GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 16 June 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY SEVEN)

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

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

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

INDEX

	Page No.
MARGARET ROSE COUCHMAN, Sworn	
Examined by MR KARK	1
Cross-examined by MR LANGDALE	35
Re-examined by MR KARK	55
Questioned by THE PANEL	58
Further cross-examined by MR LANGDALE	76
Further re-examined by MR KARK	79

THE CHAIRMAN: Good morning everybody welcome back. Mr Kark?

MR KARK: I have provided to the Panel and to my learned friends a revised witness order. We are now on Day 7 and it was hoped to have called Dr Ewenda Peters first because she deals, albeit briefly, with the patient, Robert Wilson, who we were dealing with yesterday. I gather Dr Peters has not yet arrived.

B

THE CHAIRMAN: Is anybody in contact with her.

MR KARK: We have left a message for her on her mobile, but she has not responded. The other witness we have for you today is Margaret Couchman. She is here, so I am in the hands of the Panel as to whether you want to give, say, 15 minutes to see if Dr Peters arrives and we can then deal with the end of the evidence in relation to Mr Wilson or whether you are prepared to embark on a fresh witness.

C

THE CHAIRMAN: I have a suggestion. Given that Nurse Couchman is apparently to be dealing in particular with Patients E and B, what the Panel could do at this time is re-read your opening in respect of those patients. If by the time we have finished the Doctor, Ewenda Peters is still not here, we would go straight on with Nurse Couchman.

D

MR KARK: Can I also mention that we thought we would have something of a legal argument in relation to the statement of Carl Jewel. I am glad to say that we have resolved our differences. There were not many differences and we are going to be able to read that to you by agreement. We will have a relatively short day today, depending I suppose on how much my learned friends have for the two witnesses.

E

THE CHAIRMAN: That makes it all the easier to give the extra time now. We will take 15 minutes to re-read your opening in respect of Patients E and B and assess the situation at the end of that time.

(The Panel adjourned for a short time)

MARGARET ROSE COUCHMAN, sworn

F

(Following introductions by the Chairman)

Examined by MR KARK

Q Is it Margaret Rose Couchman?
A Yes.

G

Q I think you are a nurse. Can you tell us a little about your background. How long have you been a nurse?
A I trained in the 70s at Portsmouth School of Nursing and I worked at the Royal Portsmouth until it was demolished. We moved to Queen Alexander Hospital and I worked for a length of time. I left the hospital at one point and worked for the Hampshire Autistic Society in Alverstoke for two years and then in 1983 I took a job at the Gosport War Memorial on the Children's Ward.

H

Q I will ask you about the Gosport War Memorial Hospital in a moment. Have you come along today with a nurse representative?
A I have, our RCN representative.

Q Is that Miss Betty Woodlands who is also a nurse at the Gosport War Memorial Hospital?
A Yes.

B

Q Is that the lady sitting at the back with Dr Barton's husband?
A Yes, it is.

Q The Gosport War Memorial Hospital has a number of wards and it has changed through the years. We have heard about something called the Redcliff Annex and, at the time of the events that we are going to be dealing with, I think the Redcliff Annex had closed. Did you ever work at the Redcliff Annex?
A No.

C

Q You told us that when you started you worked on the Children's Ward at Gosport War Memorial Hospital?
A Yes, I did.

D

Q How many wards did the hospital have?
A When I started there were three wards. There was the Male Ward, the Female Ward and the Children's Ward – oh, and a theatre.

Q In our bundle 1, behind tab 11, we have the most enormous plan of the hospital and I am going to suggest that you put that to one side and I will hand out one which is more manageable. I tried to open the plan that you have and it will subsume you all. Could I hand out a smaller version of small same thing. I am going to ask Nurse Couchman to give us some assistance about where the various wards were.

E

THE CHAIRMAN: Mr Kark, do you wish us to discard---

MR KARK: I suggest you get rid of the one behind tab 11 and replace it with the one I am handing out now, if the defence are content with that. At the moment you might want to keep this plan out, it is easier to keep it where it is. I am not going to give it an exhibit number, it can just go into our file. You will get one of these in a moment. I am holding it so the Dryad and Daedalus are on the right-hand side of the page, which is upside down. I think someone has written the words the wrong way to which the plan is meant to work. Dryad and Daedalus are on the right-hand side. This, I think, shows us the whole of the ground floor plan of the hospital. Since you are the first nurse witness that we are calling, I am going to ask you to try and help us. I am going to give you a moment to see if you can understand the plan. The part which is outlined and, I expect, coloured in on the original, is Dryad Ward, or meant to be Dryad Ward. Does that make sense to you or not?
A What date is this?

F

G

Q It is 2000.
A I was thinking of the old hospital previous to this.

H

Q No. Is this the hospital as it was in 1996, 1997 and 1998?

A It changed, did it not?

Q It did change, but when did it change. Can you help us?
A I do not think I can help you.

Q You cannot ask Dr Barton (Witness turning towards Dr Barton). Can you help us as to when it changed of your own knowledge?
B
A No, ten years perhaps..

Q Did the position of Dryad and Daedalus Ward change. Did they continue to exist after the change?
A Yes, the Children's Ward disappeared.

Q Can you see where Daedalus Ward is marked on the plan?
C
A Yes, I can.

Q Does that seem right to you at the time that we are going to be discussing, which is 1996 through to 1999?
A I cannot really make a lot of sense of it.

MR LANGDALE: If it assists, I do not mind if my learned friend leads and puts what his
D
case is because I am trying to manage with the larger one which helps in the sense it has colour coding. I do not know if my learned friend wants to put to the witness what the location is or not.

MR KARK: I cannot at the moment, no, but thank you for the invitation.
A I can tell you the general layout.

E
Q That would be excellent. Would you do that for us?
A If you came in through the main doors, the doors where A&E were, you walked up a long corridor and Dryad Ward was off to the left of the corridor. At the top of the corridor you actually turned right and then sharp left again into Daedalus Ward. On that floor also was physio and a Mental Health Day Ward to the left.

Q That is not Mulberry?
F
A Mulberry was upstairs and another ward.

Q How many wards did you have on the ground floor. Can you remember?
A Two on the ground floor.

Q Was that Daedalus and Dryad?
A Yes.

G

Q Were they inter-linked?
A No.

Q At the time we are discussing, was there any Accident & Emergency there?
A Yes.

H
Q Where was that?

A That was at the entrance, the front entrance.

Q You told us that in 1983 you, I think, started working on the Children's Ward?
A Yes, I did.

Q Did there come a time when you found yourself working on Daedalus Ward?
A Yes, when the whole hospital was changed and we no longer had a theatre and Children's Ward, then I worked on Daedalus Ward.

B

Q So there came a time, did there, when there were no operations being conducted?
A That is right, yes.

Q Did that mean the closure of the Accident & Emergency as well?
A No.

C

Q The Accident & Emergency kept going throughout, did it?
A Yes.

Q What was Daedalus Ward used for?
A Daedalus Ward, I think at the time we are talking about, was partly stroke and partly long stay.

D

Q How many beds did it have?
A It had 24 beds.

Q What about Dryad Ward?
A I do not think it had so many. I think perhaps it was 20, possibly 22.

E

Q What was that used for?
A I think it was mostly, then mostly long stay patients.

Q Did you ever work on Dryad Ward?
A No.

F

Q Were you a permanent member of staff?
A Yes, I was.

Q What was your seniority as a nurse?
A E-grade.

Q Can you help us what the grades are?
A Managers G-grade. The manager of the ward is G-grade, then there is a senior staff nurse who would be F-grade and then I think we have two E-grades.

G

Q You were one of those?
A Yes.

Q Does that denote a certain level of seniority?
A Yes.

H

Q Meaning you had been doing...
A A small amount.

Q ... the job for a while and you were experienced?
A Yes.

Q You know and knew Dr Barton?
B A Yes, I worked with Dr Barton.

Q For how many years did you work with Dr Barton?
A A long time, ten, maybe more, years.

Q I want to deal with her role as clinical assistant as you saw it. We know that there were consultants who did rounds on the two wards---
C A Every week.

Q Who did rounds on the two wards, Daedalus and Dryad?
A Yes.

Q You said "every week", I am not sure what that refers to?
A I think it was one day a week that we had a round, a ward round.

D

Q You cannot turn to Dr Barton, I am afraid, for assistance.
A I know, I did not mean to, I am sorry.

Q You think once a week a consultant would be doing a ward round on each ward?
A Yes.

E Q Or on one of the wards?
A Yes.

Q Which is it?
A I think it is once a week on each ward.

Q Do you remember who the consultants were?
F A Yes, the consultant was Dr Lord.

Q Anyone else you can remember?
A I cannot. We did have a male and I cannot remember his name.

Q Does Dr Reid mean anything to you?
A Yes, I remember Dr Reid.

G

Q What about Dr Tandy?
A Yes, I did not see them very often.

Q So it was mainly Dr Lord?
A Yes.

H Q Did you ever go on one of the ward rounds with one of the consultants?

A Yes.

Q How often would Dr Barton come into the hospital?
A She would come every morning.

Q At about what time?
A About eight to half past.

B

Q How long would she remain at the hospital?
A Every morning she would remain, I would say, about half an hour.

Q Can you remember, did she divide her time equally between the two wards for which she was responsible?
A I should imagine so, but as I was working on Daedalus, I do not know what went on.

C

Q You just saw her on Daedalus?
A Yes.

Q Apart from every morning coming in between eight and 8.30, are you saying she came in at eight and left at 8.30, or you saying she arrived ---
A I am saying roughly. Possibly she was there three quarters of an hour some mornings depending on the work she actually had to do.

D

Q Always arriving at about eight?
A Yes.

Q Did you go round with her when she visited patients?
A It depended. If I was in charge of the ward that morning, then, yes.

E

Q Tell us what role Dr Lord played. You tell us she was a consultant. She visited once a week you think?
A She did, the ward round once a week.

Q That would mean what?
A That would mean that she would see each patient, she would see each patient as to any problems they had, she would look at their notes, she would look at their treatment card and prescribe any further treatment she wanted for the patient. If she had asked for x-rays or blood tests previously she would look at the results you.

F

Q You told us that on Daedalus there were approximately 24 beds?
A Yes.

G

Q Is it quite a busy ward?
A Yes.

Q Would Dr Barton visit some of the patients each morning?
A She would see the patients who had had problems, basically.

Q When you said she would see the patients who had problems, either, presumably, when they came into the ward or if they were getting worse or better?

H

A If they had problems overnight.

Q Who would attend these ward rounds with her? Let us take it from your own experience.
A It would be the consultant, Dr Barton, the nurse in charge, so I did not do the round every week.

B

Q You say "the consultant" but you tell us the consultant comes round once a week, so I want to concentrate on a ward round that Dr Barton is doing on her own?
A The daily?

Q The daily ward round?
A It would be the nurse in charge.

C

Q So it would be Dr Barton and the nurse in charge?
A Yes.

Q Where were the patient notes kept?
A They were kept in the office; in a filing cabinet in the office.

Q How would the notes be made available to Dr Barton?

D

A The nurse in charge would take them out for her, or she would go and help herself.

Q Was there a trolley or something like that?
A Yes.

Q Would all the patient notes for all of the patients on the ward come out with the nurse, or just for specific patients?

E

A It would depend. If it were a weekly ward round, all the notes would go round. If it were in the morning, when Dr Barton was seeing the patients with problems, it would be their notes which would be out.

Q But who would be directing Dr Barton to the patients with problems?
A The nurse in charge.

F

Q Who had authority to write out prescriptions?
A Dr Barton and the consultant.

Q Who had the authority to administer the prescriptions as written out by Dr Barton?
A The nurse on the drug round.

Q Tell us about the drug round.

G

A They were certain times of the day: in the morning; lunchtime; in the evening; and a night-time round.

Q That would mean what? Just imagine we have never been to a hospital before and there are no nurses or medical people on the Panel. Just imagine that for a moment. It is not quite right, but imagine that for a moment. We want to know what actually happened. What happens on a drug round?

H

A The nurse in charge or one of the senior nurses will go round with the drug trolley to each patient, would check the treatment card, check the patients – patients all have a wrist band with their name on – check the treatment card and administer the drug for that time.

Q Where would the treatment card be?
A Probably at the end of the bed.

B

Q So each patient would have a treatment card at the end of the bed, which would be checked by the nurse on the drug round.
A Yes.

Q Were you able to do drug rounds?
A I did.

C

Q So you were able to administer drugs.
A Yes.

Q Would that include controlled drugs?
A Controlled drugs requires two trained nurse. They are in a locked cupboard in a locked cupboard, and we have a controlled drug register.

D

Q Tell us a bit about the administration of controlled drugs, please. You would be able to administer controlled drugs, with another nurse?
A With another registered nurse.

Q Before you issued controlled drugs to a patient, what sort of authority would you need to have?
A I do not understand.

E

Q You would need a prescription presumably?
A Yes, of course, written by a doctor. It would have to be the right date and the right time, et cetera.

Q As I am sure you know, we have heard quite a lot already in this case about variable doses. You know about variable doses, do you not?

F

A I have heard about it, yes.

Q If a variable dose has been written out, just tell us how you would decide what to give.
A I would give the lowest amount.

Q What does that mean?

G

A Supposing it said 5 to 10 mg, I would probably give the patient 5 mg, if that were suitable.

Q And if it says 80 to 200 mg, you would give 80?
A Say that again.

Q If it says 80 to 200 mg ---

H

A I would give 80, yes.

Q Are you allowed to give less than the minimum dose on a variable dosage?
A It is not normal, no.

Q Would you ever have done that?
A Probably not, no.

B

Q What about increasing within a variable dose? Say you have started off at the minimum dose, how and why would you make a decision to increase that dose, or would you need any special authority for that to happen?
A I would probably talk to the manager about it.

Q The manager at the time – was that Philip Beed?
A Yes. It is not something that I can recall doing.

C

Q You cannot remember increasing a dose?
A No.

Q Nurse Hamblin we are going to be hearing a bit about. What was her role?
A She was a sister, I believe.

D

Q You believe?
A She was a sister.

Q Does that put her a grade, in the pecking order, above you?
A Yes.

Q Would that mean she was an F or a G?

E

A G.

Q So she actually is a manager grade?
A Yes.

Q If you were thinking about increasing drugs for a patient, would Nurse Hamblin have the authority to allow an increase in the dose – provided it is within the variable range?

F

A Probably.

Q Can you help us? "Probably" does not help us a lot. If you cannot remember, you cannot remember.
A I can remember, yes, but I have told you that – that I did not have to increase any drug dose.

G

Q How long were you on ---
A Quite some time.

Q ...Daedalus Ward.
A (*Correcting pronunciation*) It is Daedalus Ward.

Q Daedalus, all right! How long were you on Daedalus Ward?

H

A Over ten years.

Q During that period, can you ever remember increasing a dose?
A No.

Q I think you made a statement to the police about a patient called Elsie Lavender. Do you remember that?
A Yes, I can remember the statement.

B

Q Do you remember the patient at all?
A No.

Q What I am going to do is try to direct your attention to some of the entries that I think you made in the patient notes. One of the difficulties we have had is reading people's writing, and even more difficulty reading signatures; so if you see an entry that you have made that I do not point out to you, would you please just tell us? Do not sit quiet and let it pass by. All right? I am going to ask you to take up the notes. To your left you will see a row of files and I am going to ask you to take up file B, please.

C

Just to bring this patient back to mind for everybody, she had a fall on 5 February 1996. You will find a chronology right at the beginning of that file. I understand that you cannot personally remember her, but it may just help us all if we very briefly recap. She had a fall and she was admitted to the Royal Hospital Haslar. How far away was the Royal Hospital Haslar from Gosport War Memorial?
A About ten minutes in a car.

D

Q She was looked after by, among other people, Dr Tandy. Then she was transferred to Daedalus Ward on 22 February, where she was reviewed. In the notes, which you now have, you will find some nursing records towards the back of the bundle. I am going to take you to the beginning of those first of all. If you go to page 1001 first of all, and then I will take you to an entry you made on 1022 – but I want to use you, if you would not mind, to introduce us to these notes. The document you are looking at on page 1001 – do you recognise that? That sort of document?
A Yes.

E

Q I do not think that has got your writing on anywhere, has it?
A I cannot see it, no.

F

Q Is this an admission form, effectively, for this patient?
A Yes.

Q We can see that there is a brief summary of the patient's condition. We can see that she is coming from A4 Ward, under the care of her GP, I think. It shows Dr Peters. Is that right? Do you see just above the words "From A4 Ward"?
A Yes.

G

Q Then we can see on the right-hand side of the page, "To Daedalus Ward, GWM" and then the next of kin is set out. We can see "Nursing requirements: needs minimal assistance with feeding; needs full assistance with hygiene needs; ulcers to both legs dressed every other day with dry…" – is it Kalbstat?
A Yes.

H

Q And then, something "padding". What is the word before "padding"? Can you read it?
A I cannot quite read it.

Q Is it "conforming bandages"?
A Yes.

B

Q "Toe to knee; all pressure areas intact although buttocks are very red but not broken; blood sugars are quite erratic so" – is it 7 BMs?
A Yes, have been recorded.

Q BMs?
A Yes.

C

Q What are BMs? Blood...?
A It is a way of measuring the sugar in the blood.

Q And "she is unable to inject herself". Then we can see that the drugs that she is on at that time are set out below.
A Yes.

