GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 26 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 FOURTEEN)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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MR KARK: Sir, may I mention something in relation to the witness attending this morning, Beverley Turnbull? She has literally just handed to us a signed version of her statement – we had previously had an unsigned draft – in which she has made some amendments. I am afraid we have only just been able to disclose that to Mr Langdale and Mr Jenkins. She did not want to send it back through the post apparently because she was frightened of it getting lost. That is why she has turned up with it here today.

I do not think the amendments will take my learned friends very long to read. They will probably be grateful for them. What I would propose to do is carry on with the witness in chief and then if the defence need any time, then I am sure they will be given it.

THE CHAIRMAN: Are you happy with that, Mr Langdale or Mr Jenkins?

MR JENKINS: He is and I am too. The amendments do not take me by surprise and it does not cause any difficulty at all.

BEVERLEY ANNE TURNBULL, Affirmed
Examined by MR KARK

(Introductions)

MR KARK: I think it is Beverley Anne Turnbull, is that right?
A That is correct.

Q Is it Mrs Turnbull?
A Ms now.

Q Ms Turnbull, I want to ask you now please about your training, your professional background, before you started working, as I think you did, at the Redcliff Annex and then you went on to Dryad Ward at the Gosport War Memorial Hospital. Before you got to the Redcliff Annex, when were you qualified as a nurse?
A I qualified in 1965 as a state-enrolled nurse – '65 to '67 was my training.

Q When eventually did you come to be employed at the Redcliff Annex, do you remember?
A I think it was approximately 1976.

Q At that time, the Redcliff Annex was what sort of ward or hospital?
A It was a continuing care unit.

Q What did that really mean? What sort of patients were you dealing with?
A Patients that were at end stage of life; they had chronic medical problems.

Q When you were at the Redcliff Annex, were you then a state-enrolled nurse?
A I was a state-enrolled nurse.

Q Did you later become a state-registered nurse?
A I did, yes.

Q Did that require you passing further qualifications?

A Yes, it did.

Q When you were at the Redcliff Annex, we have heard a little bit about that, we gather that although it was part of Gosport War Memorial Hospital, it was not in the same building; it was in an annex some miles away. Is that right?
A Yes.

B Q But still in the Portsmouth area?
A It came under Gosport War Memorial.

Q Did you focus I think your duties on night duties?
A At first when I was there I worked on day duty, just weekends.

Q Then later on?
C A In 1981, I cannot remember approximately the dates because it was a long time ago, I went on to night duty.

Q Did you remain on night duty for quite a while?
A I remained on night duty, yes.

Q Prior to coming to the Redcliff Annex, had you had any particular dealings with that
D sort of patient – long term, elderly patients?
A No, only in my training.

Q Does it follow that some of the patients that you would have been dealing with were there for palliative care?
A Yes.

E Q What was your understanding of palliative care?
A Basically to keep the patient comfortable and to give them a fair quality of life until the end of their life.

Q But at that stage of the patient's care, is it recognised that the patient is at the end or coming towards the end of their life?
A Yes.
F

Q Do not agree with me if I make a suggestion like that. You hesitated. You can put it in your own words.
A No, that is right.

Q Do you remember the time when Dr Barton came to the Redcliff Ward?
A Yes, vaguely.
G

Q Up until the time that Dr Barton arrived, what had been the system in relation to doctors at the hospital?
A The patients would have their own general practitioner to care for them, to look after them.

Q How often would you get a doctor on the ward, as it were?
H A Because I did night duty, not very often.

Q Once Dr Barton arrived, did you remember there being any sort of change of practice?
A Not immediately, no.

Q Subsequently?
A I think then subsequently the syringe driver was brought in.

B Q Prior to Dr Barton arriving at the Redcliff Annex, had you been using syringe drivers?
A Not that I can remember.

Q But your recollection is that once Dr Barton arrived, at some stage thereafter so did syringe drivers?
A That is correct.

C Q We have heard, as you will appreciate, a lot of evidence already before you are sitting in that chair now, and we have heard a lot about the use of opiates and diamorphine and Oramorph, so we know a little bit about that. Again, can you remember what the level of the use of opiates was prior to Dr Barton arriving at the Redcliff Annex?
A Not really, no, I cannot remember.

Q When syringe drivers started being used, to your recollection, what sort of drugs were
D they being sued for?
A Could you repeat that?

Q Yes. Once syringe drivers arrived at the Redcliff Annex, can you remember what sort of drugs they generally tended to be used for?
A The syringe driver, generally diamorphine, midazolam and hyoscine.

E Q I am not going to ask you for an explanation of those drugs because we have heard quite a lot about them already. Did there come a time when you transferred over; the Redcliff Annex closed and you moved over to Dyad Ward at the Gosport War Memorial Hospital?
A Correct.

Q Can you remember exactly when that was?
A No.
F

Q Did you continue to work night duty at the Dryad?
A I did, yes.

Q What would night duty at Dryad Ward mean? What was the period of time?
A We came on duty at a quarter past 8 in the evening until a quarter to 8 in the morning.

G Q How many nurses, if you can generalise this, would be working night duty?
A Generally three on a ward.

Q And Dryad Ward we have heard a bit about, would normally have how many patients, approximately?
A 20

H Q Would it be full with 20?

A Not all the time but it was a 20-bedded unit.

Q They type of patients that you had on Dryad Ward when you started were what?
A Again patients with quite severe medial problems, some orthopaedic patients ---

Q Orthopaedic paitnes means patients due to have operations at the Royal Haslar or Queen Alexandra?
B A Yes.

Q And they were coming to you for what?
A Supposedly – I say supposedly – rehab.

Q Why do you say that?
A Because we did not really have the facilities.
C

Q What other sort of patients did you have?
A Patients with dementia, Parkinson's, patients that had had a CVA, numerous CVAs.

Q Cerebral vascular accidents?
A Yes, cerebral vascular accidents and generally patients with medical problems.

D Q Somewhere in one of our bundles we have a plan and I am going to ask for your assistance, please. I think you have a plan just to your right, have you?
A I have, yes.

Q It has been put in I think at tab 11. I am probably going to get this wrong, but if we ignore for the moment the words "Dryad and Daedalus" and turn it the other way up so that the plan is as it was meant to be when it was printed with the typewritten words "Gosport
E War Memorial Hospital" on the right-hand side. Do you see at the bottom right-hand side it says Fareham and Gosport?
A Yes.

Q That is the way that we want it so that we are all looking at the plan in the same way. You and I have had a little introduction to this plan and I am very grateful to you for your assistance. On the left-hand side in the middle of that central block is that where we find the
F entrance?
A Yes.

Q We can see almost half way up the plan there is what is meant to be a door and then there is a long corridor in front of it. Can you hold your plan up and point to the entrance?
A The entrance is <u>there</u>.

G Q In front of that we can see that there is a long corridor or passageway with a number of doors in it. Let's take it from the front door of the hospital. If we were to go through that front door and then turn left into that long block heading up towards the top of the plan, is that the outpatients?
A Yes, that is right.

Q Is that whole block outpatients?
H A It is outpatients and the one on the far right there would be the health centre.

Q If we came in through the main door of the hospital and turned right that is going down towards the health centre, is it?
A Yes. It was then a separate building.

Q A separate area?
A Yes.

Q If we come back to our entrance and we walk straight down the corridor we can see that we get to a point where the corridor bears right or you can turn left through a pair of double doors.
A That is right.

Q Does that take us towards Dryad?
A That is correct, it does.

Q We can see that if we go through those double doors and then another two sets of double doors we get to a dark shaded area. Is all of that dark shaded area Dryad Ward?
A It is.

Q Let's come back to the double doors just as we head towards Dryad and we have just come off the main corridor. As we go through those doors there is another large set of rooms on the left just before we get to Dryad Ward. Can you tell us what that is?
A That would be the kitchen and the nurses' restroom.

Q It looks rather large but did that kitchen serve the whole of the hospital?
A It did, yes.

Q Opposite the kitchen on the right-hand side, going back to our corridor going down towards Dryad, is that a canteen?
A That is the canteen.

Q Then we have a sort of big open area right in the centre of that block. What was that?
A That is a quadrangle, gardens from Dryad, and also an area that you could get from the canteen into the quadrangle.

Q Was that a garden as with flowers and grass?
A Yes and a patio area so that patients and relatives could go into that area.

Q Then we find ourselves in Dryad Ward if we go straight down past the kitchens, past the canteen and we go into the ward. If we go straight ahead up towards the top of the plan, it is difficult to see because it is shaded in but is there a large room sticking out of it on the left top?
A Yes.

Q What is that room?
A That would have been a patients' sitting room.

Q Did that have chairs and a TV?
A It had chairs, TV and bookcases.

Q If we head on round presumably we have the various wards, the single rooms, of Dryad Ward.
A That is correct.

Q Let's come back to our long corridor. Instead of turning left towards Dryad Ward, let's take that route which is where the corridor bears right. If we were to follow that corridor down to those double doors at the end where do we find ourselves?
A That would be Daedalus Ward.

Q Is there a physio block to the left?
A Yes, there was a physio area.

Q If we go straight down that long corridor and through those double doors and keep to the right-hand side of the plan, is that where we find Daedalus?
A Can you repeat that?

Q Going straight down that corridor that bears off to the right and then through those double doors it looks as if you have got to do a right and a left.
A Yes, Daedalus would be sort of up this end and Dolphin Day Hospital would be down the other end.

Q Let's find the Dolphin Day Hospital. If we look to the right-hand side of that big block we can see that it is almost a mirror image of Daedalus on the other side and Dolphin Day Hospital is around that area, is it?
A Yes, it is.

Q In between the Dolphin Day Hospital and Dryad Ward there is one more area which is unshaded.
A That would be the Phoenix Day Hospital.

Q What sort of patients did the Phoenix Day Hospital look after?
A Phoenix Day Hospital looked after elderly mentally infirm patients.

Q Could you go from Dryad Ward into Phoenix Day Hospital?
A You could actually right at the far end of Dryad, yes, but obviously the doors were locked.

Q To stop people wandering too far.
A Yes.

Q Let's take you back again to Dryad Ward. You are working nights and you have now moved from the Redcliff Annex. Who were the other nurses who worked with you on night duty?
A Generally it could be another trained member or two support workers.

Q When you say another trained member, do you mean another trained nurse?
A A trained nurse, yes.

Q You have mentioned the use of syringe drivers. Did you yourself ever set up a syringe driver?
A Very rarely.

Q Why would that be?
A At that time I was still an enrolled nurse and there would have to be another trained nurse with me or the syringe drivers would already be in situ.

B

Q Did you yourself ever have to recharge a syringe driver?
A Yes.

Q Was that a common event?
A It would just be occasionally.

C Q Did you yourself change medication in the syringe driver or was that a rarity?
A Only if a syringe driver needed to be recharged.

Q When I say change medication I mean increase or decrease the amount.
A Again, very occasionally.

Q We have all heard about a lady called Sister Hamblin. Did you know Sister Hamblin?
D A I did.

Q How much contact did you have with Sister Hamblin?
A Sister Hamblin was the ward manager or the sister at that time and I would be in contact with her at the end of my shift or sometimes at the beginning of my shift.

Q Was that at the point of hand-over?
E A That was at the point of hand-over.

Q Tell us a little about hand-overs and what actually happened?
A Hand-over before you came on duty you would go into an office and whoever was in charge of the ward would give you a hand-over of the patients, their conditions and again that was done in the morning after a night shift and anything that obviously needed reporting would be handed over, any concerns about the patients.

F

Q Is that an exercise that you would sometimes perform with Sister Hamblin or would it normally be with other nurses?
A It could be with Sister Hamblin or it could be with the trained nurse in charge of the shift at that time.

Q In the early 1990s was there some disturbance among the staff in relation to the use of
G diamorphine and syringe drivers?
A Yes.

Q It is a long time ago so I want to take you to some documentation. On your left you will see a file which has on its spine "Panel Bundle Documents 1". Please turn to tab 6. I am going to go through some of these documents with you and ask for your assistance as to what was happening on the ward at the time. We can see that the first document at page 2 is
H entitled "Summary of meeting held at Redclyffe Annexe on 11 July 1991".

A That is correct.

Q We can see:

"A meeting was arranged for the trained staff at Redclyffe Annexe following concern expressed by some staff at the prescribed treatment for terminal patients".

B This, it is obvious, is that fairly shortly prior to the change to Dryad Ward?
A I cannot actually remember the dates.

Q Can we look at who was there. We can see that there was somebody called Mrs Evans. Was she a manager?
A She was at the time the matron of Gosport War Memorial.

C Q We can see that there was Sister Hamblin and Sister Goldsmith, Nurses Giffin, Ryder, Barrett, Williams, Donne, Tubritt, Barrington and yourself.
A That is correct.

