GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 29 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 FIFTEEN)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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THE CHAIRMAN: Good morning everyone. Welcome back. I am very pleased to see that the doctor has been able to join us this morning. I hope that is indicative of things having gone well over the weekend.

MR KARK: I will call Mrs Anita Tubbritt.

ANITA TUBBRITT, Affirmed

(Following introductions by the Chairman)

Examined by MR KARK

Q I think it is Mrs Tubbritt.
A That is correct.

Q I want to ask you a little bit about your professional background and then move on to your work at the Gosport War Memorial Hospital. Are you still a senior staff nurse?
A I am still a senior staff nurse, yes.

Q Where are you working at the moment?
A I am currently working day duty on Collingwood Ward, which was formerly Dryad Ward.

Q Before we get to your move to the Gosport War Memorial Hospital, we need to know a little bit about your training as a nurse. I think you qualified as a registered general nurse in 1986.
A That is correct.

Q At first I think you went off to work in a place called Beechcroft Manor Rest Home. That is in Gosport as well, is that right?
A That is correct.

Q You left there in about 1987 to take up a post at the GWMH (as we have been calling it).
A Yes.

Q Did you start off at the Redclyffe Annexe?
A I started at the Redclyffe Annexe, yes.

Q The Redclyffe Annexe in the late 1980s, was that at a site distant from the Gosport War Memorial Hospital?
A Yes.

Q What sort of patients did you look after there?
A Elderly patients. Continuing care.

Q Does that really mean that they were long-term patients?
A Yes.

Q Did you work different shifts, but mostly at night?

A I only worked night shifts at the time.

Q The Redclyffe Annexe, I think as you have told us, was a geriatric ward. Were there any other wards at the Redclyffe Annexe, or was it purely for geriatric patients?
A It was just the one ward.

Q Did you have patients there who were in for palliative care?
A Yes.

Q You did.
A Yes, from as far as I can remember.

Q Did you have a number of patients there who remained there for a very long time?
A Yes.

Q Tell us about the position, so far as doctoring at the Redclyffe Annexe, prior to Dr Jane Barton arriving. What was the system prior to the time when you had a clinical assistant?
A Prior to Dr Barton arriving, as far as I can remember, if we needed medical cover of any sort we contacted the patient's own GP.

Q They would then have to come out to the ward, would they?
A They would come to the ward and they would deal with whatever problems arose.

Q Would that include prescribing?
A Yes.

Q Dealing with pain relief, can you remember in general what sort of pain relief was used on the Redclyffe Annexe prior to Dr Barton arriving? Were you dealing with a whole range or what was the position?
A A whole range. From as far as I can remember, it was a whole range.

Q Meaning what?
A Non opioids, mild opioids, right the way through.

Q Prior to Dr Barton arriving, did you ever deal with syringe drivers?
A I think once. I can recall using a syringe driver once, initially, after I had started working at Redclyffe. I am not sure if it was before Dr Barton arrived or not.

Q All right. Once Dr Barton had started working at the Redclyffe Annexe, can you help us as to whether any changes appeared to be made about the running of the ward?
A Things were more organised. Drug charts were written up. We had someone to call upon during the day. Prescriptions were written so that needs were anticipated.

Q What does that mean "prescriptions were written so that needs were anticipated"?
A PRN night sedation. PRN analgesia.

Q Is that something you had had before on the ward?
A Not that I can recall.

Q Tell us about the use of syringe drivers. Did that remain the same as it was before, or did it change?
A The use of syringe drivers I think increased.

Q Tell us about that increase, please. How do you remember it happening?
A I am not exactly sure. They seemed to arrive and then we used syringe drivers on a fairly regular basis.

Q Of course a number of different drugs can be used in syringe drivers, as we know. What is your recollection of why syringe drivers were being introduced and what they were being used for?
A From what I can remember, if patients were unable to swallow, we administered their mediation through a syringe driver.

Q What about the use of opiates. Did that remain the same or did that change?
A I think it changed.

Q In what direction did it change?
A We tended to us opiates through the syringe drivers more.

Q Tell us about your dealings with Dr Barton. You were working on nights.
A Yes.

Q What time did that mean?
A I started my shift at quarter-past eight in the evening and finished at quarter-to eight in the morning. Dr Barton used to arrive on the ward somewhere just after half-past seven in the morning, so there would be a 15 minute overlap, and she would ask us if we had any concerns about the patients.

Q Did that mean you had direct meetings with Dr Barton?
A Yes, but not always.

Q Who, so far as you were concerned, was the main point of contact within the nursing staff for Dr Barton?
A Our ward manager.

Q Who was that?
A Gill Hamblin.

Q So which ward were you once you -----
A Dryad Ward.

Q Let us go back a little bit. Did you deal with Gill Hamblin back at Redclyffe?
A Yes, I did.

Q Once you moved to the new hospital, you moved to Dryad Ward.
A Yes, that is correct.

Q Still dealing with the Redclyffe Annexe for the moment, before you had moved, does the evidence that you have just given reflect the position there, that you were on nights and you would meet Dr Barton occasionally in the mornings?
A At Redclyffe Annexe we did not see Dr Barton quite as much as we did at the new hospital.

Q But Gill Hamblin was there.
B A Gill Hamblin was there.

Q And Dr Barton was there.
A Yes.

Q Then when things changed and you moved to the new ward, to Dryad Ward, tell us about your workings there with Gill Hamblin and Dr Barton. How much interaction did you
C have with Gill Hamblin?
A It would be at handover times, so either first thing in the morning, or if she was on a late shift she would handover to us in the evening, or possibly by telephone call.

Q Possibly by telephone call?
A Yes.

D Q How would that work?
A If she needed to ask us something, she would phone us at home. But that was very rare.

Q Are we talking about Gill Hamblin?
A Gill Hamblin, yes.

E Q So if she needed to ask you something – presumably about a particular patient.
A Yes.

Q Tell us about the type of patient you had, once the move took place. You have described the patients at the Redclyffe Annexe. Was there any difference once you got to Dryad Ward?
F A Initially there were similar types of patients, but during the course of the time of Dryad Ward, patients changed from continuing care, palliative care, rehabilitation of fractured hip patients.

Q I am sorry, the last ----
A Rehabilitation of patients with fractured hips.

Q Were those patients who required greater care, or greater intervention, as it were?
G A Yes.

Q I want to go back to the time just prior to the move.
A Okay.

Q Do you remember that when you were still at the Redclyffe Annexe there had been concerns raised about the use of syringe drivers and about the opiates that were being used?
H A Yes.

Q Were you very much a part of those meetings and the concerns being raised?
A Yes.

Q Did you have concerns yourself?
A I did have concerns myself.

B Q We will have a look at some documentation in a moment, but do you remember the essence of your concerns?
A I can remember being concerned about how syringe drivers were being used, the amount of training we had received prior to the arrival of the syringe drivers, and training in general.

C Q I am going to ask you to take up a bundle marked Panel Bundle 1 and turn to tab 6. Just so that you know, I am not ignoring parts of this. The Panel have already heard evidence from a number of witnesses and we have already looked at some of this documentation, so I am not going to go through it all again.
A Right.

D Q I am going to draw your attention to certain aspects where I think you were specifically closely involved. Looking at page 2 for the moment, do you have a document entitled "Summary of meeting held at Redclyffe Annexe 11 July 1991".
A Yes.

E Q I think you see your name in the right-hand column of the nurses that attended. Just casting your eye over the list of concerns, we have been through this and so I want to try to avoid going through it again – we can see that the concerns revolved around, first of all, the amount of the use of the diamorphine; the lack of the use of the sliding scale – which I will ask you about; the possibility that patient deaths were being hastened unnecessarily; lack of training; and too high a degree of unresponsiveness. It as all those sorts of areas that were being raised.
A Yes.

F Q Did you share those concerns?
A I think I did at the time.

Q What sort of training had you had, first of all, in the use of syringe drivers, and what sort of training did you get in the use of syringe drivers?
A Prior to this meeting?

Q Yes.
G A When I had come across the very first syringe driver during my time at Redclyffe Annexe, I explained to the ward manager at the time, Sister Green, and she said, "Surely you've come across a syringe driver before." I said, "No, I don't recall using one." So she took me to the patient and said, "It's a pump with a syringe. You won't need to touch it, there's nothing to worry about." That was the extent of my initial training.

Q Did you ever have to load at that time, after that sort of training, a syringe driver yourself?
H A No.

Q Did you ever receive more formal training on the use of syringe driver?
A I do not think I did prior to this meeting.

Q Let us just fast forward a moment. Did you subsequently receive training on the use of a syringe driver?
A Yes.

Q What sort of training did you receive?
A The first training I can recall having shortly after the meeting was, I think, a one hour session with a community nurse used to dealing with syringe drivers.

Q And that training consisted of what?
A I think I can recall she brought a syringe driver with her and talked through how to set it up and the purpose of it – as much as you can in one hour.

Q And how many of you were there – can you remember?
A No, I cannot offhand.

Q But more than just you?
A More than just me, yes.

Q So it was really a demonstration of the use of a syringe driver?
A Yes, yes.

Q What other training did you have?
A I cannot remember offhand.

Q What about the use of opiates, the use of the drugs that went into the syringe driver. Did you have any specific training about those?
A I cannot remember any specific training as such, but a number of us took it upon ourselves to do as much research as we could.

Q I think you specifically did some research about syringe drivers?
A I did.

Q We will come onto that. Can I take you, please, to page 6 of this little bundle. You will find the page number in the right hand corner. This is after the meeting in July. We are now into the end of October 1991. We can see the purpose of this visit by Gerardine Whitney, community tutor:

> "The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issue of anomalies in the administration of drugs."

Do you recall this meeting?
A Yes, I can.

Q What was this all about?
A At the time, I was attending a Care of the Elderly ENB course. As part of that course we had to discuss problems in our work area or things that bothered us. I chose to discuss

pain control. It was a result of this discussion. Apparently a previous member of staff had attended a similar course and had raised similar concerns.

Q And the person who is coming along to give this talk, was that Gerardine Whitney?
A Yes.

Q I can see that she described as Community Tutor?
A Yes.

Q Can you help us with what that actually means?
A Her involvement with me was as a tutor at the School of Nursing. She actually participated in the Care of the Elderly ENB course.

Q Which you were doing?
A Yes.

Q I see. So she came along, did she, to speak to the nursing staff that we can see at the Redclyffe Annexe?
A Yes.

Q Was that as a result of your request?
A My request and, as I stated, the outcome of a previous discussion.

Q Okay. And then we can see that some problems were identified at the day of the meeting. These were nurses, were they, speaking out?
A Yes.

Q About the problems that they had seen?
A Yes.

Q Were there any members of management at this meeting?
A No.

Q Or Dr Barton or Sister Hamblin?
A No.

Q So it is nurses together as it were with the Nurse Tutor?
A Yes. The purpose of the meeting was really to find out what our concerns were and whether there really was a problem.

Q Then we can see the two first matters were raised by Staff Nurse Giffin?
A Yes.

Q Then you reported an occasion when a syringe driver had run out before the prescribed time.

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

Was that at the time a concern that you shared?
A Yes.

Q We have heard quite a lot, as you will appreciate, in this case about the sliding case of analgesia?
A Certainly.

B Q Did you know about the sliding scale of analgesia, the concept of it?
A Yes.

Q There is a specific document called the Wessex Protocol. Had you heard of the Wessex Protocol?
A Probably not at the time, but yes, I am aware of it.

C Q But you knew the concept of starting at the bottom and moving upwards?
A Yes.

Q Then at paragraph 5 we can see a specific concern raised by you:

"Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had i.m."

D Is that "intramuscularly"?
A Yes.

Q

"... 10 mg Diamorphine at 10.40 hours on 20.9.91, and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91, administered for either a manual evacuation

E of faeces or an enema."

And the use of diamorphine concerned you on that occasion?
A Yes.

Q Over the page:

F "There are a number of other incidents which are causing the staff concern but photograph the purposes of this report are too many to mention. The staff are willing to discuss these incidents."

Then you were obviously speaking up a bit at this meeting. That is no criticism.
A I think people expressed their concerns. Then, when it was a more formal meeting, as you can appreciate, people go quiet and because I knew Gerrie Whitney it was left to me to

G do the speaking.

Q It is a bit like asking if there are any questions at the end of a lecture.
A Yes.

Q It is quite difficult to do it, but you knew Ms Whitney?
A Yes.

H

Q And so you felt it easier. Let us have a look at what you raised.

