients, new patients, the relatives of patients who had been there for some time. Are you actually grappling with the real situation or some hypothetical situation?
A Can you clarify what you mean?

Q Yes. What I am suggesting is you may have approached this task of writing a report without a full understanding of what was actually happening in the hospital and the time constraints on the clinical assistant, and, indeed, the consultant?
A You are touching on two issues there, and I think the first one is the job description for the clinical assistant, and, again, you can perhaps answer me a question that I posed in my report.

Q You can ask but it is not really the way it works: fire away.
A That seems fair. Clinical assistants that I have worked with in hospitals have been paid on a sessional basis but they have used that session undertaking that job. What I have not come across previously is a general practitioner acting as a clinical assistant, working both general practice and the clinical assistant sessions at the same time, so I can understand, if that is how it was done, time constraints are very much evident, but that to me is not what I have seen previously, a clinical assistant paid a certain number of sessions to work is actually present for those sessions, but I can see in the job description it does appear as though the sessional commitment was a nominal payment for that 24 hours a day seven days a week.

THE CORONER: That is my understanding of it.

MR JENKINS: Mine too. I know Dr Barton is going to be giving evidence after.

THE CORONER: Yes, I understand that.

MR JENKINS: And she will resolve any matter of clarity in that answer.

THE WITNESS: You are saying, yes, you are saying there is lack of time: lack of time: lack of time but also I think the job description is pretty clear and if there were issues around lack of time then there were other opportunities, from my understanding of being able to improve on that, like working a session as a clinical assistant rather than trying to do both. The other comment is by not having a doctor regularly available it does not limit your ability to use these intermittent doses subcutaneously.

MR JENKINS: No, I understand that but it makes titrating the dose a rather more complicated exercise.
A Not necessarily, not in my view, and, again, perhaps we would not all be standing here if there was an obvious, clear need demonstrated for those drugs and the dose adjustment adequately justified.

Q Those who were there at the time clearly felt there was appropriate administration of medicine otherwise it would not have been given.
A We are back to saying that there is a lack of documented justification for the use of those drugs.

MR JENKINS: I understand that, and if that is the only point I will sit down.

Cross-examined by MR LEIPER

Q Could I just ask you to expand a little bit on your answer to the penultimate question. The fact that Dr Barton was not there 24 hours a day, you said you did not think that would make it more difficult to titrate the dose. Do you want to expand on that a little bit?
A What you would be left with is a situation where patients could have what they need when they needed it. Now, as I say, if it is once a day or occasionally if it is just twice a day they are needing those doses often that is considered that their symptoms must be reasonably well controlled and it may be that all you need to do is to maintain their ability to access these intermittent drugs. If, however, they have needed two or more of these medications a day, then that would be a reasonable justification to commence a syringe driver. They would receive the regular dose through the syringe driver whilst still having the opportunity to get extra doses if they needed it.

Q Are these what have been referred to as "breakthrough"?
A As the breakthrough doses, yes. So you would still be able to give people regular doses but they would still be having their top-up if they need it, and then subsequently you would review the extra doses they needed.

Q You have mentioned the importance of the patient's condition being monitored when they are on a drug such as diamorphine, yes?

A You would look again in a hospice, people on diamorphine, it is not that we regularly assess their respiratory rate or anything like that, but obviously what we are trying to do is to ensure that the patient is as comfortable as possible and not having any undesirable effects or serious side-effects so if somebody became more agitated or more confused that would lead you to ask why, and part of asking why, it is fairly typical to think, 'are they in urine retention? Have they got a full rectum full of faeces which is aggravating or irritating them or is this a metabolic problem? Is it a drug problem? Is it that they are accumulating their drugs and the doses need to be altered?' In say 50 per cent or more situations it is really impossible to say because these people are entering their terminal phase, and it could be that it is none of those, it could be it is all of those to a smaller degree. It can be very difficult, but you should still, I think, go through that exercise of making sure you are not missing something simple to correct because the response to that increasing agitation may be to do something very different, like catheterise them, as opposed to just keep going up on a drug which may be aggravating their restlessness or their confusion.

Q Given the importance of monitoring, and I think you have been talking about in the context of a hospice just now ---
A Yes.

Q --- but in a situation where patients are in a continuing care environment do the same principles apply?
A Maybe to a lesser degree but when people are on a syringe driver often checks on use of the syringe driver occur every four hours and mainly that is to ensure that the syringe driver is running to time and that there has been no problem with the drug in the syringe, it is not running too fast or too slow, so I would have thought it reasonable to, as a general check to make sure everything is okay every four hours.

Q There should be a general check every four hours?
A What I am saying is by checking the syringe driver, you are not going to check the syringe driver and ignore the patient so it seems to me that as you check the syringe driver you are going to be present with the patient, but it is not as though you are going to count their respiratory rate or anything like that, that would not happen.

Q But if there were any untoward effects then those should be apparent at a four-hourly check?
A I think as part of the general nursing care you are going to know whether a patient is settled and comfortable or whether they are agitated and distressed. You would not have to wait four hours to know that.

Q You have described the possible adverse side-effects of excess diamorphine: in a situation where a doctor is not present 24 hours a day on the ward, would that serve to increase the importance of initial prescriptions being within a fairly tight range?
A Again, it just comes back to saying, 'Am I using a drug at a dose that is required to relieve the symptoms and at a dose which is avoiding undesirable effects or serious side-effects?' Again, if you are using morphine, insulin or lots of other drugs, that is just a general principle.

Q But if you have not a doctor there to monitor that ...
A As I say, I find it hard to separate this out from any other approach to any other drug, to any – from a *Good Medical Practice* point of view you are giving a drug that is appropriate

for that patient's needs, and again you could think of people at home, people at home are given syringe drivers but, again, generally that is based on what their existing use of drugs had been. But again the district nurses manage to – and usually change them every 24 hours, but there will not be a doctor available at home all the time, then it is this whole idea of when you are using a drug you are using it in a dose that is appropriate to the patient.

MR LEIPER: Thank you very much.

THE CORONER: Ladies and gentlemen, anything?

MALE QUESTIONER: You were talking about the job description, how many sessions or hours was it up to on that job description?
A I have not got it in front of me but my understanding is that it was initially for four sessions and then it was increased to five sessions.

MALE QUESTIONER: How many hours is a session?
A Again, it is not specified but usually it is four hours.

MALE QUESTIONER: So up to 20 hours a week, it could have gone up to 20 hours a week according to that job description?
A My reading of it is that that is for nominal payment. It was ---

MALE QUESTIONER: I do not understand the "nominal payment", I am sorry.
A If the job descriptions says, "You will provide medical cover for 24 hours a day seven days a week" but then the remuneration is based on a shorter time than that it is nominal. People were not being paid for 24 hours a day seven days a week, they were being paid a nominal number of sessions for that delivery.

MALE QUESTIONER: So they would have been paid for 20 hours a week whether they worked 10 or 40?
A Yes, it was a nominal payment.

THE CORONER: It was payment for cover for the hospital: does that make sense?

MALE QUESTIONER: Yes, that is lovely, thank you.

THE CORONER: I think we go on now to Helena Service, please? A 99 year old lady.
A Again this is a summary of my report. Helena Service was a 99 year old woman admitted to the Queen Alexandra hospital on 17 May 1997. She was confused and disorientated, mostly likely as the result of a chest infection, plus or minus a fast irregular pulse, this was atrial fibrillation which precipitated the worsening of her cardiac failure. She was appropriately assessed, investigated and managed and her condition improved relatively quickly. She was more alert. Her heart rate was controlled and her kidney function improved. She did, however, remain confused at times and noisy at night. During that admission it was likely that she experienced a cerebrovascular accident or stroke affecting the left side of her body, particularly the left arm and hand and she became more dependent on the nursing staff to transfer her. As a result she was unable to return to the rest home and she was referred to the geriatricians. She was seen by Dr Ashbal who agreed to take her to Gosport War Memorial Hospital for assessment with regards to continuing care. Her behaviour remained challenging at times and particularly at night. However, apart from the

regular use of Thioridazine as a night-time sedative her behaviour was managed by the nursing staff using what appeared to me to be non-drug means. On the day of her transfer to Dryad Ward she was seen by a consultant physician, Dr Miller, and was noted to be well. There were no concerns regarding the care that she received at the Queen Alexandra Hospital. On Dryad ward her medication was continued mostly unchanged except for Thioridazine that she was having for her disturbed nights was discontinued. She was pre-emptively prescribed diamorphine and hyoscine and Midazolam in syringe drivers by a wide dose range. The dose of diamorphine 5 – 10mgs I would prescribed as a stat dose but not apparently given.

THE CORONER: Would you keep your voice up, please, you are beginning to fade slightly.
A She was prescribed Midazolam 20mgs in a driver over 24 hours on her first night she spent on Dryad Ward because she failed to settle.

Q A blood test confirmed renal impairment and low potassium. Would that give rise to confusion?
A It can do, yes.

Q I am slightly confused from the point of view of when she was transferred, she was medically well. On Dryad Ward there is a change; she is not settling; is there a change in her physical condition at that point?
A Again it is difficult to say. It is difficult to say whether her being unsettled at night is her normal being unsettled at night, which had been occurring intermittently at the other hospital. It seems of interest to note that Thioridazine, which is a drug given to help people settle at night is the one drug that was omitted when she got to Dryad Ward. In an elderly confused patient or prone to confusion, in new surroundings, new ward, new staff, in a way you would expect or anticipate that they may well have had an unsettled night that first night, particularly if the drug that they have given for her unsettled night has been stopped, and in that respect, it seems at odds to me that the response to that was to start Midazolam 20mgs in a syringe driver.

Q We explored earlier the question of moving elderly patients and the effect that might have on them, and that that in itself could precipitate its own difficulties, what should have happened?
A If people are confused, prone to confusion and they are taken into unfamiliar surroundings then that aggravates the situation, but again this would be an example where it may have been appropriate to have given her something to settle her. Why was the Thiorodazine discontinued in the first place? Why not allow her to have her usual dose of Thiorodazine? If it were that she was agitated and required some Midazolam this is where a pre-emptive prescription of a small dose on an "as required" basis would have allowed her to have a small dose, rather than go on to the syringe driver which gave her 20mgs over 24 hours and in a way never really allowed anyone to assess was this the first night in unfamiliar surroundings? Was it that she needed Midazolam? Did she need just a one-off dose to cover that first night? Was it that she was however deteriorating in a terminal phase? Did she need more than one dose? That way you would have been able to justify the use of the syringe driver with much more certainty.

Q The death certificate gives congested cardiac failure; Professor Black thought it was congestive cardiac failure, maybe 1. Ischaemic heart disease, and 2. Cerebrovascular disease, what would your view of it be, CCF?

A Her mode of death did not particularly strike me as being CCF but I noted that Dr Petch, the cardiologist, provided a report and he felt it was in keeping and given that I generally look after people with cancer rather than cardiac failure I would have to go along with their opinions.

THE CORONER: Mr Jenkins?

B

Cross-examined by MR JENKINS

MR JENKINS: I do not know if you saw a report from the consultant cardiologist called Petch. ↳ makes it worse every time he asks Qs.

THE CORONER: He just referred to it.

C MR JENKINS: I am sorry: did you see what Dr Petch gave by way of comments of the prescription of diamorphine and range of 20 to 100mgs in subcutaneous feed (?)
A Yes, I did.

Q Together with Midazolam, 20 to 80 mgs subcutaneously via syringe driver over 24 hours?
A Yes.

D

Q You saw his comments?
A Yes, and I disagree with them.

Q His comments ---
A I disagree with his comments about the range of diamorphine.

E Q Before we get there let us remind ourselves of what he says so that we know what you are disagreeing with, and you can tell us why you disagree with it in a moment but I just want to understand what you are saying, and Dr Petch's view of the diamorphine by syringe driver 20-100mg subcutaneously and Midazolam 20-80mgs was appropriate, yes? You disagree with that?
A I am just finding the ...

F MR JENKINS: If you have got his report it is paragraph 7.0, on the fourth page.

THE CORONER: I have not taken my copy out of here for any reason, have I?

MR JENKINS: I do not know, sir. (To the witness) Do you have that?
A I do not have it.

G MR JENKINS: Let me read it to you again: What is your view on the prescription for diamorphine 20-100mg subcutaneously over 24 hours together with Midazolam 20-80mgs subcutaneously over 24 hours by syringe driver PRN [as required] in case she "deteriorated and developed pulmonary oedema?" His answer is, "appropriate", yes? That is just the prescription. We will come on to administration later because she did not get anything like the range that was prescribed, she got rather less.

H THE CORONER: Appropriate and desirable.

MR JENKINS: We will come on to the administration if I may, but just dealing with the prescription: his view was that it was a appropriate prescription: you disagree, you have told us already.

A Yes.

Q Tell us why?

A I think I have outlined(?) the reasons why I disagree with it.

Q All right. He is then asked: "What is your view of the subsequent administration of diamorphine 20mgs and Midazolam 40mg both in the syringe driver over 24 hours in order to 'reduce the pulmonary oedema and the distress and agitation from the drowning sensation of the pulmonary oedema?'" And his answer: "Appropriate and desirable": do you agree with that?

A In the context of this situation it is difficult to agree with that fully.

Q What parts of it do you agree with if you do not agree fully?

A If somebody was dying of terminal heart failure and they were breathless then opioids would be used for the relief of breathlessness but, again, it is going to be like playing a record, is it not, a drug should be used, it should be titrated accordingly and it should be given in a way that relieves symptoms whilst avoiding excessive side effects or serious side effects.

MR JENKINS: We have not heard from Dr Petch but his view is pretty clear from the document, is it not? He goes on to say that:

> "Opiates, notably diamorphine, are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema and are particularly helpful at night. The administration of diamorphine has been the standard practice for myself and other cardiologists for many decades and remains so. Intramuscular and subcutaneous administration is usual."

Are you really the right man for the job, for the job you are doing as an expert? Would you regard yourself as ---

THE CORONER: He can talk to us about diamorphine.

MR JENKINS: Yes, but dealing with the real world, the coal-face view, are you not rather presenting what might be the ideal?

A I think if you are talking about using a drug correctly, I do not see ensuring that a drug that was titrated to effect whilst avoiding side effects and serious side effects is in any way unusual.

Q I understand that but the proposition I am putting to you is that you are not really in a position to give us a "real world/coal-face" view because you do not have recent experience of dealing with geriatric cases at this time?

A I look after geriatric cases, as you call it, who have cancer within the ..(inaudible).. clinic. I am well aware about the need to be particularly cautious with the use of drugs in the elderly.

Q I understand.

A Anything that is recommended in the BNF you have to be particularly cautious in the elderly. Their cardiovascular system, their renal function is often impaired. If anything, compared to what is said in the BNF, and indeed is said in the prescribing of the elderly is pretty clear, you have to be much more cautious. I do not see there is a need, if you are actually approaching things safely and appropriately, whether I am looking after people using opioids and looking after people dying of cancer and these other problems as opposed to looking after people just dying of heart failure, there is actually any difference in that.

Q I understand. I am only asking because you have expressed a view yourself, I think in a letter or in an email to the Coroner that if he is looking for a real world/coal-face view rather than the ideal then you have no recent clinical experience.
A That was if they wanted a geriatrician view in particular. In terms of the use of drugs then I can give you the use of opioids and in palliative care at least we have much wider experience of the use of opioids.