D

Q Over the page, page 1002, that is signed by – do you recognise that signature?
A No. It is "RGN", but ---

Q All right. Then we can see that there is a nursing care plan, but there seem to be a number of different sheets as we leaf through the following pages. The first one starts on 29 February, but then we go to 24 February and 22 February after that. We can get the original records in here if we want, but how did these nursing care plan documents work?
A They are actually designed so that a strange nurse can come on to the ward and read the nursing care plans, and she is supposed to be able to see exactly how to treat the patient and what has been done for the patient.

E

Q These seem to be individual sheets rather than a running record.
A Yes.

F

Q Is that because each nurse ---
A They were at the time – individual sheets.

Q How did it work? Each nurse would fill in their own?
A Yes. At the end of each shift she is supposed to fill in the care plan and sign it.

G

Q If we go, for instance, to page 1007 – I just want to try and understand these records – do we see on 5 March 1996, is that your signature?
A Yes, it is. That says, "Dressing remains in place"; so I did not change the dressing.

Q As I say, if we go back to 1005, could you shout out where you see an entry by you? I do not need you to deal with everything perhaps, but it is just to get an idea of how these are working. So at 1005 do we see your signature?
A Yes, on 24th of the second I say the catheter is draining.

H

Q And also 1 March?
A On 1 March, "Catheter draining satisfactorily".

Q And 5 March?
A And 5 March, yes.

B

Q Why are you making notes on this document? This all seems to be to do with a catheter.
A Yes.

Q So is this a document that is particular to show how the catheter is working?
A Yes.

C

Q Then if we go back to page 1007, is that a document particularly dealing with the ulcer on the legs?
A On the right leg, or on the left leg, yes.

Q I think both of them, in fact; and over the page is the same. Then if we go to page 1009, we can see this is all about bathing the patient and washing the patient.
A Yes.

D

Q We can see your signature again on that.
A Yes.

Q You, I expect, have no recollection of doing this at all?
A No.

E

Q For that reason I am not going to ask you about each entry, but it is just so that you can help the Panel and give us an idea of how these worked. Page 1010 is still a nursing care plan.
A Yes.

Q But this now has a named nurse shown at the top of that.
A Yes, Yvonne Astridge.

F

Q That is 22 February.
A Yes.

Q Can we go to page 1013? This seems to be to do with analgesia.
A Yes.

G

Q Can you just talk us through this, please?
A On the 1st of the third I say, "Complaining of pain in shoulder on movement"; then I see on the 4th of the third she had physio.

Q Can we start at the top? 27 February 1996, "Analgesia administered". This is not your entry, is it?
A No. "Fairly effective; able to help when dressing this morning."

H

Q Whose signature is that?
A Chris Carraher. She was also an E grade.

Q I am sorry? Chris...?
A Carraher – C-a-r-r-a-h-e-r.

B

Q Then we can see under that, "Right arm less painful, able to lift it above head height, and left arm..." – is it "less improved"?
A Yes.

Q Then on 29 February, "Able to move arms for washing and dressing"; and then your entry on 1 March, "Complaining of pain in shoulders on movement". Would you try and grade the pain at all? We can see you have not here. Did you use a pain scale at the hospital?
A We did have a pain scale, yes, for analgesia.

C

Q But you have not recorded the level of the pain here.
A No.

Q Underneath that we can see, the following day, "Slight pain in shoulders when moved".
A Yes.

D

Q That is somebody else. Then we can see on 4 March, as you mentioned, she was having analgesia.
A Yes, and physio.

Q Then: "Elsie needs---" ?
A "--- reminding."

E

Q Means what?
A "Reminding".

Q I appreciate it is not your note. "... needs reminding." Does that have any particular meaning to you?
A No. Unless she had been asked to do...

F

Q It follows from the note about physio – exercises, so I do not want to speculate too much, but it might be a note to say, "Remind Elsie to do her exercises".
A Umm.

Q Then we can see "analgesia increased". Then we have your note on 5 March: "Pain uncontrolled, patient distressed, syringe driver commenced."

G

A Yes. I think... I do not if we have a plan for the night, but I think I remember from the interview that I was told by the night staff how distressed she was. Here is a one here.

Q Page?
A Not recorded, perhaps.

Q Sorry, page what is the night plan?

H

A 1017.

Q Just have a look at that.
A But it does not seem to be recorded anyway on here.

Q If we go back to page 1015. How do you tell when it is a night plan? Sorry to ask you.
A Actually, I was looking for that. It did actually say, "Requires assistance to settle for night." I think that is probably the night plan. That was 1016.

B

Q At 1015 we can see that the patient had been given an enema on 2 March and then a further one on 3 March, and the unfortunate patient was leaking faecal fluid.
A Yes.

Q There is no note there of pain.
A No.

C

Q So your note on 1013, "Pain uncontrolled, patient distressed" would be based on what you were told by somebody else?
A Yes.

Q Would you have spoken to the patient?
A I am not sure the patient could speak. I cannot really remember her.

D

Q If you had spoken to the patient, would you have made a note about it?
A Yes.

Q If the patient had complained to you directly about pain, is that something you would have noted or not?
A Probably, yes. Yes.

E

Q And so it was your decision, was it, on 5 March to begin a syringe driver?
A Yes.

Q Just give me a moment.
A It would not have been mine alone because two nurses would start the driver anyway.

F

Q If we go ---
A It would not be mine alone.

Q No. If we go back to 975 – and this is not your note but it may assist.
A Which one?

G

Q There are loads of numbers, I am afraid, at the bottom of these pages but would you look for the number with two lines either side of it. In this case I think it is circled as well – 975.
A Is it a written number, or printed?

Q It is a written number, handwritten. Shall I hold it up to you? Can you see from there or not?
A No. (The witness was shown the correct page)

H

Q We were looked at 5 March and your note "Pain uncontrolled, patient distressed, syringe driver commenced 09:30 hours" and here, on 5 March, we can see a note – is that Dr Barton? Nurse Couchman, do you know Dr Barton's writing or not?
A No, I do not remember it.

MR LANGDALE: It is.

B

MR KARK: Thank you. But you do not remember it?
A No.

Q "Has deteriorated over last few days." I am afraid I cannot read the next line.
A "Not eating or ---"

C

Q "Not eating"?
A "--- or drinking. In some ---"

Q "In some pain."
A Yes.

Q "Therefore", I think it is "start subcutaneous analgesia."

D

A "Let family know."

Q Yes. Does that help you as to how you came to make your note at page 1013?
A Yes.

Q Tell us. How did it work?
A Well, Dr Barton would have come in and I would have told her how distressed the patient was and how much in pain she was. She would have seen her.

E

Q So you would have been revealing to Dr Barton what you were told ---
A What I was told.

Q --- by the night staff who did not make a note. Right. Then she would have done what?

F

A She would have examined the patient and decided what she was going to do.

Q We know that the syringe driver – I can take you to the drug chart if you like. Have a look at page 990 and page 991. In fact, I think perhaps we are going to see your initials. Do you have 991?
A Yes.

G

Q It is very difficult to read, I am afraid, but these are the best copies we can get and I think they are legible.
A Yes, it is my initials.

Q I thought it was. Do we see at the top, "Diamorphine" – a variable dose between 100 and 200 mg?
A Yes.

H

Q Had you administered that dose?
A Yes.

Q At what rate?
A 100.

B

Q 100 mg?
A Over 24 hours.

Q Yes. I know it is obvious, but why would you have started at 100 mg of diamorphine?
A Why?

C

Q Yes.
A Because in my opinion that was enough medication.

Q So who chose the dose? I mean ---
A Not myself alone. Whoever was doing it with me. I think it was Mr Beed, Mr Philip Beed. We decided we would do the 100.

D

Q You decided you would do the 100. And how did you calculate that? How did you decide? I know it is the lowest dose.
A We decided to give the lowest dose.

Q Okay. Did you form any independent judgment about whether it was write to give the patient 100 mg of diamorphine in a syringe driver?
A No.

E

Q We have heard quite a lot about syringe drivers. Can you just tell us a little bit about the process of charging them and what you would actually do?
A Two of us would go to the drug cupboard and take out the dose required and fill in the book, okay?

Q That is the drugs book?
A The drugs book. The old drugs book.

F

Q So that would show that you are withdrawing a controlled drug?
A That is right. And two RGN nurses would sign the book.

Q Right. And if you are going to administer a dose of 100 mg of diamorphine, and in fact in this case I think you also administered a dose of midazolam?
A 40 mg of midazolam/

G

Q And who decided? I know what you are going to say, but who decided 40 mg of midazolam?
A The two of us would have said, "How much midazolam shall we put in" and we would say we would put 40, because it is the lowest dose.

Q Again, would you have questioned the conjunction of those two drugs, putting both in at the same time?

H

A We were used to using those two together.

Q Right. That was the practice?
A When we were talking about the drugs rounds and the rounds the consultant used to do, we did not tell you but every week the pharmacist would come from QA. We had the same pharmacist from QA who would look at these treatment cards every week to see what each patient was taking, whether the drugs were the right drugs, whether the doses were correct. If she felt they were not, then she would leave a note for Dr Barton.

B

Q How could the pharmacist know if the dose was correct. Because a dose –
A That is her job.

Q Yes, but the dose... You told us that you would decide the dose depending on the pain and the patient?
A Yes.

C

Q How does the pharmacist ---
A If the patient cannot tell you exactly how much pain they are in, the safest method is to give them the lowest dose.

Q Right.
A And then assess the patient to see if that is correct.

D

Q I understand. I understand. When you talk about "the lowest dose", you are talking about the lowest dose as prescribed?
A Yes.

Q By Dr Barton?
A Yes.

E

Q Because you could have a much lower dose than 100 mg, presumably?
A Yes.

Q Tell us about how the drugs came. Are they in bottles? Are they in ---?
A They are in little vials.

F

Q Little vials?
A It is powder.

Q And would there be a 100 mg vial?
A I believe so. I have not worked for some years now, as you appreciate.

G

Q If you saw that the prescription was for 100 mg of diamorphine, you would get a 100 mg vial, if there was such a thing?
A Yes.

Q And you would get, are they, 40 mg vials of midazolam. Can you remember?
A I think that was in 10s, I think.

H

Q Again, just imagine we have never seen a syringe drive in our lives. How do you get this drug ---
A It looks like a syringe.

Q So do you use the needle of the syringe to draw up the amount of the drug?
A Yes, yes.

B

Q And is there a mixing process? Do you shake the syringe or does it all go in and get mixed up?
A It is all mixed anyway.

Q How do you connect that to the patient?
A You have a little needle connected to a tiny tube. The needle just goes under the skin of the patient with a---

C

Q You are pointing to your wrist?
A Yes. I am talking about the skin, not necessarily the wrist. It does not have to be the wrist.

Q No. Where would you normally ---?
A If the patient was restless, then it would be quite a good idea to just put the syringe driver, the needle, in here.

D

Q And you are pointing when you say "here" to your shoulder?
A To your shoulder, to the little pad of flesh there.

Q Not the bony part, the fleshy part.
A Up there. The little fleshy part.

E

Q Yes?
A And then that little tube connects to the driver.

Q Again, why would you do that if the patient was restless? Why would you put it in there?
A So that it would remain in place.

F

Q So they could not dislodge it?
A So it would not dislodge.

Q Then do you put of some sort of tape over it?
A Yes, yes.

G

Q Then where does the syringe driver itself lie?
A Probably then it sits in a little case, a little cotton case, under the pillow.

Q Presumably this is an electrical device?
A It has a battery.

Q And so how would you actually start the machine going?

H

A There is a button to press, and a light will come on to show that it is actually working.

Q So on the basis of the prescription that you are given by Dr Barton you withdraw the drugs from the controlled drugs cabinet with your colleague nurse; you draw the drugs up into the syringe; you would insert a small needle very often into the patient's shoulder and that would then be connected by a very small tube to the syringe driver itself?
A The tube can be varying lengths. It might be longer.

B

Q And that would like under the patient's pillow. And that gradually injects the drugs into the patient's system?
A Yes.

Q And it is designed to last – we have heard – a bit longer, in fact, than 24 hours?
A Yes.

C

Q Just in case somebody does not renew it in time.
A Umm.

Q All right. Can we just go back, please, to your original note. I just want to make sure you have not made any other notes that we may be missing. Can we go back to page 1022, please? We just dealt with the note of the 5 March. Then we can see at the bottom of the page: "Son contacted by telephone, situation explained." That is your signature next to that, so you would have called the son?

D

A Yes.

Q And you would have explained what to him?
A I would have explained how poorly his mother was and asked his permission to set up the syringe driver.

E

Q Could we just look at the entry prior to yours on 4 March? Can you read this:

- "Patient complaining of pain and having extra analgesia PRN"

PRN means "as required" does it not?
A Yes.

F

Q "Oromorph sustained release tablets dose increased to 30 mg" – I think that means "BD", twice daily, does it not?
A It does.

Q Yes?
A Yes.

G

Q The nurse there is?
A Chris Carraher.

Q That is Chris Carraher again. Is that a male Chris or a female Chris?
A She is female.

Q That would seem to indicate, would it not, that the patient was on 60 mg of effectively Oromorph which is a form of morphine, is it not? Are you all right?

H

A Yes.

Q Okay. The patient was on 60 mg of oral morphine a day - yes?
A 60 a day, yes.

Q Sorry – 60. Yes, 60 mg a day. And then the next day you commence her, on instruction, I understand, on 100 mg diamorphine and 40 mg of midazolam. Were you ever taught anything about conversion rates?
A Yes, we were.

Q You were?
A Yes.

Q When were you... When did you have that ---
A I cannot remember them now. I have not worked for four years.

Q Tell us what you know about conversion rates?
A I know there is a conversion rate.

Q That is a good start. Can you tell us any more than the fact that there is a conversion rate. Can you tell us what the conversion rate is between oral morphine ---
A I cannot. I am sure Philip will tell you when he comes over.

Q We will look forward to that. Can you say whether, when you start with oral morphine, you should go up and down if you are transferring to a subcutaneous dose?
A That, I do not know.

Q Would you have known at the time?
A I would have known at the time, yes.

Q This change, presumably, did not trouble you. Would you have done something about it if you had been?
A Yes, if I had felt that that was incorrect – do not forget there were two of us doing it, not just me – and if we felt it was incorrect, we would have rung Dr Barton and asked for clarification.

Q Do you remember ever ringing Dr Barton?
A No, I never needed to.

Q In ten years working on this ward, you say you never needed to call Dr Barton?
A No, well, yes, I called her on certain occasions when it was necessary.

Q What would have triggered it, what would have made it necessary?
A What made me call her?

Q Yes?
A I remember calling her because somebody's blood sugar was something like 20 and I wondered what to do about it; that is rather high.

Q Specifically about the sort of doses of diamorphine?

A No, I did not question her on any doses.

Q You did not ever question her on any doses?
A No, I do not think any of us did.

Q Can I ask why not, did it never arise?
A It just did not arise and at the time that was the dose that was given.

B

Q If we turn over the page to 1023, you can see that the patient died the following evening. Can I ask you to look at the top entry. I am sorry to use you as a sounding board. The day after the syringe driver starts and the day that this patient died:

> "Seen by Dr Barton medication other than through syringe driver discontinued as patient unrousable."

C

Two things to ask about that. Patients becoming unrousable as a result of the injections of diamorphine, did that ever give you cause for concern or is that part of the norm; how did it work?
A I think it was just normal.

Q So when you started a syringe driver with diamorphine, you felt it was normal for the patient to become unconscious?
A No, not all patients became unconscious when they had a driver.

D

Q Would it concern you at all if a patient was unrousable, meaning, presumably, if you shook them they would not wake up. Would that have caused you any concern, or not?
A I do not know.

E

Q The second thing I wanted to ask you was that "medication other than through syringe driver discontinued", and again it may be obvious from what you just said, but the other medication, presumably, would be oral medication, would it?
A Yes.

Q Would there be times when a patient was on a drip for fluids and things like that?
A Yes.

F

Q What was the practice once diamorphine started. Were drips continued, discontinued, was there any regularity as to what happened?
A I think if the patient was on an IV drip, then that would continue.

Q Even though a syringe driver was started?
A Yes.

G

MR KARK: I do not think you made any other notes about this patient. I am now going to move on to another patient. Sir, I do not know if you feel that the witness should have a break.

THE CHAIRMAN: She has been on the stand for an hour and 15 minutes. We are going to give you a break now and we will all take a break. It will be about 15 minutes and you will

H

be taken to a room where you can get some refreshment. Please do not discuss the case with anyone in the interim.

MR KARK: Can I repeat it and reinforce it. (To the witness) This is not directed at you particularly at all, but for all nurse witnesses, and I know your representative will know the rules. You must not discuss with any other nurse, nor indeed with the nurse representative, the evidence that you have given.

B

THE CHAIRMAN: Fifteen minutes please.

(The Panel adjourned for a short while)

THE CHAIRMAN: Mr Kark.

C

MR KARK: Nurse Couchman, you have made a note in relation to the various patients that we have here and I am going to ask you about a patient called Gladys Richards. I think you were interviewed by the police in relation to her?
A Yes.

Q I was not going to take you through every other patient that we have, we have 12 patients, unless you have specific recollections of any of them?

D

A I do not.

Q I am going to ask you about Gladys Richards, our Patient E. You may want to take up her file, which you will find if you put away the file on your desk and take up Patient E. Right at the beginning of that you will find a chronology. I mention in passing that we are all in discussion about the chronologies. I have spoken to Mr Jenkins this morning, Mr Fitzgerald has been working on them and we have not forgotten about it. They are quite

E

lengthy documents, so it will take a while to get them together. We are still working on the chronology that we have. To remind ourselves about this patient. For you, Nurse Couchman, to remind yourself as well, she was taken, as we can see on the second page of the chronology – do you have a chronology right at the beginning of that, the document on its side?
A Yes.