Q I think all of the other nurses were state registered nurses.
A They were.

D Q For those of us who do not have any medical training, the difference between a state registered nurse and an enrolled nurse?
A Basically the enrolled nurse did two years' training and it was more on the practical sides of nursing and the state registered nurse was obviously trained in the theory as well as the practical and management sides.

Q Like it or not, is it a higher qualification?
E A It is.

Q Can we have a look at what the concerns were. This is when you were still at the Redclyffe Annexe.

"The main area for concern was the use of diamorphine on patients. All present appeared to accept its use for patients with severe pain but the majority had some
F reservations that it was always used appropriately at Redclyffe. The following concerns were expressed and discussed: not all patients given diamorphine have pain."

Looking at this document now, are these concerns that you recall being raised?
A Yes.

G Q Did you share those concerns yourself or not?
A I think I did because it was a long time ago. I think I did, yes.

Q The first concern was that not all patients given diamorphine had pain. What was your understanding of the appropriate uses of diamorphine?
A Then I think diamorphine probably would have been the last choice of drug given following the analgesic ladder and if that did not work then obviously you would go on to the
H narcotic drugs.

Q The question I asked you was slightly different. What was your understanding of the appropriate uses of diamorphine? There is reference here to it being given for patients effectively without pain. Was it your understanding that diamorphine could appropriately be used upon patients who did not have pain? Could it be used for other things?
A It could have been used for other things.

Q Appropriately?
A Yes.

Q Do you know what those other things were?
A If a patient is really distressed; if they cannot swallow.

Q You just mentioned the analgesic ladder. Do you remember what the principles of the analgesic ladder were?
A Yes, to start on the lower dose of analgesia and then work up to the next level of analgesia if the first one was not working.

Q The first concern that was being raised was that not all patients given diamorphine had pain. The second concern was that:

> "No other forms of analgesia were considered and the 'sliding scale' of analgesia is never used,"

and that is something you just referred to.
A Yes.

Q That is the analgesic ladder, is it?
A Yes.

Q "3. That the drug regime is used indiscriminately. Each patient's individual needs were not considered and that oral and rectal treatment is never considered.

4. That patients' deaths are sometimes hastened unnecessarily."

I will pause there because I should break this up. Do you recall whether you shared these concerns?
A I did.

Q "5. The use of a syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients' needs.

5. That too high a degree of unresponsiveness from the patients was sought at times."

What does that mean to you?
A That patients, when they went on the syringe driver, did become quite unresponsive.

Q The concern apparently that was raised was that too high a degree of unresponsiveness from the patients was sought at times. How would you interpret that?
A That they became ... That they were ... That they became quite un... That they were heavily sedated.

Q "7. That sedative drugs such as thioridazine would sometimes be more appropriate."

So that would be an alternative, would it?
A In those days, yes.

Q "That diamorphine was prescribed prior to such procedures such as catheterisation where diazepam would be just as effective.

That not all staff views were considered before a decision was made to start patients on diamorphine – it was suggested that weekly 'case conference' sessions could be held to decide on patients' complete care.

That other similar units did not move diamorphine as extensively."
Again, were these concerns that you shared with others?
A It ...s... Yes.

Q Were you going to say some?
A It was a long time ago. I think, yes – yes, it was.

Q We can see that there was no doctor present.
A That is correct.

Q Could you help us, what had brought this meeting about?
A Going back to the top of the page, the person did bring these concerns, unfortunately she has died, Staff Nurse Giffin. She was the one that first brought this to the other staff's attention and initiated the meeting.

Q Was this sort of meeting a common occurrence or a rare occurrence?
A It is a long time ago. I think she aired her concerns and I think she mentioned it to some other staff and then they went to the matron and they wanted a meeting.

Q Then if we go to the bottom of the paragraph:

"Mrs Evans acknowledged the staff's concern on this very emotive subject. She felt that the staff had only the patients' best interests at heart but pointed out that it was medical practice they were questioning that was not in her power to control. She felt that both Dr Logan and Dr Barton would consider staff views so long as they were based on proven facts rather than unqualified statements. Mrs Evans pointed out that she was not an expert in this field and was not therefore qualified to condemn nor condone their statements. She did, however, ask them to consider the following in answer to the statements made.

That the patients suffered distress from other symptoms beside pain but also had the right to a peaceful and dignified death. That the majority of patients had complex problems.

If 'sliding scale' analgesia was appropriate in these circumstances, particularly when pain was not the primary cause for patient distress that terminal care should not be confused with care of cancer patients.

The appropriateness of oral treatment at this time considering the patients' deterioration and possibility of maintaining ability to swallow. The range of drugs available to cover all patients' needs in drugs that can be given rectally together with patients' ability to retain and absorb the product.

It was acknowledged that excessive doses or prolonged treatment may be detrimental to patients' health but was there any proven evidence to suggest that the small amounts prescribed at Redclyffe over a relatively short period did in fact harm the patients.

It could be suggested to Dr Barton that drugs could be given via a butterfly for the first 24 hours to give trained staff the opportunity to regularise dose to suit patient."

I am going to pause there. What does that mean? Why is that different to a syringe driver? If you cannot tell us ...

A I cannot; I do not know.

MR KARK: "That treatment sometimes needs regularising as patients' condition changed – were staff contributing signs of ..."

MR JENKINS: I think it means "attributing".

MR KARK: I am grateful; you are right.

"Were staff attributing signs of patients' deterioration to effects of drug? Few patients remained aware until the moment of death."

MR JENKINS: It is "awake".

MR KARK: I think it could be either.

THE CHAIRMAN: Mr Jenkins, may I ask if you are going to interject if you could put your microphone on to ensure that we are properly on the transcript.

MR KARK: I am not going to read through all of this but we can all do that. We can see towards the bottom of the page the penultimate bullet point:

"Is it appropriate to give diamorphine for other distressing symptoms other than pain."

Then over the page we see:

"To try and find the answers to these questions Mrs Evans would invite Kevin Short to talk to staff on drugs and ask Steve King from Charles Ward if he would be prepared to contribute to discussion.

This would take time to arrange. Meanwhile staff were asked to talk to Dr Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff."

B

And the writer hopes to have included everyone's view in the summary.

If we go two pages on, to page 6, this issue seems, as it were, to have bubbled on.
A That is correct, it did.

Q Do you remember that?
C A Vaguely, but yes.

Q There was another meeting at the end of October of 1991 and again you attended, but this one was a rather smaller meeting. This is a report by somebody called Gerardine Whitney and the purpose of her visit apparently was in a response to a request by Staff Nurse Anita Tubritt to discuss the issue of anomalies in the administration of drugs. So was this a meeting that took place with Gerardine Whitney?
D A It did, yes.

Q Then I think problems were set out. The first was that:

"Staff Nurse Giffin reported a female present who was capable of stating when she had pain was prescribed diamorphine via syringe driver when she was in no obvious pain and had not complained of pain."

E

There was another patient who had been admitted from St. Mary's who was recovering from pneumonia:

"... was eating, drinking and communicating was prescribed 40 mgs of diamorphine via a syringe driver together with hyoscine over 24 hours. The patient had no obvious signs of pain but had increased bronchial secretions.

F Staff Nurse Tubbritt reported that on one occasion a syringe driver had run out ..."

And that it was not meant to.

"The staff are concerned that diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquilisers being considered or
G prescribed."

Again I am going to pause. Do you recall, first of all, these concerns bubbling on at the back end of 1991?
A I do.

Q Did you share those concerns?
H A I did, yes.

Q We see that there were three nurses actually present. May I ask you this: were you there in an individual role, as it were, or were you there representing others?
A I think I was there representing ... In both, actually – yes, in both, I think. Individually and also representing ...

Q The concerns of others.
A Yes.

Q "Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had intramuscular 10 mg diamorphine ..."

On two occasions, I think, for a manual evacuation of faeces. And there were various other concerns raised by other nurses. If we go to half way through the next page, do you see underneath the word "note", which is underlined:

"The staff cannot understand why the patient was prescribed Oramorph and diamorphine.
When the staff questioned the prescription with Sister ..."

Would that be Sister Hamblin?
A It would, yes.

Q "They were informed that the patient had pain. The staff recalled, having asked the patient on numerous if he had pain, his normal reply was no."

May I ask you this as a generality – and we will come back to it when we look at notes later on – you were a night nurse.
A Yes.

Q If a patient complained of pain while you were on duty, is that something that you would make a note about or not necessarily?
A I would make a note of that, definitely.

Q You seem very certain about that.
A Yes, I would.

Q Why? Why would it be important?
A Because it would have needed to have been addressed by the medical team in the morning.

Q So that they would see your note.
A Yes.

Q And take appropriate action.
A Yes.

Q "Conclusion. The staff are concerned that diamorphine is being used indiscriminately even though they reported their concerns to their manager on 11 July ..."

So that is many months earlier.

> "The staff are concerned that non opioids or weak opioids are not being considered prior to the use of diamorphine.
>
> The staff have had some training, arranged by the hospital manager, namely:
>
> - the syringe driver and pain control;
> - pain control."

Do you remember that training? Did you have training in syringe drivers yourself?
A Again, it is a long time. I have the vague recollection. I think yes.

Q Then we can see that somebody got hold of a video – Nurse Tubritt – entitled *Making Pain Management More Effective*

I think you also produced the letter that we have at page 10 and this was written by somebody called Steve Barnes, who is an RCN Officer. What does that mean? What is his role?
A He belongs to the Royal College of Nursing, which represents nurses, and he was at that time the representative.

Q Why had it got into his desk, as it were?
A Because we felt that we were not getting anywhere and we needed to go to the Royal College of Nursing.

Q Was that a common event or a rare event?
A That was a rare event.

Q I am not going to read all the way through this letter, but if we look at the second paragraph, this is a letter dated 22 November 1991 from Steve Barnes to Mrs Evans, the Patient Care Manager at GWMH:

> "This office was aware of the concerns that had been expressed by staff earlier this year and other discussions that had taken place with yourself as the manager. It had been understood that the concerns raised would be addressed and the RCN had anticipated that clear guidance/policy would be promulgated as a result of the very serious professional concerns nursing staff were expressing.
>
> It is now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated."

I am not going to read the rest of that but the last line of that paragraph:

> "We now expect a clear policy to be agreed as a matter of urgency."

The next page actually is a copy – a different recipient's copy I expect – of the same thing. If we go to page 13 we are now in December of the same year. I will not take you through that letter specifically. If we go to page 14 we are still in December. This is now Mr Murray who

is a Branch Convener writing to the District General Manager, Mr West. Again, do you remember this issue bubbling on into December?
A Yes, I do.

Q I am going to try to be limited with this letter. First of all he says that the problem has been brought to his attention in April 1991 but apparently has been present for the past two years. He says:

> "I was contacted by a staff nurse who is currently employed on night duty at the Redclyffe Annex. Her concern was that patients within Redclyffe were being prescribed diamorphine who she felt did not always require it, the outcome being that the patient died. The drug was always being administered by syringe drivers. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues."

Who was that member of staff?
A Can I continue to read it to refresh my memory, please?

Q Certainly. (A short pause) If you go to the paragraph after the next:

> "Following the aforesaid meeting two study days on 'pain control' were arranged. As you will see from the minutes relating to the meeting of 11 July 1991 ..."

Which we have looked at:

> "... some of the concerns voiced by the staff were that diamorphine was being prescribed for patients who were not in pain and these study days did temporarily alleviate the worries of the staff.
>
> Regrettably the concerns of the staff have once again returned. One of the staff nurses, who is currently on an ENB course, was talking to Mr Whitney."

Would that have been you or not?
A I cannot remember. I do not think it was me.

Q Over the page there is a discussion about a grievance being lodged.

> "I feel that the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain amount of ostracization."

Tell us about that.
A Sorry, can I go back to your previous question. I said it could have been me because I did do an ENB course but I cannot quite remember.

Q It is a long time ago and I do not think that anybody is going to criticise you for not remembering something that was so many decades ago. But Mr Murray writes that the staff had acted professionally and there had been a certain amount of ostracization. Can I ask you about that? What happened?

A From what I can remember there seemed to be on the unit where I worked tension, and that we were perhaps labelled trouble makers.

Q Tension between whom?
A Some other staff, mostly day staff, and that we were labelled trouble makers.

Q Was the day staff and night staff?
A Generally day staff.

Q And you of course were night staff?
A Yes.

Q And the trouble makers were who?
A Us, we were the trouble makers.

Q Next paragraph:

> "I have various concerns for the patients and subsequently their relatives, the staff in that they are working in this environment but also that this could be leaked to the media. While none of the staff or myself have any desire whatsoever to use this means, there is serious concern from both myself and the staff that someone could actually leak this and I hope you know my feelings about the media and using it as a means of resolving problems. ..... I hope you agree with me in that we have to address this issue urgently."