THE CORONER: Dr Wilcock is not here as a geriatrician, he is here as a drug man.

MR JENKINS: Indeed. A geriatrician would be able to give us a perhaps more realistic view about what is likely to happen in a community ---

THE CORONER: Professor Black did, did he not?

MR JENKINS: I am inviting Dr Wilcock to indicate that he would defer to the views of Professor Black in what is likely to happen in the real world in a community hospital setting.
A I think that is a fair ... In terms of what would be considered appropriate from a geriatrician's point of view, that is obviously what he was providing.

MR JENKINS: Yes, thank you very much.

THE CORONER: Are there any questions? Mr Leiper.

<u>Cross-examined by MR LEIPER</u>

Q We are here and you are here because we are considering the appropriate use of opiate analgesia, and that is something you have very substantial experience with.
A Yes.

Q Presumably some of your cancer patients are geriatrics.
A Yes. Well, the majority would be.

Q The majority are?
A Yes.

Q So how many? What percentage of your patients are geriatrics?
A I have never looked ... Well, it depends on your cut-off of geriatric, but whenever we have looked at the average age of our patient population within the palliative care service it is around 70.

Q I wonder if we could be told what "geriatric" is.
A It means different things to different people but 65 plus.

Q You have been looking after geriatrics with cancer for a substantial number of years.
A Yes.

Q In the course of looking after them you have been concerned to ensure that they do not suffer pain unnecessarily?
A Yes.

Q In the course of ensuring they do not suffer pain unnecessarily you have administered diamorphine?
A Yes.

Q Have you used a syringe driver containing diamorphine?
A Yes.

Q We heard from Professor Black that he had not used a syringe driver containing diamorphine. If and in so far as you are called upon to express an opinion as to the appropriateness of the amount of drugs used in a syringe driver, do you have any doubt about your competence to inform the jury as to what the appropriate practice is?
A No. I mean, we have looked at doses of diamorphine that are likely to be required in people in the hospice, how their oral morphine equivalent, the median dose, so half would be less, half would be more, is about 120mgs, that is 40mgs of diamorphine over 24 hours and these are patients who require the input of a specialist palliative care unit. These are people with severe pain, that are not easily managed in any other circumstances. These are the worst of the worst in regards pain relief, yet their median dose of diamorphine in a driver is 40mgs. When we looked at it in the general hospital setting ---

Q But that is not the starting dose?
A This is the dose they required at the end of life.

Q At the end of life?
A And that would have been achieved in a step-wise fashion, so, again that was based on 100 patients, okay, so 40mg of diamorphine, and this is the extreme end of the spectrum, extreme end of the spectrum. When we looked at auditing a number of deaths in the general hospital setting the median dose oral morphine equivalent was 30mgs which gives you a diamorphine dose of 10mgs in a syringe driver, and that included patients dying from a whole range of different pathologies not just cancer, so, no, I am not a geriatrician, but I do look after elderly patients: no, I do not go into the healthcare of the elderly wards but I have a sense of what doses of what drugs are being given.

Q In a way that someone who did not use diamorphine would not?
A Yes.

Q Would you separate out the two categories you referred to? You said that 40mgs of diamorphine was for those at the very end of life with the most extreme symptoms?
A Yes. We looked at people in the last – again, the average was nine days of life, but that was the median dose they required in the last 24 hours of life.

Q That was 40mgs of diamorphine, you then mentioned a category of patient for whom the median dose was 40mgs of oral morphine which is, I think we have heard, equivalent to about 10mgs of diamorphine.
A In Nottingham we divide by three; others would divide by two.

MR LEIPER: I think we have heard that ---

B THE CORONER: It is a moveable feast really, is it not?

MR LEIPER: It is a moveable feast but a safe working assumption is that if you have got 30mgs of oral morphine that is about equivalent of 10mgs of diamorphine.
A That is as I would see it.

Q For what category of patient is it appropriate to administer 30mgs of oral
C morphine/10mgs of diamorphine?
A I have not got the individual breakdown. I know that two-thirds of them did not have cancer and a third have cancer, but these were people that were being cared for in a general hospital setting.

Q What would the symptoms have been which required the 30mgs of oral morphine?
A Morphine is indicated for pain, breathless, cough. They are the three main indications
D for opioids.

THE CORONER: Professor Black said that anxiety and distress, being agitated, diamorphine would be indicated for that.
A Again I would have a differing view of that because again it is a matter of saying, "Why is that person agitated?" and rather than having a reflex, they are agitated because they are dying, therefore put the opioid up because opioid is good for that, my view would be
E 'well, actually, is there a simple reason why they are agitated? Are they in urinary retention? because by giving them more opioid that is not going to relieve their distress from being in urinary retention, and so their – this goes back to saying 'well, they are diabetic, let's give them more insulin, it is good for them' whereas I would say that agitation and anxiety per se is not an indication for opioid therapy.

Sorry Mr Leiper.
F

MR LEIPER: I am grateful. (To the witness) The Midazolam which would often be put in a syringe driver alongside the diamorphine, Midazolam is the drug of choice, is it not, for symptoms of agitation and anxiety?
A It depends on your school of thought. A lot of people would use Midazolam for anxiety because it is a bit like diazepam; it is a benzodiazepine, so that has well know, well proven, anxiolytic effect so if somebody was anxious then Midazolam was not unreasonable.
G There is not limited evidence to suggest that if somebody is delirious, and by being delirious or confused they are having trouble orientating themselves, by giving them a benzodiazepine that can make it even harder for them to orientate themselves, so they become more confused and agitated and in that situation an antipsychotic like Haloperidol or even Promethazine(?) may actually be a better drug to be used, or at least to be used in combination with Midazolam, but I think looking around a general hospital, looking around what other patients in other circumstances receive, the use of Midazolam on its own is not that uncommon.
H

THE CORONER: Will you be much longer, Mr Leiper, because of the machinery?

MR LEIPER: Not very long.

THE CORONER: Will you be more than a minute?

MR LEIPER: Yes, I will be more than a minute.

THE CORONER: Let us take a break for the machinery to be sorted out.

(Short adjournment)

THE CORONER: Yes, Mr Leiper.

MR LEIPER: Dr Wilcock, before the short adjournment you were informing the jury as to the appropriateness of the use of Midazolam where a patient is experiencing agitation and anxiety. In your experience, would it be appropriate having provided Midazolam to see whether or not that was successful in reducing the agitation and anxiety before commencing another drug?

A When you say "another drug" what do you mean?

Q Any other drug such as diamorphine perhaps.

A In this particular situation, because it was the first night in new surroundings ---

Q Perhaps you would talk in general terms.

A It would depends on the context, but if somebody is likely to have agitation that has not been assessed and therefore you are not sure of what is causing the agitation and therefore whether it is something potentially reversible or treatable or not, then it would seem safest in my experience to say have a single dose of the anxiolytic, whether that would be oral or subcutaneous.

Q A dose of ...

A The anxiolytic.

Q Which is what?

A Which in this case may have been Midazolam or oral diazepam because on the one hand you do not want patients unnecessarily distressed but like I said before it is a matter of understanding why they are distressed because by understanding the cause of the distress allows you to provide appropriate treatment to prevent that distress, and the answer is not always drugs. As I say, it could be that people are in urine retention or something else is happening, so whenever possible you try and determine the likely cause of the agitation.

Q If you progress straight to Midazolam and/or diamorphine there is a risk that you obscure what the cause of the agitation is, is that correct?

A You could do. I mean, again, I would not use opioids specifically for anxiety or specifically for agitation.

Q So far as you are concerned, if you are prescribing for agitation and anxiety and it was appropriate to prescribe Midazolam you would let that run its course before any consideration would be given to any other drug such as diazepam?

A If somebody was agitated you would relieve their symptoms with an anxiolytic so that would be like the Midazolam, but I personally would not feel comfortable with just then giving them sufficient doses of that drug to sedate them if I had not at least made an attempt to try and identify what the source of their agitation is, and personally I would not use opioids for agitation.

Q You have mentioned in the context of an elderly confused person going on to a new ward, surrounded by new staff one has to factor the newness of the surroundings into account in deciding what the appropriate treatment is?
A My understanding is that that experience was not outwith the experience that had been happening in the other hospital.

Q This is in relation to ..(inaudible)..
A Yes. And again it would be drummed into you in healthcare of the elderly that a change of surroundings could easily aggravate an underlying confusion, a confusional state.

Q Which could be resolved by their becoming more familiar with their surroundings?
A Again, in these situations often it is trying to determine what a proportional approach to that particular set of circumstances was, so a proportional approach may be non-drug measures. I am sure the nurses would have been good at that because they would have had to do that for an awful lot of patients, so I would have anticipated and expected that the nurses should at least have been able to do that, so that may have been having a nurse present to try and calm them, more lights on, ensuring that they are comfortable in the bed and so on, so non-drug approaches would probably be seen as a best practice approach to start with. If drugs were not required, again was there any reason not to use drugs orally? Was there any reason not to give a drug that somebody is already on? You could look at it, why omit the drug that they have been needing in order to have a settled night?

Q I think you have particularly got in mind the drug ...
A Thioridazine, so why not offer that first off?

Q If a patient who has been suffering from some confusion and anxiety has been being treated with Thioridazine and that drug is then stopped what is the likely effect on the patient?
A Again, it is hard to say with any definite – but if it was what they were needing in order to let them have a more settled night then they may miss that.

Q What would be the effect of that?
A They would be more agitated at night. They would be less sedated at night and if they are more confused at night they may end up more agitated at night.

MR LEIPER: Thank you very much.

THE CORONER: Mr Service(?)

<u>Cross-examined by MR SERVICE(?)</u>

Q You did an average of the diamorphine on the last day of their lives? How many patients was that over?

A Within the hospice we looked at the last 100 deaths, of those 85 - so again, people come into hospice they never go home again, people think you go into a hospice, you get morphine and nothing else, so the first thing to say is that half the people that come into a hospice go home again, the average length of stay is two weeks, so the care we provide is not just terminal care. We looked at people from the time of their admission to the time of their death that were on opioids throughout that admission, and I think that was 72, so the data for the hospice was based on 72 patients. The data for the hospital was around a similar number. I can check if you like but it was sort of 60/70 patients.

Q You said the average was 40mg on the last day of their lives, all those patients?
A In the hospice it was ... Again, people have different opioids by different routes and what you try and do is come up with a common currency if you like of expressing it, so one of the ways of expressing is what is called oral morphine equivalent, so you calculate – if everybody was on this opioid in terms of it being morphine by mouth, what dose would it be, so it is a summary, so that summary would be 120, half the patients needed less, half the patients needed more but that is the median dose, 120mg of oral morphine which equates to 40mgs of diamorphine in a syringe driver.

Q Do you know what the maximum was in those patients?
A You get the odd patient who does need over a gram. So the median 24 hours before death was 120mgs the minimum was 17 and the maximum was 1,950, and I think that reflects a specialist unit. Very occasionally you come across patients that need grams.

MR SERVICE: Thank you very much.

THE CORONER: We now move on to Ruby Lake, an 84 year old lady.

THE WITNESS: Sir, this was a lady who was admitted to hospital having fallen and fractured her left hip. This was surgically repaired but she had a very difficult post-operative course. She had problems with heart trouble, kidney problems and she ended up with heart failure, atrial fibrillation, which is an irregular heart rate, renal impairment, along with a chest infection, and associated with this was episodic confusion and agitation at night. She was treated with intravenous fluids, water tablets and antibiotics and they managed to support her through this period. She was seen by Dr Lord, who summarised Mrs Lake as "frail and quite unwell" and uncertain as to whether there would be significant improvement. She had experienced chest pains and these were either related to what sounded like ischaemic heart disease for which she was given an anti-anginal treatment with effect or what may also have been muscular skeletal in origin because when she was examined she had areas of tenderness over the chest wall, and for this pain she received codeine and paracetamol with effect. Despite all the above, she had appeared to be progressing rather than deteriorating while awaiting transfer to Gosport, and she had begun to mobilise. On the day prior to transfer she was noted to appear confused and to have a temperature. However, on the day of transfer she was reported to be well, comfortable and happy, with a normal temperature. Again, her progress whilst on Dryad Ward was difficult to follow because of a lack of notes. She appeared to settle in well but the next day complained of chest pain, and a syringe driver containing diamorphine and Midazolam was commenced. She became drowsy, her chest bubbly and the doses of drugs in the syringe driver were modified over the next two days. She died on 21 August with cause of death stated as bronchopneumonia.

THE CORONER: Professor Black gave us MI, ischaemic heart disease and then 2. fractured neck of femur repaired 5.8.98. I certainly as a Coroner would expect to see the fractured neck of femur in there as a 2. What would you make of the MI and the IHT?
A I do not know. I think the fact she was confused and had a temperature on the day prior to her transfer may suggest that, again, an infection was brewing. The fact that her chest became bubbly fairly quickly would point you towards a chest infection, so I feel certainly her immediate cause of death would be bronchopneumonia.

B

THE CORONER: Right. Mr Jenkins?

MR JENKINS: I have no questions, thank you.

MR SADD: No questions, thank you.

C MS BALLARD: No questions, thank you.

THE CORONER: Mr Leiper?

MR LEIPER: No, thank you.

MR JENKINS: There are others at the back of the room.

D

THE CORONER: Is there anything you want to ask? (Nothing) If there is as we go through just give me an indication. They are unrepresented. So are you today, are you not, is there anything you want to ask?

MALE: No, thank you.

E THE CORONER: Move on, please, to Mr Cunningham. Ladies and gentlemen, is there anything you want to ask? (Nothing)

THE WITNESS: Mr Cunningham was a frail 79 year old widower who lived in a nursing home. He had suffered from Parkinson's disease for many years. He had an abnormal blood count, possibly due to minor dyspostic(?) syndrome. He had long-standing back pain due to an old war injury that required maximum doses of a weak opioid. His behaviour could be
F difficult and this was the reason for recent admission into the care of Dr Banks, consultant in old age psychiatry. During this admission his abnormal behaviour and disturbed nights were considered to be due to a combination of depression and dementia. He was prescribed an antidepressant and mood stabiliser, an antipsychotic and a sedative hypnotic. These resulted in an improvement in his mood and sleep, which was maintained after his return to the nursing home. He was then followed up in the Dalton Day Hospital and over this time a sacral pressure sore worsened, and this was despite antibiotics. His general condition also
G appeared to deteriorate. He was difficult to wake. He was refusing to talk, drink or swallow medication and expressed a wish to die. On 21 September he was admitted direct to Dryad Ward for treatment of a pressure sore and high protein diet and for Oramorph solution, as required, if pain. Dr Lord had noted that Mr Cunningham's prognosis was poor but asked that the nursing home keep the bed open for the next three weeks. Again there was a lack of clear note-keeping at Gosport which made the progress difficult to monitor. He was prescribed a large dose range of diamorphine, which in my view would be excessive to his
H needs. Again, a lack of access to PRN subcutaneous doses of diamorphine/Midazolam did

make some of the increases in the doses of diamorphine/Midazolam in the syringe driver difficult to justify. There may have been other strategies that were not utilised to improve his pain on turning and these were not pursued. However, I think he was an ill and frail man whose deterioration was documented over a range of circumstances and teams and I believe his death from bronchopneumonia as the terminal event is appropriate.

THE CORONER: Have you seen mention on there as a sacral ulcer as well as Parkinson's disease?