F

Q On 29 July she was taken into the Royal Hospital Haslar after a fall at a nursing home for a fractured right neck of femur. You told us that the Gosport War Memorial Hospital had an Accident & Emergency Department. Did it have an Accident & Emergency Department in 1998?
A I think so.

G

Q Did it have a ward to look after patients, or were they transferred if they needed ongoing care?
A Yes.

THE CHAIRMAN: Sorry, Mr Kark, could I ask the witness to turn her microphone on.

MR KARK: This patient was taken to the Royal Hospital Haslar. She underwent an operation on 30 July and then we can see that she was transferred on 11 August to Daedalus

H

Ward. We know that on 13 August she had another accident in the sense that, having had her

hip repaired, she was found on the floor at 1.30 lunch time and it seems she dislocated her hip again. She then headed back to the Royal Hospital Haslar. She was operated on again and then on 17 August she came back to Daedalus Ward. Do you have a recollection of this patient?
A I did not meet her until she came back to the ward. I was on leave when she was first admitted.

B

Q I think for the period from 11 August you were away.
A I was on leave, yes.

Q You cannot comment on any of that?
A No.

Q You were there...

C

A I met her when she came back from the Haslar.

Q ... on 17 August when she came back?
A Yes.

Q Would you turn to page 51, we can see a note, under the Nursing Care Plan – and I am only going to ask you about 17 August onwards – that the patient was readmitted on

D

17 August. On 17 August she was given Oramorph 10mgs in 5mls and Oramorph we have heard a lot about. Is that a liquid morphine?
A Yes.

Q Is it taken on a spoon or a little cup. How would the patient actually take that drug?
A Possibly on a spoon, yes, teaspoon perhaps.

E

Q That would indicate, obviously, if a patient is on oral morphine that they must be able to swallow?
A Yes.

Q Did you find that patients sometimes reacted badly to Oramorph, or did you not have that experience?
A No, I did not find that.

F

Q It was always all right, was it?
A It seemed to be.

Q If we go to the back of the bundle and we go to page 294, I think the last note we are looking at, would that be a note from the Royal Haslar?
A On page 294?

G

Q Yes.
A This looks like Haslar's.

Q Would you have access to the Royal Haslar notes?
A No.

H

Q What would you get at the Gosport War Memorial Hospital?

A We would probably get a letter with the patient.

Q If we turn right back to page 8 – I do not think we have managed to find a better copy of this – is that the sort of letter you are talking about?
A Yes, something like that. I could not read this one.

Q It is dated 17 August and it gives a brief description of what has happened to her. In the second paragraph I think it talks about a knee splint – no, a canvas---
A "Knee immobilising splint to discourage any further dislocation".

MR KARK: Would be your understanding of that be? Sorry, reading on, I think it is suggesting that she should stay for four weeks.

THE CHAIRMAN: You may say "this should stay in situ".

MR KARK: I am grateful, thank you. "This should stay in situ for four weeks".
A It is like a triangular cushion which goes between the tops of her legs to keep her legs straight.

Q "When in bed it is advisable to encourage..." is it "abduction"?
A Yes, that is what I am talking about.

Q "By using pillows or…"?
A "Abduction wedge" I think that might be.

Q "She can however mobilise", and then at the bottom "fully weight bearing". At your hospital you would have got a transfer letter like this, would you?
A Yes.

Q This one, presumably, for this patient?
A Yes.

Q If we turn to page 58 of these notes and then 59, the ones with the two lines either side, we can see there seems to be an entry at the bottom on 18 August?
A Yes.

Q "Complete bed bath given". That is not your note I do not think?
A That is not my writing.

Q Over the page, also 18 August, is that, "Night oral care given frequently"?
A Yes.

Q Let me ask you about your dealings with this patient. She was transferred back from the Haslar on the 17th. Do you remember there being a problem with her transfer?
A Yes, I remember her transfer.

Q Tell us about that.
A I came back from coffee and I could hear this patient screaming as I came back down the ward. She was obviously in a lot of pain and a lot of distress. The two support workers who were on the ward came to tell me that this patient had been transferred. She was

transferred on a sheet and not the normal canvas. The canvas is quite taut and thick and they felt that she was not lying correctly in the bed, which she was not, and they were not happy with her transfer.

Q What would be the effect, as far as you are concerned, of not transferring the patient on a canvas sheet?

A She would not be lying correctly. As they said, she had to have her legs in abduction and she probably was not because she was wobbling around on a sheet. She was in a lot of pain and we did have her x-rayed and she had a large haematoma on this hip where she had had the operation.

B

Q Haematoma being a---

A Being a large collection of blood where the two pieces of bone had been rubbing together.

C

Q Can that cause a patient pain?

A Causing the patient a lot of pain, a lot of distress, yes.

Q Do you remember meeting the patient's daughter at any stage?

A Yes, I do.

Q Was she there on the 17th?

D

A They were both there, both daughters were there. The younger of the two was telling me that she was an ex-nursing officer and, because there was just myself on the ward, she helped me re-position her mother and put her legs in the correct position.

Q When this care assistant ---

A Make her more comfortable.

E

Q When this care assistant came to find you, is that the first you realised the patient was in pain?

A Yes, she was transferred whilst I was off the ward.

Q Do you know how long the patient had been screaming for?

A I do not, but I was only gone for about 20 minutes, so it was during that time she was transferred.

F

Q So you helped the daughter to level the patient out, as it were, so that she was more comfortable?

A Yes, she helped put her in a correct position.

Q Did that help her?

A That did help her.

G

Q Could you go to page 47? I am sorry to dot around this bundle. We can see there is a contact record at page 47.

A Yes.

Q Do you have a recollection of this?

A Yes, I do.

H

Q It is your writing, I think?
A Yes. I did ask the daughter if I could give her mother some Oramorph and she said yes, and I gave her 2.5 mg in 5 ml. They told me that she must be transferred back to Haslar if she dislocated again, and that is why Dr Barton ordered the X-ray and that is how we knew she had a haematoma.

B

Q That Oramorph that you gave, of course you would not have been able to give it – and I am not saying there was anything wrong with it – but you would not have been able to give it unless there had been a prescription from Dr Barton.
A Yes.

Q Or from a doctor who was allowed to prescribe controlled drugs.
A Yes.

C

Q Keep your finger in page 47, please, and also turn up page 63. We are beginning to get a bit more used to reading these charts and we can see that the first entry under "As required prescription" is Oramorph 10 mg in 5 ml. It is a bit difficult to read but I think we can make an educated guess that that is the prescription. Do you accept that?
A Yes, I do.

D

Q Then, to the right of that, we can see in the first four columns that it is given first of all back on 11 August, when you were away on leave, at 2.15 in the afternoon – no, I am wrong, I am sorry – 11.15, I think it is, in the morning, 10 mg. Is that Philip Beed? Whose is that initial? It is a pure assumption on my part because it looks like "PB", but it might not be.
A It is Philip Beed.

Q Then other nurses have made their entries below.
A Yes.

E

Q There is a gap obviously between 14 August and 17 August, when she has been off at the Haslar having her hip fixed. Then on 17 August do we see another entry?
A Yes.

Q Tell us about that, please? Who is that?
A The first one is the one that I gave, isn't it, at 13:00 it says in here? My actual time I have put is 13:05. That is the on I gave.

F

Q Whose initial is that next to it?
A That is Philip Beed. That is because the two of us drew the – as I was saying, two trained nurses do each controlled drug.

Q But only one of you has to ---
A Either of us could sign this, and he actually signed it.

G

Q You would have given that to the patient, presumably on a spoon or in a little cup?
A Yes, but you can see that I did ask the daughter first if I could give it to her mother and she agreed.

Q Absolutely, and the patient was clearly in pain?
A Yes.

H

Q Then we can see that it is given again, I think. It is a bit difficult to read the time. Let us just see if Mr Fitzgerald… (reviews document) No, I do not think he could read the time either.
A I cannot read that. Maybe Philip can.

Q It seems to be given again on 17 August and then, in total, there are four doses given of 2.5 ml for the first three and then, in the evening at 8.30, is 5 ml given? If you look to the right-hand side ---
A Yes.

Q 17 August, 20:30, 5 ml. That is not you, I do not think?
A No, that looks like Philip again.

Q That obviously would have been a dose given hopefully before the patient went to sleep. Was it your practice that you remembered to give a higher dose at night, to ensure the patient rested through the night, or can you not remember?
A I cannot answer for him, if Philip gave that one. I do not remember. I do not recall giving it myself.

Q That is why I asked you about *your* practice. Was it your practice?
A Possibly if you had given those tiny doses and they were not helping, then he decided to give the 5 ml then.

Q Keep that page open but go back to page 47, and just go back to your note – to link all of this up. 13:05, "In pain and distress; agreed with daughter to give her mother Oramorph 2.5 mg in 5 ml; daughter reports surgeon to say he…" ---
A "…her mother must not be left in pain."

Q "…to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray." Then we see in the afternoon, "X-ray at 15:45; film seen by Dr Peters."
A It is to go to radiologist. That is for reading.

Q Then, "For pain control overnight and review by Dr Barton in the morning."
A In the morning, yes.

Q Then the following day, "Reviewed by Dr Barton". Whose writing is this?
A It is Philip's.

Q We can ask him about it, but I think we can see that the treatment was discussed and Philip has noted, "They agreed to use of syringe driver to control pain to allow nursing care to be given". Are you able to interpret that or not?
A Yes, I can read it.

Q Then tell us.
A It is practice on the ward, before giving Oramorph or before giving a syringe driver, to discuss what we were going to do with the relatives and to discuss the treatment.

Q If you were giving, first of all, Oramorph, would you expect the patient to remain rousable or not?
A Yes.

Q I want to ask you about a drug called midazolam, because I think this patient was given midazolam together with her diamorphine. Before we turn to that, I want to ask you about your understanding of midazolam and what it was used for.
B
A This patient had dementia, Alzheimer's. That is one of her diagnoses. So she was quite restless and distressed as well as in pain, and midazolam was given as a sedative.

Q So it was a drug with a sedating effect.
A Yes.

Q If we go to page 63, which is the drug chart, can we concentrate on midazolam first of
C
all? Can you recall what part you played in the administration of the midazolam?
A I can see that I drew it here on the 20th of the eighth, when I renewed the syringe driver.

Q It seems to have been started before you, though. Is that right?
A Yes.

D
Q Again by Philip Beed?
A Yes.

Q Midazolam, would that be being administered by way of syringe driver?
A Yes.

Q If we go two pages on, to page 65, we can see diamorphine was also being given.
E
Yes?
A Yes.

Q If you look – just to help you – two entries up from the bottom, does that appear to be Dr Barton's prescription for a variable dose of between 40 and 200 mg of diamorphine?
A Yes.

F
Q Starting on 18 August?
A Yes.

Q So this is the day after this patient has come back from the Haslar and has been transferred on her sheet?
A Yes.

G
Q Can you help us as to your recollection of the decision to use midazolam as well as diamorphine with this patient?
A To make her more comfortable, I think.

Q The diamorphine was started at what dose?
A Forty. She only actually had 40; over 24 hours she had 40.

H

Q Prior to that, she had been on Oramorph. If we go back to page 63, to try to follow this through, she had been on Oramorph on 17 August and I think she had had – but I will be corrected – about 25 mg, effectively, of morphine; because it is 10 mg in 5 ml, is it not?
A Yes.

Q And she, on that day, is given 7.5 ml in total during the day and then 5 ml at night. Yes?
B
A Yes.

Q The day after that she is started on 40 mg of diamorphine.

MR LANGDALE: The early morning of the 18th.

MR KARK: Yes, I am grateful. (To the witness) Going back to page 63, we can also see
C
she is given two doses of Oramorph ---
A During the night.

Q Is that just after midnight and the second at four o'clock in the morning?
A Yes.

Q So she has had ---
D
A Twenty.

Q 20 mg cumulatively in those two 5 ml. Then the next day, or that day rather, she is started on diamorphine, and the lowest dose prescribed would appear to be 40. Does that seem to be right?
A Yes.

E
Q Can I just ask you this, and I appreciate you did not start this patient on 40 mg and, even if you had, it would not have been your decision. You have spoken about your knowledge about the conversion rate. Did you have any understanding of a thing called the "analgesic ladder"?
A Of course, yes.

Q I did not mean that to sound rude, but we need to know what your state of mind was.
F
What was your understanding of what the analgesic ladder was all about?
A It is all about starting on the lowest analgesia, paracetamol, and rising up the ladder.

Q As it is necessary.
A However, you have to remember that possibly she could not swallow. I cannot remember. We are talking about 13 years ago, aren't we?

G
Q I understand.
A So if she could not swallow the tablets....

Q When it comes to increasing a dose, if the patient remains in pain, you are working through the analgesic ladder; but say you have a patient to the point where you have to use morphine in one form or another – Oramorph, diamorphine, an opiate – what was your understanding at the time of the rate of increase?
H
A We did not increase it very often.

Q Right. I did not ask you that, though. What was your understanding of how it was meant to work? Of the rate of increase? If you felt that a patient was still in pain ---
A We would probably ask for guidance before we did increase it any further.

Q From whom?
A From probably Dr Barton or the consultant, if she was around.

B

Q We can see from the drug chart that on 18 August the patient was started on 40 mg of diamorphine ---
A Over 24 hours.

Q Yes, that is a given. I accept that. And 20 mg of midazolam, in the syringe driver. When we see your signature, as we do on page 63, does that indicate that you were starting a fresh syringe driver?
A Yes. Every 24 hours it would have to be changed. It would be empty.

C

Q Of course, the needle presumably remains in place.
A Yes, probably. Although, no – thinking about it, I think we did change the needle as well every 24 hours.

D

Q And a completely fresh syringe would be used?
A Yes.

Q Would you use an old syringe or would you use a completely fresh syringe?
A No, there is one special one. It is called a Graseby syringe driver.

Q And new drugs would be drawn up according to what you decided to administer.
A Yes.

E

Q There is something I meant to ask you. Would you ever put a syringe driver in when the patient was asleep?
A No, I should not think so.

Q An answer like that, "I should not think so" – I am not sure how much it helps us. Can you remember ever doing it?
A No. I will say "no" then.

F

Q With the last patient that we were looking at, Elsie Lavender – I do not want to go back through it – but when you inserted the needle into her, and you thought you might have done it into the fleshy part of the back, would she have been awake or asleep?
A Awake.

G

Q So she would have been able to talk to you?
A I honestly cannot remember. We are talking about a long time ago. I think the last patient was nine years.

Q Let us just look at the other drugs, please, on page 63. You have dealt with the Oramorph, which was stopped on 18 August at 04:20. We can see that the diamorphine

H

which was in fact prescribed on 11 August by Dr Barton – and that was a variable dose between 20 and 200 mg? The second one down?
A Yes.

Q Is that right?
A Yes.

B

Q But that does not ever appear to have been given.
A No.

Q Then hyoscine, the next one down – are we still on the same page, page 63?
A Yes. I see them.

Q What is causing you concern?

C

A No. I am just.... No.

Q What are you looking for?
A I am not.

Q I see. Page 63, hyoscine, 200-800. Is that a drug to deal with secretions?
A Yes.

D

Q Can you recall now whether secretions were an issue for people on diamorphine?
A Secretions sometimes are an issue, yes. I can see that Mrs Richards did not have very much.

Q Very much what?
A Hyoscine. She probably did not need it.

E

Q She probably did not need it? Does your initial appear?
A Yes, in the middle, on 20th of the 8th I used it.

Q Why would you have used it?
A Presumably she needed it then, so I used it, but like I am saying, it is not just me that used it. Two of us would be doing this together.

F

Q Okay. Then we have dealt with the midazolam and then, over the page, at page 65 at the top is that lactulose?
A Lactulose, yes; that was her bowels.

Q And when we see a cross?
A That means it was not given.

G

Q It was not given. So it was not given on the 18th and it was not given on the 21st?
A Umm.

Q But when we see the initial "B", this seems to have been given on the 17th?
A Yes.

H

Q Haloperidol. What are the effects of that drug?

A Again, that is used for restlessness and agitation.

Q Does that have a sedatory effect?
A I can see that she had that. When she was given that, I was not actually on the ward, so I cannot say the effect it had on her.

Q No, but what is the purpose? Had you ever administer haloperidol before?
B
A For restlessness and agitation.

Q Does it have a sedating effect?
A Yes.

Q Then underneath that we can see Oramorph has been crossed out. I am sorry – Oramorph is there, but that particular prescription of Oramorph has not been given. That is
C
10 mg in 5 ml from 12 August. Then there is another prescription for Oramorph underneath that and then there is the prescription for diamorphine and haloperidol. Can you help us with this? None of these prescriptions seem to have been crossed through. If we go back to the two pages before, does that mean that they all remain live prescriptions, as it were? Do you understand what I am asking you?
A I understand what you are asking.

D
Q Can you help us?
A Yes. I can see that we did not use the syringe driver on the first page because it was re-written on this page – on page 65.

Q That is what I am trying ---
A Yes, I can see.

E
Q --- to get at.
A I can see what you are talking about.

Q The first prescription ---
A But I cannot explain why it is not crossed through.

Q No, but you can tell us about how things should be done. You have been a nurse for
F
many, many years. If you wanted to stop a prescription, to say, "No, this one is not valid any more," what would the doctor have to do?
A Cross it through.

Q Cross it through? Can you help us? If the prescription on page 63 is still a live one, can you help us as to why it would be necessary to write a further prescription ---
A No.