"7. It was reported by Staff Nurse Tubbritt that:"

And then you reported the quantities that were being used between certain dates. Then at (b) you said:

B "b) .... (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain...".

Why, so far as you were concerned, was the lack of pain relevant?
A I think I wondered why they were having diamorphine if they did not have pain, or did not appear to have pain.

C Q Then:

"c) 8 ampoules of Diamorphine ... were used between [certain dates] (4 of the 8 ... were administered to the patient identified in 7b above ...

Note – This patient had previously been prescribed Oramorph 10 mg ... which was administered regularly commencing on 2 July 1991.

D

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?
E A Yes.

Q

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

F A That is right.

Q Do you remember this incident?
A Yes, now I have read it.

Q It is a long time ago?
A Yes.

G

Q Can you just tell us – what was Sister Hamblin's reaction generally if you confronted her or asked her about why patients were on diamorphine?
A At the time the relationship between nights and days what not necessarily at its best. On night staff, there were a few members of staff that had been around for a long, long time and a great deal of new staff, and we did not really know Gill Hamblin very well, so it was building up a rapport, I suppose.

H

Q Did you yourself have occasions of speaking to Sister Hamblin which you can recall and indicating your concerns directly to her?
A I think yes.

Q And do you have a recollection of the sort of reaction that you got back from her?
A I do not think it was the reaction I expected. I do not think it was a very helpful reaction.

Q Then we can see the conclusions where you were concerned about the use of diamorphine indiscriminately and that non-opioids and weaker opioids were not being considered prior to the use of diamorphine. The sliding scale of analgesia comes into play there, does it?
A Yes.

Q I am going to miss out a couple of documents. There is a letter from Steve Barnes at page 10 to Mrs Evans. Mrs Evans, we know, was the patient care manager. I think Steve Barnes was raising your concerns directly with management. I am sorry – back into tab 6, page 10. That is a letter we have looked at. Did you understand Steve Barnes was raising your concerns with management?
A Yes.

Q I will not ask you any more about that. Could I ask you to go to page 14, please – same tab. Here is another letter from a nurse representative – somebody called Keith Murray. Did you know Keith Murray?
A Yes.

Q He is described as a "Branch Convenor"?
A Yes.

Q In essence, was he representing the nurses ---
A He was, yes.

Q --- in this exchange. This had now gone up to the District General Manager, Mr West. This is a letter dated 2 December 1991. Would you look at the second paragraph? He writes:

> "I was contacted by a staff nurse currently employed on night duty in Redclyffe Annexe, 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 via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues."

Do you have a recollection as to who that member of staff was?
A I believe it was Sylvia Giffin, Staff Nurse Giffin.

Q Again, did you share that concern?
A Yes.

Q Page 16, please. This note refers to a letter from you referring to the meeting that had taken place on 31 October which we have looked at at page 6. Isobel Evans is your local manager, the hospital manager. Is that right?
A Yes.

Q

> "May I take this opportunity to once more state that I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion, as I feel the only alternative is disruptive criticism which achieves nothing positive and leaves staff feeling frustrated."

Did you have any face to face dealings with Isobel Evans?
A Yes, I did.

Q Was she trying to assist, did you feel?
A I did not think she was at the time, no.

Q Why not?
A I can remember one incident. At the time of these meetings, my mother was dying of a brain tumour, which I felt was totally unrelated, but she brought that up and she stated that perhaps my judgments were clouded by my own personal problems.

Q Was your mother on a syringe driver?
A Not at the time, no.

Q Was she receiving opiates?
A Yes. She did later go on to a syringe driver.

Q And it was being suggested that because of that background, as it were ---
A Yes.

Q --- you had these particular concerns?
A Yes.

Q Page 18. I am sorry – that is actually a letter not to yourself but to Beverley Turnbull, but there is reference there to a policy being written up. Was a policy ever written up that you can recall?
A I cannot recall a policy, no.

Q Can we go to page 21, please. Another meeting, I think, was set up and you had been sent a memo. The memo is back on page 17, and I am going to try and short-circuit things. You were being invited, I think, by that memo to put your views down in writing. Then, if we go to page 21 we can see that Ms Evans is writing:

> " Due to the lack of response to my memo ... Dr Logan will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on ... 17th December ... to discuss the subject in general terms.

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 so I hope everyone will take the opportunity to attend and help resolve this issue."

Then we have the note of the meeting at page 23. By this stage had you expressed such concerns as you could to management?
A Relating to the memo?

Q Yes.
A I honestly cannot remember.

Q Just before we come onto this, we are going to see that Dr Barton attended this specific meeting on 17 December. How much discussion, if any, up until this point had you actually had with Dr Barton?
A I cannot recall having any discussion with Dr Barton prior to this meeting.

Q May I ask why not? She was coming in. These concerns had started, or at least had been written about, in July 1991. We are now in December 1991. Was there any reason you did not raise them with Dr Barton?
A I think because we did not actually come into contact with her, or very rarely up until that point. Our point of contact would have been Gill Hamblin or the day nurse in charge?

Q So you were dealing with Gill Hamblin?
A Yes.

Q You described her attitude. Page 23, we can see that you were present at this meeting on 17 December. Let us go down to paragraph 3. We can see that staff were invited to give details –

"... of cases they had been concerned over but no information was received; it was therefore decided to talk to staff on the general issue of symptom control...".

I am not going to read through the whole of this. You are welcome to cast your eye over it if you wish to. Page 24 we can see that Mrs Evans had presented staff's concerns so that at this stage, Mrs Evans was apparently putting forward the concerns the nurses had, and then there is a set of propositions, one to five. Just look through those.
A Yes.

Q The Panel have read them through already, and they have had them read through for them, including (4):

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

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

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

At this stage did you still have any concerns about the use of diamorphine and syringe drivers?
A I think one of my main concerns was how staff were actually using the syringe drivers, changing the rates and things.

Q What was that? Can you just explain that a little more?
A I can recall several incidents where the practice was to initiate the syringe driver, start the rate higher than necessary for a few hours, then to reduce the rate.

Q Did you ever get a written protocol following all those meetings?
A I cannot recall receiving one, no.

Q How did things move on after December 1991? Did you receive further training?
A I attended lots of training courses. I think anything that was available, I attended.

Q Was that of your own volition or was that something arranged by GWMH?
A It was mostly off my own bat.

Q Because you wanted to know more?
A Yes.

Q Did you receive any formal training about the use of opiates and the quantities of opiates to use?
A Through Gosport War Memorial Hospital?

Q Yes.
A I cannot recall off-hand.

Q Did you go on any training courses yourself?
A I think I did, yes.

Q Can you recall whether you had any specific further discussion or training either with Sister Hamblin or Dr Barton?
A No.

Q You moved, as you have told us, about a year after this to the Dryad ward.
A Yes.

Q Can you help us? Did things change at the Dryad ward, or did your concerns resolve themselves?
A I am not sure if I can say things resolved themselves. I think my understanding was different. By that point I had attended a lot of training sessions and done a lot of reading and research.

Q So you knew more about the use of diamorphine and more about the use of syringe drivers?
A I think so, yes.

Q Did your concerns about their use resolve themselves?
A I cannot recall being as concerned.

Q Can you tell the Panel this? Did things actually change after these meetings so far as you are concerned, or was it your understanding that changed?
A I think mostly my understanding.

Q Did anything change about the actual use of syringe drivers and the use of diamorphine that you can remember?
A The use of syringe drivers possibly changed slightly, certainly at night. Once we were aware of certain protocols and guidelines, we tended to stick to those, recording on charts, regular checks, that type of thing, but this was on a more informal basis.

Q So the record keeping got better, did it?
A Yes.

Q Anything else?
A Not that I can remember.

Q What about the quantities of opiates being used or how quickly they were being used? Did that change or did that remain the same?
A I think it was about the same.

Q So far as the use of opiates is concerned on Dryad ward, you have had your training, such as it is, you have had the meetings, you have moved to Dryad ward. I just want to ask you a little bit about the authority for the use of a syringe driver, the authority for an increase in medication. We have seen through the notes – perhaps I do not need to take you to a specific note, because I expect you will remember – that Dr Barton used to pre-prescribe; she used to prescribe a variable dose.
A Yes.

Q Do you recall that happening?
A I can recall that happening, yes.

Q There were variable doses of diamorphine to be administered through a syringe driver.
A Yes.

Q As a member of the night staff, were you ever responsible yourself for setting up a syringe driver, initiating a syringe driver?
A Very rarely.

Q But it did happen?
A Possibly occasionally. I cannot actually recall setting one up.

Q If you had done, that would presumably be with another nurse?
A Yes.

Q Whether you actually set one up or not, can you remember what your understanding was about the authority to set one up? Would you need to go back to the doctor, or would you be able to set one up if it was prescribed?
A Once it was prescribed, if we found it necessary, then we could set it up.

Q The initiation dose would be what to your understanding?
A The lowest dose from the prescription chart.

Q Increases in doses would be dealt with how so far as you were concerned? First of all, did you ever deal with an increase in dose yourself?
A Probably, yes.

B

Q We will be looking in a moment at some patient notes. Again, so far as you are concerned, what was your understanding of how doses should be increased?
A We had the authority, if the patient we felt was still in pain or discomfort, the prescription was such that we could adjust the dose if we felt it was necessary.

Q If you felt it was necessary?
C A Yes.

Q But by how much? If you have a range, say, from 20 to 200, you started off at 20 and you felt that the patient required it, by how much would you feel you would be entitled to increase the dose?
A 5 or 10 mg.

D Q 5 or 10 mg?
A I think so.

Q Would you go back to a doctor before increasing it, or not?
A Sometimes.

Q But not always?
E A Not always, no.

Q You were interviewed by the police, were you not?
A Yes.

Q And you gave a number of statements also to the police.
A Yes.

F

Q You said I think all the way through those that you yourself would not give drugs to a patient unless you thought it was appropriate.
A Yes, that is correct.

Q That is part of your duty as a nurse.
A Yes.

G

Q Can I ask you what you know about conversion rates from oral morphine to subcut diamorphine, or what you knew then?
A I know that the dose of the subcut would have been less than the oral.

Q Do you know how much the dose has to be less to be the equivalent?
A About a third.

H

Q Is that knowledge that you had back in the mid to late 1990s?
A That I am not sure.

Q So that may or may not have been part of the special training that you did?
A Exactly.

Q I want to go on, before we begin looking at specific patients, to ask you about two other areas. The first is the issue of hydration of patients. Again, we have heard lots of evidence about hydration and the use of syringe drivers, but what was your knowledge about its use on Dryad ward? Did you use hydration on Dryad ward?
A Very rarely.

Q What sort of method of hydration would you use on Dryad ward?
A If a patient was unable to drink orally, on very rare occasions it would be subcutaneous fluids.

Q So not intravenous?
A No.

Q Subcutaneous?
A Subcutaneous.

Q Which means, as we have heard, a low level drip.
A Yes.

Q In what circumstances would you yourself have thought it appropriate to use a subcutaneous drip? Would that have to be prescribed by a doctor or would you be able to set it up on your own?
A I think in those days it would have been on a doctor's recommendation.

Q So there would have to be a note made that a subcutaneous drip should be set up?
A Yes, from what I can recall.

Q But then you would be able to do that?
A Yes.

Q That would involve, we have heard, inserting a small needle into the patient's skin and allowing a slow drip of what? Saline?
A Yes.

Q If a patient was unable to swallow, might that be an indication for a syringe driver to be used?
A Yes.

Q You have said I think that it would be very rare for hydration to be used, but it was sometimes used, was it, in relation to patients who were on a syringe driver?
A I am pretty certain that I can recall a couple of cases, yes.

Q I want to ask you about some other occasional notes that we have seen and your understanding of them. We have seen in some of the notes – not actually from Dryad ward,

but from the Haslar Hospital I think it was – "Not for resuscitation", or "Not for 555". Would you understand what those words mean?
A Yes.

Q "Not for resuscitation" perhaps is fairly obvious.
A Yes.

B Q We have also seen expressions such as "Make comfortable" or "TLC".
A Yes.

Q Let us deal with TLC first of all. TLC would mean what to you?
A Tender loving care.

Q What significance would that have for a patient?
C A To keep the patient comfortable.

Q Would it be any indication of what sort of state of illness they were in?
A I would assume the patient was probably terminally ill by that point.

Q So effectively for palliative care.
A Yes.
D

Q "Happy for nursing staff to confirm death". What, if anything, does that mean to you?
A That the patient was terminally ill and, if they died, nursing staff were able to confirm death.