A Yes. I think it is down as bronchopneumonia, Parkinson's and sacral ulcer, all of which I would agree with.

THE CORONER: Drug regime, have any observations to make on that?

A Again, it is being able to say 'were the doses reached in a clearly understandable way?' and again because of the lack of the extra doses as he needed them it is hard to know how to justify the increases in the driver.

THE CORONER: Thank you. Mr Jenkins?

MR JENKINS: No, thank you, sir.

MS BALLARD: No, thank you, sir.

MR SADD: No, thank you, sir.

MR TOWNSEND: No, thank you, sir.

THE CORONER: Mr Leiper.

<u>Cross-examined by MR LEIPER</u>

Q I am instructed on behalf of Mr Cunningham's step-son. He has three principal concerns in relation to Mr Cunningham's period at Gosport. You are able to confirm that Mr Cunningham was at Gosport War Memorial Hospital between 21 September 1998 and 26 September 1998? His three principal concerns are that, firstly, that he was administered palliative care too early when insufficient had been done to try and heal his sore: his second concern is that he was given doses of analgesic excessive to his needs, and his third concern is that as a consequence of doses of analgesia excessive to his needs he died: those are his three principal concerns and would be interested to explore those with you. I have the BNF which applied at the material time and in that it gives the definition of palliative care as "the active total care of patients whose disease is not responsive to curative treatment", is that a definition you are comfortable with?

A Yes. The WHO one has been modified since but that is a reasonable overview.

Q A doctor is expected to provide care with a view to curing a patient's condition until a doctor arrives at an informed decision that the condition is unlikely to be responsive to curative treatment: as a proposition are you happy with that?

A Yes. That is separate to the definition of palliative care.

Q Of course it is, that relates to the duty of a doctor in circumstances where there is a possibility that curative treatment will work.

A My general approach to the management of symptoms as a palliative care physician is correct the correctable, non-drug approaches and drug approaches, and that allows you to ... Is there anything here that is causing distress or problems for this patient amenable to treatment? Because if you can treat the underlying cause that is usually the most successful way of relieving a symptom. Obviously, in people with progressive illness, particularly cancer, often you have exhausted all curative therapies and so you are left with trying to use non-drug and drug approaches to relieve symptoms.

Q In general terms, if there is a possibility of a condition being cured then a doctor should take steps to try and cure it?
A Yes.

Q As a general proposition?
A As a general proposition.

MR LEIPER: Sir, I did ask that Mr Cunningham's medical records should be available, both the originals and copies. I am told they are here in court. (Originals handed) I was going to begin with page 457.

THE CORONER: Do you mean 457?

MR LEIPER: In my bundle page 457 is a letter. I think Dr Wilcock has it.

THE CORONER: Sorry, I had the wrong page.

MR LEIPER: (To the witness) Would you identify page 643 in the second bundle? Page 457, Dr Wilcock, is a letter which was dictated on 21 September, by Dr Lord, the consultant geriatrician, and the jury have heard that it was on 21 September that Dr Lord did an examination of Mr Cunningham, and it was on 21 September that Mr Cunningham subsequently went to Gosport War Memorial Hospital.
A Yes.

Q I appreciate it will have been some time since you have had a look at this document, but could you confirm that this is Dr Lord's letter to Mr Cunningham's general practitioner, explaining the reasons for his being admitted to the Gosport War Memorial Hospital.
A Yes.

Q What Dr Lord says is:

> "I have taken the liberty of admitting him to Dryad Ward at Gosport War Memorial Hospital with a view to more aggressive treatment on the sacral ulcer as I feel this will now need acyline(?) in the first instance. The social worker has been in contact and said that his place at the Lacer Nursing Home can be kept open for the next three weeks".

It confirms that Mr Cunningham has agreed to the admission.
A Yes.

Q On page 643 of the other bundle, the second bundle, we see the care plan which was set out by Dr Lord, do you have that?

A Yes, I do.

Q Can you confirm that Dr Lord was recommending the use of acyline cream topical use on the sacral ulcer?
A Yes.

Q Dr Lord was recommending a high protein diet to help improve his nutrition and help in the healing and sets out the position in terms of the nursing home and then suggests that Oramorph PRN of pain, yes?
A Yes.

Q We will come to the prescription in due course, but she described 2.5mgs to a maximum of 10mg of oral morphine.
A Yes.

Q Mr Farthing is concerned that it does not appear as though Dr Lord anticipated that Mr Cunningham was imminently dying when she wrote that care plan. She admitted him for more intensive therapy to his ulcer, you accept that?
A Yes.

Q Her recommendation that there should be a high protein diet, presumably that indicated that she felt there was at least a possibility that he might live long enough to benefit from that, do you accept that?
A Yes.

Q She had also asked the nursing home to keep the bed open for three weeks.
A Yes.

Q We have heard that in some cases there is a time lag between a referral from an outside hospital to being accepted at the Gosport War Memorial Hospital and the patient subsequently arriving. In this case it appears that the referral and the arrival happened on the same day.
A Yes.

Q The first entry in the medical records at the Gosport War Memorial Hospital is to be found at page 645, which should look like that. Do you see the first entry there, it is the entry of the clinical assistant?
A Yes.

Q Would you confirm what it reads?
A "Transferred to Dryad Ward; make comfortable, give adequate analgesia. I am happy for the nursing staff to confirm death."

MR LEIPER: Mr Farthing, Mr Cunningham's step-son, attended the ward that day and was told by the nurse that Mr Farthing would not survive, and indeed when Mr Cunningham went there on 23 September he had the opportunity to speak with the clinical assistant and was told that he had died. There is no evidence that he was ever give a high protein diet to help improve his nutrition and help wound healing as recommended: do you accept that?

THE CORONER: Are you aware of it?

A Yes. It is documented.

MR LEIPER: He is commenced that evening, 21 September, on diamorphine and Midazolam, yes?
A Yes.

Q It appears to Mr Farthing as though he was commenced on a regime of palliative care from the moment of his admission at Gosport War Memorial Hospital.
A The difficulty I have with this is that that is insinuating that palliative care is somehow a negative aspect of care, and obviously, as a specialist in palliative I feel very strongly against that, so, again, it depends on what people understand by palliative care.

Q It does not appear as though any attempts were made to comply with the high protein diet to help nutrition and help wound healing from the records and that a different view was taken to his prospects of success from the one that Dr Lord had originally expressed: would you accept that?
A I mean obviously I think you would get more out of Dr Lord in terms of what she wrote and what she expressed. I can only tell you what my opinion is based on the notes that I have read.

Q I understand that.
A I am happy to summarise that whenever ...

MR LEIPER: We will come on to that. It does not appear from Dr Lord's letter that I have referred you to or the care plan that I have referred you to that Dr Lord took the view that he was imminently dying.

MR JENKINS: Her statement at page 25 may express a view.

MR LEIPER: Yes, you have been referred to that.
A Again, my view is this would be a patient where there are certain signs recorded in the notes, like the drowsiness, like the difficulty swallowing tablets, tablets being held in the mouth hours after they have been administered, progressive worsening of the sacral sore, despite nursing attention and treatment with antibiotics, now this would be – I think I probably mentioned it earlier – you would have a parallel approach. There may be scope for some improvement but we are not certain. Overall, standing back, looking at this guy, his prognosis to me looked very poor indeed, and to me I think – my impression of what Dr Lord was saying was, 'Well we could try this, let's really give it a go, but nobody here is going to be surprised if this guy continues to deteriorate and die', and really, in my honest opinion reading through the notes, that was the situation with this particular chap and you never quite know sometimes. The chap could have come in; could have brightened up; his dietary intake may have improved and there may have been some realistic chance of doing something with the sacral sore, but I think the reality was he was quite poorly; he deteriorated with what I believe to be a chest infection at the very end of life, and given his further disease burden it did not seem appropriate in my opinion to have aggressively pursued that. That there was documented gradual deterioration in his overall condition across several teams and across several occasions ...

Q What you have said is that, given that there may have been a realistic chance – there may have been a realistic chance – of the sacral sore improving, it was appropriate so far as

you are concerned to progress the treatment that Dr Lord had suggested in relation to the high protein diet, by way of example.
A Yes, I think again, given the constraints of the patient's clinical condition, and again, it is my honest opinion that this guy was very poorly, you know, if there was nothing that could be done she probably would not have admitted him but I suspect the admission was based on, 'Let's really try just in case: if we can get him more comfortable: if we can do something about the sacral sore'. But my sense of having read through all the notes was that this was a man coming naturally to the end of his life.

THE CORONER: Can I interrupt you for just a second and ask, you said if he was terminal she would not have admitted him.
A What I meant by that was if she felt there was no chance at all in improving the sacral sore she would not have written what she wrote. Do you see what I mean? Why have a plan for something when you feel it is not going to do anything? So, maybe I can best summarise it as giving him the benefit of the doubt, if that is understandable.

MR LEIPER: (To the witness) I had the opportunity to ask the clinical assistant some questions in relation to her approach and I put it to her that the only reason for not following Dr Lord's care plan was that she took a different view in relation to Mr Cunningham's survival prospects, and the clinical assistant confirmed to me, yes, on a personal assessment and as a result of her examination, her interpretation of his prospects of success she said was different to Dr Lord's. There would not appear to have been any material change in circumstance between the time when Dr Lord assessed Mr Cunningham on the morning of 21st and when the clinical assistant assessed Mr Cunningham in the course of that afternoon, would there?
A No.

Q Given the absence of a material change in circumstance, would you expect that the decision not to progress the care plan as set out by Dr Lord would be something that would only be taken following a very thorough assessment of his condition?
A I think part of the difficulty for me here is, as I say, there were probably patient constraints in terms of following that path. The main issue seems to be the high protein diet but if this chap is having so much difficulty swallowing tablets that they are sitting in his mouth hours after they have been given he is not going to be able to take a high protein diet. I think the other treatment for the ulcer was progressed as the plan: that is my understanding from reading the notes.

MR LEIPER: So far as the first issue is concerned, while his step-son visited him during the course of 21 September, Mr Cunningham asked him for some chocolate and Mr Farthing went off to get him chocolate, which suggests, does it not, that there was not quite the difficulty with swallowing ---

THE CORONER: I am not sure that is right at all, I think you are deducing something there that is not supportable. Asking for chocolate and being able to swallow it is another matter. You are suggesting that that is evidence that he could swallow?

MR LEIPER: I am indeed, sir. I am asking for this expert's opinion as to whether or not that is right.

THE CORONER: I do not think you can do that. I think it is a minor point. I not think somebody asking for chocolate is an indicator that he can swallow. He may wish to; whether he can or not is another matter.

MR LEIPER: Yes. Can you shed any light on this?
A Other than to say it is not unusual that, as I say, you have to have a twin-track approach. In people with a poor prognosis, again this is part of what I have been trying to say, we do assess people. We assess them in order to identify if there is anything you can do to treat the underling condition. In certain circumstances there are patient factors that mean that you cannot progress that. For instance, would this gentleman have ever been appropriate for parental nutrition, that is, if you like, force-feeding, and given his overall disease burden to my mind the answer to that is no. Everything that you do has got to be balanced against the potential for benefit and the potential for harm.

Q Bronchopneumonia you recognise as being the appropriate cause of death.
A I think because he became chesty and then there were a lot of secretions, that would indicate to me that it would be a bronchopneumonia.

Q We have heard that bronchopneumonia can occur as a secondary complication of respiratory depression induced by excess opiates: are you aware of that as a matter of general principle?
A Yes. You could say sedation, inability, difficulty swallowing, aspiration, all these things can increase the risk of bronchopneumonia.

Q But you can develop bronchopneumonia as a secondary complication of opiate induced respiratory depression?
A I am struggling because it is trying to look at a progressive ... If you had a respiratory depression to the extent that you were concerned I think the respiratory depression itself would be more obvious. A concern ... If you see what I mean.

Q We will come to the details in due course, but would you accept that there can be a causal link between the two, in some circumstances?
A It is really – I would say it is an association, let us put it that way.

Q It is an association you are familiar with?
A Yes, let us put it that way.

Q Dealing with the opiate doses and Mr Farthing's concerns as to whether or not an excessive amount may have been administered, we know that Dr Lord had recommended Oramorph be given on an "as required" basis at a range of between 2.5 and 10mgs, correct?
A Yes.

Q When Mr Cunningham arrived he was fully conscious. He was initially given the Oramorph I think at 2.50 in the course of the afternoon on 21 September, and the reason given for it was immediately prior to his wound dressing.
A Yes.

Q At 6 o'clock that evening, and you will see this in page 753 of the medical records, he took co-proxamol. Do you see that on the drug chart?
A Yes.

Q Do you see the column headed 21 September?
A Yes.

Q Do you see there is a signature by the time 18.00?
A Yes.

B Q Which suggests he took his co-proxamol at that time, does it not?
A Yes.

Q And that is something that would have been administered orally?
A Yes.

Q Subsequently he received 10mg of Oramorph at 8.15 that evening, and you will see
C that on the page before page 752.
A Yes.

Q You say in your report, "It should be clarified why a 10mg dose was considered necessary rather than repeating the 5mg dose. There appears to be an absence of justification for that.
A Well in the sense that if the 5mg helped then it would be usual to repeat the 5mg dose
D again.

Q Mr Cunningham was due to take his prescribed medication at 10 o'clock that evening, and that is at page 754.
A Yes.

Q Page 754 is a document entitled "Exceptions to prescribed orders".
E A Yes.

Q Do you see that at 10 o'clock he was due to take another tablet of co-proxamol, sinemet and senna, do you see that?
A Yes.

Q The reason for his not taking it is what?
F A Sedated.

Q Sedated?
A Yes.

Q That suggests, does it not, at least the possibility that the 10mg of Oramorph had been too much for Mr Cunningham?
G A It may have been.

Q It may have been?
A Yes.

Q That it was a dose excessive to his needs? Does it suggest that as a possibility?
A It is a possibility. Again, when people first start strong opioids it can induce
H drowsiness and that drowsiness tends to be present for three days to seven days. My view

would be to use the 5mg and assess several doses of the 5mg to see whether it was relieving the pain or not. It is not untypical that at the lower end of the dose range two options are given, so although I would disagree completely with a 20 to 200mg dose range it would not be unusual at the lower end of the dose you would have something like 2.5 to 5 or 5 to 10. The idea there is there would be sufficient leeway to change the dose if the original dose was not helpful, but my understanding here is that the 5mg seemed helpful, so why not use the 5 again and the 10 may well have been more than he needed in the sense that he was left sedated, but not necessarily so, and this is where ... Yes.

Q It should have been a possibility in the minds of those responsible for his care?
A Yes, in the sense that you have given a drug and you need to evaluate the effects of that drug, both positive effects and also the potential for negative effects.

Q And it should have resulted in a reassessment of his need for opiate analgesic treatment, should it not, at the level at which he had received it?
A Again, this is a chap who had had several doses. He had a couple of doses – well, he had had ---

Q Two doses in the course of 21st.
A Yes, but on the background of regular weaker opioids, so this is a guy on regular analgesia needing additional doses, and so his – I would agree that the adequacy of his weaker opioids should be ascertained and if it were that he was now using stronger opioids on a PRN basis then it is not unreasonable to consider the use of stronger opioids on a regular basis.

Q But it would be incumbent on those responsible for his care to monitor how he reacted to that?
A They would need to take that into account, yes.

Q And the fact that he was sedated at 10 o'clock raised the possibility at least that 10mg had been too much for him?
A It may do.