G

Q Page 65 --- at a higher dose?
A No, I cannot.

Q You cannot. I am not saying you ever ---
A Unless this dose was necessary, was felt necessary.

H

Q Yes, okay. I am not saying you would ever have done this, but you have live prescriptions here for Oramorph, diamorphine, hyoscine and midazolam, lactulose obviously, haloperidol, two more for Oramorph, diamorphine again and more haloperidol, none of which had been crossed through?
A No. Did it not say in the nursing notes that her drugs were not given after the syringe driver?

B

Q I just want to concentrate on these drugs charts for a moment. Would that give a nurse authority to administer any of these drugs?
A It would give them authority, but then none of them would administer those drugs?

Q No, I understand. Okay. In fact there is one we have missed, page 67. This is haloperidol?
A Oh, PRN.

C

Q And what is ---
A And the date on there is the 13th, is it not?

Q Yes.
A Which was when she was first admitted.

D

Q Well, the second time.
A The second time was the 17th, was it not, or the 18th?

Q Yes, all right. This is actually, I think, the second time. She is admitted the first time on 11 August. Then she has a problem. But in any event, this is 13 August and this says, "If noisy". How would this be given, this type of prescription?
A It is liquid. It is 2 mg in 1 ml, 0.5.

E

Q So that does not go into a syringe driver?
A Well, she was not on a syringe driver anyway, was she?

Q That prescription would have been oral, would it?
A Yes, it says oral on the prescription.

F

Q As a nurse, what would "If noisy" signify to you? Does it mean what it says?
A If the patient was distressed, agitated.

Q And then you can give the haloperidol? Right. One other matter I wanted to ask you about is what I think you refer to in your police interview, is it "subcup" or "subcut" – giving fluids? What is the expression?
A It is giving fluids, not through a vein, but through subcutaneously.

G

Q Right. You have already dealt with this, but I think in your interview you indicated that you thought there was research to prove a patient would probably be more comfortable without subcut. I just wanted to explore with you what you were talking about. The patient ---
A I think there is research to prove that.

H

Q To prove what? Just explain to us.

A In those days there was. To prove that when the patient was close to death? Is that what you are talking about?

Q Yes.
A Yes. That they are more comfortable without the hydration.

B

Q So let us just try and explore that a little bit. If you felt a patient was close to death, does that mean you would withdraw hydrating fluids?
A I do not know what the form is now.

Q Do not worry about now, but when you were a nurse, if you felt a patient was close to death would you take any action in relation to their hydrating fluids?
A No.

C

Q So who would?
A What do you mean?

Q You have just told us that you thought there was research to show that a patient would be more comfortable. Is that something that was ever done when you were a nurse – withdraw hydrating fluids?
A I remember that research when I was a nurse, yes.

D

Q Is it something when you were a nurse on the Gosport War Memorial Hospital that was ever done or can you not remember?
A I cannot remember.

E

Q And would you just look through the prescription charts, the drugs charts, that we have just been looking at? Are there any other entries by you that we have missed, as it were? Just on the drugs charts for the moment. Are there any other entries by you?
A No, no. We have covered the ones that I ----

Q Right. Finally, on that last topic could you go to page 299, please, at the back of the bundle. Is this a fluid chart from the Haslar?
A This is Haslar, yes.

F

Q And if we go to page 299 we can see what the patient was taking orally on 15 August. She had some squash. Then is it co-codamol?
A Co-codamol, yes.

Q And that is a pain relief?
A Yes.

G

Q We can see what she was having intravenously in the second column?
A Yes.

Q So the first column is her oral liquids that she was able to drink down herself - yes?
A Yes.

H

Q Then the second column is her intravenous fluids. Then we can see that at 9 o'clock on 15 August her cannula was removed. That would mean that from then on she was just taking fluids normally?
A Yes.

Q And we can see that she had water and tea and juice and the like. Over the page much the same – that is 16 August, and then the 17 August before she came over to the Gosport
B War Memorial Hospital - yes?
A Yes.

Q Were there any fluid charts in the Gosport War Memorial Hospital? I am sorry if I have missed them. I am not saying there were not.
A I do not recall her drinking like that when she was admitted to us.

C Q From the time that you were dealing with her, from the 17th?
A She was in such distress, I do not recall. I recall sending her meal back that day to the kitchen to have it minced because she could not eat it.

Q When you say "on that day", do you mean on the 17th, the day of her admission?
A Yes, on the day she was re-admitted.

D MR KARK: Thank you very much indeed. Would you wait there, please.

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

Q I am going to be asking you some questions on behalf of Dr Barton. I am afraid it is more than just one or two, but I will try and keep it as confined as possible to cover the topics that we need to cover. I would just like you to deal with two particular things before I ask
E you more about background and so on. With regard to intravenous fluids, at the time we are concerned with was there a period of time when the Gosport War Memorial Hospital did not provide fluids intravenously?
A Yes.

Q Later on – is this right – intravenous equipment was supplied?
A Yes.
F
Q So they could do just that. During the period of time that we are concerned with with regard to the patient you have been asked about, in fact intravenous fluid was not supplied?
A No.

Q And equipment was not there? Yes?
A Yes.
G
Q And the second particular thing I wanted to ask you about was something you dealt with a few minutes ago, and you were asked about the process of increasing the medication. Obviously we are concerned with controlled drugs here, increasing controlled drugs. I am sorry if this is all a bit basic, but we just need to check it with you. If the doctor, Dr Barton – whoever it was – prescribed a particular dose of a controlled drug you, and all the other nursing staff in your experience, would administer what the doctor had prescribed?
H A Yes.

Q It is just a set dosage.
A Umm.

Q Just taking that simple example, if you, as a member of the nursing staff formed the opinion that that dose was not enough to control the patient's pain, would you take steps to report that to somebody?
B A Yes.

Q And if you were the person seeing Dr Barton when she was at the hospital, say in the morning, or at any other time, you would report that fact to her?
A Yes.

Q And if you reported the fact to somebody superior to you in the nursing chain, say to
C Philip Beed, you would expect him to pass that information on to Dr Barton?
A Yes.

Q In the normal course of events?
A Yes.

Q So that the doctor could decide, having heard that the pain was not being controlled,
D that the dose could be increased?
A (The witness nodded)

Q You have told us already that where the doctor had prescribed a dose with a range to it, whether it is 20 diamorphine to 200, whatever it might be, where there was a dosage prescribed with a range, you and the other staff so far as you are aware would normally start at the lowest dosage in the range?
E A Yes.

Q I want to ask you this by way of generality. Say you started the patient at 20, if a particular dose – in this case 20 – did not seem to be achieving the object, it was not controlling pain, would you – I appreciate that it is not just you making the decision; it is always you with a senior colleague – endeavour to contact the doctor, Dr Barton?
A Yes.
F

Q Do indicate why it was your view that the dosage should be increased?
A Yes.

Q Normally speaking, that would be the procedure followed?
A Yes.

G Q Is that right? If, however, when Dr Barton was not available , or you could not contact her, were there occasions when a more senior member of the nursing staff than you would have the power, have the authority, to increase the dose?
A Yes.

Q Within the range prescribed by the doctor?
A Yes.

H

Q But is this right as a matter of normal procedure – only in cases where Dr Barton could not be got hold of?
A Yes.

Q And the ultimate decision in terms of the nursing staff for increasing, or whatever it might be, would be a more senior nurse than you?
A At least two.

B

Q I appreciate it is two all the time but you always have to be with somebody more senior?
A Yes.

Q And they ultimately are the ones giving the say-so?
A Yes.

C

Q Obviously you worked together with them for years?
A Of course.

Q And knew them very well. Thank you for dealing with that, just by way of general procedure. We may have to come back to it in relation to other questions that I ask you. In terms of what you have been asked in the past, you were interviewed by the police, I think, back in the year 2000?
A Yes.

D

Q We will all understand if you do not remember dates, and if there is anything particularly important about a particular date I will make it clear. You were interviewed under caution?
A Yes.

E

Q Not a very nice experience, I should not imagine?
A No.

Q But you dealt with the matters you were asked about and it very much, in the interviews in 2000, concentrated on the case of Patient E, Gladys Richards?
A Yes.

F

Q As well as asking you some general matters about procedure at the hospital?
A Yes.

Q Then you made a witness statement. That is a witness statement to the police on 15 December 2004?
A Yes.

G

Q So some four years later, and that very much concerned itself with the patient you have already spoken to us about, Elsie Lavender – Patient B. Then you also made a statement to the GMC producing those earlier statements and records?
A Yes.

H

Q May I ask you something generally about Dr Barton. Obviously you have worked with her for a number of years. You have already told us. Did you find her to be a hard-working and responsible doctor, so far as you could judge?
A Extremely.

Q Did you also find her to be somebody who had a complete commitment to the patients' best interests?
A Absolutely.

Q And I would just like you to deal with this in case there is some suggestion in the air, and you can speak as one of the nurses who were there for many years, was there ever a case in your experience when you or any other nurse to your knowledge administered analgesics simply to keep the patient quiet?
A Definitely not.

Q In case there is any suggestion, to shut them up, because they were giving trouble?
A Definitely not.

Q Did Dr Barton in your view of her, in your experience of her, ever give you the slightest indication that she was prescribing in order to achieve a purpose like that?
A No, she did not.

Q In general terms, we all have our little ways and manners, and way of behaving, but in general terms did you find Dr Barton to be somebody who was approachable?
A Extremely approachable.

Q And was she somebody who listened to what the nursing staff had to say or ignored it, or what? How would you describe it?
A No, she listened to the nursing staff all the time.

Q Did you find that you, if you wanted to express a view about something, could always approach her?
A Yes, she listened to our views all the time.

Q I would like you to help us, again with a general matter, with regard to the patients who you dealt with over those years. We are concerned, in particular, so far as you are concerned, with the period 1995 to 1998 or thereabouts. We appreciate, obviously, you carried on working there for a number of years. In general terms, did the pressures on your ward, Daedalus, increase in terms of the needs of the patients?
A The pressures increased very much.

Q In general terms, was it the case that you were dealing with, in terms of continuing care, patients who were obviously, in general terms, often elderly and very frail?
A Multiple diagnoses.

Q This is something you explained to the police, multiple medical problems?
A Yes.

Q This is just a general picture?
A Yes.

Q Problems such as Parkinson's Disease, Alzheimer's, dementia of one sort or another?
A Stroke.

Q Stroke, and in general terms patients who were highly dependent?
A Highly dependent, yes.

B

Q Normally needing two nurses to cope with their ---
A Most often needing two nurses.

Q --- daily needs?
A For daily needs.

C

Q I may have to come back to some generalities, but I want to turn back to the patient you have already been asked some questions about, Elsie Lavender, Patient B. It is back to that patient and then I will come on to the position with regard to Gladys Richards, Patient E, in a moment. I am going to ask if you could have in front of you the file with regard to Elsie Lavender, Patient B. I am going to take you through some of the documents, and maybe there will be one or two extra documents where there is a record of you doing something that you have already been asked about. I am going to try, not only to assist you in answering any questions but also for the assistance of the Panel, to take the entries you made in relation to that patient's records chronologically, just try to take it through in sequence. The earliest one that involves you is, if would you turn towards the end, on page 1018. It has other numbers as well, it says 88 of 103, which I think is something to do with "Pressure Sore Documentation"?
A That is right.

D

Q Do you see at the bottom on the left your signature?
A I do.

E

Q It is dealing with a recording that this patient had a right leg ulcer on admission on 22 February. We can see the date early on. I think that is the earliest record where you have made an entry. I am not asking you about the detail. The consultant is shown as Dr Lord. To follow the history through, would you go back in the bundle this time to page 1005, which I think is one you have already been asked about and I am trying to take this through in sequence. Do you have that?
A Yes.

F

Q That shows incidents with regard to the catheter, is that right?
A Yes.

Q Recording that the catheter is draining and so on?
A Yes.

G

Q We can see your signature and we are familiar with that. Further on to page 1009, can we see your signature again relating to bed baths?
A Yes.

Q These are all part and parcel of the normal nursing records that would be kept with regard to patients?

H

A Yes.

Q On please to page 1012 where we can see two entries by you relating to, "Bed rest due to painful joints" and so on, then "Bed rest maintained" giving us an idea of the sort of picture that was painted in terms of these records with regard to patients. This is all 24 February.

B

I would like to move on to a letter date. I think this note refers to something you mentioned in the course of your evidence anyway. Would you move turn to page 1022, the typewritten number 1022. It is a page you have looked at and I am trying to keep the chronology in a sensible order. This is in relation to 29 February. Can we see just over halfway down the page, part of the summary, a date 29/2/96?

A Yes.

C

Q I think that is an entry by you?

A It is.

Q "Blood sugar at midday", and you show the figure of 20. "Dr Barton contacted, ordered", and I think it says, "10 units Actrapid".

A Actrapid, yes.

D

Q Actrapid, whatever it is, and signed by you.

A Yes.

Q Is that the occasion you mentioned in your evidence when you said you phoned Dr Barton because you had a concern?

A Yes.

E

Q That was one occasion you could remember?

A Yes.

Q The action was taken pursuant to her verbal permission, or verbal opinion, as to what should be done?

A Yes.

F

Q That is 29 February. On to 1 March, another entry by you, which is at page 997, the prescription sheet relating to MST. Do you see that? You had better pick out the entry by you, yourself, on the sheet. It is in relation to MST, I think we can see it, perhaps, just over halfway down, "MST 20". Can we pick up your initials on the right?

A Yes.

Q "MC" is you, is it?

G

A Yes.

Q What did you understand MST was given for, in general terms?

A For pain.

Q In what form is it given to the patient?

A Orally.

H

Q I think it is just that one entry, is it, by you or your initials appear, perhaps, twice. Does that make sense?
A Yes, 10 o'clock.

Q That is on 1 March. I am not going to ask you to turn up these pages because we have seen them already in relation to the catheter on the catheter sheet on 1 March. There is a record by you that the catheter is draining satisfactorily. There are other nursing records but I am not going to ask you or the Panel to go through them all because we are all familiar with your signature. We have records on 1 March where, "Pressure sore areas were dressed", she was given a blanket bath, "bed rest maintained" and, in a particular case, suppositories being given with no result and an enema being given. We can check all those in the records, we do not need to spend the time to look at each one. Four days later, on 5 March, so far as you are concerned, would you look at page 1003, can we pick up your signature on the right-hand side, about one third of the way down the record. Is that you?
A Yes, that is me.

Q This is part of the nursing care plan dealing with pressure areas being dressed and so on and, again, without my turning up or asking everybody to turn up all these pages, on 5 March there are other records where we can see you dealing with the draining of the catheter, the dressing remaining in place, that she has been washed and bed rest maintained. They are the same general matters where you were obviously on duty and attending to that patient?
A Yes.

Q We need to turn to a page we have already looked at, page 1013. We have seen that on that sheet the 1 March, the complaining of pain in the shoulder is there. That is going back slightly in dates, but it is your entry that we have already covered. We move down to 5 March on that particular page, "Pain uncontrolled, patient distressed, syringe driver commenced 9.30 in the morning. Son informed". In the scale of things, with your experience, when you recorded that "pain uncontrolled", what is that saying – it may be obvious?
A On the medication that she was taking, her pain was not controlled.

Q Tell us about the procedure, you say "Son informed"?
A Either myself, or perhaps Philip if he was there, would have rung the son to tell him how poorly his mother was and, with his permission, we were going to start his mother on some morphine on the syringe driver over 24 hours.

Q Again, this would be, in your experience, part of a normal procedure?
A This was the normal procedure.

Q If it was the view of the doctor concerned and the medical staff were carrying out the doctor's authorisation as it were and the patient was going to be put on to a syringe driver, normally the relatives – if they were not at the hospital and assuming there was a relative with whom contact could be established – would be informed?
A Would be informed. We would always have their consent before giving a controlled drug.

Q Had you, yourself, ever carried out this task?
A Oh yes, frequently.

Q I appreciate everybody is different and patients are different and you had to deal with different relatives and so on, in general terms what would you be saying to a relative?
A What would I be saying to you, if it was your relative? "Your Dad had a really bad night last night, he is an awful lot of pain. We can no longer give him oral medication because he cannot swallow it any more".

B

Q For whatever the reason might be?
A Yes. "We would like to start him on a syringe driver", and I would explain to you what a syringe driver does and the fact that it delivers a tiny dose of this medication over 24 hours, "Which means your Dad is not going to be comfortable for a little while and then uncomfortable until we can give him another dose of the drug". This drug delivers the same dose over 24 hours.

C

Q You would be explaining the advantage of using the syringe driver?
A Yes.

Q When you carried out this task, did you yourself ever encounter any relative who indicated that they did not want the syringe driver to be commenced?
A No, we had a patient once who was on, I think it was, perhaps, oral morphine and we could not actually give it without ringing their relative to say. She wanted to know every time we gave her relative this particular drug and we did. We complied with her wishes and we did that. But that was only once over the years that I worked there.

D

Q Something you said earlier in the evidence, I want to make sure I understood properly. What if a patient was being put on Oramorph, in other words this was the first time that morphine in any form was being administered to the patient, would you normally try to inform any relative about that?
A Yes. Yes, I did not give the patient we were talking about who came back in from Haslar in great distress, I did not give her any Oramorph without asking her daughters first their permission.

E

Q That was the case of Gladys Richards?
A Yes.

F

Q In general terms it was the normal procedure ---
A We would not give it without informing the relatives.

Q Did you ever, in your experience, encounter a relative, or have contact with a relative, who said in effect, "I do not want you to give my relative..."
A No, only the one occasion I have mentioned. I cannot even remember the lady's name.