He is seeking his advice.

> "I must stress that none of the staff have shown any malice in what they have said and that their only concern is for the patient."

Next we have a letter to Ms Tubbriff, which I am not going to ask you about. Could we go to page 17. In fact it is going backwards in time and I think it is really repeating the same matters. Can I ask you to help us with this? We have seen a lot of discussions about the issue and the hope that there would be a positive response and something would come out of all of this. Can you just help us with this? Was any protocol devised or any written policy that you can remember that came out of these meetings?
A No.

Q Can we go towards the end of December, to page 23, please? This is another meting that I think you attended. This time it is on 17 December 1991. The first page I think sets out the background. Over on page 24:

> "As Mrs Evans had presented staff's concerns she stated the problem as she saw it and invited staff to comment if they did not agree with her interpretation."

So this is the manger speaking?
A It is. Sorry, the matron.

Q Let us just see who the matron was addressing. On the page before: Mrs Evans, Patient Care Manager, is her description, then we have Dr Logan and Dr Barton was there, Sister Hamblin, a number of nurses, including yourself.
A That is correct.

Q Did you yourself have any direct discussion with Dr Barton about this issue?
A I cannot remember.

Q Mrs Evans said the following:

"We have an increasing number of patients requiring terminal care.

Everyone agrees that our main aim with these patients is to relieve their symptoms and allow them a peaceful and dignified death.

The prescribing of diamorphine to patients with easily recognised severe pain has not been questioned.

What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain."

I asked you a bit about this earlier on. I am going to come back to it. What other symptoms was diamorphine being used for?
A If a patient is in distress, if they have excessive secretions.

Q We are talking about diamorphine?
A Sorry, yes, some breathing problems.

Q Anything else that you can remember?
A I cannot think of anything else at the moment.

Q "5. No one was questioning the amounts of diamorphine or suggesting that doses were inappropriate."

Was that right?
A I think so. It is a long time ago. I cannot really remember.

Q "All present agreed with these statements, no other comments were asked to be considered."

I know it is a very long time ago but can you remember any of the staff putting up a hand and saying," Hang on"?
A No, I do not. I cannot.

Q Can you remember anything about the tenor of these meetings, what this particular meeting was like with the doctors there and the manager?
A I have a vague recollection that I think we felt that we were not getting anywhere. Obviously we were not medically experienced enough or not medically trained.

Q And so?

A Basically that we were banging our heads against a brick wall, from what I can remember.

Q Then we can see in the bottom half of the page that Dr Logan then spoke to the staff at length on symptom control and covered a number of issues.

"The first priority was to establish cause of symptom and remove cause if possible.

Where appropriate the 'sliding scale' of analgesics should be used.

Oral medication should be used where possible....

The aim of opiate usage was to produce comfort and tranquillity at the smallest necessary dose – an unreceptive patient is not the prime objective.

The limited range of suitable drugs available if normal range of analgesics not effective.

That diamorphine had added benefits of producing a feeling of well being in the patient.

The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems....

It was not acceptable for patients who are deteriorating terminally, and require 2 hourly turning, to have pain or distress during this process. They require analgesia even if they are content between these times."

Then Dr Logan said he would be willing to speak to any member of staff who still had concerns. Then this:

"....after speaking to Dr Barton or Sister Hamblin. Comments raised during discussion were:

(a) All staff had a great respect for Dr Barton and did not question her professional judgement."

Is that right?
A That is correct.

Q Are you still of that view?
A Yes.

Q "The night staff present did not feel that their opinions of patient's condition were considered before prescribing of diamorphine.

A That was true as well.

Q "The patients were not always comfortable during the day even if they had slept during the night."

So I suppose it is a fair comment to make that you did not know what was happening during the day with these patients?
A That is correct as well.

Q Other than what you read in the notes?
A That is right, yes.

Q "There appeared to be a lack of communication causing some of the problem.

Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms."

Did you share that fear?
A Yes, I did.

Q "All staff agreed that if they had concerns in future related to the prescribing of drugs they would approach Dr Barton or Sister Hamblin in the first instance for explanation..."

Can you ever remember actually doing that when you had a concern, going up to Sister Hamblin and saying, "What is happening her?"
A No, I did not.

Q May I ask why not?
A Because we felt that she would not listen to us.

Q What about going to Dr Barton?
A I cannot remember actually. I think I used to sometimes, going off duty, see Dr Barton and if I did have any concerns, yes, I think I did.

Q What would happen?
A Sometimes Dr Barton would come in just as we were going off and I would say, if I did have any concerns; yes, I would let her know what kind of night a patient did have.

Q So you would be letting Dr Barton know how the patient had been at night?
A Yes, when I did see her because I did not always see her at the end of a shift.

Q Did you ever go to Dr Barton, which this is suggesting, and say, "Dr Barton, I do not think this patient should be on diamorphine?"
A No, I did not.

Q Then this:

"Mrs Evans spoke to the remaining nursing staff.

Staff were asked if they felt there was nay need for a policy relating to nursing practice on this issue. No one present felt this was appropriate."

So nobody said, "Yes, we would like a policy, please", is that right?

A Yes, from what I can remember.

Q Speaking for yourself, and you can only speak for yourself?
A No, I do not think we did. No, there was not.

Q Why did you not? Was it because you did not want a policy or ---
A We just felt --- I think morale was still very low and we were just banging our heads against a brick wall again.

Q Did anything come out of all of these meetings, so far as you were concerned?
A I cannot really remember, to be honest. I do not think a lot came out of it.

Q Prior to looking at that correspondence, you had gone over to Dryad Ward and you had started working on Dryad Ward?
A Yes.

Q Did you ever raise similar concerns once you were there?
A No.

MR KARK: We are going to begin to look at patients on Dryad Ward. I wonder if that would be a convenient moment?

THE CHAIRMAN: Yes, thank you, Mr Kark.

We are going to take the first break that I mentioned. Ms Turnbull, someone will take you to a place where you can get some refreshment. You are in the middle of giving your evidence and I anticipate you will be for some time, so this is a warning for now and for every break that you take. Please under no circumstances talk to anybody about the case. Is that clear?
A Yes.

(The Panel adjourned for a short time)

MR KARK: Ms Turnbull, we were looking at all those notes of meetings that took place in '91. Then I was going to turn to your time on Dryad Ward. It is right to say that you made a statement to the police I think in 2002. You were asked, I think, if you had any concerns on Dryad Ward about the incorrect use of syringe drivers and you did not then have any concerns?
A That is correct.

Q You said I think in a statement, "I believe that syringe drivers were correctly used for people who needed them". You said, "As I remember it, the issue seems to have been resolved".
A That is right.

Q When you knew that you were going to be seen by the police, I think you took all of these papers that we have been looking at, the 1991 papers, to somebody called Toni Scammell?
A Yes, that is correct.

Q Who is Toni Scammell?

A She was at that time the modern matron of the hospital, of the War Memorial.

Q Can I just ask you why you did that?
A Because the hospital was undergoing a CHI investigation.

Q A CHI investigation, Commission for Health Improvement?
A Yes. My colleague and I thought we had to hand these papers in to Toni Scammell.

B

Q Can you help us: how had the issue been resolved?
A (Pause) Practice seemed to be OK. We did not have any concerns. We were quite happy with things.

Q We are going to look at some individual patients and we will see how it actually worked. Once you moved to Dryad Ward, you continued on nights?
C A That is correct.

Q We have seen through the notes, and I think I can probably lead you on this, that it seems to be common with most of our patients certainly that the syringe drivers when they were set up were set up during the day?
A Yes.

D Q Can you remember setting up any syringe drivers yourself?
A No, I cannot.

Q If a decision was taken to put a patient on to a syringe driver, that would not be a decision made by you?
A No.

E Q You would come in on nights and you would find on occasion that a patient who had not been on a syringe driver the day before was now on a syringe driver.
A That is correct.

Q Once the patient was on a syringe driver – I do not know if you can deal with this by way of generality, you probably cannot – for how long did they tend to remain conscious or did they become unconscious?
F A I cannot give a time.

Q Can we turn to a patient called Ruby Lake and pick up file F, page 394. It is the page numbers with a line either side in manuscript. Does it start at the top with 18 August?
A That is correct, yes.

Q We know that this patient had gone into the Royal Haslar on 5 August having had a
G fall at home and fractured a left neck of femur. She had come over to you on 18 August, the date you see at the top, and the very first note here is not your note, is it?
A No.

Q I am not going to ask you about other people's notes but we can simply see that she was admitted to you with "a fractured left neck of femur, leg ulcers, broken skin on sacrum, a pleasant lady happy to be here." Going to the bottom of that page do we see your writing?
H A Yes.

Q This is a summary of significant events. We have not asked a previous witness about this but we have a multiplicity of nursing notes. We have all sorts of different forms of nursing note. Can you help us with what this document is used for?
A This document is to write down any change in the patient's medical condition.

Q So far as this lady is concerned, Ruby Lake, do you have any independent recollection of her at all?
A No, I do not.

Q I am not going to ask you a huge amount. Can you help us with the notes at the bottom. You were writing on this piece of paper. How much of what had gone before would you have read?
A I would have read obviously what had happened during the day and I would have read obviously the documentation before me.

Q When you say the documentation before you, do you mean on the same day or would you have read all of this page?
A I probably would have read, yes, definitely all the page.

Q You would have seen that she had come in with a fracture of the neck of femur.
A Yes.

Q You would have seen that on the following day, 19 August, she had some chest pain but it was not radiating down the arm and she was given Oramorph.
A Yes.

Q Then she was put on that day on a syringe driver, yes?
A Yes.

Q The day after her admission she is given diamorphine, as we can see, and midazolam. Then we can see 20 August her condition appears to have deteriorated overnight, driver recharged. Please help us right at the bottom with your note. It simply says "Night", I think?
A Yes. That would be my documentation during the course of the night shift.

Q You would not put down a specific time.
A Not necessarily.

Q I think we may need to read the note prior to yours to understand your note.

"Condition appears to have deteriorated overnight."

That is the night of the 19th into 20 August, is it?
A 12:15 could have been lunchtime.

Q "Condition appears to have deteriorated overnight" would have been the night of 19 August into 20 August.
A Yes.

Q "Driver recharged at 10:10". We can see that it was continued:

"Family informed of condition. Daughter present at time of report."

You have written on the night-time of 20 August?
A

"General condition continued to deteriorate. Very bubbly. Suction attempted without success." Over the page, night continued: "Position changed frequently. Ruby rousable and distressed when moved. Syringe driver recharged. Diamorphine 60mg, midazolam 60mg and hyoscine 800mg and daughter has enquired at 0800 Ruby's condition."

I have signed that entry.

Q Please go back to page 368e. We are going to try and get the original of this because even with its very good copy it is quite difficult to read. Can you see right at the top there is a prescription written out by Dr Barton for diamorphine between 20 and 200mg?
A Yes.

Q How would you read that prescription? What would that allow you to do?
A That would allow me to give diamorphine or to charge a syringe driver between 20 and 200mg, depending on the patient's condition.

Q Would you, together with another nurse, be able to increase the dose if you felt it was necessary?
A Yes, we could.

Q Would you have a discussion with the nurse before you did so?
A Definitely.

Q What I think we may want to know from you is what your understanding of any guideline or rule there was about the increase in a dose of diamorphine. What would you look at to know by how much to increase the dose?
A If a patient was distressed, if the amount that she was having at that time was not keeping her comfortable.

Q I understand that. That would be the reason for increasing the dose, but what we perhaps need to know is what your understanding is of by how much you could increase the dose or should increase the dose. This lady the day before had been on 20mg.
A Can I just have a look again?

Q Do you want to look at the original?
A Yes, please. (Same handed)

Q This lady seems to have gone up from 20 to this increase of 60mg which you have been present at. We might all need to understand your thinking.
A It would have been if that amount was not holding her and it would not have been my decision alone; it would have been the other trained nurse.

Q I entirely understand that but you were part of the decision-making process, were you?

A I probably would have been, yes.

Q Would you have gone back to the doctor to do this?
A Not necessarily on night duty. I think it went from 20 to 40. (Short pause) Yes, it was 60.

B Q Can you help us what your training, your state of knowledge was, about the way that you were meant to increase opiates? Let's forget what the increase actually was. What we want to know is what your training was about how you increase opiates. Can you remember having any training?
A Not a lot, no.

Q Did you have any discussion with anybody – Dr Barton or anybody else – about if this sort of situation arose how you should ---
C A No. All I can remember is it would go on what a patient had the time before you actually recharged it and it would have to be two trained staff to make that decision.

Q I understand all of that.
A There were no guidelines exactly that I can remember.

Q Would you go to the BNF or not necessarily?
D A I cannot remember.