Q And in those circumstances it was appropriate, was it not, to reassess the amount of opiate analgesic that he should be receiving thereafter?
A Potentially but the 5 to 10 mg dose range, you know, I think that would be seen as a not unusual dose. I think it would be very difficult to say that that was outside what would be considered normal or usual practice.

Q At 11.10 that evening he was commenced on subcutaneous diamorphine.
A Yes.

Q Given that when not sedated he appears to have been able to take his oral medication, is Mr Farthing's concern that he was commenced on diamorphine too early a legitimate concern?
A I think the use of diamorphine, having read the notes, was not unreasonable on the basis that he was obviously requiring additional doses of strong opioid for pain, presumably due to his pressure sore, and that was occurring despite the regular use of the co-proxamol. Even if you took the view of you just want to use the co-proxamol, there is not an injectable form of that, and I suspect at around this time, this is when he was deteriorating because of

the chest infection, so it was very likely that his ability to swallow was going to diminish very rapidly anyway, and in that respect, again in the hospice setting, we would not necessarily keep getting patients to struggle with their oral medication if that was distressing for them when the anticipation was that they were going to require a syringe driver anyway. We would rather avoid the difficulty or distress of trying to swallow lots of tablets when we could actually given them what they need in a syringe driver.

B Q It appears as though there was an episode of agitated behaviour in the course of the first evening.
A Yes.

Q The jury have been read the passage on a number of occasions in the same nursing note, which you will find at page 867 in the bundle, which refers to an episode of him trying to wipe sputum on a nurse and saying he had HIV. Mr Farthing was told the following day C that Mr Cunningham had been given something on the evening of the 21st to quieten him down: would you accept that what appears to have happened on the evening of the 21st was an obvious indication of unusual agitated behaviour?
A Uh-huh.

Q And you have told the jury that when an elderly frail individual arrives in a new ward surrounded by new staff, on their first night it is conceivable that agitated behaviour may D happen and may resolve itself without resort to medication.
A Yes. Again, I think compared to other comments I think in this situation, given his overall situation and what we would call biological prospects, the likelihood of this man either deteriorating and dying from a potentially reversible cause – if it is documented that he was requiring this for pain relief and anxiety, those drugs in those doses would not be considered abnormal in this situation.

E Q He had been on a number of different drugs recommended by the old age psychiatry team, Carbamazapine, Risperidone, mirtazapine and triclofos, yes?
A Uh-huh.

Q It appears as though those drugs were not administered to him on the 21st.
A Yes.

F Q Mr Farthing is concerned that an appropriate response in this case, instead of commencing diamorphine, would have been to resume the administration of those drugs which had been recommended by the old age psychiatry team, rather that commencing straight to diamorphine.
A Again, I cannot answer the question why they were stopped, but it does seem at odds that medication that had been carefully arrived at by other specialists was discontinued and it may be that discontinuation contributed to the agitated state, but, again, from reading the G notes, it looked as though everything was just coming to a head at the same time for this gentleman and his deterioration from a bronchopneumonia was likely to result in him being unable to take that medication orally in the short-term anyway. So, again, I think the question is a valid question but I do not think this was a gentleman whose clinical condition was stable. This was a gentleman whose clinical condition was rapidly changing.

H

Q You have told the jury in the course of this morning that where somebody is complaining of pain it is important to undertake an analysis of where that pain is, duration, severity, site, etc.
A Yes.

Q In this case, it does not appear as though there was any analysis done of the site of Mr Cunningham's pain. Are you aware of any detailed analysis having been done?
A It is difficult trying to remember 10 different ...

Q Of course it is.
A Again, in this situation I think there is an obvious existing physical cause of the pain in the sacral sore, and although there is not a detailed pain assessment, as one would expect, again I think the approach to the relief of pain due to a severe sacral sore in someone who was dying, I think this approach would be within what would be considered usual practice.

Q There are references to pain in his knees, discomfort on turning, and I think one of the points you make in your report at pages 32 and 33 is that Mr Cunningham had Parkinson's disease and was immobile and highly likely to experience muscle and joint stiffness that could lead to pain on turning and moving his knees.
A Yes.

Q He presumably would have had those symptoms for a period of time.
A Once bed-bound everything will just stiffen up. Again, I may make it as a general comment, another report, but for pain on turning obviously you are rousing the patient, you are moving them. If you have ever laid still in one position you know how quickly you become quite stiff and moving in itself becomes quite uncomfortable so sometimes the act of turning a patient in order to preserve their pressure areas, they will grunt and groan on turning, but actually what happens very quickly often is they will settle right down once they are in a new position, so in some of my reports in terms of justifying the increasing doses of the diamorphine it was trying to say, a pain assessment would allow you to understand if that was the pain causing the problem. Although some people may increase the dose of opioid the difficulty you can find yourself in is you keep putting up the regular opioid but that still does not stop them being uncomfortable when you turn them, so if it is short-lived discomfort on turning then often the quickest thing is just get it over and done with. If it is severe discomfort or distress on turning that does not settle very quickly then what we would often do in the hospice is give a dose upfront, sort of a breakthrough dose, equivalent of their diamorphine, about 10 to 20 minutes before you turn them, as a way of trying to give them a booster dose during that nursing intervention. So there may have been, again, by prescribing the doses, small doses PRN, it would give the nurses the leeway to give a small way to cover these sorts of interventions rather than necessarily always increasing, increasing, increasing the regular dose.

Q Mr Farthing is concerned that that was an approach which was not followed in relation to his step-father.
A Again the difficulty with that one, and obviously I have read these carefully, is that a lot of other people in a lot of other situations would probably have followed a similar approach to this, and most of that is through a lack of understanding and lack of knowledge about the relief of pain.

Q Mr Cunningham was admitted on the 21st and commenced on that day diamorphine at 20mg, Midazolam at 20mgs. On 23 September, so two days in, his Midazolam was trebled to 60mgs. I think you refer to it at pages 31 and 32 of your report.
A Yes.

Q I think there is a suggestion that it may have been as a result of agitation.
A Yes.

Q Yes?
A Yes.

Q Mr Farthing is concerned that if that was the reason for its being increased, should not consideration have been given to the possibility of the agitation being secondary to the diamorphine that he was receiving?
A Yes. I think the difficulty with unpicking this is because increasing sedation, increasing agitation could easily be in keeping with the pneumonia and the doses that were used and how they were achieved, although because of the lack of the PRN doses that clearly indicate that those doses that were used were appropriate, they are still within a range that a lot of people would consider usual practice.

Q Mr Farthing is also concerned that it is possible that Mr Cunningham's agitation may have been due to hypoxia or lack of oxygen secondary to respiratory depression.
A I am trying to remember if the respiratory rate was commented upon in this one.

Q I do not think it is.
A If you have got a bronchopneumonia, you are elderly and frail you are probably hypoxic but there is no way we are going to know that.

THE CORONER: You are saying if there was any hypoxic injury it was probably as a result of bronchopneumonia rather than anything else?
A Yes.

MR LEIPER: The apparent justification for increasing and ultimately the diamorphine and Midazolam was increased respectively to 80mg and 100mg, that was on 25 and 26 September, the apparent justification for that is that he did not like being moved.
A Yes.

Q That is on page 8, 876 in the records.
A Yes.

Q If the reason for giving it was his discomfort when he was being turned, would not a more appropriate way of dealing with that discomfort have been by the breakthrough dose approach that you have suggested?
A Yes. I think in my report I said "minimising turning stats subcutaneous doses of diamorphine and/or Midazolam prior to turning", so, again, if you are in a situation where you are trying to relieve a patient's symptoms, if their symptoms are mainly related to pain on turning, ask yourself 'How can I best improve that?' and so from my experience, covering those period when people need to be turned, minimising the number of turns they require, is a more effective approach to that but just going up and up and up on the dose actually would be what other people would tend to do, or it is an approach that other people would take.

Q Mr Farthing is particularly concerned that when he visited his step-father on 23 September he appeared to be, so far as Mr Farthing was concerned, totally unconscious and that suggests to him that the amount of opioid analgesia was excessive to his needs.
A Sorry, this is the 24th?

Q On the 23rd.
A I do not think it can be unpicked. I do not think it can be unpicked from a deterioration due to the bronchopneumonia. In this situation compared to other situations, we have got a chap who was on regular stepped analgesics that clearly were not sufficient; he had two PRN doses of morphine. If you like, there was justification in a staged approach to his analgesia. I may have had a different approach to trying to improve his pain on turning but what he was given and how it was adjusted I think is in keeping with what other people in other situations would have done.

THE CORONER: How much longer are you going to be?

MR LEIPER: Two minutes. (To the witness) Mr Farthing is concerned that no consideration was given to the possibility, or appears to have been given to the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression which resulted in depressed clearance of bronchial secretions and given he was frail and elderly such consideration should have been given: have you any comment to make on that?
A To actually cause respiratory depression it is usually at the end of a series of other stages, and again, if this gentleman at the lower dose, let us say he was turned, which is a stimulus to wake him up, if there was absolutely no response to that you may be concerned that he have been over opiated because he is not responding to any sort of stimuli but during his opioids, and even as they were increased, often turning is what he reacts to, so he clearly was not unconscious to the extent that even a painful stimulus like turning was not causing him to react, and again to me, on an honest assessment on reading through his notes, it just seems to me that things all came to a head for him on that day and the underlying problem for him was a bronchopneumonia.

MR LEIPER: I have no further questions, thank you.

THE CORONER: Ladies and gentleman, is there anything you want to ask? (Nothing) Right we will break for lunch now until 2 o'clock. Do not talk to people about the case. Thank you very much. Be back at 2.00, please.

(Luncheon adjournment)

(In the absence of the jury)

THE CORONER: According to my reckoning Mr Wilson is next. Mr Wilson is not here. Mr Sadd is not here.

MR LEIPER: We understand Mr Sadd is going to be here tomorrow.

MR JENKINS: It was requested by Patrick Sadd that we wait for him to be here, and he is due to be here tomorrow. You will want to look at timing perhaps later in the day, and it may

be that if we are doing well you might want to hear about the case of Wilson tomorrow, Wednesday.

THE CORONER: If Mr Sadd is here.

MR JENKINS: He is due to be here tomorrow.

B THE CORONER: You would be happy with that would you?

MR JENKINS: And I suspect Mr Sadd would be very pleased if that was done.

THE CORONER: He does not want to sit and listen to me read all day Wednesday.

MR JENKINS: I do not think that would be his reason.

C

THE CORONER: The other matter is that I am minded to look at a narrative verdict in the way of answers to questions, dealing the administration of opiates at Gosport, and if you want to draft out anything that you think would be of help to me. I have some ideas and they go to the appropriateness of the medication, the appropriateness of dosage, that type of thing. That would be helpful.

D Jury in then, please. We will go to Mrs Spurgeon next because we are leap-frogging over Mr Wilson.

(In the presence of the jury)

THE CORONER: We are leap-frogging over Mr Wilson because Mr Sadd is not here today, so we will have that tomorrow. We will go to Enid Spurgeon, please.

E A Mrs Spurgeon was relatively fit and independent 92 year old widow who lived alone. Whilst walked her dog she fell and fractured her right hip, which was surgically repaired using a dynamic hip screw on 20 March 1999.

THE CORONER: Would you keep your voice up, please?

A Within hours of the surgery there was leakage from the wound and swelling of the right thigh to twice its normal size, causing discomfort and pain on palpation. It was

F considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgeon's hip and thigh on movement continued to be a problem, noted by Dr Reid who reviewed her on 24 March. The surgeon involved with the case reviewed Mrs Spurgeon but no specific comment was recorded in the medical notes regarding her pain; no changes were made to her analgesia and on 26 March she was transferred to Dryad Ward. With regard to the care at Haslar Hospital, I am aware the report from Mr Redfern (?) raises

G several concerns. During her admission to Dryad Ward there was again a lack of clear accurate patient records and an inadequately documented assessment as to her condition. She became increasingly less well, drowsy, spilling things, had a nightmare and she was commenced on a syringe driver of diamorphine and Midazolam, which in my opinion were likely to be excessive to her needs. At one point, when reviewed by Dr Reid, she was unresponsive. The diamorphine dose was halved but at the same time the dose of Midazolam was doubled and she died shortly after.

H

Q On what basis do you reach the conclusion that the diamorphine and Midazolam were too high? Is that your assessment of it or is it Dr Reid's assessment of it?
A Both. I think in the medical notes, "unresponsive" is highlighted. I cannot remember if it is underlined or with an exclamation mark, but it is "unresponsive since syringe driver commenced" or words to that effect. I assume it was considered responsible because one of the actions was to halve the dose of diamorphine in the syringe driver.

B Q But not the Midazolam?
A What I do not understand is why the dose of Midazolam was in fact doubled at that time.

Q The doses that had been given were more than you would have expected?
A The initial dose of oral morphine, given the degree and severity of the pain that she was experiencing, was not unreasonable: I think that was 5mg four times a day and 10mg at night but the dose that was commenced in the syringe driver, which I believe was 80mg of diazepam would to me be excessive based on her current analgesic requirements.

Q What would you have expected to see as a starting dose?
A Well, again, if you add up the previous 24 hour opioid requirement you are getting something like 30mg of oral morphine, you would divide that by three, so that would be 10mg of diamorphine.

D Q There was obviously no explanation for the prescription being written up that way?
A No explanation given in the notes.

Q What would the effect of that medication be on Mrs Spurgeon? Is it that which would make her unresponsive?
A I believe that to be the case, yes. I mean, just to underscore that in comparison to the other situation where there was a gentleman who was on a high dose of opioids but when he was turned, i.e. a stimulus that caused pain, he reacted to that, whereas here, this lady was on a dose of opioids such that when her leg was moved she was now pain free and I think that indicates the depth to which she was unresponsive.

Q Would that not have been achieving the desired result?
A Not at the expense of – again, you are trying to achieve the positive benefits of the analgesia, i.e. the reduction or removal of the pain whilst at the same time avoiding undesirable side effects or serious side effects, and I think rendering somebody unresponsive would fit into the category of serious side effects.

Q So it is part of the balancing exercise to achieve the desired result at no risk, or minimum risk?
A Yes.

G THE CORONER: Mr Jenkins?

MR JENKINS: I have no questions.

THE CORONER: Mr Townsend?

H MR TOWNSEND: No questions, thank you.

THE CORONER: Ms Ballard?

MS BALLARD: No questions, thank you.

THE CORONER: Mr Leiper?

B

Cross-examined by MR LEIPER

Q You say at the conclusion of your report, headed "Conclusion" that the inappropriate doses of diamorphine and Midazolam would have contributed more than minimally, negligibly or attributably to her death.
A Yes.

C

Q Can you explain what you mean by that to the jury?
A Again, I think it is taking a step back and actually saying had this lady got something that was correctable? Was the cause of her pain something that should have been addressed by other means? I am not an orthopaedic expert but I think anybody reading the notes would be left with the conclusion that something was not right with her leg and similarly you do not have to be an expert in orthopaedics to actually say, 'why is there that problem?' If somebody has fractured their leg and they had a surgical intervention to repair that fracture,
D the natural expectation is that things would progressively improve, and in this situation things were not progressively improving; they were progressively worsening, and so in a way part of the issue here is should something more have been done about her painful hip and thigh? One of the responses may be to have adjusted her analgesia, but again it goes back to what I was saying earlier about can you correct the correctable, can you treat the underlying cause of the most as the most and more appropriate way of managing somebody's symptoms, so to me something was obviously not right with her hip. It should have been x-rayed. There were
E plans to do that. I do not know if it ever was x-rayed but even so I would have been on the phone to the orthopaedic team saying, 'Something is not right with this lady's hip. What do we do about it?' and, yes, you want to improve the pain relief but to give pain relief sufficient to render her unresponsive to me is not – it does not strike me as being a reasonable approach.