G

Q There is another note with regard to the same patient on 5 March. I am not going to ask people to turn it up, but it is two pages on 1015, where we can see your signature saying that, "She continued to leak faeces", just part of the nursing care plan, so that would normally be noted down?
A Yes.

H

Q Lastly, on this particular date, this particular topic if we can move on again in the bundle to 1022, we can see that the matter which was recorded on the other document we looked at a moment or two ago on 5 March, the entry by you talking about, "Pain uncontrolled, very poor night" and exactly the same information, not expressed in identical form but conveying the same picture, "Son contacted by telephone, situation explained". I think we have covered that.
A Yes.

B

Q Bearing in mind the sort of patients you were caring for at the hospital, when you recorded "very poor night" with an elderly frail lady who was in distress, what picture are we to get from that? Because people can use words in different ways.
A It is the picture of a very restless patient in lots of pain.

C

Q I appreciate that obviously you are not a doctor, but did you feel that, if you had any concern about either the type of medication prescribed or the amount of medication prescribed, you could make a point?
A Yes.

Q Did you ever have occasion in the time you were there, and in the period that we are concerned with up to 1999-2000, to query the medication, either by way of its type or the amount of the dose, with any doctor?

D

A I cannot recall querying a dose.

Q I would like to ask you about something you mentioned in your evidence when you were being asked questions by Mr Kark. You spoke about the pharmacist. Do you remember you were being asked questions about ---
A Yes, I remember. The ward round.

E

Q --- more than one drug being prescribed at the same time, and so on?
A Yes.

Q What is the picture there? The pharmacist would come in?
A She used to come across from QA every week and then she would go through our stock of drugs, order what was needed, go through everybody's treatment card, check that the drugs given were the correct dosage, the fact that some drugs you cannot give with other drugs, et cetera. She would make a note of anything that she wanted Dr Barton to look at, and perhaps change something. And every week she would do this.

F

Q So that is a regular ---
A It is a regular occurrence.

Q --- visitor and inspection in that sense.

G

A Yes.

Q Was the pharmacist somebody called Jean Dalton?
A Yes, she was.

Q So she would obviously be seeing not only the physical stocks of the drugs, but would she be seeing the prescription?

H

A She would be seeing everybody's prescription and what they were prescribed.

Q So she would be seeing the documents which showed, in some cases, a dose range for diamorphine or midazolam, whatever it was?
A Yes.

Q And would be seeing where drugs were combined in a syringe driver and would be seeing where that occurred.
B
A Yes. If they could not be combined, then she would say so.

Q May I ask you too about another isolated point, but it is one that may come up in other aspects of this case; that is, the Barthel score. Are you familiar with that?
A Yes.

Q What is the significance of the Barthel score, and tell us what would happen if you
C
had to sort it out yourself?
A This lady had a very high Barthel, I recall. We have already looked at it. I think it was 21; therefore she would have been nursed on an air bed, which means ---

Q I am asking you about one thing and I was going to ask you about another. When you say "nursed on an air bed", is that something to do with their skin condition?
A Yes.
D

Q Is that something called Waterlow? Have I got it right?
A Yes, a Waterlow score.

Q What is the difference between the Barthel score and the Waterlow score? What are they dealing with?
A Waterlow is purely pressure care and Barthel is general nursing care.
E

Q Dealing with Waterlow, the higher the rating, or whatever you call it, or the higher the points ---
A Score.

Q --- does that mean more of a problem?
A Yes, it does. This lady, I believe she had bilateral leg ulcers, apart from everything.
F

Q All right. I am leaving that for the moment and just dealing with it generally. Waterlow, the higher you are the worse off you are.
A Yes.

Q Barthel score, the lower you are the worse off you are. Is that right?
A Yes, that is right.
G

Q Did you yourself ever complete a sheet or card relating to a patient's Barthel score?
A Yes, it was something we had to do when the patient was admitted; it was part of the procedure.

Q We have seen examples already, and I am not going to take you through them – whether they can feed themselves and so on.
H
A Yes.

Q If somebody rated zero on the Barthel score, in your experience what would that indicate to you?
A Quite self-caring. Self-caring almost.

Q I am sorry – the Barthel score is zero. Is that good in terms of the patient?
A No, it is not good.

B

Q It may be difficult to remember which way round they were.
A It is not something I have done for some years. You will have to excuse me.

Q I think when you were being interviewed by the police, you told them ---
A That was four years ago, the last interview. Well, five years ago, actually.

C

Q Five years ago. I think when you were speaking to them about this, and you were talking about Gladys Richards, you were talking about the Waterlow pressure score prevention – and we have already covered that. In her case, that is Gladys Richards, I think she was 27, which was pretty much on the high side. Then the Barthel score, you were indicating to them – this is page 19 of interview number two – and the patient you were dealing with there, again Gladys Richards, "...because she scores nought, she is totally dependent".

D

A Yes. I believe she was paralysed left and right side.

Q I am pausing for a moment to see whether I need to ask you anything more about the first patient we were dealing with, Elsie Lavender. Again, perhaps a matter of generality but it arises in her case. We have seen the record of the syringe driver being commenced and your note of it. In general terms, assume that Dr Barton had, in anticipation, in advance, prescribed the administration of diamorphine and midazolam – let us just take those two as an example – to be administered subcutaneously. That is what she has done in anticipation. First of all, this. The reason for Dr Barton, or indeed any other doctor who did it in terms of prescribing in anticipation, was to prevent there being a gap between the failure of one form of pain relief and the start of something to deal with pain relief more appropriately.

E

A Yes.

Q In case the doctor was not immediately to hand.

F

A Yes.

Q No doubt on a number of occasions when there was an anticipatory prescription like that, Dr Barton could be spoken to on a morning round and could give a specific instruction to start.
A Yes.

G

Q Because in order to administer the medication subcutaneously you have to be using a syringe driver, normally a syringe driver would not be started – in other words, the patient would not be put on a syringe driver – unless Dr Barton had specifically authorised it.
A Yes.

H

Q Were there ever any occasions which you can recall where a syringe driver was started – subcutaneous analgesia is prescribed – and Dr Barton was not consulted, or her opinion or authorisation sought?
A I cannot remember an occasion.

Q If there was such an occasion, it would be somebody senior to you – if Dr Barton could not be obtained for some reason and the on-call doctor could not be obtained or could not come out – it would be somebody more senior to you who would actually have the final say-so.
A Yes.

Q So in the case that we looked at, with regard to Elsie Lavender, you made it clear in your evidence that Dr Barton must have given the authority to start the syringe driver.
A Yes.

Q In the cases when that occurred – in the case of Elsie Lavender, you have told us – she would have examined the patient and decided what to do.
A Yes.

Q Was it your experience that in the case of a patient who had, let us say, developed a problem overnight and Dr Barton was informed in the morning of the problem, whatever it might be, she would carry out some examination of the patient – normally?
A Yes.

Q Because you have told us that what you would do, or you and the other nursing staff would do, would be to draw her attention in the morning to anybody who had a particular problem that had developed.
A That is right, yes.

Q Would that therefore also apply, on any occasion that you can recall, when the report to Dr Barton was that the patient had been suffering overnight and the existing medication did not appear to be controlling the pain, the discomfort, the anxiety?
A Yes.

Q In your experience she would normally carry out an examination?
A Yes.

Q As well as discuss the matter with you?
A Yes.

Q I want to ask you one other matter before we turn to the case of Patient E, Gladys Richards. Patients being unrousable – if a patient was unrousable, and assume that this is not a patient who is in terminal decline, normally speaking would the issue be raised as to whether the medication they were on was too strong, too much – in an ordinary circumstance?
A Yes.

Q If you found a patient was unrousable, you would obviously want to find out the reason.
A Yes.

Q On this ward, for all sorts of obvious reasons, patients on occasion died. They were very ill when they came; they were very frail, and they died.
A Yes.

Q Obviously something that you saw more than once. Yes?
A Yes.

B

Q As you became more experienced as a nurse, did you find that you were better able to make a judgment, not as a doctor but as an experienced nurse, as to whether a patient appeared to you to be entering a terminal phase?
A I do not think you can always make that assumption, in my experience. I have called patients' relatives in and, by the time they have come in, the patient was sat up, eating something. It is not an easy thing to do.

C

Q I am not going to disagree with that for a moment. Not an easy thing to do, but did you find your experience and your ability to make a judgment about it improved as time went by?
A Yes.

Q You could get it wrong, of course.

D

A Yes.

Q In the case of a patient who was in the terminal phase of their life, you would find presumably that, when analgesia was administered subcutaneously, diamorphine and midazolam, they would at some stage become unrousable.
A Yes.

E

Q So was your judgment as to the significance of a patient being unrousable dependent on what stage of their care they were at? It may be that I have expressed that badly. Assume an ordinary case where a patient has pain. They are not, in your view, in a terminal phase. They have pain which needs to be controlled and it needs to be controlled by subcutaneous analgesia. That is necessary, but it is not the case that they appear to be in a terminal decline. All right? Imagine that sort of circumstance.
A Yes.

F

Q If such a patient became unrousable, would you want to wonder and investigate why?
A Yes, we would call a doctor.

Q In such circumstances it may well be that it was because the dosage was too high. Yes?
A Yes.

G

Q What I am trying to get at is not that case but a case where the patient is in terminal decline and they are therefore having to be given the diamorphine and the midazolam subcutaneously to deal with the situation, their pain, and so on; but they are, in your view – being blunt about it – dying.
A Yes.

H

Q In such a case, was it your experience that a patient might well be unrousable?

A Yes.

Q In that last phase, whether it lasted a day or two days or whatever it was. Yes?
A Yes.

Q I am going to turn now to what you told us about Gladys Richards.

B

THE CHAIRMAN: Mr Langdale, the witness has now been on the stand since 11:15. I anticipate that this patient will take some time for you to deal with.

MR LANGDALE: It is more than ten minutes.

THE CHAIRMAN: On that basis, we will take a slightly earlier lunch so that you can go into the next phase of your questions. We will return at ten minutes to two. (To the witness) Mrs Couchman, please do not discuss the case with anybody during the lunch adjournment.

C

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. (To the witness) This is just to remind you that you remain on oath. Mr Langdale.

D

MR LANGDALE: I want to turn to ask you some questions about Gladys Richards, as you have already told us. You first encountered her as a patient when you had come back from your holiday or break, or whatever it was.
A Yes.

Q And she had been re-admitted to the hospital, having been back to the Haslar in circumstances of which you were made aware. Correct?

E

A Yes.

Q Do you have the collection for Patient E, the file? The one I would like you to look at please is the file marked "E" – Patient E. Would you look there, please, at page 34. We can see your name in the bottom left hand section and you are the named nurse?
A Yes.

F

Q Would you just indicate what the significance is of you being in this particular case the named nurse. What does that mean?
A I was supposed to be the main nurse who liaised with the patients and I was the one they could come to if they needed anything.

Q With the ---?
A With the patients' relatives.

G

Q The patients' relatives – yes. So you are their link person, if you like. Yes?
A I was the go-between.

Q Any other particular duty that you had?
A You are the patients' advocate.

H

Q Yes?

A You are there to stand up for the patient.

Q You have told us that when she was re-admitted, you could remember this particular incident anyway. You had been on a coffee break of perhaps 20 minutes?
A Yes.

Q And during that time she must have been admitted - yes?
B
A Yes.

Q And is it right that the first person to contact you about her or to point out there was a problem was, I think, a care assistant, as you described her?
A Yes.

Q Would that be the same thing as a support worker?
C
A Yes, it is a support worker.

Q I think you were able to remember when you spoke to the police about this back in 2000 that the person who came to you to tell you about the problem was somebody called Linda Balduccino?
A Yes.

D
Q What was it she was concerned about?
A She came to tell me – I could hear the patient was upset and in great pain – that she was transferred whilst I was at coffee break and that the paramedics transferred her on a sheet instead of the normal canvas, which is obviously much thicker than the sheet.

Q So you were aware that that was ---
A I was aware that there was this problem.

E
Q Caused by ---
A Also she said that she did not think she was lying correctly, and that was probably again adding to her discomfort, but she did not want to move her. She wanted me to do it.

Q I see.
A She was waiting for me.
F

Q Is this the right sequence: after she had spoken to you and told you what the position was ---
A Yes.

Q --- you went to the room where the patient was?
A I went to the room, introduced myself to the sisters.

G
Q So both daughters ---
A Had a look ---

Q Hold on. Sorry.
A Both sisters were there.

H
Q The daughters, the two daughters? The sisters?

A The sisters, her daughters, yes.

Q Right. And was the patient still screaming?
A Yes, she was. So I checked her and found out she was not lying properly. I mentioned it to the sisters, and one of them – one of the daughters, I should say – said, "I will help you. I am an ex-nursing officer."

B

Q Thank you. Thank you for that. She helped you?
A She helped me ---

Q You got her into a better position ---
A She helped me position the patient.

Q And did that alleviate the pain and distress?

C

A She seemed a little more comfortable.

Q Was she still screaming, or had she stopped?
A Yes, she was still screaming.

Q Still screaming?
A Yes.

D

Q Thank you.
A Which is why we eventually gave her some Oramorph.

Q It was obvious to you from any conversation you had with the sisters, Mrs Richards' daughters, that they were not at all happy about the transfer from the Haslar?
A No, they were not. We also knew – we had had a communication from the rest home where she came from to say that there had been whispers of suing the rest home.

E

Q So you knew when you ---
A We knew there were problems.

Q You knew, without going into unnecessary detail I hope, you realised from what you had been told that the sisters were ready to complain if they felt they had a reason to complain?

F

A Yes, yes.

Q I think also at that stage, or at least in relation to that same day – please tell me if this is wrong – there was a problem with Mrs Richards being able to take the food that somebody was trying to feed her with?
A Yes, yes.

G

Q And then you got somebody to go and mince the food?
A That is right, yes.

Q Back in the kitchen, and have it brought back?
A Yes.

H

Q Did that seem to work?

A No, she did not actually want it.

Q She did not want it?
A She was quite poorly, actually, when she arrived, and looking at the transfer letter, the fact that she could stand and weight-bear... That was quite hard to believe.

B

Q Did you sometimes find that patients arrived at the Gosport War Memorial Hospital with perhaps an impression that their physical state was rather better than it actually was?
A Yes. Yes. We also gathered that they were coming for a rehabilitation. They were told this, when it was obvious to all that perhaps that was not going to happen.

Q Did that sometimes affect, in your view, the view that relatives had as to the prospects for the relative who was a patient in your hospital? Did they sometimes have a rather unrealistic ---

C

A I think sometimes they did have unrealistic expectations, and that did not help.

Q In any event, on the day that you saw Mrs Richards in the way you have described, did you later on go into the room again and have a look at her because she was still in pain?
A Yes.

D

Q Again, I am using what you told the police in the year 2000 for this. Did you indicate to one of the daughters – sisters – that you would like to give her mother something to relieve her pain?
A Yes, yes. I asked if I could give their mother a small dose of Oramorph and they agreed.

Q Did you speak to Philip Beed ---
A Yes.

E

Q --- the manager, about it?
A Yes, I did. He agreed with me, and we administered the dose between us.

F

Q And we can see, as we have already looked at in the file at page 46 – if we can just turn that up again, please. We have the record of really what you have been telling us about just now at the bottom of the page. On the 17th – the day we are talking about – you set out the position with regard to, "To remain in straight knee splint," and so on. All the detail is there. Is that your writing over on the left: "No canvas under patient ---"?
A Yes.

Q "Patient transferred on sheet by crew." Then, over the page, still the same day, we can see a further note that you made:

G

> "In pain and distress – agreed with daughter to give her mother Oramorph 2.5 mg in 5 mls.
>
> Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again."

So that is something one of the sisters was telling you?

H

A Yes.

Q That she had been told by a surgeon at Haslar?
A That is right.

Q Is that it?

"Dr Barton contacted and has ordered an X-ray."

B

Was that you who would have contacted her?
A Yes.

Q And she had indicated – what – over the telephone?
A Yes.

C

Q "Get an X-ray."
A Yes.

Q That takes care of your notes in relation to that. I would like to ask you a little bid more in terms of Mrs Richards, did you find that she was somebody who, even when she was able to eat, had great difficulty eating?
A Yes, I think she did.

D

Q I think you described it in this way to the police when you were seen by them: "I think even before she had the medicine she was having great difficulty problems [eating]"?
A Yes.

Q "Eat and drink", you said.
A Yes.

E

Q Obviously she was somebody who was in great pain and had multiple problems?
A Yes.

Q When she was put on the syringe driver is it right that there was some discussion between you and Philip Beed? Perhaps I can take it in stages. Did it become clear to you from what Philip Beed said to you that he had already spoken to the relatives about this?

F

A Yes, yes.

Q And the doctor?
A Yes. That would be normal practice.

Q And so it was, as it were, a decision in which the relatives – in this case the sisters – were involved?

G

A Yes.

Q And obviously nobody, in terms of confining it simply to you and to Philip Beed, but nobody wanted to leave any patient in distress and pain?
A No.

Q And I think you also told the police that in your view a couple of days before she died you had got the impression that she was starting to die?

H

A Yes.

Q And described her as being very poorly?
A Yes.

Q Did you get the impression at any time that you had dealings with them when they were at the hospital, that the sisters had any complaints about anything?
A At our hospital?

Q Yes.
A Yes. Yes, I did.

Q Would you help us with that?
A One of the support workers became quite friendly with her. She was very much into astrology, this girl. She did the two sisters' charts and they sort of became friendly. We were invited to a spiritualist meeting.