Q To what degree did you have discretion about how much to increase drugs like this?
A Only what the patient was presenting in terms of pain distress.

Q You have a patient who is on 20mg. When they are turned they appear to you to be distressed. You have then got to make a decision that you might on that occasion increase the
E diamorphine. Are you able to help the Panel at all as to how you mind would work when you decided whether to put it up to 30 or 40 or 80 or 100?
A To be honest I cannot remember.

Q Are you still in nursing now?
A Yes.

F Q Do you deal with diamorphine now?
A Yes.

Q Do you ever increase doses now?
A No, the prescription is written entirely differently. There are perimeters with the diamorphine.

G Q These ranges between 20 and 200mg of diamorphine – had you ever come across that sort of system before?
A No.

Q Have you ever come across it since?
A No.

H

Q In any event it seems that this patient was indeed put up to 60mg and you have made a note of that in the record. "Distressed when turned" – what does that signify? I know that is your bread and butter as a nurse.
A She could have been in pain. She resented being turned; it was causing her distress.

Q If we go back to your note at 395, keeping a finger where you are, it is easier to read. We have dealt with the diamorphine but the midazolam also went up I think, did it not?
A Can I just go back on this one? The time was 07:35 in the morning. Sometimes whoever was in charge of the ward, the manager might have come on before that and the night staff might have approached her and asked her advice of what to give. That sometimes happened as well so that could have been a managerial decision as well.

Q If you want to look at the controlled drug book we have got that here but it shows that 07:35 60mg was withdrawn and administered to the patient and it is witnessed by I think Nurse Tubritt.
A Yes.

Q Was Nurse Tubritt day or night staff?
A She was nights and she was senior to me.

Q I want you to understand that I am not trying to fix personal responsibility on you. I am just trying to see how things worked and what actually happened. Not only was the diamorphine increased to 60mg but the midazolam was increased to 60. What would be the effect of that upon the patient? What is the purpose of increasing the midazolam?
A Midazolam sedates a patient, keeps them calm, calms them down like a sedative.

Q You would understand that, would you?
A Yes, definitely.

Q You would have known that at the time.
A Yes.

Q Can you remember what your thinking would be, not about the fact that you are increasing midazolam apparently but the amount by which you are increasing it? Would there be any process you would go through to think about how much?
A Yes. Was the previous one keeping the patient calm and not in distress?

Q This appears to be a triple dose, does it not?
A It does.

Q You have tripled. Looking back on that now does that surprise you?
A To be honest, no. It surprises me the amount, yes, but ...

Q What does not surprise you?
A The amount. I suppose the increase in the amount.

Q That does not surprise you?
A If she had been very distressed and 20mg was not holding her. Yes, it does surprise me now, yes.

Q Why?
A Because it is quite a big range to increase that drug.

Q We can see that that syringe driver continues because although at page 394 it says "Night" and it appears to be on 20 August is actually the early hours of 21st, is it not?
A It is, yes.

B Q That syringe driver at which you had been present at the recharge, would you have actually recharged it yourself?
A Not necessarily, no.

Q But you have made a note of it, so presumably would you have been there?
A Yes. Two trained staff have to go and do it.

C Q The hyoscine I think is also increased. It was previously on 400 and so that has been doubled, and the hyoscine would be for what?
A If a patient has secretions in their airways it reduces the amount of secretions, dries up secretions.

Q We have heard from other nurses about the nurses' duty to challenge if they think that something is being done to a patient which is wrong – personal responsibility. You are
D nodding but is that a concept you understand?
A Yes, definitely.

Q Is there any difference between the duty of a State Registered Nurse to the duty of a State Enrolled Nurse?
A No.

E Q So as a State Enrolled Nurse would part of your training be to challenge if you think something was being done wrong?
A Yes.

Q It follows from this, it would appear, that you did not and would not have challenged this.
A That I do not know. I might have challenged but it might have been overruled, is all I
F can say.

Q If you challenged something, if you had been uncomfortable with something would you have made a note about it or not?
A I would have done, but ---

Q Right.
G A Yes.

Q Can we look at it a little further. Going back to the Redcliff, up until getting to the Redcliff had you dealt much with diamorphine?
A No.

Q Once you were on the Redcliff and the syringe drivers were introduced you began to
H deal with diamorphine.

A Yes.

Q Did you have any special training about diamorphine?
A Not really, no.

Q So do we take it from that that your knowledge came from your working on the job, as it were?
A Yes.

Q And you were working on the job at Redcliff when these concerns arose in 1991.
A That is right.

Q And you had training about syringe drivers.
A We did have courses when we moved up to Dryad.

Q Tell us about those?
A We used to attend – it was in the medical centre from the hospices, Countess Mountbatten; they would put on lectures, sort of workshops every so often.

Q Did those increase your understanding of the use of diamorphine?
A Yes, it did.

Q Did they increase your understanding of how you were meant to increase it?
A It did.

Q Can you remember when those took place?
A What year?

Q Yes.
A It must have been ... I cannot remember when we moved up – between about 1992 and ... I cannot remember how long they went on for ... Up to about 2000; I do not know, that is just a guess.

Q We can see the end of your note at page 395 is:

"His daughter has enquired."
A "Daughter has enquired. 8 o'clock Ruby's condition."

Q Shortly after making this note can we take it you would have gone off duty?
A I would have gone off duty.

Q Because 08.00 hours was actually beyond the time that you are meant to be there.
A Yes. Unfortunately, this is what makes me think if that decision might not have just been staff alone; but there is no documentation to prove that.

Q What time did Dr Barton generally come on to the ward?
A Any time between half past seven and quarter to eight in the morning.

Q So she might or might not have been around when this decision was made?
A I do not know.

Q You make other entries in this lady's notes. I do not want to waste time. The note that you have made about the patient being distressed when moved, that may of course be an indication of pain.
A It could have been, yes.

Q I want you to glance through the previous notes. Is there any other indication by you about the patient's pain? I think this is the only note you have made, in fact.
A I think that is the only entry I have made.

MR JENKINS: 388?

MR KARK: Hold on, Mr Jenkins. In relation to that point of you being present when the syringe driver was increased, that is the only note I think you made in the summary of significant events.
A On that particular page, yes.

Q We have also seen that there are nursing care plans to deal with various aspects of the patients' care.
A Yes.

Q And there are nursing care plans to deal with wounds and catheters and the like.
A That is correct.

Q Can I ask you to go through some of the nursing care plans that we have? Mr Jenkins has invited your attention to 388 and also I am going to ask you to look at 389. On 388 first of all, is that your note at the bottom?
A It is.

Q I think we can read:

"Condition continues to deteriorate ..."

This is 20 August.
A Yes.

Q Is it "remains very 'bubbly' suction attempted without success."
A Yes.

Q So this appears to be reflecting your note on the summary?
A That is right, yes.

Q When would you make this note?
A That would have been some time during the night.

Q And we see again the words, "distressed when turned"; so it is exactly the same words.
A It is, yes.

Q Why do you have to make two separate notes about this?

A Because this one is in a care plan and the other one is a summary of medical hist... of significant events.

Q 389 is not your writing, is it?
A No.
Q Can I ask you about your knowledge in relation to another issue. This lady was on a syringe driver. Would she have been receiving any hydration?
B A That I do not know.

Q If a patient was unable to swallow was there any system that you remember on Dryad Ward of hydrating a patient?
A Is this in relation to this patient?

Q Any patient.
C A On occasions we could have put down a nasogastric tube or subcut fluids.

Q In what circumstances would you use a nasogastric tube?
A If a patient is unable to swallow.

Q Would you insert a nasogastric tube?
A In those days? If it was written up in the medical notes; if it was a doctor's decision.
D

Q I think I can tell you in relation to that, none of the patients that we are dealing with is there any indication a nasogastric tube was used – certainly not for this patient.
A Sorry, can you repeat that.

Q I will stick to this patient for the moment. There is no indication for this patient that a nasogastric tube was used.
E A That is correct.

Q You mentioned subcut fluids as well; do you remember those being used?
A On this patient?

Q On Dryad Ward?
A On occasions.
F

Q If it was used, if a subcut needle was inserted and fluids were being put into the patient by that system would a note be made about it?
A Definitely.

Q I am going to ask you to put that file away. I am trying to deal with these patients chronologically and if you could turn to file G and if you go to page 647.
G I am not going to spend very long, unless you have a specific recollection of this patient, and I think you have previously indicated that you do not. Could you look at 647 first of all? That is the clinical note that shows that he was transferred to Dryad Ward on 21 May 2008 and can you see the words "make comfortable"?
A Yes.

Q Then "give adequate analgesia" – this is the top note made by Dr Barton.
H A Yes.

Q "Am happy for nursing staff to confirm death".
A Yes.

Q Can I ask you a little bit about those expressions? "Make comfortable" – how did you understand that?
A To ensure that the patient is not in any distress; give him all the nursing care required; and that would be to make sure that they are not in pain as well.

Q Would it be any indicator to you of the state of the patient?
A Yes, it would mean that the patient is probably very poorly, at the end of life care.

Q We see the words at the bottom "am happy for nursing staff to confirm death". Is that a note that you remember seeing?
A Yes, it is.

Q Fairly frequently.
A Yes.

Q Is that any indication of the state of the patient?
A That the patient is very poorly.

Q Is it also an indication to you as nursing staff that you are entitled to do something that without that note you would not be entitled to do?
A Yes.

Q To verify death?
A Yes.

Q In fact the word used is to "confirm death"; that does not mean certify death because you are not allowed to certify death?
A No, it is to confirm.

Q If we look at the rest of the page do we see your writing on this page?
A Yes.

Q Just above your writing we can see another entry, 25 September, "On syringe driver. For TLC".
A Yes.

Q "TLC" is a similar expression?
A It is; it means tender loving care.

Q Meaning in reality?
A That the patient is going to die.

Q Then we can see the next entry and that is yours?
A That is right, yes.

Q "Brian condition continued to deteriorate and died" and then you have gone through the various tests to ensure that you are not making a mistake.
A Yes.

Q And that the patient truly has died. Then that has been signed by you, and who else was present?
A Senior Staff Nurse Tubritt.

Q Then is it "family notified" ---
A "And visited".

Q I think in fact – unfortunately, perhaps – that was your only dealing with this patient. In any event, if you have made other notes your recollection is extremely limited.
A It is.

Q Can we put this file away, please, and go to file I? File I is dealing with a lady called Enid Spurgin. I am going to ask you to turn up page 132. They do not follow necessarily one after the other so you will find a couple of gaps in the page numbers. This is not your note, but if we look at the beginning of the page we can see that she had been admitted on 26 March of 1990 to your hospital for rehabilitation and gentle mobilisation.

> "In Haslar she was mobile with a Zimmer frame and two nurses – short distances, and apparently transferring satisfactorily. However, transfer has been difficult here since admission. She has complained of a lot of pain for which she is receiving Oramorph regularly now with effect."

Is Oramorph something that you would on occasion administer?
A Yes.

Q Being a member of night staff would you use it on occasion to help the patient sleep?
A Not necessarily sleep; it is for pain control – Oramorph – if she was in pain.

Q "Eats and drinks with encouragement. Can feed herself. Is a little deaf.
Night. Requires much assistance with mobility at present due to pain discomfort.
Oramorph 10 mgs. 5 mls given 23.15 and 5 mgs given at 06.50."

Is that your significant?
A It is.

Q That is on the night of her admission and we could just have a quick look at the drugs chart – if we go to page 164 – if we look at the first entry on page 164 we can see that there is a prescription for Oramorph, which I think must be prescribed on the 20... It is difficult for us now to read the date, but it looks as if it must be 26 March because that is the first date in the calendar at the top; yes?
A Mm hmm; yes.

Q Does your writing appear there? Have you administered any of that?
A No.

Q Then if you look down toward the bottom, we can see the second entry up from the bottom, some Oramorph was provided on 27 March at 2200 hours. I am trying to find your entry for 26th and I cannot at the moment.
A Is that the Oramorph at 2200 on 26th?

Q Do you mean the second one up from the bottom?
A There is one on 27th and from what I have got here, there is Oramorph 10 mg in 5 mls at 2200 administered on 26th. That is not my signature.

Q If you were providing Oramorph to a patient, would you necessarily be the one making an entry?
A Not necessarily, no. There are two trained staff.

Q And your reason for giving Oramorph, and perhaps you have already explained it, would be what?
A If the patient is in pain.

Q And your reason for giving Oramorph at this level; how would you ascertain how much to give?
A You would start with the minimum dose first of all.

Q You would start with the minimum dose. If a prescription is written at 10 milligrams in 5 mls, do you have to give 5 mls?
A No. It has got here from 2 to 5 --- 2.5 mls to 5 mls.

Q So could you give anywhere within that range?
A Within that range, yes.