Q So that would be its significance to you; it would indicate that the patient was terminally ill.
E A Yes.

Q I am sorry. I began by asking you about "Make comfortable" and I forgot to come back to it. "Make comfortable". What would that signify to you?
A Similar to TLC, I think.

Q So "TLC", "Make comfortable", "Happy for nursing staff to confirm death", in your
F mind at least were end of life type words?
A Yes.

Q Was there any other notation to indicate to you that a patient was for palliative care and would it ever be written in the notes that you saw "For palliative care only" or whatever might be written?
A Possibly "For palliative care".
G

Q Do you remember that ever being written?
A I have seen it written, but I cannot recall if it was then or if it has been in more recent years.

Q When the police investigation started, I suspect that word of that raced round the nursing environment fairly fast, did it?
H A Yes.

Q You handed your notes about what had gone on in 1991 to somebody called Tony Scammel.
A Yes.

Q Just tell us, please, why you did that?
A It was as a result of a comment in the CHAI report. It stated that nobody had ever questioned pain control within Gosport War Memorial Hospital.

Q You were concerned about that because?
A A number of staff were concerned, so I felt it was appropriate to take my notes to Tony Scammel.

Q I am going to start dealing with various patients. We can deal before we break I think with Patient E, Gladys Richards, very quickly. You were interviewed by the police in 2000 about this lady. I am not going to invite anybody to turn up the notes of this patient, because I think your dealings with this patient were extremely limited.
A Yes.

Q In fact, I think according to your interview, you had almost no dealings with her until she died.
A That is correct.

Q Then you were asked to hand a note or a book of some sort to one of the relatives?
A A book, yes, from a relative to a colleague.

Q I may have to come back to Patient E, but for the moment I am going to move on. I think you went through Patient E's notes, did you not, with the police and you did not find any notations.
A No.

MR KARK: I am going to move on to Ruby Lake, who is our Patient F. I do not know, sir, when you want to take our break. This patient will probably take about 10 or 15 minutes, so it might be convenient to have the break now.

THE CHAIRMAN: Very well. We are going to take our break now. The Panel assistant will take you to somewhere where you can get some refreshments. You are on oath – and I will probably remind you of this later – and your oath continues every time we take a break and so it is absolutely essential that you do not talk to anybody about any aspect of this case. Is that clear to you?
A Yes.

THE CHAIRMAN: We will return, ladies and gentlemen, at 10.45.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone.

MR KARK: Sir, I do not know if we are waiting for the doctor. She is not here.

THE CHAIRMAN: I am sorry, there is such a rampart of files, that we cannot see from this end.

MR LANGDALE: She is not here at the moment, but perhaps we may just continue. She will be here.

MR KARK: Mrs Tubbritt, we were about to turn to Ruby Lake, Patient F. I think, with one exception, it is fair to say that you do not have an individual recollection of these patients.
A No.

Q So far as Ruby Lake is concerned, she is one of those about whom, unfortunately, you have no recollection.
A That is correct.

Q That is no criticism of you; it is all a very long time ago. I only want to ask you very briefly about some entries in her records. Could I ask you to take up bundle F, page 78 – and the page numbers that we are looking for are those with two short lines either side of them. This is not your note at all, but it shows us that this patient was transferred to Dryad Ward – that was your ward ----
A Yes.

Q -- for continuing care. Do you know what the "HPC" notation means?
A I am not sure, no.

Q I am sorry, it is "history of presenting complaint," it is not?
A Yes.

Q Then fracture ...
A Neck of femur.

Q Thank you. We can see that she had a Barthel of 6. "Get to know. Gentle rehabilitation. I am happy for nursing staff to confirm death" – which you have indicated to us was an indication of palliative care. A Barthel of 6. We know there is a maximum of 20, but is a Barthel of 6, on Dryad Ward, good, bad or average?
A Average, I would think.

Q It means she can do some things for herself, with assistance.
A Yes.

Q She is not totally in the hands of the staff.
A That is correct.

Q Can we turn to the prescription charts, please, which you will find starting at page 368A. We can see that she has been written up, at page 368B, for Oramorph 10 milligrams and temazepam, and various other drugs at page 368C. At page 368E, she has been written up, under the daily review prescriptions, for diamorphine 20-200 milligrams. Do you see that?
A Yes.

Q How do you interpret that prescription?

A That we could adjust the dose between 20 and 200 milligrams.

Q Depending on what?
A Depending on the patient's need for pain control – if we felt the patient was in discomfort.

Q Would you regard that as a PRN prescription?
B A Yes.

Q Meaning "as required".
A As required, yes.

Q But it is written up in the daily review prescriptions.
A Yes.

C

Q But you would not automatically give that?
A That drug or the dose?

Q You can see: "Diamorphine 20-200 mgs." Who would have written the dates at the top: 19, 20, 21, 22?
A The person who administered the drug.

D

Q And they would be administering it on the basis, would they, of their decision about the patient's need?
A Yes.

Q Would this sort of prescription normally be under a "PRN" heading?
A Yes.

E

Q You have told us, quite rightly, that you would not issue a drug unless you thought it was appropriate.
A That is correct.

Q Before issuing a drug, would you look at the Haslar notes necessarily, or would you be reacting to the patient at that moment?
F A Probably reacting to the patient at that moment in time.

Q I think you were shown a controlled drugs record, but I am going to ask you about one of these entries here. On page 368E, do you see your initials anywhere? We can give you the original, if that helps you. (Original handed to the witness) You can look at the original controlled drug record if you need to, but in your police statement you reveal that 60 milligrams was withdrawn on 21 August at 7.35, and the entry was witnessed by yourself and
G it was given by Nurse Turnbull.
A That is correct.

Q I do not suppose you have any independent recollection of that at the moment.
A No.

Q All right. When we look at 21 August, where we see "07.35" that is 60 milligrams
H being given with you being present.

A Correct.

Q But it has not been initialled by you.
A No.

Q I do not think your initial appears elsewhere on this page, does it?
A No.

B

Q Can you tell us, so far as you are concerned, how this would have worked. Who would have made the decision to increase this patient's prescription by 20 milligrams?
A It would have been a joint decision between myself and Nurse Turnbull.

Q And you would be entitled to do that because of what?
A Because we have the leeway in the prescription and we were caring for the patient.

C

Q You told us earlier that your recollection was that any increases would normally be between five and ten milligrams.
A Yes.

Q This is an increase of half again, as it were.
A Twenty.

D

Q From 40 to 60 milligrams.
A Yes.

Q Can you recall anything about the basis for it?
A No, I cannot. I am sorry.

E

Q There is a nursing note at page 394 which you might like to go to. If you would look towards the bottom of the page, I do not think the first writing is yours, is it?
A No.

Q 20 August 1998. This is the day before that drug that you have issued. "Condition appears to have deteriorated overnight, Driver recharged ..." You would have had nothing to do with the initiation of the driver.
A No.

F

Q Nor the starting dose.
A No.

Q And you cannot tell us why it was initiated.
A Only making assumptions from the records in front of me.

G

Q Diamorphine, we can see 20 milligrams is where it started off, and midazolam 20 milligrams. Then, towards the bottom of the page, do we see "Night"?
A Yes.

Q "General condition continued to deteriorate. Very "bubbly". Suction attempted without success. Position changed frequently ..." Can you read this for us?
A "Only rousable ..."

H

Q It has been suggested that is "Ruby rousable ..."
A "Ruby rousable and distressed when moved. Syringe driver recharged. Diamorphine 60mgs. Midazolam 60 mgs. Hyoscine 800mcg ... Daughter has inquired 08:00 [something] condition".

Q Whose signature is that?
A Staff Nurse Turnbull's.

Q She was present with you, you have told us.
A Yes.

Q At the withdrawal of the drugs. When we see on the page before, "General condition continues to deteriorate" this is a patient who is on a syringe driver, and there is no note, I do not think, that the patient is being hydrated.
A No.

Q She has been on the syringe driver, as we can see, from 19 August. When you describe that a patient's condition is deteriorating, it may be obvious to you but what does it mean?
A The patient's breathing, perhaps, might have deteriorated. They appear uncomfortable, distressed. Their physical condition and observations would have changed.

Q Their physical condition would have changed.
A Yes.

Q In what way? What would you be looking for?
A Signs of distress and pain.

Q Right.
A Agitation.

Q If there is pain, would you make a note of it normally?
A Usually, yes.

Q "Condition deteriorating" means what? All of those things? Some of those things?
A I think all of those things.

Q If pain is the basis for you increasing a dose, is that something that you would note or you would not normally note?
A I think I would normally note.

Q I am going to ask you to put that file away, please. There is almost no need for you to turn it up, but so far as Patient G is concerned, Arthur Cunningham, who was known as Brian, I think you have signed a note, just to have a very quick look at it, at page 647, and that relates to the patient dying on 26 September.
A Yes.

Q These are clinical notes. You would only put a note into these notes presumably if the patient was dead.

A Usually, yes.

Q Because they do not form part of the nursing record.
A No, that is correct.

Q We can see previously that the patient had been transferred to Dryad Ward on 21 September. We see the words, "Make comfortable. Give adequate analgesia. I am happy for nursing staff to confirm death." How would you read those three comments?
A I would assume that the patient was still in a very poorly state.

Q Presumably, it was as a result of those words, "I am happy for nursing staff to confirm death," that you, together with Nurse Turnbull, were able to do what you did.
A Yes, that is correct.

Q If you could have a very quick look at page 758, please, I want to make sure that we have not missed anything. I do not think that you have initialled any of these.
A No.

Q Okay. You can put bundle G away, please. I want to turn to Mrs Enid Spurgin, our Patient I. At page 164 we can find a drug sheet. You are about to be handed the original drug chart. (Original handed to the witness) This patient had been transferred to Dryad Ward on 26 March 1999. We can see at the top of this page that she was prescribed Oramorph. There are four separate prescriptions for Oramorph on this page, but we can see that the first date at the very top is 26 March – yes?
A Yes.

Q I do not think that you can recall this patient specifically, is that right?
A No, I cannot remember her. I am sorry.

Q I think you have initialled an entry for the administration of Oramorph at 2200 hours. In the second row up from the bottom, do you see Oramorph has been written up? Is that ten milligrams.
A Ten milligrams in five millilitres.

Q 2200 hours would have been written by whom?
A That is a member of the ward staff's handwriting.

Q That is...?
A It is one of the ward nurse's handwriting.

Q If we look up above that, we can see that there is also Oramorph prescribed, seemingly at the same time, but those are the sorts of daily prescriptions to be given at six o'clock, ten o'clock, 1400 hours and 1800 hours, is that right?
A Yes.

Q Again help us with how this works. Is this a PRN prescription or a regular prescription?
A This is a regular prescription.

Q You would expect those drugs to be given at those times.

A Yes, that is correct.

Q Not depending upon the nurse's evaluation of pain or anything else.
A No.

Q Is that your initial, at 2200 hours?
A Yes.

B

Q With an "X" next to it? Is that right?
A I think it is a "T" rather than an "X".

Q It is a "T", is it. Right, okay.
A I think that is one of my initials.

C Q That is you? All right. You gave those drugs when? On which day?
A On 26 March 1999 at 2200 hours.

Q And at ---
A And then again on 27 March 2999 at 6 o'clock in the morning.

Q So do we have to go up to the top for that?
D A Yes.

Q And you would have been giving the patient those drugs because they were written up?
A Yes.

Q On 26 March, I just want to understand this. Have you given any drugs in the
E evening of the 26th?
A At 2200 hours?

Q Yes?
A I have given Oramorph.

Q In your statement you also referred to 23.15. I have to confess that I have not been
F able to find that.
A It is probably the same thing.

Q It is probably the same thing?
A The due time for the drug would have been 2200 hours but it was probably administered at 23.15.

G Q Then, on 27 March, as you told us, in the morning, you have given some more drugs - yes?
A Yes.

Q I think you have witnessed Staff Nurse Lloyd on 28 March giving her drugs. Would you have had reference to any of the nursing notes at the time that you gave these drugs, or witnessed these drugs being given?
H A I think so, yes.

Q If you go back to page 96, you will find a nursing care plan. If we look at the bottom of that page – I do not think this is your writing, is it? It has a big "84" in bold but it is actually page 96, with two lines either side of it. Do you have that?
A Yes.

Q Is this your writing anywhere?
A No.

Q At the bottom we see 28 March:

"Is having regular Oramorph, but still in pain."