Q It is not your fault. I am going to stop you there.
A Yes.

Q Because I think you were going on to say something about a spiritualist meeting which had taken place some time later. Is that right?
A No. That was before the mother died.

Q All right. Sorry. Go on. I am confining it to the period when she was still alive.
A Yes, yes. In Chichester. I went myself with Linda Balduccino and another support worker to this meeting.

Q Pause there. Was the meeting that you went to after Mrs Richards died?
A No, before she died.

Q Before?
A Before she died.

Q All right.
A It was very peculiar because they went round the actual meeting, people saying what they did, this sort of thing, and apart from saying what she did – which was not much, it was not anything at all, I do not think – she said something about what awful treatment her mother had had in the War Memorial. This is in front of the three of us. She obviously got us there to complain about the War Memorial.

Q This is before her mother had died?
A Yes, yes. It is actually in the interview. I did tell the police.

Q I appreciate that. I was just trying to make sure that it was a time before the mother had died rather than later.
A We did not actually meet them after she died.

Q So apart from that, when there was this thing being said at the meeting, did either of the sisters ever complain to you directly about the treatment?

A Not directly to me. And in fact after her mother died, she gave about nine presents to the staff, mainly books and things, and then she left. She gave her mother's chair to the ward, which was one of these electric type things, quite expensive chairs. She gave that to the ward. I do not think we had any complain for a few weeks.

Q Sir, may I just indicate this to the Panel. There are some other notes made by this witness in relation to the patient Alice Wilkie. There are not very many of them and they are all, if I can use the expression, relating to mundane matters, but since we know what this witness's writing looks like, I do not think it is necessary for me to go to that file and take the Panel through it or, indeed, take the witness through it. My learned friend, Mr Kark, and I can agree it, I am quite sure, if there is any difficulty. I am not going to go into any further records.

(To the witness) May I just ask you please about one other matter. Again, in general terms – all right – obviously you have been able to remember certain things with regard to the patient, Gladys Richards ---

A Yes.

Q --- that you told us about. The other patient we talked about, you were not really able to remember ---

A No.

Q --- anything of any significance. Would you just give the Panel some idea of the amount of patients who you must have seen at the Gosport War Memorial Hospital?

A I do not have the numbers.

Q What are we talking about? Hundreds or thousands, or what?

A I should imagine it would go to thousands.

Q Over the period of time you were there?

A Yes.

Q Finally, would you help us with this. I have asked you some questions about Dr Barton already. It is clear from your evidence that she was somebody who was obviously very busy. Yes?

A Yes.

Q Was she somebody who took time to speak to relatives? How would you describe her ---

A Yes, she did take time to speak to relatives.

Q Sometimes relatives would be there when she came in the afternoon?

A Yes.

Q Would relatives ever be there in the morning when she did her morning round?

A No, normally that was perhaps a bit too early.

Q It tended to be later on in the day?

A Yes.

Q We have heard evidence about her coming back at lunch time or in the afternoon?
A Round day, the day the consultant did her round.

Q Those would be the sort of occasions when relatives might be there and she might be able to speak to them?
A I think they were able to make an appointment as well on round day, when the round had finished, if they needed to come into the office and talk.

B

Q Might there be occasions when she came in on her own deliberately in order to see a relative?
A Yes.

MR LANGDALE: Thank you, that is all I need to ask you.

C

Re-examined by MR KARK

Q Just a few questions from me. In relation to Elsie Lavender, Mr Langdale was asking you about the normal procedure and why a patient would be put on to syringe driver. You have been asked questions in this case – you do not have to look it up – it is file B, page 1013 and you said to him, "We would say that the patient is having uncontrolled pain and cannot swallow any more". Did the two of those have to go together before you would initiate a syringe driver?

D

A If the patient cannot swallow, it has to be administered some other way.

Q I understand that?
A It is either a syringe driver or ---

Q If a patient could swallow, would there be any reason to switch?

E

A No.

Q You told us a bit about the pharmacist and you mentioned somebody, I think, is it Jean Dalton?
A Yes, that is her name.

Q Is it Philip Watling, Mr Watling?

F

A Yes, I think he was over occasionally.

Q The prescription sheets, the sort of documents we have looked at already on which Dr Barton would fill in a prescription and then the nurse administering it would put their initial and the time of the administration, where would those notes be kept?
A At that time, I believe, by the bed.

G

Q What notes would be kept by the bed and which notes would be kept in a cupboard?
A I believe then the treatment card was by the bed and the care plans, the care plans you have been reading from.

Q The drug charts?
A By the bed.

H

Q We also know that because controlled drugs were used too, you had to keep a record of the controlled drugs in a Controlled Drugs Record Book. I am holding one up just to show the Panel and we can exhibit these in due course if it is necessary. These books would be kept for each ward?
A They were locked in the cupboard, the controlled drug cupboard.

Q They would be a record of every controlled drug that was withdrawn for administration?
A Yes.

Q So, by way of example, this is a book I am looking at for Dryad Ward commenced June 1999 and it has a list of all the controlled drugs in it. When you told the Panel that the pharmacist would come and check the dosage, can you tell us what they would be looking at, which documents the pharmacist would look at?
A She would check that book as well when she came over so that the amount of drugs in the controlled drug cupboard had to tally with the book, and then she would check each prescription for each patient.

Q Are you saying that she would go round the ward and look at the prescriptions at the end of each bed?
A Yes.

Q What would they be looking for?
A She would be looking for dosage, she would be looking at the drugs that were prescribed for that particular patient, whether they should be given together or, if there were any discrepancies then she would contact Dr Barton.

Q Did you ever know her to object to the drugs that were being given?
A I have known her leave a few notes about different things.

Q About what?
A Not about dosages, no, but, perhaps, there are certain drugs which cannot be given together. I cannot give you an example, but I do know.

Q Did you ever know her to haul anybody up, Dr Barton or anybody else, to say, "Hang on, you should not be giving that much"?
A She would do.

Q In relation to one of these controlled drugs?
A No, no, I do not think that ever happened anyway.

Q You told us also that you, I think, were there when Dr Barton made examinations?
A Yes.

Q When she made an examination, did you see her making a note of the examinations or would somebody else make a note of an examination on her behalf?
A Yes, I would see her making the notes.

Q You were also asked by Mr Langdale about patients being unrousable, and I think it was being put to you that if a patient was coming towards the end of his or her life, there would come a point when that patient would become unrousable?
A Yes.

Q Is that what you were agreeing with?
A Yes.

B

Q I want to understand what you were saying?
A Yes.

Q If you had any concern about it, you would bring it to the attention of Dr Barton?
A Yes.

C

Q Did you ever say to Dr Barton, "I am very concerned, this patient is unrousable"?
A I cannot recall.

Q Or the medication being reduced as a result?
A No, I cannot recall.

D

Q Dealing with Gladys Richards, you told us, and it must have been distressing for everybody concerned on 17 August when this patient was screaming and you had to reposition her, do you know who would have put her in the bed, who would have been responsible for this patient?
A I would imagine it was the ambulance people that did that actually.

Q Would ---
A Deposited her in the bed.

E

Q I am sorry, can you say that again?
A Put her in the bed.

Q Would anybody have been there from the nursing staff to make sure that things were done properly?
A Yes, the support workers were there, but they knew it was not right.

F

Q They knew it was not right?
A They knew she should have been transferred on a proper canvas which is much thicker than a sheet.

Q When it was brought to your attention that the patient was screaming, the daughters were already there?

G

A Yes.

Q In relation to that patient, you told us that the fact that she could stand and bear weight was hard to believe?
A Yes.

H

Q Do you have Patient E's file, I want to know what your evidence is about this. Page 8 is the transfer note from the Royal Hospital Haslar. We can see the note at the bottom, page 8 of Patient E:

"When in bed it is advisable to encourage abduction by using pillows or..."

is it "abduction wedge"?
B A Yes.

Q

"She can however mobilise fully weight bearing."

"Fully weight bearing", presumably, does not mean that she can dance down the corridor?
A It does not mean to say she can walk, but I did not actually see her mobilised.

C

Q Are you saying you do not believe that note?
A I am saying she was a poorly old lady screaming in pain, but I did not see her mobilised. I did not see her stand.

Q When she was at the Gosport War Memorial Hospital from 17 August when you were dealing with her, did you ever see her out of bed?
D A No.

Q Would it have been any part of your function to try to mobilise a patient who needed mobilising?
A Yes.

Q Was any effort made to mobilise this patient?
E A I think she was too poorly.

MR KARK: That is all I ask, thank you.

THE CHAIRMAN: Members of the Panel have indicated to me that they would welcome at this stage some time to discuss amongst themselves the questions that the Panel will be putting to the witness. Therefore, what I propose is that the Panel will remain in the room
F and I will ask everybody else to withdraw and we will call you back as soon as we are able. Mrs Couchman, you will be taken to somewhere to await and we will try to get you back as soon as possible. We are aware that you have spent a considerable amount of time on the stand and we are grateful for that.

(The Panel adjourned for a short time)

G (Questioned by THE PANEL)

THE CHAIRMAN: Welcome back. Thank you, Mrs Couchman, for allowing us to hold you back still further. The Panel are now in a position to put their questions to you. We are going to start with questions from Dr Roger Smith who is a medical member of the Panel.

DR SMITH: You will be familiar because you were entered in the notes as a named nurse.
H A Yes.

Q On these wards, where you worked, Daedalus and Dryad, was each patient allocated to a named consultant or did all of the consultants look after the patients?
A Dr Lord looked after the patients on Daedalus Ward.

Q For each of these two patients that we have discussed today, Dr Lord was the consultant in charge of the case?
B A Yes, I think so.

Q It is just as a matter of enquiry because it caught my eye, who was Dr Matthews – I have lost it?
A I do not know.

Q You do not know who Dr Matthews was?
C A No.

Q He was on the head of a sheet at Gosport. You said towards the end of your questioning by Mr Kark that, at times, relatives, and indeed the doctors and nurses at the hospital sending you patients, might have had unrealistic expectations of the outcome?
A Yes, we did feel that.

D Q That when they arrived you thought, "Well that is not going to be possible"?
A Yes.

Q Can it work both ways, that you might have had, at times, unrealistically pessimistic views?
A No, I do not think we did.

E Q For instance, I think you said that sometimes you could call a relative in because you were very worried that the patient was ill, but when they got in ---
A I did say it was very difficult to actually say if someone was dying or not because, occasionally, we would call relatives in and perhaps they would be sitting up eating when they arrived.

Q You would agree at any particular point in a patient's management, at any particular
F moment, that may not indicate what is going to happen next?
A Yes.

Q We have dealt with two patients and, although they are quite different patients in what happened to them before they came to Gosport, the same things happened when they got to Gosport. The first was a lady who was a little demented, no she was quite demented, I think, and before transfer she had been mobilised after a fall and she was walking about with a
G Zimmer and some help, and she was described as being quite well. On the day she went into your ward at Gosport, she received a dose of morphine Oramorph?
A Yes. She had had a transfer from one hospital to our hospital. She had a haematoma on her wound, which I guess was causing her great pain.

Q Your assessment of that patient seems to be different from the assessment of the people who sent her to you in that ---
H A This is how we found her on our ward.

Q You felt that she was in great pain and she received ---
A Not just myself, the staff on my ward.

Q Yes, generally she was found to be in great pain and given a dose of Oramorph and she never regained consciousness?
A Yes, she did. It was a tiny dose when she arrived, 2.5. If you recall from the drug sheet, she had more than one dose that day actually.

B

MR KARK: I am sorry to interrupt. I want to make sure we have not crossed wires. I want to make sure Dr Smith and the witness are talking about the same patient. I think the witness is talking about Patient E, talking about the haematoma. I wondered if that was the patient Dr Smith had in mind.

C

DR SMITH: No, it is Patient B actually.

MR KARK: It is just that the witness may be answering about Patient E.

DR SMITH: Let me generalise it a bit more because I am trying to understand the mechanisms of decision making. The generalisation is that patients – either of these patients could be used as an example – came in and had some Oramorph and certainly one of them never regained consciousness thereafter. The treatment regime continued to eventually become subcutaneous diamorphine.
A Not on that day.

D

Q No, but through the next few days. For instance, the lady who came in in agonising pain who was screaming in pain, we have evidence that she received a dose of morphine and she never spoke again, Oramorph?
A I did not think she spoke very much on that admission. I did not actually see her on her first admission, I was actually on leave, but on her second admission when she had to have a dose of Oramorph, I do not think she spoke very much at all.

E

Q She went on to have more Oramorph and then subcutaneous and so did the other lady we spoke about today. Both of these ladies were unconscious at least at some point, certainly by the time they were on diamorphine subcutaneously. Each day the pump was changed?
A After 24 hours it would be empty.

F

Q On each day the pump, the syringe driver, was continued until they died. Neither of those patients regained consciousness before they died. How do you, a very experienced nurse, you have worked there for 10 years with Dr Barton on the elderly care ward, how do you assess, how do you make up your mind, what an unconscious patient needs in the next syringe driver? First, why do they need it again, can you help us with that. What are the pointers, what are you looking for?
A To keep the patient comfortable and pain free.

G

Q How do you know the patient is comfortable, how do you know whether the patient has pain?
A We can only assume that the patient is comfortable if they cannot tell us.

H

Q So why would you continue?
A It is not my decision to continue.

Q It is not?
A No.

Q But you are part of the team and I am trying to understand ---
B
A I am part of the team, yes, but ultimately it is not my decision.

Q Of course it is not, but you are an important person. You, the nurses, are important people in informing the doctor as to how the patient is.
A Yes.

Q If it is the doctor's decision or if it is a joint decision, nevertheless your input is very
C
important. So how would you know whether a patient still needs to continue that pump driver, that dose?
A The only answer I could give is that you do not give it and you just let the patient be in pain.

Q That is right; so how do you know whether, by reducing or stopping the painkiller, the patient will still be in pain or not?
D
A By observation. You would not know any other way.

Q But the pump is not stopped and the dose is not reduced; the patient remains unconscious. So how do you know whether the patient might perhaps not have been in pain any more if the dose was reduced or stopped?
A We do not.

E
Q You do not. So what is the object of continuing this drug regime? Is it that a decision has been made that there is nothing more to be done for this patient; that this patient is now terminally ill? Is that the reason why the syringe driver is changed every day, continuing the same dose or increasing it? (Pause) Is it because somebody has made a decision that there is nothing more to be done for the patient because nothing can be done for the patient? (Pause) I am not asking you if you made that decision.
A I know you are not. I have told you, the decision is not mine.
F

Q Absolutely, but you are part of a team.
A I know.

Q I am trying to understand, and we want to know, if that would have been the case: that you continue these drugs, these pumps, because the team, if you like, or the doctor – whoever – has made a decision, an executive decision, a care plan decision, that "We can't do
G
anything more for this poor patient who has been in terrible pain and we are now into terminal care".
A I cannot answer you.

Q You cannot answer for either of these two patients?
A No.

H
Q Why do you think then that no fluids were exhibited to these patients?

A No what?

Q No fluids were given.
A I think we have been over that, haven't we?

Q Let me put it a different way. If you thought that a patient had the chance of getting better ---
B
A I do not orchestrate a patient's treatment; I carry out orders and do them.

Q I take issue with that slightly. You are a registered nurse.
A Yes.

Q With professional responsibilities, with training, with experience.
A Yes, but I do not prescribe drugs.

C

Q No, but you give drugs. You deliver the drugs; you administer the drugs.
A Mmm.

Q And you are not on trial here.
A I feel as though I am on trial.

D
Q I apologise if I make you feel that way.
A I feel as though I am on trial.

Q I am trying to understand whether, in these patients in this ward, decisions were made, rightly or wrongly – and often rightly – that the patient ---
A I think that decisions were made in the patient's best interest.

E
Q How was that communicated?
A I do not know what you mean.

Q When that decision has been made, how would everybody understand that it had been made?
A When an order is given and a decision is made, it is made, isn't it? We all know.

F
Q But how is it given? Perhaps that is how I should put it. How is it given?
A Everybody knows how poorly the patient is.

Q But what if you are ill the next day and somebody has to come in? How do they know that that decision ---
A Because we all work the same.

G
Q So it is word of mouth?
A And written word.

Q Written?
A Mmm.

Q So, in your experience, in that unit it was written down that a patient would be
H
designated as – what? For terminal care?

A No. The patient was on a syringe driver.

Q For pain?
A For pain. Syringe drivers are given in lots of cases, as you know yourself, for lots of drugs, for the ease of giving the drug over a 24-hour period, to have no troughs and peaks.

Q So I come back to what I suppose was my original question. How do you know that the patient still needs it for pain if they are unconscious?
A We do not.

B

Q And so ---
A I do not know how we could know.

Q By reducing the dose and finding out?
A Possibly, yes, by taking it away and seeing if they are in pain.

C

Q But that was not done with either of these patients.
A No.

Q Would that be usual in that unit?
A Yes.

D

Q That is all I needed to ask, thank you.

THE CHAIRMAN: The next Panel member is Ms Joy Julien. She is a lay member.

MS JULIEN: My question is about the syringe driver but in general terms, and really about the communication with the patients' relatives. First, I think you started off by saying at some point that you informed the relatives about it before.
A Yes, someone would speak to the relatives.

E

Q One of the things I wanted to clarify was whether you informed them or whether you sought their consent.
A We did both. We sought their consent and informed them.

F

Q Before you went ahead?
A Oh, yes.

Q Would that be a one-off or would it happen as things ---
A Certainly on our ward it would happen with each patient.

Q With that patient, you would inform and seek consent initially ---
A Yes.