Q I think you also made a note on the same day. Perhaps you can just confirm this is your writing on page 144, going aback a few pages. Helpfully or unhelpfully it has 114 written in manuscript but it is 144 with a line outside of it. Is that your writing on there?
A It is.

Q We can see that there are entries for 26 March and we can see under "Nursing action"

"Assist with the use of slipper pan. Enid will request when needed."

Then underneath that, and I think that is your signature, for 26 March,

"Use slipper pan with assistance as required."
A Yes.

Q Whose writing is that?
A That line is my writing.

Q That is an entry made at night. Yes?
A It is.

Q Does that indicate that Enid was capable at that stage of calling for the assistance of a slipper pan?

A It does, yes.

Q So it follows that she at that stage must have been conscious?
A Yes.

Q Does your writing appear elsewhere on the page? I think you made all of the initial entries?
B A Yes, from the top until the second line from the bottom. The one after that is not my writing.

Q Again, I think you have made other notes in relation to this patient but I think that there is no need for me to ask about those. My learned friends may do in due course. I am going to move on to the next patient. That is file J, please, and there are some questions I want to ask you about this gentleman. This is Mr Geoffrey Packman. I think you do have
C some recollection of this patient, is that right? Let me just remind you. Go to page 64 of the notes, please. First of all, do you see your writing on that page?
A Yes, I do.

Q Help us, please, is it where it says "nocte"?
A Yes, "nocte".

D Q Can we just look at the entry before that? "Dr Reid here." We were looking at this note yesterday with another witness:

> "Syringe driver renewed at 19:15. Diamorphine 60 mgs and midazolam 60 mgms as previous dose not controlling symptoms. Dressings removed this afternoon. Mrs Packman has visited this afternoon and is aware of poor condition. Mrs Packman being admitted to (another) ward for surgery. Please contact her in the event of
E Mick's death."

Then what is the next bit?
A "No night calls please".

Q Then your entry is what, please?
A "Incontinent of black tarry faeces on settling."
F

Q Then "Peaceful night".
A "Peaceful night. All care given. Syringe driver satisfactory."

Q Can we just pause there for a moment and think about that note. What does that signify to you?
A If the patient had been on iron, that could have caused his black tarry faeces.
G

Q What else?
A It could mean that he could be having an internal bleed.

Q I think we know in fact he was having a gastrointestinal bleed. When you made that note, first of all, would you take any action upon that discovery, apart from making a note?
A I would have reported it at hand-over and definitely made a point of handing that
H over.

Q It may be obvious but why would you have made a point of handing that over in relation to it?
A Because it needed some investigation.

Q Would you expect there to be investigation?
A Yes.

Q Would you expect there to be a care plan of some sort or a change of care plan?
A I would have thought so, yes.

Q Would you be responsible for initiating such a care plan or not?
A Then not necessarily.

Q The next note: "Diamorphine increased to 90 mgms" is not yours?
A No.

Q Where you have written simply "syringe driver reprimed" would that be with the same drugs as before?
A I do not think -- That one is not my writing.

Q I am sorry. I just want to understand this then. Against the word "nocte" we can see "incontinent of black tarry faeces on settling. Peaceful night. All care given." Then "Syringe driver satisfactory".
A Yes.

Q Then your signature appears on that line?
A Yes.

Q Then underneath that, "Syringe driver reprimed".
A That is another entry.

Q I beg your pardon. That is relevant to "diamorphine increased to 90 mgms"?
A Yes.

Q Would you have had any responsibility for that decision?
A No. That one has nothing to do with me.

Q I think the next day the patient died and that is not your writing?
A No.

Q Could you go to page 80, which is the nursing care plan, and I think it is probably going to reflect what we have just looked at but perhaps you can confirm that for us. This is the nursing care plan for Mr Packman. Do you see your writing on that page?
A Yes.

Q Is that for 31 August, first of all?
A Yes.

Q Help us with that entry. Perhaps I should have dealt with this one first?

A The "peaceful night"?

Q Yes?
A "Incontinent of black tarry faeces +++ nil taken by mouth. Remains hot."

Q I am sorry; I have dealt with them the wrong way round. That is entirely my fault. When you make a note "31 August '99 Peaceful night" is that relating to the night of 30th or
B the night of 31 August?
A 31 August.

Q Again, do your comments about black tarry faeces obviously apply?
A Yes.

Q The fact that he is nil taken by mouth, is that another factor that you would consider?
C Is that relevant?
A Yes, because he obviously was not able to take or he has not taken fluids for a reason; he is unable to take fluids.

Q Is that why you have made a note of that?
A Yes.

D Q Is that something that might be a signal for others to act upon?
A Yes.

Q Would you go over finally to page 175, please? Do you see the entry for Oramorph up at the top?
A I do, yes.

E Q Did you administer any of that, can you help us?
A Not on the first line.

Q Do you see your writing anywhere on that page?
A Yes, the second line down, the "Oramorph 20 mgs", which is written up at 2200.

Q Do you mean the second box down?
F A Yes, dated 27th and 28th.

Q So that means that you administered that drug at 20 mgs, and that was written up?
A Yes.

Q If it is written up in that way, that is not under the "as required" form; it is a regular prescription?
G A A regular prescription, that is right.

Q You would give that automatically?
A Yes.

Q I am sorry, I have missed one other note which I should have mentioned in passing, page 82, please. Again it may be self-explanatory but have you made the note right at the top
H on 2 September?

A Yes, I have.

Q "Incontinent of weak tarry...."
A "....of black tarry faeces on settling".

Q It is "black", I am so sorry. The same as before?
A Yes, "Nursed on side. Peaceful night – strong radial pulse – opens eyes when spoken to."

Q So that would demonstrate what to you?
A That he responds when spoken to.

Q Is that the same as being rousable or is rousable something different?
A No, that would mean that he is rousable.

MR KARK: Then the next entry I think is not yours. That is all that I ask you about that patient.

THE CHAIRMAN: That is a good opportunity for the break. The panel assistant will take you to another place again and we will come back at 12.25.

(The Panel adjourned for a short time)

MR KARK: I want to go back to one issue with patient F, Ruby Lake. If I could invite the Panel to go back in the notes of Patient F and go to page 368E, Mr Jenkins raised a concern and he is absolutely right. It is very difficult to read on our copy 368E but I have misread the bottom entry of diamorphine. Do you see the entry at the bottom that I read as 60? Mr Jenkins' view is that it is clearly a 40 and I am afraid he is right.

MR JENKINS: Looking at the original is of great assistance so can I suggest that the witness is shown it and then each Member of the Panel is shown the original because there is red writing. "Destroyed" is written in red and the prescription is written in black ink and it is much easier to see the black ink when you look at the original.

MR KARK: I am going to do that. I am also going to show the witness the drugs record. I will show it to the witness first and then to the Panel. (Same handed) When you look at that can you see more clearly that that is 40 and not 60?
A It is 40.

Q Could that be shown to the Panel? If you want to look at it you are very welcome, but also the drugs book confirms that because you could not get 40mg ampoules, could you, of diamorphine?
A No.

Q Whether you could or not, I think what was withdrawn was a 30mg ampoule and a 10mg ampoule.
A Yes, that is right.

Q Would you just take it from me, and you can certainly look at this if you wish to, that at 16:55 on 20 August the controlled drug record shows that a 30mg ampoule and a 10mg ampoule was withdrawn at 16:55 on 20 August for Ruby Lake.

THE CHAIRMAN: Mr Kark, is it right that the observation Mr Jenkins made in respect of the diamorphine is also true of the midazolam?

MR KARK: I think it will be, yes. I would have to check that. The two entries here are flagged in pink. Could I invite people to exercise caution because the spine has gone and all the pages will fall out. I do not know if the Panel want to see that now.

THE CHAIRMAN: The original seems quite clear.

MR KARK: It also means that our chronology is missing an entry but the new improved chronologies, which have been worked on extensively, will have that in. I do not think we need to go through that at the moment. (To the witness): Apologies if I led you into error on that. It appears as if the entry prior to your night entry of 60 was 40.
A Yes.

Q We can put that away for the moment. Finally, in relation to the patients can I take you on to a lady called Elsie Devine, our Patient K, starting at page 195. Do you have a recollection of Elsie Devine?
A A very vague one.

Q What does your vague recollection tell you about this patient?
A I think she required a lot of nursing care at night. That is basically it.

Q She came to Dryad Ward on 21 October 1999. I think the first entry where you made a note is at the back end of her treatment. Can you see your notes on this page?
A I can, yes.

Q Tell us where they are and tell us what you noted?
A An entry dated 19/11/99.

Q Tell us what you have said?
A

"Relatives stayed until 2300. Elsie has had a peaceful night. Syringe driver satisfactory. Position changed as required."

There is another entry on 20/11/99 which reads:

"Peaceful night – position changed regularly – skin marking – extremities remain oedematous. Oral care given."

And my signature.

Q The fact that you had to change this patient's position, what, if anything, would that indicate to you?

A That the patient was unable to turn over in bed and she needed her position changed. She needed help in changing her position. That she was quite poorly as well that she could not move herself.

Q Poorly by reason of what?
A It could be her medical condition.

B Q If a patient is on a syringe driver what other reason could there be for her not being able to move herself?
A It could be that she was unable to move herself because she could not move herself.

Q Why would that be?
A It could be because of her poor condition or it could have been due to sedation of the syringe driver.

C Q Could you go to pages 223-224. Page 223 reflects her admission to your ward. Is that right?
A That is correct, yes.

Q With increasing confusion and aggression but I think she is also described as "very pleasant". At the bottom of the page we can see the note: "Marked deterioration". I do not
D think your writing appears on that page, does it?
A No.

Q Over to page 224, did you make a note of the care given to this patient?
A I did on nocte.

Q To identify it, it is 19 November still.
E A Yes, it is. I have written:

"Peaceful night – syringe driver satisfactory. Position changed as required. Syringe driver recharged at 07:35. Diamorphine 40mg, midazolam 40mg."

And I have signed that entry.

F Q The time that you made that entry, first of all is that an indication that you or your colleague recharged the syringe driver?
A Yes, it is.

Q Would you have taken any steps to review in any way the drugs that the patient had been on or would you simply be dealing with the drugs that they were then on? What would you do, if anything, looking at the previous drug chart?
G A We would have obviously looked at the drug chart, seen what drugs she had been on or what drugs she was on.

Q Does you writing appear elsewhere on that page?
A Yes, further down the page, the night of 20/11/99 nocte I have written:

H

"Peaceful night – skin marking. Position changed regularly. Extremities remain oedematous. Syringe driver recharged 07:15. Diamorphine 40mg and midazolam 40mg"

And the rate that it was going.

Q Could you keep a finger there and go to page 281, which is the drug chart. We can see that the prescription written by Dr Barton for this patient starts on 19 November.
A Yes.

Q It follows perhaps from what you said that you would not have played a role in the decision to initiate the syringe driver.
A That is right, yes.

Q Because when you came on at night your role, as I have understood it, might be to recharge it but you were not starting it.
A That is correct.

Q When it was recharged you recharged it, as we can see, at the minimum dose provided for by Dr Barton.
A That is correct, yes.

Q And you were continuing the previous dose.
A Yes.

Q When you make reference to "a peaceful night" should we read that as anybody would normally read that?
A Yes.

Q There is no special nursing indication?
A No.

Q And no indication of the patient being in any pain?
A That is right.

Q When nurses make reference to a "poorly" condition, as we can see in the note following yours, does that have any particular significance?
A No.

Q At page 281 do your initials appear against any of these entries?
A Yes, they do on the date 20/11 and 21/11.

Q Is that 7:35 and 7:15 in the morning?
A Yes. My colleague has also initialled it as well.

Q You are the one with your colleague who has carried on the syringe driver at the same level as before.
A Yes.

Q Would you have known what caused the initiation of the syringe driver?

A If a patient's condition has deteriorated or if she was in pain or something.

Q That is what you would expect.
A Yes.

Q The note that you have made that we have just looked at "extremities remain oedematous", we understand what it means but what does that arise from?
A It can be her general medical condition.

Q I asked you earlier, and I just want to have your evidence clear, in relation to any of these patients – we see on occasion that patients were distressed when turned –but if there are signs of pain from a patient you will make a note of it.
A Definitely.

Q We can put that patient away and again you may be asked about other entries you have made but that is all that I ask you. When you left Dryad Ward where did you go onto?
A From Dryad we went to Haslar.

Q You went to Haslar.
A The unit moved. I have always been on that ward but we had to go to Haslar for refurbishment of the War Memorial and now I am back on Collingwood Ward.

Q Was that after Dr Barton had left?
A Yes, that is a different trust, still in the War Memorial. I am still there but in a different trust and on a different type of ward.

Q After Dr Barton had left you came presumably under the responsibility of other doctors?
A Yes.