On 28 March:

"Has been vomiting with Oramorph. Advised by Dr Barton to stop Oramorph."

So you would not have stopped the Oramorph unless told to by Dr Barton?
A Unless the patient was vomiting but probably after speaking to Dr Barton or getting authorisation.

Q That is all that I ask you about that patient. We are going to move on to Mr Packman. That is file J. Is it fair to say, you do have a little bit of recollection about this gentleman, Geoffrey Packman? Let us get you to the notes first of all.
A Okay.

Q Would you go first of all to pages 171, 174 and 175 you will find the drug charts. Do you remember that this patient was a patient with pressure sores?
A I think I do, yes.

Q And we know that he was admitted to your ward on 23 August 1999. What, if anything, can you remember at the moment about this man's sores?
A If I can recall correctly, I think they were large.

Q And was he a very large man?
A I think he was, yes.

Q Because you were dealing with these patients on night duty, does it follow that the decision to initiate syringe drivers and the decision to initiate opiates was more often made during the day?
A Yes.

Q Does that follow for all of the patients that we have been looking at?
A Yes.

Q So when you would come to a patient at night, they would – if they were going to be on a syringe driver – in general already have been on a syringe driver?
A Yes.

Q And part of your duty would be to continue with that syringe driver and ensure that it was operating correctly?
A Yes, that is correct.

Q I think before we get to a syringe driver with this patient, can we just look at the issue of Oramorph first of all. Then if we go to page 174, I think we can see Oramorph was written up. First of all we are going to look over the page as well. There are more references to Oramorph on the following page. Oramorph was written up on the 26 August. Is that right?
A Yes.

Q And all of these prescriptions are written up by Dr Barton. Can we also see that there is a range prescription written up for diamorphine?
A Yes.

Q I just want to understand this. If we go over the page to 175 can we see there is a regular prescription and Oramorph has been written up as well?
A Yes.

Q That is 10 mg in 5 ml. Is that right?
A Yes, that is correct.

Q I just want to deal with what you administered. Do you have the originals? We do not have those. We may have to find that. I am sure we have it somewhere. In your statement you make reference, I think, to witnessing the administration of Oramorph by Staff Nurse Irene Dorrington on 26 August at 22.55?
A Yes.

Q Can you see that entry?
A Yes.

Q Where?
A On 26 August.

Q Yes. At page ---?
A Page 172 . At page -175-.

Q At 175? .
A Yes.

Q I see. Is it the second row down?
A Second row down, yes.

Q Was that 20 mg?
A Yes.

Q Then on 27 August have you witness that administration? Again, according to your statement you said "22.15: I have signed that I witnessed the administration of Oramorph. This is from the controlled drugs record."
A Yes.

Q You did not give the drugs yourself, but they were being given?
A Yes.

Q It may be obvious but what is the purpose of giving an extra 20 mg dose, as it were, in the evening?
A The dose in the evening we were given to believe was a stronger dose so that the patient was comfortable throughout the night.

B

Q Right?
A Because it would have lasted until six o'clock in the morning.

Q Has the same happened on the 28th and the 29th?
A Yes.

C

Q Just going back to the page before, please, we can see that the syringe driver was started on the 26th, so three days after the patient's admission, at 40 mg diamorphine. Yes?
A Yes.

Q The minimum dose prescribed was 40 mg?
A Yes.

D

Q And as a nurse would you take it, are you entitled to administer to the patient any less than the minimum dose?
A No.

Q So on 26 August the syringe driver is set up so the patient receives 40 mg over a 24-hour period, together with midazolam. Do we see that?
A Is it actually the 26th, or is it the 30th, which is written below.

E

Q I am sorry – I think you may be right. It is written up for the 26 August, and then it may be administered on the 30th. Let us just have a look at the original. Can I pass the witness the original? (Document handed to the witness) We know from the nursing notes that the syringe driver was actually commenced at 14.45 in the afternoon of 30 August. It is quite difficult to read the prescription sheet.
A It is, yes.

F

Q Does it look like the 30th?
A It does look like the 30th.

Q So on the days leading up to the 30th, as you described, on 26, 27, 28 and 29 the patient is on Oramorph with an extra dose given at night?
A Yes.

G

Q And then the diamorphine is started intravenously ?
A Subcutaneously.

Q Sorry. You are quite right. It is subcutaneously. So far as the initiation of the syringe driver is concerned, as you have indicated, that would be based on the doctor's prescription?
A Yes.

H

Q And the doctor's assessment?
A Yes.

Q Can we put that away, please. The last patient I want to ask you anything about is, I think, Mrs Devine. Would you put that file away and turn to patient K, please. Do you have any recollection of Elsie Devine?
A No.

Q Again, I think the only part of her notes that I want you to have a look at please is page 281, and could you keep a finger there, please, and also turn up page 223. Again, this is just to orientate you and just to see if this triggers any memory.
A Okay.

Q So do you have page 223 as, I think, a nursing note – I think the nursing summary of significant events?
A Yes, I do.

Q We can see at the top of the page that this patient was admitted on 21 October with increasing confusion and aggression. At the bottom of the page we see that on 19 November there is a note:

> "Marked deterioration over last 24 hours. Extremely aggressive this a.m. Refusing all help from staff..."

And then she is given chlorpromazine at 8.30 and then, over the page, we see a syringe driver was commenced at 9.25. By 9.25 you would have been well off duty, as it were?
A Yes.

Q But just reading through these notes again, does it bring back to mind the patient at all? During the day, apparently, she was aggressive?
A I think I have some vague recollection of her.

Q But can you tell us what that recollection is?
A I can remember an incident shortly before I went off duty where she was very aggressive, or she became very aggressive.

Q Right. Would you normally have made a note of that?
A Probably, but it might have depended what time it was. I think if ---

Q Would the note have appeared here in the summary?
A It would, if I had made a note.

Q Could you just look through pages 223 and 224 please. I think we have identified all the writing here.
A No entries by me.

Q And if that sort of incident did occur but you did not note it, would you relate it orally to the day staff?
A Yes.

Q But it is the sort of thing that you should have noted if it had happened, or not necessarily?
A I think, if I can remember rightly at the time, although I was based on a ward, I would have been the nurse in charge of the hospital and looking after minor injuries as well, so there would have been another staff nurse actually in charge of the ward who probably would have made notes as such.

Q Or not?
A Or tended to make more of the notes. Yes. Or not.

Q I think so far as this patient is concerned, you witnessed some withdrawals of diamorphine, not administered by you, and so I am not going to ask you about those. I said that was the last patient. I think there may be one more reference to you in the notes of Jean Stevens, but it may be that we do not need to turn it up. Would you just give me a moment? Yes. It is Patient L and you, I think, have simply verified her death?
A All right.

Q You can turn it up certainly if you want to remind yourself. It is page 1292, right at the back of the bundle. Do you have that?
A Yes, I have found it.

Q This patient was transferred to Daedalus ward – so not your ward – but nevertheless you have, as I think we can see at the bottom, witnessed the verification of her death. Would that be because, as senior nurse, you would have been called over to do that?
A Yes.

Q But normally you would not be on Daedalus Ward?
A Occasionally, but it was not my regular ward.

Q As we saw when we started with Mrs Gladys Richards, she was actually also on Daedalus ward, but you performed a specific duty presumably because you were the senior nurse and the patient had died.
A Yes.

MR KARK: Thank you very much. Wait there, please.

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

Q Mrs Tubritt, I am going to ask you some questions on behalf of Dr Barton. If you keep that folder open in front of you and just turn to page 1337, I think there is a note of yours about Mrs Stevens.
A Yes.

Q It is fairly legible, so I do not think I need ask you to read it out. You gave evidence at the inquest, did you not?
A Yes.

Q And I asked you a few questions then.
A Yes.

Q Is it right that Dr Barton, during the time that you had worked on the same patient that she was working with, you thought her to be very conscientious as a doctor?
A Yes, I do, and I did then.

Q She was, so far as you could tell, hard-working?
A Very.

B Q And always concerned to do the best for the patients?
A Yes, she was.

Q The staff knew that if Dr Barton needed to be contacted, she could be telephoned.
A Yes.

Q And that was no problem at all.
C A No problem at all.

Q You have been asked about a number of specific patients and you have been asked to look at their medical records. These are obviously the patients with whom the Panel are concerned in 1996 and thereafter. Would it be right to say that you would not have given medication to any of those patients unless you, as a nurse, thought it was appropriate?
A Correct.
D

Q You were in a position, with the patient in front of you, to discuss matters with another qualified nurse.
A Yes.

Q You had had the experience of dealing with that and other patients and you would be able to judge their level of comfort or their level of need for the medication.
E A Yes.

Q If you had felt that the medication that was written up for the patient was inappropriate, you would not have given it, would you?
A No, that is correct.

Q That would be your duty as well as what you would want.
F A Exactly.

Q Is it right that in the mid to late 1990s, the War Memorial Hospital was taking patients that were often elderly and often had many complicated medical histories.
A That is correct.

Q Did it feel, as a nurse on Dryad ward, that you may be taking patients that other
G hospitals locally would not have wanted to take?
A Yes, it did.

Q Were the patients often in poor condition when they arrived with you?
A Very poor condition, some of them.

H

Q Was it obvious, as a nurse, with a number of years experience then, that a lot of the patients who were transferred in the mid to late 1990s were unlikely to leave the War Memorial Hospital?
A Yes, that is correct.

Q Your assessment of a number of the patients was that they were in poor shape; they were towards the very end of their lives.
A Yes, they were.

Q Can I come to the beginning of the 1990s, because that is a time you have been asked a lot of questions about and you have been asked to look at a number of documents. Would it be fair to say that by 1996 and thereafter, any concerns that you might have had in 1991 had been resolved?
A I think so. I cannot remember being concerned at the latter date.

Q You were asked questions by several people at the inquest. Is it right that you said that by 1996, you had no concerns about anything that had affected you earlier on?
A I cannot recall having any concerns.

Q In the early 1990s, right at the beginning, obviously we were dealing with a different ward and what you have told us is that there were some new staff on Redclyffe.
A Yes, there were.

Q There were some staff who had been there for many years.
A Yes, correct.

Q Was there a process going on of the two sets of staff getting to know each other?
A Yes, there was.

Q I think there were some tensions.
A There were.

Q The day staff and the night staff did not always speak with one voice.
A No.

Q On top of that, is it right that the mix of patients that the Redclyffe Annex had been taking had been changing over the last couple of years?
A Yes.

Q Right at the end of the 1980s and beginning of the 1990s, you were getting some patients on to the ward that were really rather poorly.
A Yes, that is correct.

Q I think before that, in the late 1980s, the patients had not needed a great deal of nursing or medical care.
A That is true.

Q As the type of patient changed, you were dealing with more complicated patients and I think the nursing and medical needs of those patients changed as well.
A Yes, that is correct.

Q Was that one of the issues that was arising in 1991?
A I think it was. There were a lot of changes.

Q Not just personnel or the type of patient, but the types of treatment that patients were getting, including giving opiates by syringe driver.
A That is correct.

Q You have told us that your introduction to a syringe driver was by a Sister Green, who basically showed you a syringe driver and told you to get on with it.
A Yes.

Q Did that feel like that was adequate training for someone on the night staff?
A No, it did not.

Q What about your night nursing colleagues? Were they getting any more training in the use of syringe drivers than you?
A I think they had less training.

Q So is this the picture that we should have of 1991 and the events that led up to the meetings that we have seen notes from: that you and your night staff colleagues, with no training at all, were being expected to deal with complicated patients and syringe drivers containing diamorphine?
A Yes.

Q Which you had never really dealt with before, syringe drivers containing that type of drug.
A No, that is true.

Q Was it your understanding then, at the time that concerns were raised, that it should only be patients who had pain that should be put on a syringe driver and diamorphine?
A At the time, yes.

Q At the time. So concerns were raised, as we have seen, essentially by night staff I think.
A Yes.

Q You, Nurse Giffin, Enrolled Nurse Turnbull.
A Yes.

Q Were you the three main people who were raising concerns?
A We were the main people. There were other people that were concerned, but did not want their names involved in anything.

Q A significant part of that was the failure to have provided you with training up to that point.
A Yes.

Q We know that there were meetings at which various members of the administration were present, Isabel Evans for one.

A Yes.

Q We know that a Dr Logan, who was a consultant geriatrician, was present at a meeting and he explained how he wanted his patients to be dealt with.
A Yes.