G

Q ...and then that would be it, and then you would carry on making adjustments.
A Yes. We would probably see the relatives again when they came in to see the patient.

Q If there were any changes in the dosage or anything like that, would they be party to---
A Yes, we would inform the relatives.

H

Q At each stage?
A They would be kept informed all the way along.

Q What form would that take? Would it be face to face or ---
A Face to face or by the telephone if they were not there.

B

Q I think you gave us an example of how you might put it to them. Would you use the same language each time? Do you have a script?
A Hopefully we would use as sensitive language as we could.

Q So you would be adjusting it, depending on the circumstances?
A Yes.

C

Q Would you have anything to assist you, like a checklist, *aide-mémoire* or script, or anything like that?
A No, we are taught how to speak to relatives.

Q Are there key things you need to say to them?
A Pardon?

D

Q Are there key things, key statements that you need to make when you are seeking consent?
A Yes.

Q Could you give me an example of what essential things you would have to say?
A I would say to you, "As you know, your mother has been very poorly for some time and we think she could benefit from a dose of Oramorph. Would you be happy if we gave it to her?" Most people will say, "I would like my mother to be comfortable and pain-free, please".

E

Q Would you explain exactly what it is?
A Yes. If we were using a syringe driver we would explain exactly what it is.

F

Q In your experience, are most people familiar with a syringe driver? Do they know what it is?
A Occasionally someone is but, no, mostly they would need to hear about it.

Q So you would explain it? You would explain what it is?
A Yes, although it is used at home as well, I think, by the district nurses.

G

Q You mentioned that you would record that you had informed or ---
A Oh, yes, we would always – we should always record that we have informed the relatives.

Q So it does not always happen?
A It might escape, if we are called away to another patient. If we are very busy, there are times when perhaps the written work....

H

Q What if you cannot get hold of the relatives?

A We normally manage to get hold of the relatives somehow. Either they come in to see their relative or we can get them on the telephone, or leave a message to ask them to come in.

Q But you do not go ahead until you have actually ---
A Not normally, not till we have spoken to the family.

B

Q When you say you speak to the family, is it the named next of kin?
A It would be best if the named nurse could do it, but obviously they are not always there or they might be on leave. It could be somebody else who does it.

Q What I actually meant was do you speak to a specific person in terms of relatives?
A We would speak to the next of kin if we could.

C

Q So it has to be the next of kin?
A Yes.

Q When you are explaining to the next of kin, obviously you talk about the advantages but do you talk about the possible disadvantages or risk associated, or the consequences associated of going on?
A Yes.

D

Q What would they be?
A I would say the advantages are there are no troughs and peaks, and this drug would be administered over 24 hours whereas, previous to using the syringe driver, we would give the dose four-hourly probably; so the patient will be very comfortable perhaps for two, maybe three, hours and then quite in pain, and have to wait a whole hour before we could give the dose again, till the four hours were up. Therefore to use the syringe driver is much better.

E

Q In terms of consequences, for instance if the patient would become unconscious and therefore not able to communicate with their relatives, is that explained to the relatives as a possible consequence?
A Yes, we would explain what is happening.

Q I think that is all, thank you.

F

THE CHAIRMAN: Mr William Payne, who is a lay member of the Panel.

MR PAYNE: Good afternoon, Mrs Couchman. It has been a long day.
A Yes.

G

Q I have a few questions, I am afraid. I shall keep you as little as I possibly can. Am I right in saying that you worked on the ward for ten years?
A Yes, probably over that.

Q Over ten years?
A Yes, a little over.

H

Q Did you work with Dr Barton throughout those ten years? Was she there for ten years?
A Maybe not at first, because I did work on the children's ward when I joined the hospital; but then the children's ward was taken away.

Q So you had worked with Dr Barton for a number of years anyway?
A Yes, a number of years.

B

Q Did I hear you say that you started there in the Eighties?
A Started where?

Q Did you start at the hospital in the Eighties?
A I think it was 1983.

C

Q My colleagues touched on the syringe driver – and this might sound a basic question to you, but I have no connection with hospitals – but did you get any training in the use of a syringe driver?
A Lots of training, yes. At St Mary's, in QA, War Memorial.

Q Is it a very in-depth training on it, or does somebody show you?
A Well, yes. It is quite a simple instrument actually, like most of them are when you sit down and look at it. And this was 13 years ago, so it had been going some time then.

D

Q So you were well versed in the use of it then?
A Mmm.

Q Did that training incorporate the types of drugs that you would be using?
A Yes. Say we were using Oramorph, morphine --

E

Q And diamorphine?
A Yes. It is a derivative of morphine.

Q And the mixture of different types of drugs?
A Yes.

F

Q You know when you said that you administer drugs and you administer them impairs – there are two of you ---
A The controlled drugs, yes. That is the law.

Q And it is always two?
A Yes, it has to be two.

G

Q There were occasions when you were the senior of those two?
A Yes.

Q And I am right in saying that you said that you would follow the prescriptions and you, in those ten years, never had to increase the amount?
A I cannot recall. Yes, that is what I said.

H

Q You would give the minimum?
A Yes.

Q May I ask you to turn to pages 63 and 65? We are on E. Are you with me?
A Yes.

Q Do you recognise the handwriting?
B
A Are you on 63?

Q Page 63 or page 65.
A Yes, I have got both of them here. Yes, I recognise most of that handwriting.

Q That is Dr Barton's handwriting?
A Yes.

C

Q Would you say that this is a normal sheet that is not necessarily just for this patient but this is the type of thing that she would write for every patient?
A Yes.

Q Are these prescriptions – let us say, for instance, page 65 and the diamorphine, 40 to 200. Can you see that?
D
A I have seen it, yes.

Q Would that be normal for her, to write those amounts?
A Yes.

Q For me, that seems to be quite a wide ---
A It is a wide range, yes.

E

Q Forty to 200. You would always start with 40.
A Yes.

Q You said that you had never had to change it ---
A I do not think so.

F
Q But if someone else on, say, the day before had been up from 40 to ---
A I think they would have probably used the same.

Q Yes, but if they had gone up from 40 to, say, 60 and it was your turn the following day to administer the drug, you would have started at the 60, would you?
A If they had, you mean?

G
Q Yes.
A Yes, probably I would have followed on.

Q You have told us that you are trained in this. If you are increasing the dosages, what is a normal increase from, say, 40? What would you normally increase to?
A What would I go up to after 40?

H

Q Yes.
A Perhaps it would be 60. From 40 perhaps to 60. But I cannot recall ever going up.

Q But that would be the normal, to go up to about 60?
A Yes.

Q Then you would obviously not increase that for some time at least, because you would see how the pain was monitored.
A Yes.

Q I think it was you who told us that Dr Barton would be there at least every morning, at between eight and eight-thirty.
A Yes.

Q And sometimes in the afternoons?
A Yes, if we called her in.

Q My question is, if you would only increase it in, say, twenties or maybe forties, and the doctor would be there within 24 hours under normal circumstances, why is there such a range between 40 and 200? I do not understand why that seems appropriate or necessary.
A I see what you are saying.

Q But that was how it was done normally?
A Yes, I have seen it before.

Q Were all the nurses happy about this range of prescription?
A I never heard anybody comment on it.

Q There had never been any comments ---
A No, I never heard any comment on it.

Q No comments in the past?
A No.

Q Nothing complained about years ago?
A No. Because it is there, you do not have to use it, do you?

Q But it is there so you can use it?
A You could, yes.

Q But you had never heard any complaints previously or anything like that?
A No.

MR PAYNE: I think those are all the questions I have. Thank you very much.

THE CHAIRMAN: Thank you, Mr Payne. Now it is Mrs Pamela Mansell, who is a lay member of the Panel.

MRS MANSELL: You explained to us that the purpose of the nursing notes, when different nurses come on duty, they pick them up and they can have a look and know how ---

A This is what is supposed to happen, yes.

Q --- to deal with the patients.
A Yes.

Q I am looking at page 1013 and Patient B. Elsie Lavender.
A I think I have it.

B

Q If we look at the 4th of the 3rd, I get the impression that here is someone with slight pain in the shoulders when moved, so she has the physio exercises, and "Elsie needs reminding," but because there is a slight increase in pain the analgesia is increased. Then the next date, the next day, "Pain uncontrolled. Patient distressed."
A I believe that was overnight, the "pain uncontrolled".

C

Q Yes, yes.
A Because the driver was started at 9.30 in the morning.

Q So you commence. Is that you who commenced that?
A Yes.

Q Is that your name?
A Yes, it was me.

D

Q But this patient could take medication orally. If we turn to 1017. I understood from that, if I look at the 2nd of the 3rd, "Took medication well." I am interested in where the notes are that help me to understand why we have moved from oral medication to syringe driver.
A Yes. That was at night, I believe, that 2nd on the 3rd. So it was three days later that I started the ---

E

Q The syringe driver. But I do not have a note there that indicates to me why the pain in the shoulder is increasing and I find nothing that helps me to understand why we have moved from "Took medication well," to a syringe driver?
A There is not a reason.

Q So that seems quite a step forward.
A It was obviously reported to me on the 4th of the 3rd, but not actually written in her care plan.

F

Q Right. So you can throw no light on that one really?
A Seeing as I started it on the 4th.

Q Because I understood, it is only when patients could not take it orally that you started to use a syringe driver?
A Yes. That was two days later.

G

Q Yes. It is quite a progression without a note?
A It was quite a long way for a poorly patient, but obviously the night staff actually had not written in since the 3rd.

H

Q Right? So you are talking again about it like being a progressive deterioration?

A Yes, yes.

Q Rather than the improvement for the patient?
A Umm.

Q Are you saying it was another patient, where it was seen that the patient was progressing towards death?
B
A No, no. I do not think we thought at that time. We just thought her pain was uncontrolled.

Q The other way. What we do not seem to know is, what has suddenly happened to this shoulder to make it worse, that the pain became uncontrolled?
A Who are we talking about?

C
Q Elsie Lavender.
A Elsie Lavender? She was... Not quite sure... But the diagnosis we had was a brain stem CVA, which was a left and right paralysis.

Q Right?
A Of the body.

D
Q Right?
A So she was actually paralysed.

Q Okay. You probably cannot help me further, then, to understand, to make sense of those notes. Thank you. One other thing, and I think it follows on really from some of the questions that Dr Roger Smith was asking you. You made a statement as you were giving your evidence, and this was relating to Mrs Richards, Gladys Richards, and talking about her
E
progressive deterioration. You said some things about when the patient starts to die. What does that mean – "a patient starting to die"?
A I do not know.

Q "Starting to die."
A I do not know that either. I do not recall saying that now.

F
Q Just that I made quite a note of that.
A No. I cannot tell you when a patient starts to die.

MRS MANSELL: Right, okay. I will leave that one then. Probably I heard something that you did not say. Okay, thank you.

THE CHAIRMAN: You are very nearly there. I am the last member of the Panel and I
G
suppose, by definition, my job is a bit of a sweeper, and I will attempt to sweep up a number of points. First of all, just following on from the evidence that you have just given in respect of Patient B. I think I heard you say that she was paralysed?
A Left and right. Brain stem CVA.

Q From the neck down? I am not a medical member so you will need to help me.
A Her left side. I think I am right in saying that her left side and her right side were
H
paralysed.

Q From the neck down, that would be, would it?
A Umm.

Q It is just that on the page that you were referred to, 1013, I note that in the higher part of the page, the second entry, for 28 February – this is 1996, yes.
A Oh yes. I can see she was ---

B

Q "Right arm less painful able to lift it above head height."
A Maybe my diagnosis is not right. I am thinking back.

Q I am not going to hold you to it because ---
A I am not sure whether this was 11 or 13 years, but ---

C

Q It is very confusing when there are so many different records, so many different patients and, as you say, so much time has passed and then you have a variety of people firing questions at you from different corners. I do understand how difficult that can be. Clearly that was not right?
A No.

D

Q Obviously she was able to move. The question that had been asked earlier about the syringe driver – I think you had said that if a patient could swallow, then a syringe driver would not be instituted because there would be no reason. You only use that when the patient is not able to take the ---
A It is used in the medical profession for people. Sometimes people walk around with them in their pocket. It is so they can have whatever drug they are having ---

E

Q I should be more specific.
A --- gradually over the 24 hours, or continually over the 24 hours.

Q But syringe drivers on these wards with these sorts of cocktails that we have been looking at appear again and again.
A Yes.

F

Q In those circumstances you would not put somebody onto a syringe driver if they were able to swallow.
A Yes.

Q Is that the point you were making?
A Yes.

G

Q You also said to us that if you were going to put somebody onto a syringe driver, you would not do it if they were unconscious. That was in response to a question ---
A Yes.

Q --- I think from Mr Langdale. As a non-medic, my rather naïve question is, "Why not"? Is there a reason why you would not?
A Would they need it? I do not know if they are not, and you do not know that they are in pain. Would they be? I do not know.

H

Q I am just trying to understand where your answer came from because of course the question would have been again this kind of syringe driver with these kinds of drugs in these circumstances. So I take it from what you say that your point is you would not administer if they were unconscious because if they were unconscious they would not be in pain, so there would be no point. Is that the ---
A Yes.

B

Q That clarifies that one too. Thank you very much. On the matter of consent that I think was particularly dealt with by Ms Julien, you told us at an earlier stage today that we would always get consent before starting them on a controlled drug. If in the normal course of events you were required to start somebody on a controlled drug and you were able to contact the patient's relative, you would give them the information that that was what you wish to do and, as you have said, you would explain why and you would get the consent. Having got the consent to put them on to a morphine or a morphine-type, would you need then to get consent to put them onto a driver or, if you had already got the consent, would it have been necessary?

C

A Yes. It was normal. It was normal to see the relatives before we started the driver, or at least talk to them.

Q Why was that? What is the significance of the driver?
A So that they were kept informed of their relative's condition.

D

Q But if the driver is just containing the same sorts of things – they are opiates designed to keep them pain-free – and you already have permission, is it necessary or is it just a matter of fact?
A It is something. It is a matter of form that we did.

Q Would you say that everybody always did, or that that was your practice?

E

A Yes, yes. On this particular ward, we did.

Q And I think again, picking up from what my colleague had asked, I think you have told us that the words used would depend upon who you were talking to?
A Yes.

Q So, for example, if you were talking to somebody who had only a very basic grasp of medical matters, you might be a lot less specific than if you were talking, for example, to a retired nurse whom you would tell very clearly?

F

A It did not matter who we were talking to. We just tried to make them understand what we were doing, the treatment we were ---

Q Fundamentally what you were doing was giving opiates for the purpose of relieving pain?

G

A Yes, yes.

Q And it was your job to make sure they understood that?
A Yes, yes.

Q You said that you were a named nurse?
A Yes.

H

Q One of your duties was rather colourful – that you were a patients' champion?
A Advocate, I said.

Q Advocate.
A Same sort of thing really, just the nurse to look after their interests if they were unable to, and to liaise with their relatives on certain matters – things that they needed, or washing, or whatever.

B

Q So you would be there to fight their corner, as it were?
A Yes, if they needed somebody. Yes.

Q If they were not able to do so. If they were unconscious, for example ---
A Yes, yes.

C

Q --- you would be the one to question if, for example, a driver should continue?
A Well, we would not give the okay for a driver. We would not take the place of the relatives, but...

Q But if you were the champion or the advocate, it would be part of your role to question whether the driver should continue once it had been instituted?
A Yes, yes.

D

Q And did you ever do that, as a matter of interest?
A I never stopped it, no.

Q Did you ever query, as an advocate for a patient, any of the prescriptions that had been given by any doctor?
A No, no.

E

Q Not this one.
A No.

Q Was that because on the whole the doctors that you worked with were always good professionals and there was not a need to do so?
A There was no need to do so, yes.

F

Q You have been very complimentary about Dr Barton. You have told us that from your experience she clearly had the best interests of her patients at heart and you told us that she would always see patients' relatives ---?
A Yes.

G

Q --- when that was needed.
A Yes.

Q How would you describe her?
A I would describe her as looking after each patient's interests.

Q And with the ---
A She had their interests at heart.

H

Q And when she was seeing the relatives of patients, how would you describe her bedside manner, for want of a better word?
A It was good. It was good.

Q Would you say that all your colleagues would agree with that particular assessment?
A Yes, yes.

B

Q Mr Payne, I think, asked you earlier about the views of your fellow nurses, about the sort of drug regimes that we have been looking at in these records and asking whether they were normal.
A Do not forget we had a pharmacist look at them every week on the ward.

Q Yes, absolutely, and I understand ---
A So why would we question her?

C

Q Indeed. I understand you to say that there is a pharmacist who would come in once a week and who would conduct an audit and had a whole system of checks and balances, including checking to see the appropriate ---
A Checking the treatment, each treatment card.

Q And no doubt that gave you some comfort?
A Of course.

D

Q Because that is a responsibility that you do not have.
A Yes.

Q But were you aware around 1991, for example, of any difference in opinion amongst some nursing colleagues about, for example, the use of diamorphine?
A I was not aware, and I do not think it took place on the ward where I was working.

E

Q So you were not aware?
A No.

Q But you have subsequently become aware of something?
A I have become aware, but it did not actually take place on Daedalus Ward.

F

Q Right. I am not going to ask you about ---
A I was not actually ---

Q --- what you have become aware of afterwards. It was really what you were aware of at the time that you were working.
A No, I was not really.