Q You go on to say that it was the use of the inappropriate doses of diamorphine and
F Midazolam that would have contributed more than minimally, negligibly or attributably to her death.
A Yes.

Q Would you explain that aspect, please?
A In the sense that she was rendered unresponsive and once you are rendered unresponsive then you are by definition you are not going to be taking fluids in, you are
G going to dehydrate and your body can only survive a certain amount of time without fluids, so in that respect it would have contributed more than minimally.

Q We have been told that in some circumstances excess opiate analgesic can result in loss of consciousness, coma and where the loss of consciousness is profound that in itself can be a cause of death.
A Yes. I mean, ultimately you are not going to be drinking; you are going to dehydrate.
H Again, I am trying to remember whether there is a comment on respiratory rate, but certainly

the fact that even a painful stimulus, i.e. moving her leg, did not trigger a response suggests she was sedated to quite a significant degree.

Q So the mechanism of death when there is an excessive amount of diamorphine and Midazolam is, as you say, dehydration, lack of food, profound coma resulting in death?
A Yes.

B

Q And, fourthly respiratory depression?
A Yes.

Q So those are the four mechanisms of death.
A They could all contribute to the death.

Q It is your view that that is what happened here?
C
A That was my view having read the notes and asking the question 'was there a more appropriate way of managing this lady's pain?' and I think understanding the underlying cause of the pain was key to appropriately managing it, and again in this particular patient's case there was obvious evidence in the notes that the dose, to my mind, was excessive to her needs.

MR LEIPER: And it was as a consequence of that dose that she died when she did?

D

THE CORONER: Be careful with that.

THE WITNESS: I can only conclude what I concluded in the report.

MR LEIPER: That it contributed more than minimally or negligibly attributably to her death?
A Yes.

E

MR LEIPER: Yes, thank you very much.

MR JENKINS: Can I just come back on that?

THE CORONER: Can I delay you for a second, I am looking for something and when I find it I will feel much better. (Pause) Do go on, Mr Jenkins.

F

Cross-examined by MR JENKINS

Q The jury have heard from Dr Barton, they certainly heard her statement read and part of that statement (paragraph 43) discusses the day before Mrs Spurgeon died. She died on 13 April at 1.15 in the morning and the night staff recall that on the night of the 12th that she remained ill; the syringe driver was apparently satisfactory although she appeared to be in some discomfort when attended to, and at the time she was on 40mg of diamorphine. The note for the previous day, the 11th, says, "Enid was complaining of tenderness around her wound site". This is not a woman who was unrousable is it?
G
A I think on 11 April the nursing summary said she was "very" – and that is the nurse's emphasis – "drowsy, unrousable at times."

Q Sure, but if she is also complaining of tenderness around the wound site and she is on a syringe driver, it does not suggest that she is being over-medicated, does it?

H

A Again, the original comment you alluded to, "syringe driver satisfactory: appears to be in some discomfort when attended to", the other comment there that you did not mention is "breathing very shallow".

Q If a patient is dying they may drift in and out of consciousness, irrespective of any medication they are on?
A Again it is trying to follow the logic through. If that was correct then the logic would not have been to have halved the dose of diamorphine when seen by Dr Reid because the assumption would have been that she was dying naturally and not in any way shape or form related to the dose of diamorphine which therefore did not need to be halved.

Q I understand but what we have heard from Professor Black, a geriatrician, was that patients do drift and out of consciousness if they are dying, or may do.
A They may do.

Q I think she would have received part of the dose prescribed by Dr Barton before she died, she was on a syringe driver; she would have received a fraction of it.
A It would have been at an increased rate though. I am not quite sure what you mean.

MR JENKINS: The cause of death ---

THE CORONER: I am not sure what you mean either.

MR JENKINS: It is a point made by the gentleman behind me, you do not get the whole dose if it is on a syringe driver.
A No but the rate at which it is administered would have gone up.

MR JENKINS: I do not understand that.

THE CORONER: A bigger dose going in over the same period of time, means that more ---

MR JENKINS: Yes, it goes at a faster rate, I understand that.
A Not necessarily a faster rate.

THE CORONER: Not a faster rate.

THE WITNESS: You would be getting a bigger dose over that same time period, so either way the dose has gone up.

MR JENKINS: What is the cause of death here? It is put as a cerebrovascular accident.
A Yes, and that ---

Q That is a stroke?
A Yes, and I do not feel the mode of the death is in keeping with that, that is my view.

Q But again, you are trying to interpret things through the notes which may not be complete?
A They may not be. My interpretation is that something was seriously wrong with her hip and that resulted in pain. It was tender; it was red; it was hot, which suggests there was an infection. She may have been becoming unwell because of sepsis from that infection, but

the other notes here really coincide with her becoming less alert, more drowsy, less responsive with the dose of diamorphine; the medical team at the time who were contemporarily assessing her obvious considered that likely as well because they ended up reducing the dose of the diamorphine. If they did not think it was relevant they would not have done that, so, for me having read through the notes, there seemed sufficient evidence to suggest that the dose of diamorphine was excessive to her needs.

B THE CORONER: Professor Black gave 1(a) infected wound. 1(b) fractured right hip, operated on 20 March 1999.

A Again, as best as I can come up with from reading the notes I would concur with that.

THE CORONER: Okay. Ladies and gentlemen, anything arising from that? (Nothing) On to Geoffrey Packman, a 67 year old man.

A Mr Packman was an obese gentleman to the extent that it impaired his mobility, C caused swelling to the legs, leg ulcers and he was admitted to hospital because of cellulitis, which is an infection of the skin, affecting his left leg and groins. He had pressure sores over his buttocks and thighs. These sores improved to a certain degree with treatment with antibiotics. On one occasion he passed loose black stools which is suggestive of melaena or blood in the stool. His haemoglobin was checked, which is his blood count, and this was stable, which excluded a significant bleed from his gastrointestinal tract. He was then transferred to Dryad Ward for rehabilitation. Again there was a lack of clear accurate patient D records and documented assessment of his condition, and there was prescription and use of diamorphine and Midazolam in doses likely to be excessive to his needs. He became acutely unwell on 26 August; haemoglobin checked on that day actually revealed a significant drop in his blood count, which made a significant gastrointestinal bleed likely. His deterioration, however, was put down to a myocardial infarction, although as far as I could tell the haemoglobin result could have been available by ringing the on-call service. He was considered too poorly to transfer to the acute hospital so with a working diagnosis of E myocardial infarction he was not considered well enough to transfer. The following day he had improved somewhat but even so he was not considered well enough – he was not transferred and at least by that day I would have thought the haemoglobin result should have been available to indicate that the likely diagnosis was gastrointestinal bleeding. He was not resuscitated (?) with fluids; he was not transferred; he was not discussed with the on-call medical team. His haemoglobin was not rechecked and I feel that the cause of death was a gastrointestinal haemorrhage.

F

Q Although the certified cause of death you say is the MI?

A Yes.

Q Professor Black took the view that it was the GI bleed with the pressure sores and morbid obesity as two. The dosage of diamorphine and Midazolam in this case, again you take the view that that was excessive?

G A Again it is taking a step back before that and saying 'what is the cause of this gentleman's problems?' and 'what is the appropriate response to that?' If somebody was having a myocardial infarction you may say giving him opioids is a reasonable response to that, either to relieve the chest pain or to relieve any heart failure that may occur alongside that, so giving his stack doses PRN may be appropriate, but I have not seen it that people are given regular opioids in order to treat an acute myocardial infarction. Similarly, if somebody presents with a bleeding ulcer or a bleed from the gastrointestinal tract, again, if you do not H know what the cause of that is I think the emphasis is on trying to determine what the cause

of that is. There may be reasons why that is impractical or impossible but because this is such a key decision for this gentleman I would have thought that that decision would have been taken in consultation with the medical team, senior members, members of the medical team, and if it was decided to have been inappropriate that would have been documented somewhere.

Q Dr Barton's reasoning on that was that the transfer was not going to be effected and that he was unlikely to – I cannot remember the word she used – the endoscopy – incapable of being endoscoped because of his obesity, his condition.

A Again, I am not a gastroenterologist but a patient who was not known to be terminally ill and develops an acute medical condition for which the underlying cause may be something, I will say relatively straightforward like an ulcer, then if you are making the decision not to pursue that on the grounds of it is not appropriate or not practical I still feel it is such an important decision to take that that should be documented in the notes. I think the other thing that nags a little bit for me is that the result of the blood test, which would have confirmed the diagnosis of a serious gastrointestinal bleed was probably available that evening, or at the latest the following day and it does not seem as though that was even obtained or if it was obtained it was not acted upon. It is signed by the doctor but it is not dated when it was signed.

THE CORONER: Is that the note that says "phone not being answered" at ..(inaudible).. Okay, you go with the GI bleed then? Mr Jenkins?

Cross-examined by MR JENKINS

Q One question from me: Professor Black's view in relation to this patient was that the doses of diamorphine used with Mr Packman were required to control the symptoms and did not contribute in any significant fashion to his death: do you agree with that?

A Again, it depends on what you consider appropriate treatment.

Q There is a range, is there not, and you are at one point on the spectrum and others may be somewhere else?

A My view of appropriate treatment is again whether it is seen as reasonable to evaluate somebody who has got an acute medical complication and determine whether you can treat the underlying cause. The first step of my approach, as I have explained, is correct the correctable, drug and non drug approaches, and to me the issue or the stronger issue is was this gentleman likely to be bleeding from a stomach ulcer, say. It could have been another cause, we do not know because it was never evaluated, but it is a possible cause that this was something as [in inverted commas] a "relatively straightforward" as a stomach ulcer. There may be various patient factors which meant it was not appropriate to investigate that further and so on, but this is a guy who had an acute deterioration. Whether or not he was too poorly to move on the evening we could discuss again but he had levelled out. He seemed to settle down the following day, and there seemed to at least have been a second bite of the cherry or a second opportunity, plus the blood count result should definitely have been available by that second day to say, "Well blow me down, he has not had a heart attack, he has dropped his HB as much as he has, he must have bled from the gut somewhere", and at that point that situation would be discussed with the consultant in charge of the case, to discuss it with the physicians if necessary if the consultant deemed that relevant.

Q Leaving aside the discussion with the consultant, the jury know that there are documented discussions with Mr Packman's wife, several of them, and it is Professor Black's view that it is within the boundaries of a reasonable clinical decision to provide symptomatic care only at that stage after the doubt(?) Would you agree with that?
A I would say only if it is clear at that point that that was the appropriate course of action.

B Q We know as well that Dr Reid was involved and that after his involvement on a ward round the diamorphine was increased.
A Uh-huh.

Q You do not have any concerns about that?
A I am not sure why it was increased.

C Q Does he not note it?
A "Rather drowsy but comfortable".

Q Yes.
A So, okay, "Remains confused". Drowsy, confused, but apparently comfortable. You know, there is not an obvious reason there for me to say, "Let's put his diamorphine up again."

D MR JENKINS: Thank you.

THE CORONER: Mr Townsend?

MR TOWNSEND: No, thank you.

E THE CORONER: Ms Ballard?

MS BALLARD: No, thank you.

THE CORONER: Mr Leiper?

<u>Cross-examined by MR LEIPER</u>

F Q Can I ask that this witness have a copy of the medical records? I have ask that they be available and perhaps I could have a copy as well. Dr Wilcock, I appear on behalf of Mr Packman's family. They have four key concerns; that there was an omission to adequately assess his condition on 26 August; there was an omission to obtain and act upon the blood results on 26 or 27 August; there was an omission to transfer to an acute hospital; and there was an administration of diamorphine and Midazolam likely to have been excessive to his
G need, those are their four principal concerns. Do you regard those four concerns as being justified in this case?
A I can only say if we are dealing with them one at a time, maybe that is the best way.

Q Okay I will come to them in due course. What you say in your report is that it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage, together with his exposure to unjustified and inappropriate doses of diamorphine and Midazolam that
H

contributed more than minimally, negligibly or attributably to his death. Does that accurately represent your opinion?
A Yes.

THE CORONER: Can I just remind you, Mr Leiper, what we are dealing with and what we are not dealing with?

B

MR LEIPER: Yes.

THE CORONER: The expressions you have just read out are perhaps not helpful to the jury in being judgmental. I do not think Dr Wilcock actually read that out.

MR LEIPER: That is his evidence in relation to cause of death.

C

THE CORONER: Which bit are you looking at?

MR LEIPER: His report, at pages 3 to 4.

THE CORONER: Is that the bit he read out?

MR LEIPER: No, sir.

D

THE CORONER: The jury have not got the rest of it.

MR LEIPER: No.

THE CORONER: We are not dealing with any questions of culpability.

E

MR LEIPER: We are dealing with the cause of death.

THE CORONER: Yes.

MR LEIPER: And it is ---

F

THE CORONER: I thought you just read out that there was negligence?

MR LEIPER: Not negligence, no, no.

THE CORONER: What was the comment?

MR LEIPER: That it contributed more than minimally, negligibly or attributably to his death.

G

THE CORONER: Forgive me, I misheard you.

MR LEIPER: I am sure it is my fault for not being sufficiently clear in what I was saying. (To the witness) The learned Coroner has confirmed that you are entitled to provide an opinion as to whether or not the care and treatment that was provided was in accordance with your expectations: you are entitled to give that evidence, and in providing the jury with your opinion as to what was expected, the standard that you should apply should be guided by

H

what you consider a reasonably competent clinician, clinical assistant or GP would have done in 1998-1999, do you understand that?
A Yes.

Q If you consider there was a responsible body of opinion that would have arrived at a different view to the one that you express you will say so?
A Yes.

Q Mr Packman was not terminally ill when he arrived at the Gosport War Memorial Hospital.
A That is my opinion from reading the notes, yes.

Q He had a history of obesity, limited mobility. He had a history of swelling of his legs which in turn predisposed him to leg ulcers, and he had had an episode of catheterisation.
A Yes.

Q But none of those factors made him terminally ill?
A No.

Q Before going to the Gosport War Memorial Hospital he was at the Queen Alexandra Hospital for about a fortnight, correct?
A Yes.

Q During his stay there it appears as though his condition improved.
A In terms of the sores, the cellulitis, yes.

Q I will take you to the specifics: page 48 of the medical records, there is an entry on page 48 dated 10 August 1999, do you see that?
A Yes.

Q It is the bottom entry on the page. Do you see there is a reference to the temperature being taken? Would you confirm to the jury what that entry says?
A Temperature 36.5, apyrexial, blood pressure 150 over 90, ECG AF. PR means pulse rate 85 regular, Patient well. Cellulitis improving on antibiotics; still awaiting physiotherapy.

Q So the patient there is recorded as being well and that his cellulitis is improving.
A Correct.

Q If you then go to the entry for five days later, page 51, this is an entry dated 18 August, and perhaps you could confirm what that says?
A Allowing for the bad writing, I think it says: stable. Wounds look better. Stop antibiotics from tomorrow. Recheck bloods tomorrow. Continue as planned. Withhold thelodapine(?) I think for two days and monitor blood pressure. If blood pressure normal stop thelodapine.