Q How did the use of opiates and syringe drivers change, if they did?
A They were not used so often and there was definitely the perimeters changed if we do set up a syringe driver.

Q Do you mean the variable dose?
A The doses, yes.

Q In what way have they changed?
A The patients have to have IM diamorphine. I am not medically qualified obviously. They might have to have diamorphine written up IM.

Q Intra-muscular?
A Yes, for a few doses and then that is reviewed and then it is decided and the perimeters are set of how to set up a syringe driver. Doses are much lower.

MR KARK: Does are much lower. Thank you. Wait there, please.

THE CHAIRMAN: Mr Jenkins, given the time that we have reached, would you prefer to break for lunch now and then have a full run at it, as it were, after lunch?

MR JENKINS: I hope I will not be having a full run. I am entirely in your hands. I can start now or whenever is convenient.

THE CHAIRMAN: We would only have about 15 minutes now and then we would be breaking, so we will break now for lunch and Mr Jenkins can start afresh at a quarter to two. I remind you that you remain on oath and you should not speak to anybody about the case and of course nor should anybody speak to you about the case.

(Luncheon adjournment)

Cross-examined by MR JENKINS

MR JENKINS: Ms Turnbull, you will remember me, I think; I asked you a few questions in the inquest a couple of months ago.

A You did, yes.

Q What we have heard is that in the late 1980s, beginning of the 1990s Dr Barton was working as the clinical assistant at the War Memorial Hospital.

A That is correct.

Q And that syringe drivers were being introduced for some of the patients.

A That is right, yes.

Q You had not dealt with syringe drivers before?

A That is correct, yes.

Q And you have never been trained in their use.

A That is right.

Q You would have certainly known that opiates were being administered for those patients who had syringe drivers.

A Yes.

Q And as night staff you were expected to be able to deal with those patients and nurse them appropriately.

A Mm hmm.

Q And that must have been, knowing that drivers like diamorphine were being used, rather worrying for you.

A Yes.

Q And the other nursing staff working nights that we have heard about are Nurse Giffin and Nurse Tubritt.

A Yes.

Q I think the hospital had not arranged for any training for you.

A That is correct, yes.

Q So how did you learn about syringe drivers and where their use might be appropriate and how they should be changed and set up?

A I cannot remember. I think at first it was just with the management of them as they had been set up, because on nights we very rarely set up a driver and were just managing them.

Q Was there a night sister you could call to help?
A There was, but she was based up at the ... This is the Redcliff Ward?
Q Yes.
B A She was based up at the War Memorial.

Q So would this be fair, that in the late 1980s and beginning of the 1990s as night staff you were left treating patients where you were not confident that you knew about the syringe drivers?
A I think we were confident and we could manage the syringe drivers, yes.

C Q What we have seen obviously are some letters and some other documents, notes of meetings from 1991.
A Yes, that is right.

Q And what lay behind that was a concern about the use of diamorphine.
A Yes.

D Q And it was concern that the nursing staff dealing with patients during the day were not taking into account the views of the night staff.
A Not totally. I think that some of the night staff, as mentioned in the letters, our concerns were perhaps other analgesics had not been considered before the syringe driver.

Q Were there problems between the day staff and the night staff other than with regard to ...
E A No, not at first; no.

Q Not at first?
A Not until that period.

Q What was the feedback that night staff got from Sister Hamblin?
A That was a pretty negative one.
F

Q Tell us what you mean by that?
A We felt there was not much support there.

Q Would we be right to interpret what was happening at the beginning of the 1990s as a difference of view between the day staff and the night staff?
A Only where the use of syringe drivers were concerned.
G

Q I think it is right that a lot of the day staff thought that you did not know what you were talking about.
A Not all the day staff, I do not think.

Q We will come back to 1991 but what you told the coroner in the inquest – tell me if this is right – was that all the concerns that there may have been in 1991 were all resolved.
H A That is correct, yes.

Q And by the time of the patients that you were being asked about the inquest – 1996 and thereafter – all the earlier concerns from 1991 had been dealt with.

A That was right, yes.

Q Is this right, that to that extent what happened in 1991 is part of the history but it is not relevant to what happened with patients in 1996 and the others that you have been asked about here.

A That is probably true, yes.

Q I am grateful. You were asked by Mr Kark what diamorphine was being used for on the ward and you told us it was used for distress.

A Yes.

Q For excessive secretions?

A Umm, yes.

Q For some breathing problems.

A Yes.

Q I think you learned that after 1991.

A Probably, yes.

Q But in 1991 you did not know that.

A I do not think that was considered in 1991; it did not come into the issue then.

Q I think the concerns in 1991 had been that patients seemed to be getting diamorphine who were not in pain.

A That is correct, yes.

Q But you were then to learn that you do not just give diamorphine to patients because of pain – there may be other reasons to give it.

A That is correct, yes.

Q And you have mentioned some of them already – distress, excessive secretions or some breathing problems.

A Yes.

Q It helps with patients who have breathing difficulties or a sense of breathlessness.

A That is right.

Q For patients who have excessive secretions – chest secretions – is it your understanding that they feel as if they are drowning?

A They can be, yes.

Q And although they may be getting medication to try and reduce the secretions – analgesics, this kind of drug can lift them out of that sense of drowning or the fear or it.

A It can do, yes.

Q That is your experience.
A Yes.
Q Again, I suggest that at the time that concerns were raised in 1991 none of that had been explained to you or the other night staff.
A That is right, yes.

Q Your approach was that people should only be on a syringe driver – on diamorphine, if they are in pain?
A I believe so, yes.

Q But you were told that that was not right and you now know that that is not right.
A That is right, yes.

Q Let us go to the documents in 1991 again, if we may, just to confirm that picture, as I suggest they do. Do you have bundle 1 in front of you, it is tab 6?
I think the front page wrongly describes the document that we have at page 2. The document is the summary of the meeting held on 11 July 1991.
A Yes.

Q You have been taken through that and I do not propose to do so again, but the first concern that is listed is that not all patients who were given diamorphine had pain.
A That is right.

Q If we go over the page to point number 10, these are the points that Mrs Evans was making and after point number 10 she is saying:

> "It is evident no one present had sufficient knowledge to answer various questions ..."

And she said there were the following questions:

> "What effect does diamorphine have?
>
> Are all the symptoms that are being attributed to diamorphine in fact due to other drugs patients are receiving, or event their medical condition?
>
> Is it appropriate to give diamorphine for other distressing symptoms other than pain."

A Yes.

Q If we go on through that tab, we have seen the correspondence with the Royal College of Nursing, in which the question of a policy is raised and we then get to the notes of the meeting. But let us just look at tab 6, page 17. I do not know whether you can tell us whether you got this or not, Ms Turnbull; this was one of the documents you later handed over to Toni Scammell, so one assumes you did get this.
A I think I might have done, yes.

Q Where in the middle paragraph Isobel Evans is saying:

"I am therefore writing to all the trained staff asking for the names of any patients that they feel diamorphine (or any other drug) has been prescribed inappropriately."

A Yes.

Q And she was hoping for everyone's cooperation. We see the next memo from her at page 21, which again is addressed to all trained staff at Redcliff, and she says:

"Due to the lack of response to my memo of 7 November ..."

And page 17 was the memo of 7 November:

"Dr Logan will be able to comment on specific cases. However, we have arranged a meeting for all members of staff who have concerns on the prescribing of diamorphine ..."

And it sets out the date, 17 December. She says:

"It is not our intention to make this meeting in any way threatening ... our aim is purely to allay any concerns staff may have."

A Yes.

Q Does it follow that you certainly did not notify Isobel Evans of any specific cases where you had concerns?

A I cannot remember because it was a long time ago, but I do not think I did.

Q I cannot ask you whether others did or did not but we have seen what her memorandum says. We then go to page 23 – and you have been asked about this document. It is not clear whose note it is but the initials at the end on the last page, page 25, may suggest that it was dictated by Isobel Evans.

A I would have thought so, yes.

Q I do not need to ask you about page 23. You were asked about page 24 and the numbered points at the top, in which Mrs Evans set out the concerns as she understood them to be. We then have on the bottom half of that page an indication of what Dr Robert Logan said to the staff.

A Yes. What page was that one?

Q 24; the one with the letters (a) to (h).

A Yes.

Q I hope you have had the chance to read it. Can you confirm that that is broadly what he said?

A It was a long time ago but obviously he must have said that, yes.

Q Dr Logan was a consultant in geriatric medicine.

A That is right.

Q Was he the consultant responsible for the patients on Redcliff?

A At that time I cannot ... He was one of them anyway.

Q I understand. So if there were patients admitted to Redcliff he was a consultant who had responsibility for the treatment that those patients were to receive.
A I would have thought so, but as I said it was a long time ago and I cannot really remember. He could have well been at the time, yes.

Q I do not need to take you through his various points. Reference is made in this note at letter (g) of:

> "The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or had multiple medical problems, and the decision to prescribe for those patients had therefore to be made on professional judgment, based on knowledge of patient's condition, to enable patient to be nursed comfortably.

A That is right.

Q Were there discussions as well that the day staff may well have a different perception of patients because they were able to do more for them than the night staff.
A That was possibly true, yes.

Q What we know is that if things were working well patients would be asleep at night.
A If they were comfortable, yes; if patients were comfortable.

Q How many night staff would there be on Redcliff, and for how many patients – roughly? Was it two?
A Around about this time it probably would have been three but sometimes it could have been ... No, I think it was two or three ---

Q And how many day staff would they have on Redcliff?
A ... because we increased the patients. Day staff, I cannot really remember.

Q Significantly more than the night staff.
A About four, five, because it was not a big unit.

Q At point (h) Dr Logan said that:

> "It was not acceptable for patients who are deteriorating terminally and require two-hourly turning, to have pain or distress during this process. They require analgesia even if they are content between these times."

A That is right.

Q Was the point also being made – if you turn to page 25 it is there at letter C – that patients were not always comfortable during the day, even if they had slept during the night.
A Yes.

Q Was that an issue that was being discussed? That patients may appear to night staff to be comfortable and yet in the day time they might be distressed or showing signs of agitation or discomfort when they were being nursed during the day.
A Yes.

Q If we are still on page 25 can you confirm – it is the second paragraph up from the bottom – that people were asked if they felt there was any need for a policy and that no one thought that it was appropriate.
A That was true.

Q If you go back to the RCN letters earlier in that bundle, page 10 or page 11, I think they may be the same letter, Steve Barnes, the Royal College of Nursing officer, refers to the memorandum to the staff dated 7 November, the one that we have looked at on page 17, and he deals with it in this way by saying at the end of the third paragraph, "We now expect a clear policy to be agreed."
A That is right, yes.

Q At the time of the meeting which was clearly convened four weeks or so after that, staff were saying effectively they did not need one?
A Yes.

Q I wonder if I could ask you to turn on in that bundle because, starting at page 26 to see what it is, it says it is typed minutes of that same meeting. Do you have page 26?
A I do.

Q "Minutes at Redclyffe Annex, 17/12/91" – that is the meeting you were at. "(Typed minutes)". We see it is produced by Robert Frederick Logan and, if we turn over, I think we will see that it is indeed Dr Logan's own typed note of that meeting. I say we see it is his because he tells us what it was that he said and that ties up with the minutes that you were asked to look at on pages 23 to 25.
A Yes.

Q I am going to take you through this, if I may, and ask if you agree that this was what was said. Yes?
A Yes.

Q "Isabel Evans started by saying how pleased she was that we were at last talking face to face since she was concerned that developments were having an adverse effect on patient care, putting undue strain on Jane in particular..."

– meaning Dr Barton I think?
A Yes.

Q "...and also leading to rumours some of which were rather distorted being spread outside the unit.

"She then – "

– meaning Isabel Evans,

"invited me to talk in general terms about the use of opiates in the long stay wards. I expressed the view that it was often very difficult to know what was best for very frail elderly patients who couldn't clearly express their symptoms, and that one could only do one's best in interpreting them. I felt when there was any question that the patients had pain then they should be given the benefit of analgesia. Unfortunately

there were no really very useful middle range dugs between Codeine and Dihydro-codeine and Diamorphine. I also explained that, besides the pain relieving properties Diamorphine and Morphine had very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity. I said that it was, however, vital for us to make sure that there were not more simple reasons for the patient's pain or distress, such as a full bladder or faecal impaction that could be quite simply dealt with. Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary. Obviously the oral route is the best if the patient can manage it, but if not, as is often the case, then injections or sub-cutaneous infusion were perfectly acceptable. I said I felt it was vital that a team effort should be maintained, and that this would obviously require good communication of one's observations and views to other members of the team rather than involving third parties."

Did you know who he meant by third parties? Do not worry.
A No.

Q Can you remember this being said? Are you able to agree that this is ---
A I cannot remember what it said but is written down. It was a long time ago. Yes, obviously it must have been said.