Q Were you given the explanation that diamorphine should not just be used for pain, but it had other uses as well?
A I think so, yes.

Q That syringe drivers were extremely useful as a means of ensuring a regular administration of medication to a patient so that their blood levels of the drug did not go up and down.
A Yes.

Q I think you explained when you were interviewed by the police the benefits of a syringe driver, in that it did not lead to peaks and troughs in the patient.
A Yes.

Q Had you known that before the sort of conversations that were had around 1991?
A I would not have thought so, no.

Q Is it right that you were told in about 1991 about other uses of diamorphine: for breathlessness or for agitation?
A Yes.

Q Is it right that after those concerns had been raised and explanations had been given, I think you had been told by doctors other than Dr Logan, but by people like Sister Hamblin as well about the benefits of syringe drivers and diamorphine?
A Yes.

Q Is it right that communication between day staff and night staff started to get better?
A I think it did.

Q What you have told us is that you organised courses for yourself to go on.
A Yes.

Q I do not know. Did the hospital or the administration organise courses for your colleagues, did they have to do it themselves or just rely on a talk from Dr Logan?
A Courses were available usually at QA. They were sometimes advertised and it was up to us whether we applied to attend or not. They were mostly short courses: an hour, a couple of hours at most.

Q I think by the time 1996 arrived, the time of the patients with which the Panel are dealing, your knowledge was significantly greater.
A Yes.

Q And your understanding of the use of syringe drivers.
A Yes.

Q That is how we reached the point that you were comfortable with the doses that you have been taken through by Mr Kark.
A Yes.

Q So again, what had happened in 1991 was perhaps as a result of inadequate training of staff and, because of that, inadequate understanding by night staff.
A Yes.

B

Q Can I just deal with two other issues? One is hydration. If a patient is right at the end of their life and they are drifting in and out of consciousness, perhaps receiving medication by a syringe driver, but maybe not, is it your understanding that there may be good reasons not to give hydration to a patient?
A I believe that hydration would have been of little benefit at that point.

C Q In fact, it can cause problems, can it not?
A Yes.

Q The last issue I ask about is this. You were asked about the entry that there might be in medical records by a doctor, "I am happy for nursing staff to verify death" or something of that nature. You have told us that you understood from that that the patient was very ill, very poorly, or that they may die soon.
D A Yes.

Q I think the most important information that a nurse would get before they start the shift is at handover. Would that be right?
A Yes.

Q What has happened before may be irrelevant now; the patient's condition may have
E changed.
A Yes.

Q And you would expect at handover to be given information about how the patient has been doing over the last shift and is likely to do on the shift you are just about to nurse.
A Yes.

F MR JENKINS: I am very grateful, Mrs Tubritt. Thank you very much.

Re-examined by MR KARK

Q I only have one matter I want to ask you in re-examination. Going back to the 1991 matters, who was it who explained to you, as it were, that you had had this misunderstanding as a result of which your mind changed and you had a better understanding? Who were you
G dealing with?
A I cannot recall any one person explaining. I think it was more of a gradual thing, you know, as I gained knowledge.

Q Prior to working at Redclyffe, had you worked in palliative care before?
A Not in a nursing capacity.

H MR KARK: Thank you.

THE CHAIRMAN: We are going to take another break now and resume at 12 o'clock, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. I have asked for the witness not to be called back immediately because what I am about to say really has nothing to do with that witness at all. It is a matter that I am raising at this point simply because we have come to the time when there is a growing sense amongst the members of the Panel absolutely, including myself, that we felt there is a need for us to make this point. We do so, if I may put it this way, with the greatest of respect to fine and senior advocates appearing before us. We do so because we feel that it would be helpful to the advocates to understand what is helpful to the Panel in going about our business.

We fully understand what the rules are concerning the manner in which cross-examinations are to be conducted and when leading questions are permissible and when they are not. So what I am going to say is placed before you as much as anything as an observation. Nobody has to take the slightest bit of notice of what I say, but it is simply this.

Where there are witnesses who are to be cross-examined and those witnesses are in the main, shall we say, not hostile to the cross-examiner, there is a great deal of value for the Panel if the cross-examiner gives that witness as great an opportunity as they might think sensible to answer with their own words. The difficulty with a large amount of leading is that at the end of the day one really hears a great deal from the cross-examiner and very little from the witness, other than to agree. In terms of the impact that that makes on the Panel, I am sure you can understand it is a lot less than it is if we hear the words of the witnesses themselves.

I put this forward at this stage not particularly as a result of the cross-examination of the last witness, but rather because this is a sense that has been growing amongst the Panel for some time now. We take, as I am sure you appreciate, very seriously the need for us to weigh each witness carefully and it is very difficult to do that when a large part of their testimony is really boiling down to agreeing or not agreeing with what is said. So if possible, we would like to hear far more of the individual witness's own words in cross-examination. As I say, it is a matter for all of you whether you go along with that or not. Mr Langdale?

MR LANGDALE: Sir, thank you for those observations. I make no comment about them. We have heard them, but of course the Panel will understand that with a large number of witnesses, the words being put to them are things they had already themselves said. For example, the last witness gave evidence at the inquest and we have heard that with other witnesses. So that is the case very often; I am not saying in every case, because obviously we have to put our case to a witness. If they agree with it, fine. If they do not, then they will say so.

With a large number of witnesses this is quoting back not counsel's words but what the witness himself or herself has already said. For example, I know that we are going to be getting to one of the consultants before too long, Dr Reid, and there is a mass of material where he has already said certain things. I can say now that if they are not elicited in examination-in-chief, I shall obviously be asking him what he said based on what he has already said.

THE CHAIRMAN: That is helpful, Mr Langdale. Of course the Panel has already appreciated the fact that a lot of the style of questioning that we have seen does result in the saving of a great deal of time, particularly where people have already said the same thing before, but the point that we really want to get across is that we have not heard that before. It is the lack of spontaneity which, frankly, reduces the impact of evidence that should be impacting on us more than it does in that format. If it means that things go a little bit slower so that, at least in the first instance, a witness is given the opportunity to put it their way, of course there is absolutely the opportunity to come back and say, "On another occasion did you not say such and such ..." This was designed to be helpful because we really do wish to be giving the maximum weight to the words that are spoken to us, and it is merely observation that it is difficult to do so when they come from the mouth of counsel rather than from the witness, even though it may very well originally have come from the witness. If the same question that had been put to the witness on the previous occasion could be put, it might well elicit the same answer, and that would be much fresher and have much greater impact on the Panel than if it came, in the first instance, from the mouth of counsel.

MR LANGDALE: Sir, thank you again for the observation. I simply say two things in response to that. The mere fact that a witness agrees with the way that it is put by counsel should not, with great respect, reduce the impact of the answer. It may be another illustration that it is 100 per cent correct. The other difficulty which we all have to bear in mind as advocates – and we appreciate the difficulties in eliciting evidence sometimes: with some witnesses it is very easy and sometimes it is very difficult – and one of the things which counsel tries to avoid in cross-examination, when one already knows what the witness has said in answer to a question, is asking an open question, getting a slightly different answer, and having to say, "Do you remember on 14 April you said this? Would that be correct?" That is partially what we are trying to avoid.

Sir, I will say no more because I am slowing things down even more as I speak. We will bear in mind what you have said. Thank you.

THE CHAIRMAN: That is very kind. Thank you.

Mr Kark?

MR KARK: I have no observation to make, sir.

THE CHAIRMAN: Very well. Then we will have the witness back, please. (Pause)

Welcome back, Mrs Tubbritt. I am sorry we kept you out for a little while. We were dealing with matters that had absolutely nothing to do with yourself and there was no point in asking you to sit there whilst we did so.

I remind you that you remain on oath. I think I am right in saying that we have now completed questions from the barristers – at least for now –and so we come to the stage where members of the Panel are able to ask questions of you if they have any.

I am going to turn first of all to Mrs Pamela Mansell, who is a lay member of the Panel.

Questioned by THE PANEL

MRS MANSELL: Hello. I am really wanting to get an understanding of this aspect from a practical perspective and from the nursing perspective. We have heard a lot of evidence to date about the positive and negative effects of both Oramorph and diamorphine.
A Yes.

Q We have also looked at a lot of patients who have been very poorly and deteriorating. I need to understand just a little bit more how you, as a nurse, distinguish within that deterioration what is the contribution of the drugs and what is the failing health of the patient. How do you distinguish which is causing the deterioration? For instance, Oramorph can contribute to sickness and it can contribute to confusion.
A Yes.

Q We know that diamorphine can contribute to repression of the systems, et cetera. When you are looking at the deterioration of that patient ----
A Sometimes it can be difficult, but I think mostly it is experience.

Q I think I need a little bit more than that if you can help us.
A It is hard to put into words exactly. I think it would be looking at each individual patient, looking at their specific symptoms, looking at the whole picture, the drugs, the patient, their physical condition.

Q Because, you see, I look at some of the notes that we have had and it can tell me that the patient is restless, anxious, agitated, and that is an indication of deterioration.
A Yes.

Q And hence a decision to increase the medication.
A Yes.

Q This does not help me to understand how that is different from if it was the medication that was causing that agitation.
A I see.

Q I was just trying to get from the nursing perspective your sorting out of the difference.
A I think that is quite difficult. It really is experience, I think.

Q If you cannot help me any more ----
A I am sorry, I am not sure if I can put that into words.

Q I cannot see the safeguards in that, and so that is what I was trying to get out, how it might not lead to moving to increase the drugs.
A Yes, certainly, I understand.

Q And yet it might have been the drugs that was causing this to start off with. Saying it is experience does not feel like a big safeguard to me. But maybe you cannot help me.
A I cannot think of a way to explain it. I am sorry.

MRS MANSELL: Okay. Thank you.

THE CHAIRMAN: I am going to turn now to Mr William Payne who is a lay member of the Panel.

MR PAYNE: Good afternoon. Just to go on from where my colleague has started, you said it is about experience.
A Yes.

Q About the individual patient.
A Yes.

Q Therefore it must be the amount of experience of the individual nurse.
A Yes.

Q You could be in a situation where perhaps a less experienced nurse than yourself is having to make a decision whether or not to increase or decrease the amount of drugs, because they are perhaps reading the signs and symptoms incorrectly.
A That could happen, but often, if that is the case, if I was in that position, I would probably try to find another more senior or experienced member of staff to discuss my concerns with.

Q With the greatest of respect, you are still nursing, I believe.
A Yes.

Q So you have a vast, wide range of experience.
A Yes.

Q And you are able to draw on that experience to say, "I'm not necessarily sure about this."
A Yes.

Q "I need to confer with someone." But 15 years ago, or whatever time it was, you were not as experienced.
A No.

Q Would all your colleagues have thought that in that same respect?
A I like to think so. I think a lot of them would have, yes.

MR PAYNE: Thank you very much.

THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

MR SMITH: Hello, Mrs Tubbritt. Just thinking about the drug Kardex, in general, on a drug Kardex there are two kinds of prescription. The first is a PRN prescription.
A Yes.

Q And if it is written up on a particular day, that date is there.
A Yes.

Q To say that it was written up today. How do you know, as a nurse in charge at night, when to give a drug that is written up PRN?
A Do you mean by the chart?

Q The chart is your instruction to give the drug PRN.
A Yes.

B Q How do you decide when to give such a drug?
A If we felt the patient needed it by looking at the patient's physical condition.

Q You make a decision based upon the state of the patient.
A Yes.

Q The other kind of prescription is called a regular prescription.
C A Yes.

Q Or it was on the drug charts at Gosport. It is written up today, with today's date, regular.
A Yes.

Q When would that drug be given?
D A On that day.

Q If it is not given for three days, what can be the explanation for that?
A There could be several explanations. It could be that the patient was unable to take it, or the patient had refused it, or the drug was unavailable.

Q How would we know that?
E A Hopefully it would be recorded somewhere.

Q Somewhere in the nursing notes or the medical notes.
A Yes, in the nursing notes.

Q Somebody would have explained why a prescribed drug has not been given.
A Yes.
F

Q Is that because a prescribed drug on regular prescriptions is an instruction to give?
A Yes.

Q Thank you. That is very helpful because there is just something that is bothering me about one prescription. In a completely different area, cast your mind back to those days in 1991 when you were still at Redclyffe and you and colleagues made what amounted to quite
G serious criticisms of drugs and the way they were used.
A Yes.

Q I think it is true to say that you stated that you thought that patients had come to harm, or at least one patient had come to harm because of that.
A Yes.