Q The fact that the doctor was recommending antibiotics be discontinued at that stage, what would that indicate?
A Given that they have also annotated that the wounds look better, that it has responded to treatment.

Q If you then go to page 163, it is the Barthel index. Just remind the jury what the Barthel index is?
A It is an overall score that takes into account patients' abilities really in a range of different dimensions, ability to feed themselves, mobilise, dress, washing.

Q Can you confirm that by 23 August, so his last day at the Queen Alexandra Hospital his Barthel index had improved?
A Yes. It remained low but it had improved.

Q The jury has heard from Victoria Packman – I am not sure that you have been provided with all the witness statements in the case ...
A No.

Q She has told the jury that:

> "Dad quickly made good progress. He had injections of antibiotics and soon his legs dried up and he seemed much better. I remember he looked the best he had for years. He was happy and chatty and keen to go home. He was eating and drinking properly and quite able to do things for himself. Because of dad's lack of mobility around the house mum and I were told that he would be going to the Gosport War Memorial Hospital for rehabilitation and mobilisation. Whilst he was there the social services department were going to assess our house in order to put in handrails to help dad get around. Everyone seemed very positive".

Does that as a snapshot accord with your impression of his condition from the medical records?
A Yes, that if anything he was getting better compared to when he was admitted to hospital.

Q When he was admitted to the Gosport War Memorial Hospital on 23 August, an entry was made on page 54 of the medical records, do you have that?
A 23 August?

Q Yes, 23 August. The clerking doctor I think notes the pre-existing problems with obesity, arthritis in his knees and immobility, pressure sores and constipation, correct?
A Yes.

Q There is also reference to an episode of possible melaena on 13 August 1999, so some two weeks/10 days previously.
A Yes.

Q So again, just remind the jury what melaena is?
A Melaena is a black or dark stool because it contains blood.

Q It refers to his being on a high protein diet, and to his being better in himself.
A Yes.

Q And there is a good mental test score there.
A Yes.

Q Do you then see halfway down the page to the right there is a reference to "no pain"?
A Yes.

Q So there is no indication from that page that he was terminally ill when he was admitted to the Gosport War Memorial Hospital?
A That is my opinion.

B

Q He had been admitted for the purposes of rehabilitation, yes?
A I do not know if it specifies there but I think it was for a period ---

Q It is specified. I can take you to the reference if need be. If you go to page 68, do you see there is an entry dated 26 August 1999?
A Yes.

C

Q Do you see a reference there to an expectation that he would be having physiotherapy?
A Yes.

Q If you go to page ---
A In my report I have put the plan was to transfer him to Dryad Ward for rehabilitation and there are several pages that therefore refer to that.

D

Q At page 108 ---
A 121, 122.

Q If you look up page 108 in the medical records that confirms that he was admitted for the purpose of rehabilitation.
A Yes.

E

Q The fact that he was due to be receiving physiotherapy: what does that indicate?
A That would suggest that is in keeping with a rehabilitative approach.

THE CORONER: Did he actually get any physiotherapy? He did not get any of the hour a week?

F

MR LEIPER: No. (To the witness) During his stay at the Queen Alexandra Hospital there is evidence on the records of his having experienced internal bleeding which was being monitored. Can I take you to page 133? I think it is the penultimate entry and it is timed at 13.45 and is dated 11 August 1999.
A Yes.

Q There is a reference there to "loose black stools".
A Yes.

G

Q Then if you go to page 52, and this is an entry two days later, dated 13 August 1999, it is the second one down the page, and do you see there is a reference to "black stools overnight"?
A Yes.

H

Q We have been told that it was Dr Tandy who assessed him on that occasion, and it appears as though in the light of the black stools, can you confirm this from the records, that she then proceeded to do a digital rectal examination?
A Yes.

Q So far as Dr Tandy was concerned it was appropriate for his full blood count to be checked and he was found to be essentially stable?
A Yes.

Q Which appears to exclude his having had a very significant bleed at that stage, as you suggest in your report?
A Yes.

Q Some five days later, on 19 August, again there is a reference to black tarry stools, page 137, do you have that, the third line from the bottom, 19 August, "small amounts of black tarry stools"?
A Yes.

Q Those entries suggest that there may have been some sort of gastrointestinal bleed while he was at the Queen Alexandra Hospital, is that right? There is the possibility that he had?
A Definitely, yes.

Q There is a definite possibility of it having happened?
A Yes.

THE CORONER: Is it not more than that? Is that not the diagnosis. Is that not the diagnosis you would draw from that?
A Again, all you can say from that is that there was blood in the stool, more than likely to be blood in the stool by the fact it was black, at least.

THE CORONER: That is the third entry, is it not?
A My understanding is he had a further blood count on 20 August which again revealed a stable haemoglobin, so although he had at least two episodes of melaena, on monitoring his haemoglobin there had not been a significant drop in that, so although he may have had, let us say, a couple of small bleeds it was not sufficient enough for him to have lost a large amount of blood.

MR LEIPER: But for anyone reviewing those records it would be apparent to them that there was at least a possibility that he had suffered from a gastrointestinal bleed?
A It would alert you to that possibility.

Q So the doctors who were responsible for his care at the Gosport War Memorial Hospital would, had they read these previous medical records, been alert to the possibility of his having suffered that previous gastrointestinal bleed?
A Yes, that was a possibility, yes.

Q Two days after he arrived at Gosport War Memorial Hospital, page 62 in the bundle, dated 25 August 1999, there is a reference to, in the first four words there?
A On the 25th?

Q The 25th, exactly.
A Yes. "Passing fresh blood, PR".

Q What does PR mean there?
A By the rectum.

B Q In the light of your conclusion that the appropriate cause of death in this case is one of gastrointestinal bleed, is that entry there linked in any way to a gastrointestinal bleed having happened?
A I suspect not, in the sense that, again, there is a lack of detail but if it is fresh blood that would tend to suggest it is bright red, and the passage of bright red blood would suggest a local cause of bleeding, and the most common local cause of bleeding may be piles or haemorrhoids, so although it is relevant, and it is relevant because he is having his blood
C thinned by the Heparin, the Clexane, these actually may be two separate incidents.

Q He was seen on 26 August, and the entries are on page 62, by the clinical assistant. Do you see the entry on page 62 for 26 August 1999?
A Yes.

D THE CORONER: "No further vomiting. Dr Ravi contacted re Clexane. Advised to discontinue, repeat blood count today".

MR LEIPER: Exactly, so, sir, that is the entry.

MR JENKINS: ..(inaudible)..

E MR LEIPER: Dr Ravi we have been told is the locum consultant geriatrician.

THE CORONER: That is what it says in the note. Maybe Gill Hamblin has written it but the reference is "Dr Ravi contacted re Clexane and advised to discontinue".

MR JENKINS: Sorry, I thought it was being said that the nurse had written that, it is not.

F THE CORONER: Thank you.

MR LEIPER: (To the witness) It appears that on 26 August the locum consultant geriatrician, Dr Ravi, was contacted, yes?
A Yes.

Q And the advice that is recorded, her management plan was to get blood tests done that day and the next, do you see that?
G A Yes.

Q We know that the clinical assistant was aware of that, as a result of my having had the opportunity to ask her some questions. The blood test which has been referred to is at page 205 in the bundle.
A Yes.

H Q Would you confirm to the jury what that document is?

A This is a printout of the haematology report, so this records the blood count result.

Q It is dated in the bottom line on the right-hand side ---
A The 26th.

Q 26 August?
A Yes.

B

Q And it has got a comment in the larger box above, can you confirm for the jury what that says?
A Many attempts were made to phone these results: no answer from Gosport War Memorial Hospital switchboard."

Q Is it apparent from those results why they would have been trying to make many
C attempts to phone the result through to the Gosport War Memorial Hospital?
A I think because the clinical details on the request form said "Bleeding PR" and because the haemoglobin was low I suspect that is why they chose to try and phone the results through.

Q When you say the haemoglobin is low, what should it be and what is it?
A On the results it is 7.7, normal varies from lab to lab but you would want it to be 11 or
D more.

Q So it is getting on for half what it should be?
A I guess what is more relevant is how it had changed compared to what his normal level was.

Q What would be the relevant there?
E A That the bleeding would have been significant enough for a large amount of blood to be lost.

Q So anyone who saw the pathology service results would be able to draw the inference that there had been a significant bleed?
A I would have thought anybody would be able to say, "Something is not right here, this
F chap has had episodes of melaena. Yes, he has had some fresh blood PR which may or may not be related but the overall outcome is that this guy has lost blood, and it is most likely to be from his gastrointestinal tract."

Q You have said that these significant results were not commented on at any stage in the clinical records.
A Yes.

G

Q Is that in line with what you would expect to have happened?
A I mean, a medical assessment was made of Mr Packman, and a differential diagnosis was reached, and again a medical assessment consists of the history, the examination and appropriate investigation. Now, given that a blood count had actually been checked that day it seems ---

Q It was checked?

H

A A blood test had already been taken that day on Mr Packman, it would have seemed very reasonable, to me at least, to have phoned up the labs and asked for the results because that would have helped you come to an ultimate diagnosis. In this situation I think it would have helped you come to a more appropriate diagnosis of a gastrointestinal bleed rather than a myocardial infarction.

Q And the note you referred to is I think the note at page 55, the clinical assistant's note, the top entry dated 26 August 1999, do you see that?
A Yes.

Q Is that the note that you say is the one that records the differential diagnosis?
A Yes. I think it says: "Alternative possibility gastrointestinal bleed but no haemoptysis".

Q Perhaps if you take it from the top?
A "Called to see; pale, clammy unwell suggest ? MI [myocardial infarction]. Treat stat, diamorphine and Oramorph overnight. Alternative possibility GI bleed but no haemoptysis". Haemoptysis is vomiting blood: "Not well enough to transfer to acute unit; keep comfortable. I am happy for the nursing staff to confirm death".

Q Had the clinical assistant reviewed the pathology results that you have referred to, would you have expected her to be able to arrive at the appropriate diagnosis of gastrointestinal bleeding?
A I think in terms of where it came on your list, it would come top. Instead of myocardial infarction versus gastrointestinal bleed, you would have gastrointestinal bleed at the top of your working diagnosis.

Q Given the circumstances in which Mr Packman was in hospital, would you have expected a thorough medical assessment to have been performed as at 26 August to ascertain the possible cause of his condition?
A Yes, because it was an acute change in his clinical condition. It was unexpected. You were requested to see the patient so called to see him because he had acutely become unwell.

Q Would part of the reason for that assessment to take place be to ascertain if his condition was reversible?
A A medical assessment at the end of the day is to come up with a diagnosis, or at least a working diagnosis and based on that working diagnosis gives you an idea of whether this is something that is treatable or the most appropriate way to treat the circumstances you find yourself, in, so you try to come up with the cause of the problem.

Q And the reason for doing that is because if it is a reversible condition ...
A Some of the underlying causes may be eminently treatable.

Q The medical assessment that you say should have been undertaken on that occasion, what basic observations would you expect to have been taken?
A I think as a minimum most people would expect to see a temperature; they would expect to see a pulse rate; they would expect to see a blood pressure, particularly if somebody is related to be clammy or unwell because that is really describing a patient who is shocked, if you like. You would want to listen to their heart. You would want to listen to their chest,

have a feel of their abdomen, and I would have thought that would be a reasonable minimum examination.

Q From the medical records, does it appear that that was done?
A There is no record of those parameters.

Q Had those basic observations been undertaken, are they likely to have founded a likely indicator as to the appropriate diagnosis of Mr Packman?
A Well you could be shocked as a result of a heart attack and you could be shocked as a result of bleeding, but because of his history, bleeding for me at least would be top of the list and because you have gone to the trouble of taking a blood test that morning, checking the results of that blood test would have been a reasonable course of action in my opinion, so adding all of those up together I think you would have been left with a working diagnosis that this man had lost a significant amount of blood through a gastrointestinal bleed.

Q That is what you would have expected the diagnosis to be in the circumstances?
A I feel that would be a reasonable conclusion to come to based on the history and based on the results of the blood count.

Q The most likely explanation for a gastrointestinal bleed I think you have suggested is a peptic ulcer?
A That is one of the commonest causes. Obviously, there is a range of other causes.

Q But that would be a distinct possibility in the circumstances of this case?
A Yes.

Q When a patient has a gastrointestinal haemorrhage, is that a medical emergency?
A Yes.

Q What should happen? What would you expect to happen in those circumstances?
A Well, again, I am not a gastroenterologist and I believe you have got a report from a gastroenterologist.

Q We do not, as it happens. There is no report at the moment.
A Oh, right.

Q I understand that one in the past has been done.
A Yes.

THE CORONER: It is not admitted and it is not included in the bundle.

MR LEIPER: You have had the opportunity to look through that?
A Yes.

Q Okay.
A By and large, if someone has lost sufficient blood in order for them to be shocked, then that suggests that a lot of blood had been lost, then what you need to do is what is going to resuscitate them and resuscitate them in this circumstance means to restore their blood pressure, to restore their circulating blood volume. That would be done in the first instance with an intravenous infusion of fluid. People may be given oxygen as well. Subsequently

they may need a blood transfusion, but the other part of the process once they are stabilised is to actually try and make a diagnosis of the cause of the bleeding so that definitive treatment could be offered.

Q Is it your view that he is likely to have had a – I think it is your view – potentially treatable and reversible medical condition?
A On paper he had a potentially treatable and reversible condition, but we do not know what the ultimate diagnosis would have been but as a working diagnosis, common things being common, then a peptic ulcer would be top of the list.

Q Given that it is a medical emergency, could it have been dealt with on the Dryad Ward at Gosport War Memorial Hospital?
A From my limited understanding of Dryad Ward the answer would be no.

Q What would you expect to have happened to a patient with such a medical emergency on Dryad Ward?
A I would take the view, whether it turned out he was having a myocardial infarction or whether it turned out that he was having a gastrointestinal bleed, a decision needed to be made at that point, what was the best course of action for him, and whether it was a myocardial infarction or a gastrointestinal bleed this guy was shocked, and by "shocked" I mean pale, clammy, his blood pressure was likely to be low, so whether you take the view he was having a heart attack or whether you take the view he was having a bleed, these were significantly affecting him. It may be, like every situation in medicine, you have to weigh up the pros and the cons so for somebody with advanced cancer who had exhausted all treatments it may not have been appropriate to have pursued diagnosis and keeping him comfortable may have been very relevant, but in a patient who is not known to be terminally ill they have significant morbidity in terms of his morbid obesity but, nevertheless, because you are left very much with that not knowing, should we? Shouldn't we? This really should, in my opinion at least, should have been a point for discussion with a senior member of the medical team to determine whether he should have been transferred or whether, or whatever reason, and those reasons should have been stated, whether or not it turned out to be a heart attack or a GI bleed, it was not in his best interest to take a more aggressive approach, and that to me is the bit that is missing. If you know that that discussion has gone on; if you know that the doctors concerned had weighed up the various pluses and minuses to the various treatment approaches and had come up with a conclusion and you can understand that conclusion, you would feel more satisfied about it.