G

Q And finally, can I look briefly with you at the matters of admission, and when patients first came in and we had been shown the sorts of referral letters that you were given, and you have explained to us that unfortunately the nursing notes do not come on to you from the releasing hospital, which of course must make life more difficult for you than it would be if you knew precisely what had been happening. Fortunately, though, within the system is an assessment by a doctor, and we have seen in these files and others numerous assessments conducted by Dr Barton. There is a particular phrase that we see that comes up time and

H

time again, that you will no doubt be familiar with. It is: "I am happy for nursing staff to confirm death." Am I right that that is something that you ---
A That was written.

Q Yes. It was a common phrase within the ward, would you say?
A Yes.

B

Q And what did it mean?
A It meant that the nurse in charge could do the confirmation.

Q The confirmation of?
A Or two of you usually would perhaps.

Q The confirmation of?

C

A Of the death.

Q So it is at that stage, assuming that there is going to be a death?
A If it did.

Q I am sorry?
A If. If it occurred.

D

Q Yes. If a death occurred. Was it a signal to the nurses that this was one of those patients they are going to have to take a particular care because death was regarded as being ---?
A No, I do not think so.

Q Would it be a normal thing to have ---?

E

A Yes.

Q In all admissions?
A Umm.

Q Somebody comes in ---
A Yes.

F

Q --- for rehabilitation, recovering from a broken wrist?
A We did not actually have anybody come for rehab with a broken wrist. Not this ward that I was working on. I have had heard a story of a man coming in a broken wrist. It did not come in on this ward.

Q So on your particular wards, then, this was a common occurrence?

G

A On our particular ward we would have patients in with perhaps nine diagnoses. It may be a stroke or what had happened to them last, but they all had a string of diagnoses.

Q And some, or all of them, would have had that note at the beginning?
A Yes.

Q Saying, "Happy to confirm"?

H

A Some or all.

Q Did you ever see any patient who had that on their notes at admission, or very soon thereafter, leave the ward recovered, or did they always die?
A I cannot answer that. I do not know.

Q Because you do not remember?
A I do not remember.

B

Q That is absolutely fair. The length of time that has elapsed makes it quite impossible, and perhaps it was an unfair question. Very well. I think that is all I have. Where we go now is that I ask each of the barristers, I am afraid, whether they have any questions arising out of the questions that the Panel have asked. Is that okay? Are you fit to go on with that now, or do you need a break? I know you have been ---
A No, no. We need to get home. We have a long way to go.

C

Q Very well. Then let us go straight across to Mr Langdale and see what questions he may have.

Further cross-examined by MR LANGDALE

MR LANGDALE: Sir, I do have some. I will try and keep them as short as possible as far as you are concerned. Back to Patient B, Elsie Lavender. Do you have that file in front of you?
A Yes.

D

Q You will remember that a member of the Panel was suggesting to you that the case of Elsie Lavender, Patient B, and the case of Gladys Richards, although they had different backgrounds, that there were similarities in relation to what had happened to them at Gosport. It was suggested that they had been rendered unconscious as a result of morphine very soon after their arrival. Do you remember the suggestion being put to you?
A I remember the suggestion, yes.

E

Q I would like to use you to take a look at the history to see what similarities there are. Looking at Patient B, Elsie Lavender, if you look at the very beginning of the file, there is a helpful chronology. It saves you looking through masses of pages. This is the history. Do you see that it shows how she went into Haslar following a collapse?
A Yes.

F

Q I am taking it shortly. That was in March 1995 and the year we are concerned with, February 1996, she goes into Haslar following a fall. On 6 February, this is still in the Haslar, she is commenced on Amoxicillin and she is prescribed coproxamol and dihydrocodeine, which is administered – in other words she gets it – until she is transferred to Gosport. That is on 6 February. Over the page, still at Haslar, the 8th, "Seen by a physiotherapist"; 13th she is seen by a consultant geriatrician; the 16th, Dr Tandy, "Transfer recommended"; 20 February, "Reviewed by physiotherapist", still at Haslar; over the page, there she is on Daedalus on 22 February.
A Yes.

G

Q On that date, assuming that is right, she is prescribed the same drug that she was already on at Haslar.
A Yes.

H

Q There is no change when she arrives at the Gosport War Memorial Hospital. Dr Barton is the person who deals with that. Following on, let us look at the history, 23 February she is not unconscious; 24 February she is not unconscious; over the page you can see that Dr Barton has changed the prescribed drug to MST, which is morphine sulphate tablets. Is that right?
A Yes.

B

Q Still not unconscious. 25 February it is administered, still not unconscious; 26 February, the same drug is administered and on that date, as you can see at the top of the following page, some four days after she has been admitted to Daedalus, Dr Barton does what we have been calling an anticipatory prescription because she prescribes diamorphine?
A Yes.

C

Q If the staff had thought it appropriate to administer the diamorphine, if they had, they could have contacted the doctor?
A Yes.

Q And said, "We think it is time to start". That does not happen, you can see, because on 27 February, the next day, the morphine, the MST continues, and on 4 March, that is almost a week later, four, five, six days later, she is still on morphine sulphate, still conscious. "Reviewed by Dr Barton" on 5 March and then on that date the diamorphine is administered subcutaneously. Do you see that?
A Yes.

D

Q Can we take it that she was not unconscious throughout that period of time?
A Yes.

E

Q Can we tie that point up and turn to a page you have looked at before, page 1013. You can see that she is obviously conscious on the dates covered by that page until we get to the bottom.
A Yes.

Q You will have noticed that the analgesias administered are "fairly effective". She is less painful on 28 February, there is some movement in the right arm. On 1 March she is obviously conscious because she is complaining of pain and slight pain on the 2nd. On 4, March can you see that ---
A What number are you on?

F

Q Sorry, 1013 at the bottom.
A I cannot find 1013.

G

Q Page 1013?
A It is not the printed 1013?

Q It is a typed or printed ---
A You were talking about 28 March, were you? This one only goes up to 06/03.

Q That is the page I am asking you about. I ran through the top dates showing that she is obviously not unconscious, she is conscious. On 4 March she is seen by the physio. Let us

H

look at the exercises when you were asked about your recollection of whether she was immobile in terms of her arms. On 4 March the physio appears to be recommending turns of the head to the right, that is three turns?
A Every two hours.

Q And five neck retractions every two hours, obviously not involving the use of the arms, at least if I am reading it right it does not, but "Elsie needs reminding", so she does that. "Analgesics increased", "Pain uncontrolled, patient distressed". Does that mean, again, that she was not unconscious, she just had a pretty bad night?
A Yes.

Q The syringe driver was commenced at 9.30 and you followed up your normal procedure of explaining matters to the son and informing him?
A Yes.

Q Pain was controlled by the syringe driver on the record on 6 March. I think we can see that that appears to be a rather different history to the history of Gladys Richards who is the lady who came in on readmission to Gosport?
A Yes.

Q Can we turn to her so we can see whether there is any similarity. Would you turn to the file for Patient E, Gladys Richards. Looking at the very beginning of the file again, do you see there is the chronology, do you have that?
A Yes.

Q We can see it goes back quite a way in the early part of 1998. Can we move on to 11 August, which is the third page in on the chronology. She has been operated on at the Haslar, she comes into Daedalus on 11 August, is reviewed by Dr Barton as we can see on the 11th. Dr Barton prescribes Oramorph and also does an anticipatory prescription for diamorphine and the other drugs, midazolam and so on, and that is on the 11th. She is reviewed by the nursing team on the 12th. Oramorph is administered but none of the diamorphine anticipatorily prescribed to be administered subcutaneously is administered. She stays on Oramorph on the 13th. She does not stay in the Gosport War Memorial because she has a fall and is readmitted to Haslar on the 14th.

She comes back, having been administered in the Haslar – it may be wrong – Oramorph. Back to Daedalus on the 17 August which is when you first saw her. You described what happened when she was in a great deal of pain from the unfortunate transfer, it would seem?
A Yes.

Q The Oramorph is administered, as it had been before she left. She is reviewed again on the 18th and that is the first day when the diamorphine is administered. That goes on in the way we can see on the chart with regard to that lady.
A Yes.

MR LANGDALE: That is all I wanted to deal with you so far as any questions from me are concerned.

THE CHAIRMAN: Mr Kark?

Further re-examined by MR KARK

MR KARK: Not very many questions. Dealing with that last patient, just for the Panel, the drug chart at the Haslar is at page 286 onwards. I think midazolam was prescribed in that period and Oramorph was prescribed, but not administered. I want to return to Patient B again, page 1013, which we have already spent quite a lot of time on. Mr Langdale just took you through it and I will not go through all of it, but it appears that right up until 4 March she was able to speak. Are you with me?

A Yes, I am with you.

Q She is seen by the physio, he recommends some exercises for her and he says, "Elsie needs reminding. Analgesia increased". Can we take it from that that the patient at that stage still must have been talking?

A Yes.

Q On 5 March you told us that that note that you made, "Pain uncontrolled, patient distressed" came from the night nurses?

A It must have done, must it not, because it was first thing in the morning?

Q That is what I want to ask you about. How do we know that it did not come from the patient herself?

A I can only assume because it is not actually written down and it should have been written on her night chart that she had a really poor night.

Q I understand that, but this is your note?

A If she had said to us in the morning, "I have a very painful shoulder", she had said that before, we would not have administered a syringe driver for that.

Q When you decided to administer this, would she have been talking to you or would she have been already ---

A I cannot say, can I?

Q That is why I ask you?

A It is 11 years ago.

Q That is why I asked you earlier, would you have given a syringe driver to somebody who was unconscious?

A No, no I would not. I assume she was given it because she had had a very painful night.

Q The only note you have comes from the nursing staff.

A From me.

Q If the patient is awake and talking to you, we have heard a lot about relatives' consent, what about the patient giving consent. Would you have asked the patient for consent...

A Yes.

Q ... to start a syringe driver?

A Yes.

Q You would?
A I could have asked the patient if she would like some morphine for her pain.

Q That is different in a sense. Would you have said specifically to a patient, "We would like to start you on a syringe driver, is that all right?"
A I could have done.

B

Q Would you have made a note of that,"Patient consents to syringe driver"?
A Like I say, she had been complaining of pains in her shoulders right from the first.

Q She has pain from her shoulders all the way along and I wonder what triggers---
A Even the 28th. I said she was distressed, so I assumed she had a really distressing, painful night.

C

Q It follows on from a day when she had some physiotherapy?
A Which may have caused pain, of course.

Q Would you have thought a syringe driver was the appropriate answer to that?
A It depends how much pain she was in, does it not? I obviously thought she was in a lot of pain. Previous to that, even on the 27th, she was complaining of a painful shoulder and we did not put her on a syringe driver then.

D

Q You told us earlier, and I am afraid I had not picked up on this but it came from questions that I think Mr Langdale asked you, that you did not have kits for intravenous fluid. Is that right?
A No, I do not think we did then.

E

Q If the effect of a syringe driver is that the patient becomes unconscious, the effect of that equally is that they cannot take fluid any more. Is that right?
A Yes.

Q If they cannot take fluid any more and you do not have any intravenous kits, what is going to happen to the patient? What effect is that going to have on their body?
A (Pausing to review documents) I am just looking for a fluid chart and I cannot find that.

F

Q If the patient becomes unconscious because a syringe driver has started, is there an effect not only from the opiates but also from the fact that the patient is not getting any fluid?
A We always gave the patient mouth care and moistened their mouth.

Q Yes, I understand that. It is to make the patient more comfortable. But is that going to rehydrate the patient?
A No, it is not enough.

G

Q Was there any system for rehydrating a patient once the syringe driver had started?
A Yes, we used to give the patient a sub-cut, but I cannot remember if we gave it when Elsie Lavender was on the ward.

H

Q I am sorry, just explain that, could you? A "sub-cut"?

A We place a little needle under the skin, in the subcutaneous part of the skin. The actual needle has a tube on it, which is connected to an IV bag; so we could actually give the patient fluids.

Q I am not a medical person, so I might have misunderstood. When you said you did not have any intravenous kits, I assumed that was what you were talking about.
A That is IV, into the vein. I cannot remember if we had the sub-cut on the ward at this time when Elsie Lavender was there.

B

Q If you did not, would there be any other way of getting hydration into the patient?
A No.

Q If you did have a sub-cut, intravenous kit, would that be noted on the record somewhere?
A It should be, yes. There should be a chart for it.

C

Q When you get consent, as you spoke about to a number of Panel members, from one of the patient relatives – and that is to the start of a syringe driver – would you explain to the relative, "But we don't have any system for rehydrating your mother/your father"?
A We would explain if they asked us, yes.

D

Q I am sorry? You would explain if they asked you?
A We would have explained if they had actually asked, yes.

Q If they did not ask…?
A Yes, we would explain.

Q You would explain?
A Mmm.

E

Q The effect of that would be what on the patient?
A I mentioned before that there was research at one point to show that that was more harmful for the patient.

Q Is that when the patient is in the last stages of life?
A In the last stages, yes.

F

Q It is when the patient is dying. You do not want to rehydrate them.
A Yes, but I should imagine that is why the sub-cut was brought in: for wards that could not use the IV.

Q One last topic, and it is very short I promise you. This is in relation to Patient E and her hip. Do you remember when she came back she had a haematoma?
A Yes.

G

Q The doctor was asking you about how you make a decision about the level of pain relief that that patient would need, if you would ever wake them up again. Do you remember that discussion you had with him? If the patient is unconscious, how do you tell that they still need pain relief?
A I said I cannot understand how anyone can ascertain that.

H

Q No, we understand that. Is there any active measure that can be taken to relieve a haematoma?
A I am not sure. Not being a surgeon, I cannot really answer you.

Q Do haematomas sometimes resolve spontaneously?
A Yes.

B

Q Would you have any way of knowing whether that haematoma resolved after the X-ray or not?
A Unless we gave another X-ray, I do not know.

Q Or woke the patient up and asked if it still hurt?
A But we did give her 2.5 mg of Oramorph at the time. It was only a small dose, for her pain.

C

Q Not from the 18th onwards.
A When she came; when she actually was admitted on the ward, that is what I gave her.

THE CHAIRMAN: Mrs Couchman, that really is the end. Thank you very much indeed for coming to assist us today. I know it is very hard, particularly when you have to take so many questions from so many different people over such a sustained period, and we are extremely grateful to you for maintaining your patience and good humour. You are free to go.

D

(The witness withdrew)

THE CHAIRMAN: Do we have any news of Dr Peters?

E

MR KARK: We do. We have finally made contact with her. We gather that she did not realise that she was meant to come today. I have to say that my instructing solicitors had made quite strenuous efforts to ensure that she did know, and it is a surprise and unfortunate that she did not.

We have rescheduled her at the moment, after much discussion, for 30 June, which is something of a sort of clear-up day before we start on the expert, and we have made it very clear how important it is that she does attend on that day. In a sense, it is actually a good thing she did not come today, because we would have run out of time to hear her. As a result of that, we are essentially still on track; but, as one can see from this last witness, we do think that things are going to go rather slower with the nurses, who we are beginning to get to.

F

The next event, as it were, is the reading of Mr Jewel's statement; but you, I expect, will want a bit of time to change gear and have a look at Patient I, Enid Spurgin's opening and note. Then tomorrow, other than that reading, we have three relatively short witnesses for you. They are all coming to talk about Mr Geoffrey Packman, and no doubt you will want time to read that as well. We are therefore in your hands as to how you want to play this.

G

THE CHAIRMAN: I am not going to ask the Panel to embark on any more reading today. It has been a long, difficult day, I think, for all of us, but a useful day none the less.

H

What I propose is that the Panel will start here at 9.30 tomorrow as normal and will use the first 30 minutes to reacquaint themselves with Patient I; then we can hear the statement read. Then I guess that it will be another period of study before we get on to the witnesses.

MR KARK: Sir, I do not think that you have Patient I's medical records yet.

THE CHAIRMAN: No, we do not.

B

MR KARK: I do not know if that is included in the 30 minutes that you are giving yourselves.

THE CHAIRMAN: No, probably not. I think that would be over-ambitious.

MR KARK: Can I say that Patient I's notes are about the thinnest so far, if that is any encouragement to you; nevertheless, they will take a bit of time. I would have thought that you might want to set aside an hour.

C

THE CHAIRMAN: Shall we say not before 10.30, unless you are otherwise requested to attend?

MR KARK: Yes, certainly.

D

MR JENKINS: Sir, can I deal with one matter arising from the transcript of yesterday? I do not know if you have it in front of you.

THE CHAIRMAN: We can swiftly do that.

MR JENKINS: I just have one, what I hope is a typographical error, because it was me speaking at the time. It is Day 6, page 41E. The question I think I asked was, "But was she", meaning Dr Barton, "telling you that your *husband's* condition, sadly, was rather poor?" The word has come out as "benzodiazepine's".

E

THE CHAIRMAN: Yes, they are not phonetically similar but I think that you are probably right.

F

MR JENKINS: I am grateful. I think the answer that the relative gave, Mrs Kibley, was "I cannot think of the *word* at the moment", not "ward".

THE CHAIRMAN: Again, I think that is likely.

MR JENKINS: I raise it while it may still be fresh in the memory. I will not trouble you again if there is an error as small as the second one, but the first was rather a departure from what I think I said.

G

THE CHAIRMAN: Any careful scrutiny of minutes will always reveal a few like that, but that is clearly quite an important one; so thank you for that.

MR LANGDALE: Perhaps we can ask Mr Jenkins to check all the transcripts!

H

THE CHAIRMAN: What an excellent idea! As he has been so under-employed so far, it seems only fair that he carries his share!

The Panel adjourned until 9.30 a.m. on Wednesday 17 June 2009
and the parties were released until 10 a.m.

B

C

D

E

F

G

H