H Q So your concerns were very serious.

A They were at the time, yes.

Q In the first place, did you feel that your concerns were addressed fairly early on in the year?
A No.

Q Can you say how you felt? Do you remember how you felt after the first meeting?
A Frustrated, I think.

Q Because?
A If I can remember correctly, I think management seemed to be of different beliefs from the rest of us. I am not sure if we were necessarily looking at things from the same angle. We felt frustrated.

Q What was your angle?
A I wanted to make sure patients were being treated correctly. I wanted to make sure that I knew what I was doing.

Q What do you think their angle was?
A I think they were looking at ... That we were maybe even accusing people of things, that we were just looking and saying, "Well, patients are having too many drugs" without looking at the bigger picture.

Q You did not think they really listened very hard.
A No.

Q But it festered.
A Yes.

Q And then you made a second complaint.
A Yes.

Q Towards the end of the year. You were asked, "Do you think they took it more seriously the second time?"
A I think they did, yes.

Q Indeed, I have forgotten her name, but the matron asked you for specific evidence on particular patients.
A Yes.

Q To back up what you had been saying.
A Yes.

Q And nobody replied to that request.
A No.

Q Why do you think that was?
A I honestly cannot remember.

Q Was it because you did not have any specific information? I am sorry, that sounds like a criticism. I do not mean it to be a criticism.
A I can remember, at the meeting with Gerrie Whitney, that we were able to access controlled drugs books and to look at records and things, and at a later date when we tried, I do not think we were able to find necessarily what we needed to sort of back up our concerns.

Q Your first approaches were to "management".
A Yes.

Q Is that management or is it nurse management?
A Nurse management.

Q To the people you relate to.
A Yes.

Q Your second complaint was, similarly, to the same people.
A Yes.

Q Then doctors started to be involved in the process, did they not?
A Yes.

Q Was it as easy to make complaint in general? Was it easy to make complaint about things that were going on once there were doctors in the room?
A I think for some people no.

Q Why do you think that is?
A I think people were concerned for themselves, really – how long they would still be in a job, how things would affect them.

Q Why should that be, in 1991?
A I think that is just the air ... That is how it felt at the time. It felt too definite sides: them and us.

Q Sides?
A Yes.

Q But you are looking after the same people: patients.
A I know.

Q Does that mean there is a sense that a nurse would find it very difficult to criticise a doctor?
A Well, to criticise – full stop.

Q Would it not be fair to say that in a way you were criticising your own nurse management by going to them and complaining.
A Yes.

Q That was easier.
A Yes.

Q Why was it more difficult to complain about or to a doctor in 1991?
A I think we always felt doctors were superior and that was just how we felt.

Q Is a doctor's view of a problem more valuable than a nurse's view of a problem?
A Not necessarily.

Q Was there a perception that it might have been in 1999?
A Yes.

Q Would that amount to a fear that a nurse would not be believed but a doctor would?
A Yes, I think so. Yes.

Q Is that a generalisation of what would happen nearly 20 years ago?
A Yes, it would be.

Q In any kind of complaint?
A Well, I can only talk about the complaint I was concerned in. That is how I felt.

DR SMITH: Thank you very much.

THE CHAIRMAN: Mrs Tubbritt, it comes to me now. I am also a lay member of the Panel. Mrs Mansell raised with you an issue about the potential for an error in ascribing observed deterioration in a patient to something other than the effect of the drug or drugs that the patient was taking. I think you said that the best way that you could describe the way in which patients were safeguarded against the risk of a mistake being made in that regard, was the experience of the nursing staff. I am not sure if you did mention also not just their wider experience in nursing but their experience of the patient himself or herself. If you did not, would you accept that experience of that individual patient ---
A Yes.

Q --- is important in that regard?
A Yes, I would.

Q It is right, is it not, that in many instances deterioration will be noted in a patient of whom the nurse has very little experience because they have only recently come onto the ward?
A That is true.

Q In those circumstances the danger and the risk would be much greater than a patient that the nurse had been nursing, perhaps for months?
A That is true.

Q Thank you for that. Following on slightly with a point that was raised by Dr Smith, the writing up of a prescription and when one would expect that prescription to have been administered: in your evidence today in respect of Patient I, it was pointed out to you that there was one time at which the prescription was written up for administration, but apparently a different time at which it was actually administered?
A Yes.

Q I think it is clear to all of us how the two can, for the best of reasons, be different. What would assist me, at any rate, is to know what sort of difference would be permissible from the point of view of a nurse signing before they would feel a need to put a note of explanation in? So, for example, if a particular dose is due at, say, 10 a.m. and it is not, for the best of reasons, administered until a later time – we have heard from you that if it were an hour or two hours, even later, it would still get the signature and the tick.
A Yes.

Q How much further would it have to be outside the time before you would expect yourself or a colleague to feel the need to put in a note to the effect, actually this was delivered at a different time?
A I think it would need to be quite a reasonable time outside of the prescribed time.

Q And what would that be, a "reasonable time"? Are we talking three hours, four, five, six?
A Probably less than that. Probably no more than about two hours, perhaps.

Q So up to and including two hours, you would not expect there to be a note, but thereafter you would?
A Yes.

Q And I can absolutely see that in terms of if it is administered late. Are there occasions when it can work the other way and it is administered earlier than the time expected? Say ten o'clock a.m. was the time that it is written up for; would it only ever be potentially late, or could it also potentially be actually administered early?
A Possibly only a few minutes early.

Q Right?
A But it is usually at the exact time, or as close to it.

Q Possibly a few minutes early and possible up to two hours late ---?
A Late.

Q --- after which one would expect, if it were later, that there would be a note indicating the same?
A Yes.

Q That is extremely helpful. Thank you very much indeed. That completes the questions from the Panel. I now am required to ask if there are any questions arising out of the Panel questions that the barristers wish to ask. Mr Jenkins?

MR JENKINS: Just a few, if I may.

<u>Further cross-examined by MR JENKINS</u>

Q The patient's condition.
A Yes?

Q You can tell a great deal about a patient just by looking at their skin, can you not?
A Yes.

Q Can you expand that answer for me?
A You can see their colour; you can see whether they are hydrated; whether they are well oxygenated; their nutritional state.

Q What if the skin is breaking down?
A That would show that they were probably under-nourished, that they were generally in a poor condition.

Q If you are looking at a patient and you look at the limbs, arms and legs ---
A Yes.

Q --- can that tell you a great deal about the general health of the patient?
A They could become cyanosed.

Q Blue tinge?
A Blue tinge, yes.

Q Not enough oxygen getting to their ---?
A Not enough oxygen.

Q --- tissues. If you see patients whose limbs are wasted?
A Yes.

Q The word "cachectic" ---
A Yes.

Q --- is sometimes used of patients, I think ---
A Yes.

Q --- towards the ends of their lives if they have had a lengthy decline?
A Yes.

Q Again, if you see a patient who is rather wasted, or very wasted, is that going to tell an experienced nurse a great deal about their recent health, if they have not been eating properly for quite a while?
A Yes. That is how it would be.

Q You are not going to become severely depleted or wasted after being off your food for two days, are you?
A No.

Q Again, if you are nursing a patient it is easy to tell whether there is swelling, whether the patient has temperature?
A Yes.

Q You can see their breathing. You can see how laboured they may be?
A Yes.

Q Just sitting around or lining around?

A Yes.

Q Is it fair to say, you can tell a great deal about a patient's condition just by looking at them?
A That is true.

Q Is it right that with a patient who does not speak to you at all but whom you are nursing, moving in the bed, perhaps changing a dressing or changing something in the bedclothes, you are still able to tell a great deal about their level of agitation and draw inferences about whether they are in pain or not?
A Yes.

Q And would you be aware if a patient was unconscious and unrousable?
A I think so, yes.

Q And should we draw a distinction between a patient who is unconscious and unrousable, and one who is responding, who is clearly in some discomfort when you are nursing them?
A Yes.

Q Can I turn to a second topic. You were asked about 1991.
A Yes.

Q And you were asked about the circumstances in which you raised concerns?
A Yes.

Q What you had told me and told the Panel in your earlier answers was that at the time you were raising concerns, your knowledge was limited as to the use of syringe drivers and the circumstances in which it might be appropriate to use them?
A Yes, that is correct.

Q And you have made it clear that those shortcomings in your knowledge, because you had not been trained, were such that the doctors were giving you far more information?
A Yes.

Q Certainly Dr Logan was?
A Yes.

Q In the last of the meetings that we have heard about?
A Yes, that is true.

Q And were you well aware when you raised your concerns that you needed to have more training? You needed to have more information?
A Yes, we were.

Q Is that part of the reason why you were raising concerns, but not challenging the doctors, because the doctors knew why the drugs were being prescribed?
A Yes.

Q The doctors knew why syringe drivers were being written up?

A Yes, that is probably true.

Q And was it absolutely plain, certainly from Dr Logan, the geriatrician, the consultant, that that was the way he wanted the patients to be treated?
A Yes.

Q And Dr Barton was treating patients in accordance with what Dr Logan was saying was appropriate?
A Yes. That is true.

Q And is it fair to say that the senior nursing staff – sisters – who may have been at the meetings were agreeing with the approach that Dr Logan was advocating?
A Yes.

MR JENKINS: I ask this last question, sir, with some trepidation because it does not strictly arise from any questions the Panel have asked. I was going to ask the witness why she says Dr Barton is a good doctor – if that is a fair one to ask.

THE CHAIRMAN: It certainly was a fair one to ask at the appropriate time, but I do not suppose Mr Kark is going to take particular objection to it. He is indicating not, so if you feel a burning desire to ask it, please do so.

MR JENKINS: I do feel a burning desire to ask it in the light of observations that have been made. (To the witness) You thought Dr Barton conscientious?
A Yes, I do.

Q That was my word, and you agreed with me?
A Yes. That is true.

Q I put it to you that Dr Barton wanted the best for her patients?
A Yes, she did.

Q And you agreed?
A I did, yes.

Q I want you to tell us why you thought that?
A She was always helpful. My experience from seeing Dr Barton at work, she always appeared to do the best for her patients, whatever that might be. She strived to give them the best care.

MR JENKINS: I am grateful. Thank you very much.

THE CHAIRMAN: Mr Kark?

Further re-examined by MR KARK

Q You have just been asked about Dr Logan?
A Yes.

Q And Dr Logan was here consultant on Redclyffe?

A He would have been based at QA.

Q He was at QA, was he?
A Yes.

Q At the time when Dr Barton was on Redclyffe?
A Yes.

Q What was Dr Logan's approach to diamorphine? To the use of diamorphine?
A I honestly cannot remember.

Q You were asked by Mr Payne, and also by the Chairman, about being able to tell the state of the patient requires, first of all, a good knowledge of nursing?
A Yes.

Q And good experience, but also good knowledge of the patient?
A Yes.

Q And a good knowledge of the patient, is that something that is built up over a period of time?
A Usually, yes.

Q When a patient first comes into your hospital, sometimes they are in a slightly bewildered state, as it were, to be in a new environment?
A That is true, they could be.

Q And so to get to grips with that patient's needs, and how they responded in different ways, would it take perhaps a little while to get to know that patient after they had transferred?
A Yes, it would.

Q But you were asked by Mr Jenkins, and you agree with him, that you could tell a great deal from just looking at the patient?
A Yes, that is true.

Q And you used the example of looking at the patient's skin?
A Yes.

Q And you spoke specifically about oxygen and cyanosis?
A Yes.

Q And also breathing becoming laboured?
A Yes.

Q Were you saying that those are indications for patients' deterioration?
A Yes.

Q And do you remember, you were asked by Mrs Mansell on the Panel, who was asking you about how you distinguish between what is the drugs, what is being caused by the drugs, and what is being caused by the illness?

A Yes.

Q Just looking at the question of the skin and cyanosis and laboured breathing, can that be a symptom of either the use of opiates or illness?
A I would think illness.

Q You think illness?
B A Yes.

Q Why? You do not think morphine has an effect on laboured breathing?
A It does. It does.

Q So why would you put, for instance, cyanosis or laboured breathing, down to illness rather than diamorphine?
C A I do not know.

Q You do not know? And you also spoke about hydration?
A Yes.

Q And a lack of hydration ---
A Yes.
D

Q --- might be an indication of the patient worsening?
A Yes.

Q Getting iller? Is that what you meant?
A Yes.

E Q Would that be written down in the notes as "patient deteriorating"?
A Probably, yes.