Q We have been told by Professor Black that the risks of transfer themselves would be very low.
A Again, it is almost an impossibility to quantify I think, but it is a catch 22, and I think what I put in my report was if people were poorly at home, let us say he was at home and this suddenly happened, you would not say, "Oh, we can't transfer him from home to hospital because he is too poorly to move", you would accept the fact that this person was ill and may be very ill but if your decision as a doctor is that this guy is not terminally ill; they deserve to be treated like anybody else should be treated, then I would have thought it reasonable to get them into a place where they can receive that treatment. The idea might have been to resuscitate him beforehand, before moving him, if you like to stabilise his condition but in the absence of the ability to do that to me was not a reason to say, "Well we just can't send him anywhere" and it seemed ... You know, if you were at home and this developed you would end up in hospital via an ambulance, it seems slightly odd that if you are in another situation

and developed absolute acute medical condition you do not end up where you need the treatment.

Q But you would have expected him to be transferred in the circumstances?
A If the decision – and, again, this is the critical bit – if the decision was that he, on the basis of probabilities, of the likelihood of this being a reversible condition, that he could be successfully treated for it, then I would have expected he should have been transferred to an acute medical setting.

Q Had he been transferred to an acute medical setting, what are you saying is likely to have happened there?
A Again, I am not an expert in gastroenterology but I think just to reiterate, people would have been stabilised, so if the blood pressure was low they would have received intravenous fluids, followed by a blood transfusion and then some attempt at making a diagnosis made, and again on the basis of probability that would have been an endoscopy.

Q Had he been suffering from a peptic ulcer, which I think you feel is the most likely diagnosis, is that a condition which could have been reversed?
A Usually with treatment, yes. Again, a gastrointestinal bleed is a medical emergency and the reason it is a medical emergency is that it has high morbidity and people can die from it, and that is why people take it seriously and try and address it rapidly, so you cannot say necessarily that if everything had gone to plan he would have survived this; there is a chance that he would die from a gastrointestinal bleed, but getting the relative risk right is what you need to ask a gastroenterologist, but it is more a matter of saying the basis of the potential good we could do here against any potential harm or any other co-existing morbidity, on balance should Mr Packman have been given that chance? Should he have been given that opportunity to receive that treatment?

MR LEIPER: So while you cannot say for definite, can you go as far as saying that had he received that treatment the likelihood is he would have survived?

THE CORONER: No.

MR LEIPER: No?

THE CORONER: No, that is the "what if?" game is it not, and we have gone far enough on the what ifs. I think "should he have received that treatment?" and if the answer to that question is yes, that should have happened is your view?
A On the basis of what I have read, I cannot see a reason not to do it, although a reason not to do it may have existed, but nothing that I have read ...

MR LEIPER: (To the witness) One of the suggestions that has been made is that he may not have been transferred because there was a mark on his medical records to the effect that he was not for resuscitation: what was the relevance of that in this context?
A Again, the whole issue of resuscitation status is a very confusing one, but actually it is a very specific issue. When doctors write "Not for resuscitation" that in my mind purely relates to the circumstances if their heart or their breathing stops unexpectedly and it relates to no other aspect of their care. Now, because of his morbid obesity, if he had suddenly collapsed, let us say he had a massive heart attack and he was unconscious on the floor, then because of his morbid obesity it probably was not appropriate to have instituted what is called

cardiopulmonary resuscitation, the kiss of life. Because of his morbid obesity, the likelihood of getting him back would be incredibly low and so it is not unusual that people's resuscitation status is assessed when they come into hospital and it is decided, weighing up the likelihood of success of applying the kiss of life, if you like, or basic resuscitation, if their heart and breathing was to suddenly stop, so for a lot of people coming into the hospice, for instance, it is not appropriate that we would institute cardiopulmonary resuscitation, but that does not mean we do not treat people appropriately, so if somebody comes into the hospice suffering from a chest infection they are not imminently dying, and they have symptoms or they are distressed with their chest infection, we will treat that chest infection because it is what is distressing and bothering them, so it is really important, and I think this is something that people get very confused about, they see "Not for resuscitation" means not for any treatment at all, and that is wrong, that is completely wrong, so the fact he was not for resuscitation is reasonable but that is not a reason not to treat him appropriately, and if he developed an acute medical complication or acute medical condition for which there was an underlying cause that had the possibility of being treated adequately, the two ... You know, there is no problem with having those two approaches side by side.

Q In the light of what you have said, you said obviously the decision of the utmost importance so far as Mr Packman was concerned, the decision not to treat his condition, is it correct that the decision not to treat his condition as at 26 August meant there was in fact no prospect of Mr Packman recovering?

A So on the basis that he had an intestinal bleed then again what could happen, if you imagine it this way, your blood pressure is normal, or high, say, you then bleed and your blood pressure will drop and sometimes as the blood pressure drops the pressure causing the bleeding is reduced so the bleeding might stop. Sometimes you can have a situation where people bleed and then it stops bleeding and they level out, so there could be a period of where people seem to level out and, if you like, their body sort of catches up and adapts to that. We do not know what the underlying cause was, so we do not know what the likelihood of this, if you like, spontaneously improving would be but on the basis that he had a significant bleed I suspect once he has crossed this threshold, as it were, it was always going to be likely he was going to die of his bleed.

Q If it went completely untreated?

A It went untreated.

Q Professor Black has told us that because of the complexity of the decision and the seriousness for Mr Packman it certainly should have been discussed with the patient, with the consultant and with the family, is that something you would agree with?

A Again, I would in the sense that he was not obviously known to have a terminal illness. He was not obviously known to be coming to the last days of his life and I think it would be seen as good practice when doubt exists to actually lay that – or involve the family and the patient in the discussion around that, say, "Look, we are not sure what is going on. Maybe the move is going to be difficult or dangerous; we do not know what the cause is, it might be something as simple as an ulcer, it might turn out to be something as awful as a stomach cancer, we just don't know" and trying to get a feel for what that particular patient would like to happen, so, yes, you would need to include the patient's views, you would need to take note of the family views, but again there may be – and this is why I think you need a gastroenterologist, if there are technical reasons – you know, if a gastroenterologist turned round and said there were technical reasons for why he could not ---

THE CORONER: Can I shift this from speculation: the situation on the ground is that there was no consultation with a gastroenterologist, so whatever the position, the decision that was being made at that time was not in consultation with the gastroenterologist or anyone else at that point, and it goes again to the what ifs? The fact of the matter is it did not happen.
A It was not discussed, no.

THE CORONER: That is not intended to be difficult in any way at all, it is intended to be helpful, believe it or not.

MR LEIPER: (To the witness) On 27 August you say his condition had improved.
A The nursing entry was "Some marked improvement since yesterday."

Q If it had been inappropriate to transfer him to an acute hospital on the 26th, would it have been appropriate to transfer him on the 27th, in the light of the marked improvement in his condition?
A Again, the key is what decision had been made in terms of managing this gentleman, and if the decision was made that, for whatever reason, it was not appropriate to undertake aggressive therapy then it would make no difference, but if that decision had not been taken, and, again, it seems to me that even if the blood count had not been obtained the day before ---

Q The 26th, yes.
A --- there should have been something that would have made the doctors in charge of his case say "Let us chase it up from yesterday", and every now and again if you need an urgent result of a blood test then you pick up the phone and you ring the lab.

Q That is what you would have expected to have happened on the 27th?
A Yes, you would not wait for it to come by post because that can take however long, but if you were seriously concerned about the chance of a bleed you would pick up the phone and ask for the result.

Q You say in your report that his changing condition, the marked improvement, was not discussed with Dr Ravi or any other consultant?
A It is not documented that that has been discussed.

Q Is it your expectation that should have happened?
A Again, I would have thought as a consultant in charge of a patient's case I would want to know about their condition, because ultimately it was the consultants who are in charge of their care, and so I would anticipate whether it was a house officer, senior house officer, junior hospital doctor or whoever, you would relay important information relating to the development of the care of one of my patients.

Q Dr Ravi, you know, had suggested that a blood test be done, not only on the 26th but also on the 27th.
A Yes.

MR LEIPER: And that does not appear to have been done, is that in accordance with your expectations?

THE CORONER: That it would not be done?

MR LEIPER: That it was not done.
A I mean, again, it is like a second bite of the cherry, is it not. If for whatever reason you had done a blood test and not looked at the result, maybe by doing what was agreed with the consultant may have given you a second attempt to actually see what was happening.

Q So would you expect that second blood test to have been done in the circumstances?
A Again, there is nothing documented to say why it could not have been done or should not have been done.

Q So is it your expectation that would have been done?
A Yes.

THE CORONER: How much longer are you going to be, from the point of view of the equipment rather than anything else?

MR LEIPER: I will be probably another 15/20 minutes after the break.

THE CORONER: We will take a five minute break.

(Short adjournment)

MR LEIPER: Sir, while the jury are coming in, I will quickly deal with Gregory and that will leave Wilson and Devine for tomorrow.

THE CORONER: Will you do Gregory in its entirety?

MR LEIPER: I will do Gregory in its entirety.

(In the presence of the jury)

THE CORONER: Mr Leiper?

MR LEIPER: (To the witness) You have dealt with 26 and 27 August, we know the clinical assistant saw Mr Packman on 28 August and on 31 August, can I ask you please to look at page 79 in the bundle? The entry dated 30 August, would you confirm what that nursing entry reads?
A I will have to refer to my notes.

THE CORONER: "Peaceful night. Incontinent of faeces" is that?
A It is "Black tarry faeces +++", which means a lot, "Nil taken by mouth; remains hot".

MR LEIPER: It was the entry before, the entry for 30 August, would you confirm what that says?
A "Appeared to have a comfortable and peaceful night. This morning has passed a large amount of black faeces".

Q You have identified one of the references to black faeces on 31 August, I think in fact there were two other separate entries in the medical records which refer to black faeces on 31

August. What would those entries indicate to you as regards the likely cause of his condition?
A Again I think that would indicate the most likely cause of his problems to be a gastrointestinal bleed.

Q What you say in your report is that "On 31 August Mr Packman passed a large amount of melaena and the diagnosis of a gastrointestinal bleed should not have been in any doubt".
A In terms of your differential diagnosis between a myocardial infarct or a bleed, that would reinforce that a bleed should be top of the list.

Q We have heard that Dr Reid reviewed him on 1 September and Professor Black has told us that as of 31 September, given the period of time which is likely to have elapsed between the gastrointestinal bleed on 26 August, and what happened thereafter, he had by 1 September 1999 essentially reached the point of no return: would you accept that as being correct or not?
A I think what you have got there is a plan based on an assessment of a consultant for TLC, for tender loving care, so at least at that point you have got a documented plan, a documented decision that has involved a senior clinician and that was the decision of the team at that time.

Q Do you disagree with Professor Black or not, as of 1 September when seen by Dr Reid was he ...
A Again, it is a matter – again the issue here is, has a reasonable decision been made about how best to manage this gentleman's condition, and that is why there was a critical period that we have talked about before where a decision whether to treat this gentleman like you would treat perhaps anybody else, with active resuscitation, transfer to an acute medical area and so on was appropriate or not. By the time he got to this point I would accept that several days would have gone by and the likelihood of, if you like, getting him back would have diminished but at least here we have got a decision by a senior clinician in charge of the charge of the patient stating a clear plan. Now what is not stated are the reasons for that, but, nevertheless, it is still a stated treatment plan, so at that point if somebody is in for TLC then the focus obviously is on relieving symptoms appropriately.

Q Given what we know about the likelihood of their being some gastrointestinal bleed before he got to the Gosport War Memorial Hospital; given his acute episode on the 26th and given the evidence of gastrointestinal haemorrhage after 26 August, would you expect the diagnosis at that stage to have been gastrointestinal haemorrhage?
A Yes.

Q Did the omission to identify and treat the gastrointestinal haemorrhage amount to conduct which fails to meet your expectations?
A Again it is repeating to a certain extent what has already been said: there may be a situation where people have had a gastrointestinal bleed and it is not appropriate to pursue the usual management plan of resuscitation, transfusion and attempted diagnosis, so the decision really comes back to at the time of his acute deterioration or certainly by the following morning, when the results of the full blood count should have been easily obtainable, that is the time period at which the decision should clearly have been made and clearly documented, in my opinion, and anything that has happened subsequent to that, it all goes back to that time point, and, as I say, that is the critical time.

Q Just dealing with the first three of the concerns that the Packman family have in relation to there being an omission to adequately assess his condition, an omission to act on the blood results and an omission to transfer to an acute hospital, are those concerns justified so far as you are concerned?
A I think they are owed an appropriate explanation why the treatment plan not to do those things was considered appropriate.

B

THE CORONER: I think we have heard that the blood tests was an omission and that nobody had picked up on that, it is not that blood tests were not done, they were done and it is the results that were not ---

MR LEIPER: Acted upon.

C THE CORONER: --- but that is what has happened there. You are looking concerned, Mr Jenkins.

MR JENKINS: I know it has been signed by Dr Barton, the blood test result, so she did see it.

THE CORONER: Yes.

D MR JENKINS: We do not know when.

THE CORONER: Forgive me, I do not mean to be unfair in any way but it is not timed.

MR LEIPER: (To the witness) Yes, and given that it was signed by Dr Barton, does that make it more or less in accordance with your expectations, the fact that she was aware of that blood test?
E A I do not know. You will have to ask Dr Barton that, but ---

Q I am asking for your opinion as to what is expected in this situation?
A There was no documentation in the notes that suggested that that result was looked at or acted upon.

Q We know it was looked at because it was signed.
F A There is no date. What is slightly confusing is that even if at the time it was reasonable to say the differential diagnosis is between a heart attack and a gastrointestinal bleed, that the subsequent clinical progress of this gentleman passing large amounts of melaena stool I think, as I say, would be gastrointestinal bleed at the top of your list, yet the death certificate put myocardial infarction and I do not know how long printed blood results take to get from the lab to the hospital but occasionally they can take a very long time so it is not impossible that this was signed – I am afraid we are back to the what ifs – but this may have been signed after the death of the gentleman, but if it was viewed before the death of the
G gentleman and if it was viewed on the day of his decline or the next day it does seem odd that it was not recorded in the notes or a more informed discussion about the likely cause of his acute deterioration was not entered into the medical notes and were discussed with a senior member of the clinical team.

H

Q Could we move on to the prescription of opiate analgesics: I think they were commenced in the evening of 26 August, correct, when Oramorph was given (page 172 in the bundle should you want to refer to it).
A Yes.

Q Thereafter, diamorphine is commenced, I think diamorphine and Midazolam were given over a period of five days, diamorphine beginning at 40mg then increasing to 60 and then to 90. Midazolam increases from 20 up to 80 over the same period, yes?
A Yes.

Q This is not a case of terminal agitation, or any evidence of there being terminal agitation on the part of Mr Packman is there, there is no evidence of that? The only justification would be for that level of opiate analgesia to be for the relief of very severe pain.
A It would be indicated for the relief of pain, yes.