Q He goes on:

"Staff Nurse Giffin then said that it seemed to be routine now for patients to receive opiates before they died and she questioned whether this was necessary. I said that I agreed entirely, it was not necessary for the patient who was tranquil and apparently asymptomatic. On occasions a patient would only become distressed when disturbed, for example when two-hourly turning was necessary. I explained that I felt in these circumstances the patient should have this pain dealt with, even if it was only transient and intermittent. I am not sure if she accepted this view or not. I think we were all agreed that when opiates were given there was no need for the patient to be rendered totally unconscious. Far from it, the aim was to keep the patient comfortable, but as awake as possible. She expressed a wish that, in the future should she have any misgivings, she should be able to discuss these with me. I said I was fully in agreement with this, but that I should not become her first contact. It was vital that she discussed any problems with Dr Barton or Sister Hamblin first. I said it was a bad idea that they should be short circuited. I tried to get across the idea that although the night staff perception of how much discomfort the patient was experiencing may be different to the day staff's, they should accept the observations of their colleagues. The general concept that improved communications between day and night staff and between night staff and medical staff might help in the future was met with little apparent enthusiasm from Staff Nurse Giffin."

I do not think she was persuaded?
A She was not, no.

Q Was it being made quite clear by the medical staff, the consultant at the meeting and perhaps the more experienced nursing staff that it was appropriate to use opiates and indeed

syringe drivers with diamorphine, even for patients who may not be in constant pain but for those who might be in discomfort intermittently?
A It was, yes.

Q And so are we now at the position, or were you in 1996 certainly of the view that diamorphine via a syringe driver may well be appropriate for a patient who does not have pain but who may be showing signs of distress or agitation or have secretions, excessive secretions, or breathing problems?
A Yes.

Q That is what you told us?
A Yes.

Q Can I turn to Patent F please very briefly? This is the only patient I am going to ask you about, or the only patient rather in relation to whom I am going to show you some records. We have looked with this patient, you will recall, at the prescription sheet on page 368E. We know now that this lady was started on a syringe driver on 20 August, the syringe driver with 20 mg of diamorphine in and I think 20 mg of midazolam. You were not involved in that because you would not have been on duty in the morning at 9.15 on 20th?
A That is right.

Q What we have heard and what I think you said to the police in your statement was that it was 40 mgms of diamorphine given at 16.50 and 40 mgms of midazolam?
A Yes.

Q Would you have been on at that time, 16.50?
A No.

MR JENKINS: That is, I am going to suggest, what the prescription sheet, 368E, says, 16.50. I think we heard that the drug book for that day shows an entry in the name Shirley Hallman for 16.55 for a 30 mgm ampoule of diamorphine. I am sure we can look at it and check it if there is a need to do so. I am looking across the room to see if the drug book is to hand. If it is checked over that side of the room, that is fine by me.

MR KARK: I hand it over to Mr Jenkins. It is the two pink tabs I think. (Same handed to Mr Jenkins)

MR JENKINS: If I can just hand it to the witness. (Same handed to witness) I do not know if you made entries in this book, Ms Turnbull. It is where the pink sticky is. What you are being shown I hope and what you can see are entries for 20 August and in the first entry you see that a 10 mg ampoule of diamorphine is signed for by Shirley Hallman on 20 August at 16.55.
A Yes.

Q And a second sticker shows a 30 mg ampoule taken by Shirley Hallman at the same time, 16.55 on 20 August.
A That is right.

Q Both with the patient's name as Ruby Lake?
A Yes.

Q Those, I suggest, relate to what is written up on page 368E at 16.50 – 40 mgs.
A Yes.

THE CHAIRMAN: Mr Jenkins, there is some concern at this end. Dr Smith was asking whether he could clarify something on the paper.

B MR JENKINS: Would he like to see the original record?

DR SMITH: No, it is all right. I take what you say. On 368E on the prescription, do you say that the time 16.50 is under what you described as the red overwriting before?

MR JENKINS: I think it is. I am going to suggest it is easier if the Panel have the original prescription chart so they can look at it. The different ink makes it so much easier to see.
C What we have seen, and you have the drug book, is that at 16.55 Shirley Hallman has signed for the drugs in the drug book on 20 August?
A She did, yes.

(Drug book shown to members of the Panel)

MR KARK: May I interject to say that what we are thinking of doing, and it might assist
D everybody in due course, is getting out all of these original prescription sheets for these patients and exhibiting them, so that the Panel will ultimately have them.

THE CHAIRMAN: That might be useful when we ultimately are in camera and discussing. Thank you.

MR JENKINS: If we go to the corresponding nursing entries, and page 394 is the summary,
E it might be useful if the original of that document can be withdrawn as well. What we have for 20 August '98 is an entry I think by Sharon Ring timed at 12.15.
A Yes.

Q "Condition appears to have deteriorated overnight. Driver charged 10.10" it says.
A Yes. If that was at night that should have been 22.10 but I do not know if that was morning or night.
F

Q If we go back to the drug chart, do you still have a finger in the drug chart, 368E?
A Yes, although this one is not very clear.

Q It says the diamorphine is given at 9.15 at 20 mgs.
A Yes, 09.15.

G Q If you just look to the left, on 19th on the drug chart, at 1600 hours, 20 mg of diamorphine is given and an equivalent quantity of midazolam?
A Yes.

Q If you go back to page 394, you will see that Shirley Hallman has written those up on 19th, "Pain only relieved for a short period – very anxious. Diamorphine 20 mg, midazolam 20 mg commenced in syringe driver."
H A Yes.

Q If you look at the original document, to your right, of page 394, I think she has written the drugs in in red?
A Yes.

Q Is that standard?
A Yes, it was then for controlled drugs.

Q Again the Panel can obviously look at this document but the first two lines of that "Pain only relieved for a short period – very anxious" is written in black ink.
A Yes.

Q And the next bit, "Diamorphine 20 mg, midazolam 20 mg" is written in red ink?
A That is right, yes.

Q What about the words "commenced in syringe driver", is that in red?
A No, it is in black.

Q She has signed it in black?
A Yes.

Q So Shirley Hallman is the nurse starting this lady on the syringe driver. We know from the prescription sheet that another syringe driver was started on the morning of 20th, and that I suggest is the one which is referred to lower down the page, "Condition appears to have deteriorated overnight. Driver recharged" and she has written "1010". That is all in black I think?
A Yes.

Q And the next bit is in red: "Diamorphine 20 mg, midazolam 20 mg, hyoscine 400 mg".
A That is correct.

Q Is that all in red?
A Only the "diamorphine" because that is the controlled drug.

Q I understand. So "midazolam 20 mg" is written in black?
A Yes.

Q "Hyoscine 400 micrograms"?
A That is in black.

Q "Family informed of condition" and the rest of Sharon Ring's note in black?
A Yes.

Q Then we go to your note, night, as the next entry on this summary?
A Correct.

Q Someone has missed out, would that be right, putting in the 40 mgs that we can see from the prescription chart was administered.
A Yes, it looks like it but I cannot verify that.

Q I understand. We know that from the entries you have seen it was Shirley Hallman who was increasing the dose because she was the one taking the drugs and signing for them in the drugs book.
A Yes.

Q But she has not written down in her summary why that might have happened.
A That looks like it, yes.

Q All we have is that the condition appears to have deteriorated overnight and then the dose going up.
A Yes.

Q We have another page, page 388, which is part of the nursing care plan and the only entry we have for the 20th is your entry which is the night of 20th over into the 21st.
A Yes.

Q No one has written up on this document syringe driver being changed twice: once in the morning of the 20th and again in the afternoon.
A That seems correct.

Q What we know is that the dose was increased again to 60mg of diamorphine, the midazolam was increased to 60mg and the hyoscine was increased to 800mcg on the morning of the 21st. You have written that up on your two notes on 388 and 394.
A Yes.

Q It is you that signed for it on the prescription chart.
A Yes, that is correct.

Q You would have been satisfied that that was an appropriate dose to give.
A Yes.

Q But you say you would certainly have discussed it with others.
A I would have definitely, yes.

Q Possibly Dr Barton.
A Not necessarily. It would have been my other colleague or at that time of day it could have been the ward sister because she used to come on duty early but I cannot remember.

Q But your note at 388 details how Ruby Lake had passed the night.
A Yes.

Q "Continued to deteriorate" you have said.
A Yes.

Q "Remains very bubbly. Suction attempted without success." What does that mean – "without success"?
A That the patient was not willing to let me use suction.

Q How do you do suction?

A It is a catheter which is attached to a suction machine and you just put it in the patient's mouth to get rid of excess excretion. It could have been that she closed her mouth, did not want me to do it. That is probably what it meant. Some patients obviously do not like this procedure; it is not very nice for them.

Q "Distressed when turned" you have said.
A Yes.

B

Q "Syringe driver recharged. Oral care given. Catheter draining. Looks flushed."

A That could have been because she was agitated or she could have had a temperature.

Q Again, your other note, page 394, at the bottom of the page you have written an identical entry. "General condition continued to deteriorate".
C
A Yes.

Q "Ruby rousable and distressed when moved".
A Yes.

Q Is it right that the patients you were asked about by Mr Kark, although you may not recall them, when you were treating them if you were involved in the administration of drugs you would not have given drugs which you thought were inappropriate.
D
A That is true, yes.

Q The patient's condition would have been such that you thought the drugs that were being administered by you and other nurses were appropriate.
A Yes.

E

Q You have told us that you left Dryad, although you were still working for the War Memorial but during a refurbishment and you have said that with other doctors opiates and syringe drivers were used but not so often.
A That is true, yes.

Q What we have heard was that there were a very limited number of syringe drivers in use in Dryad Ward.
F
A On Dryad?

Q On Dryad. They have about three syringe drivers on Dryad is what we have been told. Is that right or not?
A I cannot remember to be honest.

G

Q When you say the doses changed, are we talking about the same type of patient?
A Can you repeat that question?

Q When you say the doses changed, you were comparing, when asked questions by Mr Kark, how things had been at the War Memorial Hospital when you had been there and how things were different now that you had moved away from Dryad Ward.
A Yes. I am talking about now. Yes, the prescribing of diamorphine has changed.

H

Q You have said that patients are given intramuscular injections of diamorphine a few times.
A They first start off with a subcutaneous injection of diamorphine over a certain period of time and then the clinician might then write up a prescription then for diamorphine but in very minute doses.

Q Is this a clinician who is working Monday to Friday nine to five?
A They are what are termed housemen or registrars.

Q They are attached.
A They are attached to the elderly care unit.

Q Are these the same type of patients that might have been on syringe drivers at Dryad or may they be different?
A No, they could be the same kind of patients on Dryad.

Q Elderly patients who might have had a hip fracture and been stepped down from ---
A Yes, they could be rehabilitation orthopaedic patients, patients that have had severe strokes and are showing no signs of rehabilitation.

Q The fact is, and you know this well, do you not, that there was a huge fuss following on a police investigation?
A Yes, I do.

Q Everyone is extremely sensitive about the issues raised by this case?
A Extremely. They are.

Q Nursing staff as much as any of the doctors.
A Yes, that is true.

MR JENKINS: Thank you very much, Ms Turnbull.

Re-examined by MR KARK

Q In relation to that last issue, after you moved on the doses became smaller. Were these patients left unnecessarily in pain in your view?
A That is a difficult question. I have to be honest, yes, some could have been.

Q Some could have been?
A Yes. That is a difficult one. Every patient obviously is different. That is a very delicate issue.

Q You used the expression "very minute doses". Just give us an idea of what you mean in terms of the change from Dryad to what you mean by "very minute doses"?
A As I said, I am not a doctor.

Q I understand that. It is just your understanding of what a very minute dose is.
A 2.5mg to 5mg in 24 hours.

Q That would be a minute dose.

A Yes, or no higher than 10mg in 24 hours.

Q The only other thing I wanted to ask you about was you were asked about the explanations that were given to you by the day staff and others about the use of syringe drivers.
A Yes.

B Q I want to understand it. Were you saying, as I think you were to Mr Jenkins, that it was as a result of those explanations to you that you changed your mind about the appropriateness of the use of syringe drivers?
A Yes, I did.

Q After things had been explained to you, you accepted that that was the way that it should be?
C A It was an acceptance, yes.

Q Did the practices actually change or not?
A Can you explain that?

Q You told us all about 1991 and the concerns that were raised. There were various meetings.
D A Yes.

Q You have told us that no document was drawn up, no protocol.
A That is right.

Q You have told Mr Jenkins that explanations were given to you which you accepted ---
A Yes.
E

Q --- as to why syringe drivers were being used and why the doses were being used in the way that they were.
A Not necessarily the doses were not really explained.