Q If you are not hydrating the patient because they are on a syringe driver, again how do you distinguish between the lack of hydration because there are on a syringe driver and the patient is just getting iller?
A It would be difficult.
F

Q It would be difficult what – to distinguish?
A I think so, yes.

Q Just one last thing. You mentioned, and I may have misheard you, but I just want to make sure that we have asked you everything that we should. You were being asked by Dr Smith about the 1991 complaint and you said that you thought that they took it more
G seriously the second time, so the back end of the year?
A Yes.

Q But at one stage I thought I heard you say that you were not able to find the records to back up your concerns. Did you say that?
A I did say that, yes.

H Q What were you talking about?

A I can remember at some point during my concerns with colleagues looking for controlled drug books and looking for back-up records, and being unable to find them. I cannot recall exactly when but I can recall that happening.

Q During this period?
A Yes.

Q It may be that somebody else was looking at them as a result of concerns?
A Could well have been.

Q You do not know why they were not there.?
A No.

Q You have also been asked by Dr Smith about the relationship between nurses and doctors and how easy it was for people to make a complaint. Did you at any stage feel that you, or any of your colleagues, were actually being regarded as trouble makers, or anything like that?
A Yes, I think I do.

Q Why did you think that?
A I suppose the attitude of our ward manager towards us.

Q Was that during the first part of the complaining process, or the second part ---
A Both.

Q --- or throughout? Sorry?
A Throughout, but mostly the first part.

MR KARK: That is very helpful. Thank you.

THE CHAIRMAN: Thank you very much, Mr Kark. Mrs Tubbritt, that brings you to the end of your testimony. We are extremely grateful to you for coming to assist us today. It is only through the presence of witnesses such as yourself that a Panel is able to build up a clearer picture of what happened, very often months, even years in the past. We cannot do it without people like yourself coming, and I want you to know that we are extremely grateful to you for coming to assist us today. You are now free to leave. Thank you very much.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIRMAN: Mr Kark, unless there are any short matters that we can usefully deal with now, I propose that we take an early lunch, and start fully at quarter to two.

MR KARK: Yes, certainly. The next witness is Dr Banks. I do not think she will be all afternoon.

THE CHAIRMAN: Thank you very much indeed. Quarter to two then, please, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. I think the witness is being called for, Mr Kark.

VICTORIA BANKS, Affirmed

(Following introductions by the Chairman)

Examined by MR KARK

Q Is it Dr Victoria Banks?
A Correct.

Q Are you still employed by the Hampshire Partnership Trust?
A Correct, yes.

Q Could you tell us your position there, please? Are you still a consultant in old age?
A I am a consultant in old age psychiatry.

Q Which hospital are you attached to now?
A I am based at Moorgreen Hospital in Southampton.

Q I think obviously you went through your general training and then you began specialising in psychiatry in the mid 1980s.
A Yes. I did my basic medical training, then general practice training, then psychiatry training.

Q I think from 1992 until 2002, were you working as a consultant in old age psychiatry in the Gosport catchment area.
A Correct.

Q Between 1992 and 1995, you were based at Knowle Hospital.
A Yes.

Q Then I think did you move to Mulberry ward at the GWMH?
A Correct.

Q Just tell us a bit about Mulberry Ward. It is within the main hospital, but it is on the first floor.
A It has moved at the moment, but it was on the first floor and Mulberry ward was divided into an organic assessment unit – so that is primarily for people who have dementia – and into a functional unit, which was Mulberry A.

Q When did the move come about? When did you move to the Mulberry?
A We moved in 1995, sort of June/July. Somewhere around that sort of time.

Q Apart from working on Mulberry ward, did you also do some work at the Phoenix Day Unit?

A The Phoenix Day Hospital was a day therapy unit for people with mental health problems over 65.

Q Was that down on the ground floor?
A That was on the ground floor.

Q In fact, it is next to Dryad, I think, but there is a sealed door, as it were, between the two.
A That is correct, yes.

Q We have also heard about the Dolphin Day Hospital.
A Correct.

Q Did you have much dealings with the people in that hospital?
A From time to time I would go to Dolphin Day Hospital and would meet up with Althea Lord, Dr Lord, with whom we sometimes shared the care of patients, and we would see them jointly together.

Q Was that as an outpatient?
A That would be as an outpatient, yes.

Q So far as Mulberry ward is concerned, how often would you actually attend Mulberry ward and do a session?
A I would do a session once a week, which would generally be for two or three hours, which was a ward round, and on Friday afternoon I may or may not go to the ward, particularly if there were patients of concern, and just check that there were not any issues that the junior doctors or the nursing staff had any concerns about.

Q So when you were not at Mulberry ward, where were you?
A I had an office in the Gosport War Memorial. I still at that point I think had patients up at Knowle on the continuing care ward and I did a lot of community work and clinic work outside of Gosport War Memorial.

Q So it is not that you were attached to a different hospital?
A No.

Q This was your base.
A That was my base, yes.

Q I want to ask you about two patients that we have been dealing with in this case. I appreciate you have re-read your statements I think.
A Correct. I have, yes.

Q I do not know if you have re-read the notes, but do you have some recollection of these patients?
A I have some recollection of Mr Pittock. I have, I am afraid, a very vague recollection of Mr Cunningham.

Q I am just going to ask you to give us a brief resumé, as it were, with reference to the notes, which I hope will assist you. If you look to your left, I hope you will see a file marked

Patient A. If you take that file and turn first to page 37. Can I explain that I am not going to ask you to read through the whole of the very extensive notes that I think you made, which will be a relief to you, me and the Panel, but I am just going to ask you to give us a thumbnail sketch. Is it fair to say that you had been looking after Mr Pittock I think since 1992?
A Correct.

Q He had suffered for a very long time from something you describe in your statement as a chronic resistive depression.
A Correct.

Q A chronic resistive depression is what?
A It is a chronic depressive disorder which responds poorly to treatment and, as a consequence, he was very debilitated by his chronic depressive illness, such that he lacked motivation and drive; his mood was persistently low and he really did very little.

Q Can you help us, with a patient like this, with that sort of depression, is that anything to do with organic changes in the brain, or is it something quite different?
A It can be, but for Mr Pittock, I do not think – my recollection is that that was not the case. He had been chronically depressed for some years. Depression is a common illness, but at the severe end, for someone like Mr Pittock, there is a significant risk of having a chronic depressive illness that does not respond to treatment and I believe that he fell into that category. But you are correct in saying that there is a sense that cerebrovascular disease can prevent someone with a depressive illness from getting better.

Q If it is organic, presumably it is progressive as well?
A Correct.

Q In relation to this note that we see at page 37, is this your note?
A No. That is Dr Bayly's note. She would have done the admission clerking.

Q We can see a quarter of the way down the page, "[diagnosis] chronic resistant depression". Then we can see something about his history, "Feeling very low, inwardly tearful".
A I think it means "increasingly tearful".

Q Again, just skipping forward, if we go to page 48, we see in September 1995, "Informal admission by Dr Banks."
A That means arranged by me or facilitated by me.

Q "Chronically depressed gentleman." At the bottom of the page, under "Past Presenting History", we see, "Chronic depression since ?" and is it SOS?
A I think it is "50s".

Q I have consistently misread that. " ... 50s when attempted suicide ..."
A Yes.

Q Then over the page, we can see a list of the drugs that he was on.
A Correct.

Q We can see diazepam. I am looking for any analgesics.

A He is not on any on that list.

Q The diazepam, will that have a sedative effect though?
A It could be quite sedative, yes.

Q Could I ask you to go, please, to page 54 onwards, which I think deals with his inpatient treatment during this period.
B A Yes.

Q Was he under your care in September 1995?
A Yes, he was.

Q It may be obvious from what you have said, but what were you trying to treat him for?
A Trying to improve his mood.
C
Q If we go to page 55, for instance, we can see on 18 October 1995:

"Ward round, Dr Banks
Eating well
Seems better + brighter – wife has
noticed the improvement
D Receiving visitors."

Then, "[Therefore] no ECT". Is that electro convulsive therapy>?
A Correct.

Q Which is sometimes used still I think for depression.
A Yes, it is still used.
E
Q We will find a letter at page 57. This is written by Dr Rosie Bayly, who was your registrar.
A Correct. Well, SHO.

Q She describes herself as your registrar.
A In that case, she may be a registrar. The titles of junior doctors change over the years.
F Her role was as a junior doctor, so do not let us get pedantic.

Q Again, we can see that it reflects that the patient was admitted on 14 September.
A Correct.

Q And discharged on 24 October. Where was he? Which hospital does that mean he was at?
G A The admission was to Mulberry Ward at Gosport War Memorial.

Q We can see, just reading the first few lines:

"This 71 year old gentleman was admitted informally by Dr Banks complaining of an exacerbation of his chronically depressed mood."

H A Yes.

Q Over the page, we see under his mental state examination that he had been very flat and his concentration was very poor. He said if the opportunity to die came along, he would be glad to accept it. Then again over the page, just skipping quickly through, on page 49, under "Treatment and Prognosis", the last four lines:

> "Leslie's mood did in fact improve quite a bit during admission and he seemed to have more energy and to become more sociable with both patients and visitors. Therefore he was discharged back to his rest home and will be followed up as a day patient attending the ward on Thursdays."

His rest home, I think was that the Hazeldene Rest Home?
A That is correct, yes.

Q This was a patient who certainly on occasion was capable of getting a bit better.
A Yes, and sometimes a change of environment for someone like Mr Pittock was enough to enable that to happen.

Q Sadly, if we can move on to page 63 – this is effectively a month and a half after his discharge – he is back in for an informal admission. Again, an informal admission to where?
A To Mulberry ward.

Q We can see the presenting complaint, "Everything's horrible". Then the following words are:

> "From [Rest Home]
> verbally aggressive to wife + staff
> staying in bed all day
> not mobilising
> constipated
> not eating well
> sleep 'alright'
> No DVM"

What is DVM?
A Diurnal variation in mood.

Q Meaning?
A Diurnal variation in mood is one of the symptoms that you can get with depression, where you feel pretty dreadful in the morning, but by the end of the day your mood has improved and day in, day out, it would present like that. But he did not have that.

Q Then:

> "Feels bad all the time.
> Hopeless + suicidal"

A Correct.

Q Moving on quickly, can we take, please to page 126. This is on 13 December 1995 and there is a reference here to past psychiatric or medical history, Parkinson's disease. Is that a diagnosis that you made?
A No. I cannot recollect that, to be honest, at all.

Q Then we can see:

"REASON FOR ADMISSION TO HOSPITAL The rest home cannot cope with him, he has put himself to bed and refuses to get up. He has become both physically and verbally aggressive towards staff at the rest home. Lack of energy and self motivation."

I think he then remained in hospital for quite some time over the Christmas period.
A Correct.

Q Can I take you, please, to page 68, which deals with his moving on from your care. That date at page 68 I think is 4 January 1996.
A It is 4 January 1996.

Q Is this your note?
A No, that is Dr Lord's note.

Q I am sorry, it is, indeed, Dr Lord's note. It is entitled "ELDERLY MEDICINE" and says, "Thank you [something] ..."
A It says: "Thank you. Frail 82 year old man."

Q "Frail 82 year old man with:

(1) chronic resistant depression – very withdrawn completely dependent – Barthel 0.
(2) Catheter – by-passing
(3) Ulceration (superficial) of left buttock and hip."

Then is it:

(4) hypoproteinaemic."
A Correct.

Q Meaning, what?
A That means that the albumen and the protein in his blood were low – almost certainly related to poor dietary intake.

Q Can we look at what is suggested below. I appreciate this is not your note but this is, I think, while he is still at your hospital.
A Yes. It was some suggestions as to how we might help Mr Pittock, who was very unwell at that time.

Q Was Dr Lord a geriatrician consultant?
A Dr Lord was a consultant geriatrician.

Q He suggests high protein drips, bladder wash-outs times two per week.
A That says "[something] tulle to buttock ulcers" and I guess that is a specific dressing that the nurses would know about.

Q Then:

"I'd be happy to take him over to a long-stay bed at GWMH. I feel his rest home place can now be given up as he's unlikely to return there."
A Correct.

Q We know, I think, that he transferred to Dryad on 25 January 1996.
A Correct.

Q Can you just deal with this position when he left your hospital?
A Left Mulberry, do you mean?

Q I beg your pardon. You are quite right, left Mulberry Ward.
A When Mr Pittock left the ward and went to the long-stay ward, to Dryad, his physical health had become the major concern, and although his mental health was definitely an issue, his physical health had deteriorated significantly. The priority at that time was to address his physical health problems rather than his mental health problems.