Q You would not put it any higher than that, given the amounts which had been given?
A Again, it is being able to justify the dose that is given, and what there is not here is the availability to Mr Packman to use a small dose of diamorphine when he needs it in order to gauge his likely requirements; the response to that sort of dose and to guide whether a regular dose needs to be subsequently altered. There was obviously a discussion of what sounded like lower chest pain or upper abdominal pain at the time of his acute deterioration; there was comment about left-sided abdominal pain, again it revolves back to say, "Well what is the cause of his pain?" and if you can understand the cause of the pain better it may allow you to guide the use of the right drug more clearly. So left-sided abdominal pain: was this a constant pain? Is it a colicky pain because of a spasm of the gut? This is often severe but short-lived. We often use hyoscine butyl bromide, an antispasmodic for bowel colic. We do use opioids for that as well, but, again, they may not be as helpful as the antispasmodics so, again, it comes back round to ensuring that a clear assessment of the pain and its likely cause has been made. Morphine and diamorphine is not the treatment for all types of pain, or it is not the best type of treatment for all types of pain. Using diamorphine does not relinquish a doctor from the duty of assessing the pain carefully and coming up with the most appropriate treatment.

Q What you have said in your report at page 46 is that the ongoing use of regular morphine and subsequent use of diamorphine and Midazolam were inappropriate.
A In my opinion, even if somebody has had a heart attack or a gastrointestinal bleed it is not usual to give them regular morphine therapy thereafter. It would be perfectly reasonable and acceptable to allow them access to those drugs if they did have pain, but that is very different from giving them a regular dose because if it is an acute event that settles, say if it is a myocardial infarc, the pain of a myocardial infarc tends to settle and so there often is not a need for ongoing pain relief. Similarly, pain from an intestinal bleed, we are back to saying, "What has caused it?" We do not know what has caused it but, again, it may have been an acute thing that would naturally settle, so again, if he was written up for things on the PRN side and it turned out over the subsequent days he was requiring several doses a day and in response to that the syringe driver went up then you had got a documented reason for why that was necessary.

Q Those are the reasons which inform your opinion that the use of diamorphine and Midazolam in these circumstances were inappropriate?

A Again, back to the crucial decision about how best to manage this gentleman's situation, and my opinion is if it was not that his condition had been adequately considered, i.e. he has had a gastrointestinal bleed and the decision how best to manage that had not been reached with a senior clinician then it is hard to justify anything that happened subsequent to that.

Q You are aware of the fact that at one stage the clinical assistant said, and this is something you commented upon: "Anticipate that Mr Packman would have continued to experience pain clearly in view of the significant sacral sores it was highly likely that he would have been experiencing significant discomfort", what do you say about that as a justification for the use of the diamorphine and Midazolam which was used in these circumstances?
A Again, all I can say having read through the notes is that pain due to the pressure sores had not been particularly flagged up as an issue and although many of the instances record a comfortable night, not complaining of chest pain, poorly but comfortable, condition remains poorly and variable, drinking well, dressings remain intact. I think there may have been "some discomfort", are the words that come to mind.

Q So far as the sacral sores are concerned, if you look at page 54, which is one of the first records I took you to, which his analysis and his being clerked in on admission to Gosport War Memorial Hospital ---
A Yes, it records no pain.

Q 23 August 1999, it records ...
A No pain. And I think he had been receiving paracetamol at the other hospital for that as well, but it may also have been for his temperature.

Q He was reviewed by Dr Reid on 1 September 1999. If one then goes to page 171, the chart is difficult to read but it appears as though the diamorphine was commenced in the course of that afternoon.
A I think when I looked at this before and I probably used the DVD or CD ---

Q It is clearer than this.
A 30 August. 2.45.

Q It is recorded, I think, on 31 August, that he had a peaceful night (page 63), yes?
A Yes.

THE CORONER: I wonder if we could take the rating up one, it is becoming very repetitive.

MR LEIPER: I do apologise.

THE CORONER: I do not mean to stop you but we just need to get on.

MR LEIPER: Certainly, sir. (To the witness) Again, reference to a peaceful night on 2 September and then he died on 3 September, yes?
A Yes.

Q In light of what the Coroner has said, it is your view that it was the inappropriate management of Mr Packman's gastrointestinal haemorrhage, together with his exposure to

unjustified and inappropriate doses of diamorphine and Midazolam that contributed more than minimally, or negligibly or attributably to this death: is that a correct interpretation of your opinion?
A Yes.

MR LEIPER: Thank you.

MR JENKINS: May I come back on one or two points?

THE CORONER: Yes.

Further cross-examination by MR JENKINS

MR JENKINS: You disagree entirely with Professor Black on that last point, I will remind you what he said, he said the diamorphine doses used were required to control the symptoms and did not contribute in any significant fashion to death; so far as the decision not to transfer Mr Packman over, Professor Black said it was within the boundaries of a reasonable clinical decision to allow symptomatic care only at that stage.

THE CORONER: I do not know whether he did disagree, did you? What he said was the decision was not documented.
A Yes.

THE CORONER: I think that is the point he made.
A Yes.

MR JENKINS: (To the witness) On 26 August, the day of his significant change, we know Dr Barton was called in to see Mr Packman; she had not seen him before, and she does say that he was not well enough to transfer to an acute unit. The jury have heard her evidence, but it is clear from that note alone that the issue of whether or not to transfer is in her mind.
A That is her view that is recorded there, yes.

Q Of course. You were asked about an entry in the notes saying "Not for resuscitation". I think that was the view of Dr Ravi on that self-same day, not for resuscitation. We have that at page 62 of the records, included in a nursing note. This was before Mr Packman had his bleed or heart attack, whatever it was, on that day.
A Yes.

Q We have got it recorded on page 62, "Not for resuscitation" and then following on in the note, "Unwell at lunchtime ..(inaudible).. seen by Dr Barton this afternoon" and then there is a further deterioration later in the day, according to the nursing note. There is obviously no doctor there. In relation to a discussion as to what should happen, we know that Mrs Packman was informed and the note says, "Will visit this evening" and then at 7 o'clock that evening the entry shows, "Dr Barton here. Wife seen by Dr Barton, explained Mr Packman's condition and medication used." You would expect during that discussion that questions as to possible transfer to an acute unit, what the future may hold for Mr Packman, that those issues would be discussed?
A They may have been, but they may have been based on the fact he may have had a myocardial infarction rather than a gastrointestinal bleed.

Q That may be right but it would also involve the general state of his health and what the future may hold for him, that he was in very poor shape.
A I think I would still have expected that any discussion – I mean, you have said yourself, this is the first time Dr Barton saw the patient – I do not know if that is correct or not.

Q It is.
B A But if you are not familiar with a particular patient that would be another reason to seek senior clinical input I would have thought.

Q That may be right. I am just dealing with the discussion when Dr Barton had the first chance to speak to the wife.
A Yes.

C MR JENKINS: Thank you.

THE CORONER: Vicki, what were you going to say?

VICKI PACKMAN: Just to come back to what Mr Jenkins said, there was no discussion about medication or transfer with my mother. She was just told that my father had died.

D THE CORONER: Okay.

VICKI PACKMAN: Thank you.

THE CORONER: You will be aware that Dr Barton was of the view that that did take place.

VICKI PACKMAN: Yes, and it did not.

E

THE CORONER: Ladies and gentlemen, anything on that?

FEMALE SPEAKER: Do you normally in your ..(inaudible).. consider the weight of a patient when you are doing the calculations for doses of medication and we have heard that Mr Packman was obese so would you have taken that into consideration or would you again start very low?
F A The general tenet is that you would start with a small dose and work up but within what would be considered a small dose, again there is a range, and that can vary, let us say diamorphine from 2.5 to 10mgs depending on the size of the patient, so whereas your 90 year old frail patient you would be using 2.5, for a heavier younger man you would be using 10mg.

THE CORONER: Right. To finish the afternoon can we go to Mrs Gregory, please? We will
G Mr Wilson tomorrow and take Dr Barton ..(inaudible).. tomorrow. Will we get through Dr Wilcock in the morning?

MR LEIPER: In the light of your comments, sir, I will endeavour to make sure we do.

THE CORONER: Thank you very much. Right, Gregory, please.
H A Mrs Gregory was a 91 year old woman who was confused or prone to confusion with a significant medical history of asthma and heart failure. All medication for her heart failure

and asthma was discontinued of her stay at Haslar and Gosport War Memorial Hospital. On transfer to Dryad Ward she was prescribed oral morphine and diamorphine PRN without clear indication. During her stay on Dryad Ward she experienced a possible transient ischaemic attack, which is a mini stroke, and was put on aspirin. She was also put on Fluoxetine an antidepressant but her nights became more disturbed. She had a low potassium but this was not corrected. She was given increasing sedation; became less well, with a chest infection and experienced nausea and episodes of breathlessness. Despite her history of asthma and heart failure there was no recorded comprehensive medical assessment to consider the possible cause of her breathlessness. It was however considered she may have had a further stroke and morphine was prescribed regularly without a clear indication documented in the notes. On 19 November she became short of breath and stat dose of Furosemide, which is a water treatment given in heart failure, was given following a telephone conversation and as far as I can tell without a documented medical assessment that day or the following day. Subsequently a syringe driver was commenced with diamorphine and cyclizine. She died two days later with a cause of death given as bronchopneumonia.

THE CORONER: The reason for the infusion is not documented. What would it have been, what was it likely to have been, in your estimation?
A I will refer to my notes if I may. (Pause) I think it comes back again to actually saying what is the symptom that needs treating and, again, my approach would always be correct the correctable, non drug/drug, so was there a more specific treatment that could be offered to relieve breathlessness, for instance, so an element of heart failure must have been considered a possibility, although you cannot diagnose it over the phone, in order for the water treatment, the diuretic Furosemide to be given as an intramuscular injection but in the absence of a documented medical assessment it is really hard to know why that opioid was being given.

THE CORONER: Mr Jenkins?

Cross-examined by MR JENKINS

Q Can I just remind us of Professor Black's view about this patient and invite you to make any comments, Dr Wilcock that you have. Professor Black, at paragraph 6.9 on page 15 of his report, said that by 18 November she had very rapidly deteriorated. Dr Barton makes a record in the notes but because of her deterioration in general condition, oral opiates should be started in a small dose. He said:

> "Based on the nursing assessment of her distress at breathlessness, this was an appropriate response to someone who has an extremely poor prognosis, multiple chronic illnesses and is making no significant progress after three months in hospital."

I think three months is a slight exaggeration but that is what he says:

> "An appropriate response to start Mrs Gregory on a small dose of oral opiates by that stage".

Do you agree or disagree?
A Again, opioids are used for the relief of breathlessness, so I am very happy that people would use opioids to relieve distress in breathlessness. I think that is acceptable and wide practice. The doubt that is raised in my mind, because of the lack of documentation is again

whether the breathlessness was caused by something that could have been treated. The relevance here is that she was someone with medical problems like asthma and all that medication had been discontinued, the effects of which may take several days or weeks to become apparent. The second thing is that her only heart failure treatment is discontinued and again that may take days or weeks to become apparent, and obviously there may be other causes of breathlessness, like a chest infection, so, again, it is not so much that the opioids were used to relieve the sensation of breathlessness but it is going back to that first step, what is causing the breathlessness? Generally, if there is a new symptom or if there is a symptom that is worsening, causing significant distress to a patient I would hope that they would receive a medical assessment to come to a likely diagnosis of the cause of that symptom.

Q So if the jury want to make a note about your response, can you put that in a couple of words?
A In the absence of a thorough medical assessment it is unclear if the use of opioids is justified.

Q So Professor Black says it is an appropriate response: you say you cannot say?
A No, I did not say that at all.

Q Pardon?
A It is not what I said at all. What I am saying is she is deteriorating and she is developing breathlessness which is distressing her and opioids may be an appropriate symptomatic relief for breathlessness, but what is causing her breathlessness and at that time, when she was deteriorating, it may have been too late to do anything, but what about days preceding that, and because there is a lack of a thorough medical assessment ongoing, if you like, despite opportunities to have a medical assessment to look at what is causing the problems in these patients, that is why it is hard for me to say whether you can justify it because it could be there was an opportunity here to treat a chest infection, and obviously if you do not treat it people will deteriorate, so by not treating a possible chest infection she deteriorates.

Q He goes on:

> "She receives 5mg six-hourly of oramorphine on 18 and 19 December, which I believe to be an appropriate dosage and therapeutic regime. No improvement is made and she starts on diamorphine pump 20mgs on 20 November".

He said:

> "It would appear to start this was a nursing one. However, I believe this to have been a reasonable decision for a patient who is dying."

What do you say about starting the patient on a diamorphine pump?
A Again, if somebody is distressed with breathlessness and it is considered that they are dying, the use of opioids is acceptable but it is coming back from that point: has she got an underlying problem that was treatable but was not assessed or appropriately managed, and that is the bit I cannot satisfy myself with a great degree of certainty.

Q He then goes on to discuss diamorphine and what it can be used for, it is commonly used for pain and cardiac disease, and widely used for distress and agitation but may be

associated with a terminal illness. He goes on to discuss the dosages and says that the increase to 20mg over 24 hours after two days of 20mg or oramorphine would be within the range of acceptable clinical practice: do you agree with that or not?
A Again it is repetitive but it comes back to saying, what is the cause of the breathlessness and if the cause of the breathlessness was considered to be an underlying medical condition or terminal condition for which all usual therapies were either exhausted or not considered appropriate, then, yes, but what I am not certain about having read the notes is that potentially treatable causes of her breathlessness existed. They may not have, and I am quite happy to say that, but without there being a medical assessment documented it leaves you with that question.

Q He goes on:

"Seen on the 22nd, she is now very ill, with a rapid pulse, a rapid respiratory rate and a clear sounding chest. This suggests to me that the agonal event (the event that causes the death) may well have been a pulmonary embolus ..."

That is a blood clot in the lungs?
A Yes.

Q "However, this would not be surprising after a long period of poor mobilisation following a fractured neck of femur."

Do you agree with this proposition as to the agonal event, or the cause of death?
A The answer is we will not know, but in terms of was it a possibility the answer is yes.

THE CORONER: Which would you go with, the bronchopneumonia or the PE? You are going to ring me and say, "Mr Bradley, we have got this death, it looks like a PE to me" and am I going to say, "Yes, you are probably right" or am I going to say, "No, it is bronchopneumonia"?
A I think by its very nature it is very difficult to diagnose a pulmonary embolism clinically. It is very difficult.

Q So you are not going to ring me, are you?
A Bronchopneumonia, I can see why Professor Black said what he said about pulmonary embolism and it is perfectly possible. I do not have a problem with that being a possibility but in terms of being able to say with any certainty which was it, that is the difficult thing. The trouble about the clear chest is you do not know to what degree the chest has been examined; you do not know the extent to which the patient was able to cooperate with the examination, and the signs in the chest for the bronchopneumonia can be very misleading. I would accept that a clear chest makes severe asthma or severe heart failure less likely but it does not make a pneumonia less likely.

MR JENKINS: Thank you.

THE CORONER: Ms Ballard.

Cross-examined by MS BALLARD

Q Just to clarify, the conclusions that you reached at the end of your report, and I am reading one dated 22 December 2005, is, putting any other issues aside, that Mrs Gregory's decline was noted over a number of weeks "and this would be in keeping with a natural decline into a terminal phase".

A Yes.

Q You further go on to say:

"Whatever the reason was for the use of diamorphine, the physical findings on the day of her death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression".

A Yes.

MS BALLARD: Thank you, sir.

THE CORONER: Mr Leiper?

MR LEIPER: I have no questions.

THE CORONER: Ladies and gentlemen, anything? (Nothing) Thank you very much indeed, we will take Wilson and Devine tomorrow and we will start at 10.00.

There is a rumour that this building ceases to function at 1 o'clock on Thursday so would you bear that in mind for timings.

(The hearing adjourned until 10.00 on 7 April 2009)