Q Did the practices themselves change after 1991 as far as you were concerned or was it simply that you accepted what was happening?
F A I think I accepted what was happening.

MR KARK: Thank you.

Questioned by THE PANEL

G THE CHAIRMAN: There are no questions from my colleagues but just a little from me. The first thing I would like to do is to seek your help with bundle G in respect of Patient G, Mr Cunningham. It is a matter of just identifying a signature which you may or may not be able to do. It is page 861 where you will see that there are two entries dated 21/9/98.
A Yes.

Q It is the second entry which appears to have been made by a member of the night staff on Dryad Ward. I was just wondering whether you recognised the signature on that entry. It
H is on the line that reads "Peaceful following" and there is a full stop and then a signature.

A I do not, unfortunately.

MR KARK: I think we have heard that that is Lloyd.

THE CHAIRMAN: It was a question I asked yesterday and we did not have an answer. That is very helpful, Mr Kark.

B In relation to the answers that you have given about the concerns that were raised in 1991, I have to confess, having heard your answers to Mr Jenkins and your answers to Mr Kark, I am still not entirely sure as to what it is that you are saying and I wonder if I can ask you for some help in clarification. In answer to Mr Kark, after he had taken you through the various notes of meetings, I think you said to him that after the meeting we felt we were not getting anywhere. They were banging our heads against a brick wall. You had earlier said that you had been labelled as "troublemakers".

C A Yes.

Q When you said "they were banging our heads ---

MR KARK: "We were banging our heads ..."

THE CHAIRMAN: Was it "we were banging our heads"?

D A Yes.

Q That makes even more sense. When you said, "We were banging our heads against a brick wall" what did you mean by that?

A I think the rest of the people that had their concerns we just were not getting anywhere and that we were sort of making a fuss about nothing and we just felt that people were not listening to us. I think that is what that referred to.

E

Q On the face of it they are addressing your issues.

A Yes.

Q They are giving you answers and they are saying to you, for example, in the future if you have any particular questions or queries about particular treatment for a particular patient go and see Nurse Hamblin and your response was well we did not. I think you said the

F reason for that was that you did not think that she would take any notice of you.

A Yes.

Q You were referred by Mr Jenkins specifically to a memo signed I Evans. That is in bundle 1, tab 6, page 21. Mr Jenkins drew your attention to the second paragraph which reads:

G

> "It is not our intention to make this meeting in any way threatening to staff. Our aim is purely to allay any concerns staff may have."

It is a bit of a strange opening to the paragraph. I am trying to understand why somebody would write that. Was it the view among some of the staff that this process was in some way threatening to you?

A I think it was. It is a long time ago and I was just part of a few staff and I think it was.

H

Q Having raised this issue and gone through what was clearly a very painful and difficult process for the members of staff who were involved in raising those complaints you felt that you were banging your heads against the wall, that you were not really being taken seriously, that you were just being given the run around. You have told us that but then you have said that there came a time, however, when you no longer had the concerns that you have indicated you did have at that time.
A That is right.

Q What I am wondering – this is a question that Mr Kark asked you – is how it was that having come to the end of the process still feeling many of these concerns in place and feeling that you are being given the run around you then find yourself in a position where your concerns have resolved. Is it that as a result of all of these meetings there was a resolution of your concerns because the very things that you had been concerned about ceased to happen or did they continue? Have I made myself clear?
A Yes, you have. That is a difficult ... I think things did get better afterwards and I think the other nurses that had raised their concern sort of accepted the situation.

THE CHAIRMAN: Thank you very much. That has helped me to resolve a little bit what appeared to be different answers to different barristers and they could not both fit together so thank you very much for that.

MR JENKINS: Just a couple, sir.

Further cross-examined by MR JENKINS

MR JENKINS: Part of it was that Nurse Giffin did not like Sister Hamblin.
A No, I do not think that was true.

Q No?
A No, definitely.

Q Was not Sister Hamblin one who was very efficient in the way she ran the ward and required others to be effective and efficient as well?
A That is a difficult question.

Q Did she not express her views fairly plainly about how much work some of the night staff were doing?
A I do not recall that at all, no.

Q No?
A No, I do not.

Q And that Nurse Giffin came in for quite a lot of criticism because it was felt that she was not doing very much when she was at work.
A From what I remember of Staff Nurse Giffin she was a good worker.

Q What happened at the meeting, certainly the last one in December, was that you were told by one of the consultants how he wanted his patients dealt with.
A Yes.

Q And was it not clear that what had been happening was that patients had been receiving diamorphine, even though they may not have been in pain.
A Yes.

Q And that was the origin of the concern, the feeling people are getting diamorphine when they are not obviously in pain. And the consultant was then brought in to tell the nurses – or just the night nurses, I suggest – that that is the way it should be, that is the way he wanted it done.
A I think yes, he did.

Q Is that not why your concerns were resolved and not raised again?
A I cannot really remember, but I think probably yes.

Q The more senior nurses and the doctors, particularly the consultant, were explaining things to you that you had not been told before, although you should have been.
A Possibly, yes.

Q And is it not right that you were then given some training in the use of syringe drivers?
A It was very minimal training. I had training by a night sister and we used to attend these workshops at lunchtimes and that was it.

Q It may be that the management should have done a lot more and at a much earlier stage.
A Possibly, yes.

Q But would you agree that some steps were taken by the management after this series of meetings?
A Yes.

THE CHAIRMAN: Mr Kark.

Further re-examined by MR KARK

MR KARK: I am stuck on that same groove in the record, I am afraid, and I also want to ask you about the questions that the Chairman asked you. You said two things to him – and again I just made a brief note. You said, "I think things did improve" and you said, "Those who had been complaining accepted the situation." Those two things may or may not be the same – and I am sorry to pursue this – but accept a situation they may have done, but then Mr Jenkins was asking you about this. I am going to ask you again: did things actually change or was it your understanding that changed?
A I think things ... (After a pause) I think things did change.

Q If they changed can you tell us what the change was?
A I think we did have a better understanding of the use of diamorphine but I think the thing that did not change was still the range of the dosing – that still was written I think in the same way.

Q What about the frequency of the use of syringe drivers? Did that actually change or was it your understanding of why they were being used that changed?

A I think it was the understanding of the use of them.

MR KARK: Thank you very much indeed.

THE CHAIRMAN: Ms Turnbull, I am pleased to be able to tell you that that completes your testimony. It has been a long day for you and I want you to know that the Panel really do understand and appreciate the strain that answering questions for such a length of time in this sort of setting puts on any witness and we are most grateful to you for coming to assist us today and for staying the course with us. Thank you very much indeed for your assistance; you are free to leave.

MR JENKINS: Sir, can I help you with one thing? The question you raised about Mr Cunningham and the note on page 861? I know that a couple of statements were read the other day; there is a third one from a nurse called Lloyd, which I think will refer to that specific entry.

THE CHAIRMAN: I see that; that is one to be read that would have been read earlier, on Day 12, and I was going to raise the question on that but I think we should allow the witness to go first of all.

(The witness withdrew)

THE CHAIRMAN: Mr Kark, of course at this time the Panel do not know what is in the statement of Ms Lloyd, which is to be read; nor do we know why it is to be read and why Ms Lloyd is not at the moment expected to give evidence in person.

MR KARK: It is being read because it is agreed. I think this one is agreed evidence.

MR LANGDALE: Yes, it is.

THE CHAIRMAN: I do not know whether this will make any difference but you will recall that yesterday there was with a witness some confusion over exactly who had seen what in terms of the unfortunate behaviour of Mr Cunningham shortly before he was put on a syringe driver, and it transpired when the witness had a second chance to look at that page that she recognised that in fact she had not seen any of the things that she reported. And that was why I was keen yesterday to establish who the authority of that note was because as the witness yesterday told us, she would have expected the night staff to report in writing the incident that occurred; it was by no means a run of the mill minor matter, it was the sort of thing that she would have expected to have had recorded. It may be that it would assist the Panel to hear from the persons who did actually witness it, the circumstances in which they came to produce that particular note, which simply read, you will recall, "remained agitated".

MR KARK: Which is rather more limited. Nurse Lloyd, whose statement is going to be read to you, does not actually deal with it in the sense that she did not witness the behaviour either. That only adds, I expect, to the question mark, rather than clarifies it. I will discuss this with Mr Fitzgerald and with my learned friends but I do not think that we have tracked down the night staff who did witness it.

THE CHAIRMAN: We can only deal with the evidence we have. I was just concerned that if there were a live witness who could shed light on this area and was available to us, that we would take the opportunity to hear from her or indeed him if that were the case.

MR LANGDALE: Sir, I know that it seems difficult to work out without working out practically what is sensible, but certainly so far as the defence and Dr Barton is concerned we have no objection to my learned friend's team trying to see if they could find out anything more from this potential witness if it can clear this up.

THE CHAIRMAN: That is very helpful, Mr Langdale, if we can make some progress on that.

MR KARK: In those circumstances we may avoiding reading Ms Lloyd just now and we may want to make some inquiries. We will have to find out if she is still alive. We hope she is, of course, but some of our nurses have sadly departed; but we will make inquiries.

There is only one other statement that we were going to read to you and that is the statement of Sharon Ring, but I do not know if the Panel are feeling up to it now, or whether you would like a break.

MR JENKINS: Can I discourage you from reading it now? I have not checked it.

MR KARK: I can indicate to my learned friend that there is quite a lot of irrelevance that I have taken out but he will need to see it. I am sorry, I had not appreciated that. So I am afraid at the moment that we do not have anything that we can readily read to you.

THE CHAIRMAN: We are due to return on Monday at the normal time with Nurse Tubritt.

MR KARK: Can I mention one other matter? I have been in discussion with my learned friends today and they know I am going to raise this. We are beginning to be a little bit concerned about the lack of an export report. The reason for that is that of course Professor Ford is going to be giving evidence, potentially at the back end of next week. I would not want to call Professor Ford before he has had an opportunity of considering the defence expert, if there is one; indeed one of his duties under both the civil and criminal procedure rules would be to consider whether there are areas that he could agree with the defence expert. We are now at a stage where I think that we are beginning to be concerned. The defence know of this and I am really raising a flag, as it were, that I hope this will not cause us problems later on. But we do not want to call Professor Ford before the production of a defence expert report, if there is going to be one.

THE CHAIRMAN: Are you able to help us in any way, Mr Langdale?

MR LANGDALE: I suppose the short answer is no. We are aware of the rules; we are aware of the situation, and any material by way of any expert report or expert material will be provided to my learned friend at the appropriate stage, when it is available to be provided. Can I just say this, without sounding too mysterious? I do not think that there is going to be any difficult at all – and I cannot commit myself at the moment – and there is not going to be some sudden new issue that is going to cause Professor Ford to require hours or days or nights burning the midnight oil to grapple with some novel issue.

THE CHAIRMAN: Can I take it then that by the time the professor is likely to be called to give evidence he will have had an opportunity to view the report of the defence?

MR LANGDALE: I feel confident that whatever material we need to supply to my learned friend will be available and I would be astonished if it turns out that Professor Ford says, "My goodness me, I must have some more time to consider this."

B THE CHAIRMAN: I am trying to decode that, Mr Langdale.

MR LANGDALE: There is going to be no radical issue, can I put it like that? And I speak in the absence of anything immediately to hand as far as I am concerned. In an effort to clarify, the GMC have sought the views of a number of experts – indeed, I think it is Dr Black, who might well have been used as the expert and called by the GMC but I understand he had difficulties and could not attend. He, for example, gave evidence at
C the inquest. There is a range of material which is already there, which makes me feel more confident in saying that I cannot envisage a situation – whatever the differences of view there might be about certain things – that there is going to be any novel difficulty or novel issue which will require Professor Ford to think, "My goodness me, I must have some time."

THE CHAIRMAN: But Mr Langdale does that mean that by the time Professor Ford is called to give evidence if there is a defence report he will have had that served upon him, or it
D will have been served upon the GMC.

MR LANGDALE: Sir, that is what I was endeavouring to say right at the outset. I am quite sure that there will be no difficulty about him seeing in time – in other words before he gives his evidence, and not five minutes before he gives his evidence – any material that we may provide to the other side.

E THE CHAIRMAN: Thank you. Does that reassure you, Mr Kark?

MR KARK: Not enormously. It is not just novelty that we are interested in, it is any report upon which reliance will be placed. Mr Langdale knows our concerns, so does the Panel and we will see where we get to.

MR LANGDALE: I am sure my learned friend will not lose any sleep over the weekend
F about this. I do not think there is going to be any difficulty. We are well aware of what the rules say and we are well aware of what we have to do in terms of this sort of aspect of the case.

THE CHAIRMAN: May I wish you all a good, untroubled weekend and we will resume again at 9.30 on Monday morning.

G (The Panel adjourned until Monday 29 June 2009 at 9.30 a.m.)

H