Q His physical health problems, as described in that note, were his ulceration.
A His ulceration.

Q He had had a chest infection since his admission to Mulberry Ward which he had had physio for, two courses of antibiotics. It has added to his physical frailty overall and he was really very frail. By that, I mean generally frail and very poorly. He as not getting out of bed. He was entirely dependent on nursing staff, so despite the best efforts of the nurses, et cetera, we really had not made any headway with him at all.

Q The suggestion of high protein drinks, bladder wash-outs, et cetera, the purpose of them would be?
A He had been catheterised, my recollection is, not long before that, because he had gone into retention one night – I think between Christmas and New Year, maybe longer, but it was during his admission – and what was happening was that the urine was by-passing the catheter and coming down the urethra, out of his penis, outside the catheter rather than in the catheter. I am not a physician but I would imagine that is because the catheter was blocked, therefore the washouts were to try to improve the flow of the catheter functioning.

Q And the high protein drinks?
A To try to help with his poor dietary intake and increase his albumen and protein and his general health.

Q Once he had transferred to Dryad, did you have further dealings with him?
A I did not have further dealings with him.

Q You deal with this on the last page of you statement from my learned friend. Did you have patients dying on Mulberry Ward?

A Yes, would did have patients who dies on Mulberry Ward, more likely to be on the organic unit rather than on the functional unit.

Q If there are concerns that someone's physical health is so poor that there is a possibility of them dying, do you have a process you go through?
A We asked Dr Lord, who was our patch geriatrician, to come and assess them and help to make a decision what was the best treatment and intervention for that person.

Q So that would not be your decision. Would that be a joint decision with Dr Lord?
A It would be a decision of Dr Lord. If she discussed it with me, then it would be clearly a joint decision – there was jointness to it, I guess. It was not always formally a joint decision.

Q Could we put that file away and turn to the file of Mr Cunningham, file G. At page 112, first of all, please, there is a letter from Dr Lord dealing with the patient's admission to Mulberry Ward. He was admitted on 21 July as an informal admission.
A Correct.

Q Of 1998. Do you have any recollection of this patient now?
A I am very sorry but I do not have an enormous recollection of him. I have some recollection and the recollection is more about a series – I suppose of a process – rather than remembering Mr Cunningham himself.

Q Let us see if this triggers any memory. If you go to page 465, I think you will see a discharge summary. You are shown, I think, as the named consultant.
A Correct.

Q Admission date 21 July 1998.
A Yes.

Q From Alverstoke House. Was that a -----
A Alverstoke House was a nursing home in Gosport.

Q "<u>Reasons for admission:</u>

Mr Cunningham had been attending the Phoenix Day Hospital since June 1998 and was well known to Dr Mary Scott Brown. She had reviewed at Alverstoke House prior to admission where he was presenting with low mood, especially in the evenings and with disturbed nights sleep. He expressed feelings of worthlessness and hopelessness regarding his future but denied any suicidal thoughts. He was commenced on Sertraline 50mgs mane but his mood decreased."

Sertraline does what?
A Sertraline is an antidepressant.

Q The note continues:

"Alverstoke House found him difficult to manage. He was therefore transferred to Mulberry Ward A ward for assessment."

A Mulberry Ward A. Mulberry Ward was split into A and B. A being the functional unit.

Q Underneath, we see "Diagnosis:

"(1) Parkinson's disease + dementia.

(2) Depressive episode

(3) Mylodysplasia."

A Mylodysplasia is a function of blood and bone marrow, where you have poor production of some blood cells. I believe that was – I would have to look – platelets and white cells.

Q "PROGRESS AND TREATMENT

PSYCHOLOGICAL – he was low in mood and irritable on admission he was very distressed by his lack of mobility and independence as his Parkinson's disease worsened. He was reviewed by Dr Lord ... for his Parkinson's medication. His sertraline was stopped and he was commenced on mirtazapine."

A Mirtazapine is another antidepressant.

Q Then:

"His behaviour at times was very difficult and he was often rude to the nurses. He was very demanding of the nurses' time and preoccupied with his medication regime. Carbamazepine was introduced."

Physical – he had regular reviews by Dr Lord for his Parkinson's."

Parkinson's was not something that you would be directly dealing with.
A No, generally not.

Q Do you recall this admission to Mulberry Ward?
A I recall some of it. It is just that it is not as clear as Mr Pittock, who I had known very well.

Q Just dealing with this admission to Mulberry Ward, if we go to page 72, I think we will find a note of yours. Again, I am not going to spend very long on this. Do we see an entry for 24 July.
A Yes.

Q Is that you?
A That is me writing, yes.

Q You can hopefully read it to us.
A I can. It says:

"Seen on ward. Depressed. Tearful. Talks about wife and alienation from step children. Irritable. Difficulties with placement. Start mirtazepine 30 mgs at night."

The asterisk is to say:

"Check full blood count next week and weekly."

B Given his mylodysplasia, I felt it was important that we kept an eye on that.

Q If we leaf through the following pages, again I am not going to alight on any of them for very long, the following page records an incident on 25 July at 2300 hours:

"Had got himself out of his chair and crawled on all fours to his bedroom, did not want to sit in a chair, would not use frame to walk or attempt to weight bear."

C Was he quite a difficult patient?

A He was not an easy man, I think, for the nurses to manage.

Q At the bottom of the page:

"Brian managed to attend to this own personal hygiene. He became quite rude and abusive to a member of staff early am. Spoken to Brian about his rudeness did apologies to member of staff ..."

D At this stage were his mental faculties there, as it were, or impaired? How would you put it?

A I cannot comment on whether his faculties in terms of his memory and that level of functioning and self-awareness were totally there. I really cannot comment. I would say that clearly he had periods where he was frustrated and his behaviour was difficult, but behaviour and having your faculties do not always match.

E Q We can all be rude.

A We can all be rude, but I cannot tell you whether this man was just always rude or his behaviour was part and parcel of his psychological make-up, his mental state, him being depressed. He had Parkinson's, which he found difficult because it made him dependent on other people. With Parkinson's you do get fluctuating physical states because of medication. Having seen the notes and from my personal recollection of this man, it would be difficult to say it was either one or the other and more likely to be a combination of his person and his illnesses.

F Q Can we skip on, please, to page 88. I am obviously dealing on only with very short aspects of this statement. We see a note that may be by Dr Taylor on 19 August 1998: "Discussed with Dr Banks ..."

G A Yes.

Q I think this revolved around the problem that Mr Cunningham was agitated and unsettled at night.

A Yes. Also, there is a comment about having hallucinations and being paranoid as well, and risperidone is an antipsychotic medication and would be used for the treatment of hallucinations and paranoid delusions.

H

Q Finally in relation to this submission, could we go to page 93. Does your writing appear on this page?
A No.

Q This is asking you to help us with the history of this patient. Right at the end, we can see that he was due for discharge to the Thalassa Nursing Home. He was quite anxious and fluids were encouraged. Urinary output good. If he was fit enough to discharge to the Thalassa Nursing Home, does that tell us anything about his state of health?
A It would suggest that the challenges for the nursing homes had been his behaviour, which could well have been part and parcel of his low mood, and that behaviour must have been settled enough for him to move back into a nursing home environment.

Q I should have taken you to this earlier, but right at the beginning of his admission, I think you had written a note?
A Yes.

Q It is page 116.
A Yes. I have to confess, I am somewhat embarrassed by this note because I did not read it, and it was dictated and signed without me seeing it, and it is not the sort of language I would normally use.

Q I was going to ask you.
A Because that is not what I would normally send out.

Q Very well.
A Clearly, given the tone of the letter, things had not been easy.

Q No. But that, of course, was prior to his admission?
A That was prior to the admission.

Q And when you refer – and I am sorry if it slightly embarrasses you ---
A That is all right.

Q --- but when you refer to a patient as being "a bit of a saga"?
A Yes. I think it was the whole... My recollection was that Mr Cunningham had somehow managed to come from one nursing home, probably another nursing home, and he was not settling. I think he had actually turned up just with the social worker hoping, I think I am correct in saying, that the situation would be resolved. I believe that is what led to his admission.

Q Then he gets through with the admission?
A Uh-huh.

Q Which we have looked at?
A Yes.

Q He is released back, as it were, to the Thalassa. Could we go to page 100, this was cc'd to you.
A From John Allen.

Q The psychiatric nurse?
A Correct.

Q

"Mr Cunningham has settled well into Thalassa Nursing Home. There have been no real management or behavioural problems. He can be awkward at times but mostly he is pleasant and compliant. His mood seems good. I plan to review him in one month."

We know that in fact, I think three days later he was actually transferred to Dryad. The reason for that we find at page 458. That is that unfortunately he developed a large necrotic sacral ulcer. This was cc'd to you again, as we can see at the bottom.
A Yes.

Q We can see from the third line:

"His Parkinson's disease doesn't seem any worse and mentally he was less depressed but continues to be very frail."

He was really being admitted for treatment for his sacral ulcer.
A Correct.

Q Can we take it that you had no further dealing with him?
A I had no further dealing with Mr Cunningham.

MR KARK: Thank you very much. Will you wait there, please.

Cross-examined by MR JENKINS

Q I am going to ask you questions on behalf of Dr Barton. Can I just ask about Parkinson's disease and whether it is a disease that can itself lead to death?
A Yes.

Q If a patient were to die – a patient who had Parkinson's disease – what would be the mode of death? Would they be bed-bound?
A Certainly bed-bound, yes. With Parkinson's disease it is a fairly prolonged chronic disease, very debilitating, gradually deteriorating and, in general, people become entirely bed-bound and entirely dependent for activities of daily living on nurses and other carers who may be looking after them. There may be difficulty with eating and drinking because of problems with swallowing and may spend many months or years in bed prior to this happening.

Q If someone did develop bedsores, as we know Mr Cunningham did in the nursing home before he was sent into hospital at the War Memorial, are there likely to be difficulties in dealing with the pressure sores because of inadequate nutrition because of the Parkinson's, or might there be such problems?
A I would imagine there are going to be enormous problems treating bedsores. They are very difficult to treat. It is a very lengthy process and, in addition, if you have someone who could be bed-bound then, as a matter of turning them, keeping them off the sacral area, I have

to confess I am no expert in managing bedsores, but it would strike me that that is a very difficult... Sorry. Can you just repeat the question. I have got lost on my....

Q I was just asking about inadequate nutrition.
A Sorry.

Q Problems because of the Parkinson's, whether that was likely or whether it could lead to problems in dealing with the bedsores?
A The Parkinson's, purely by the consequences of physical immobility, the stiffness, difficulty moving someone, is going to make it difficult, and someone would need regular turning and it would take a very long time – months if not years – to treat that sort of level of bedsore. In terms of maintaining nutrition, that is going to be very difficult because someone would have difficulties in swallowing and taking adequate nutrition and may lose weight. That would not be uncommon for someone to lose weight with Parkinson's.

Q We have seen through the correspondence that you have been referred to that Mr Cunningham had lost quite a lot of weight?
A Correct.

Q In the correspondence we have seen the consultant was remarking on that?
A Uh-huh.

Q Yes?
A Sorry. Yes.

Q Can I ask you about a creatinine figure?
A Yes.

Q You shudder! If you prefer me not to, I will not.
A Try me out!

Q You have been referred to page 465.
A Yes.

Q The creatinine is over 301.

Q Yes.
A And his urea of 28.

Q Tell us what creatinine is?
A Oh, goodness me! Creatinine is a chemical in the bloodstream that reflects renal function.

Q Right. If creatinine is significantly elevated?
A That suggests poor renal function.

Q I understand. Renal – relating to the kidneys?
A Sorry. Kidney function. Thank you.

Q I am not going to ask you what a normal range would be for a male or a female unless you know?
A No, but it is less than that. Just over 100 or something along that.

Q Yes, that is very significantly elevated, 301?
A Yes.

B Q And is an indicator of poor renal function?
A Correct.

Q Put the notes away now. I am not going to ask you any more questions about that. I am going to ask you about your knowledge of Jane Barton.
A Okay.

C Q What the Panel know, I think, is that she took up a clinical assistant's job at the Gosport War Memorial Hospital in about 1988. Did you know her before that time?
A 1988? Sorry, I am just trying to think and place myself in time. Our paths may have crossed but I cannot think that I actually knew her before 1988.

Q I think it is right that you will have shared patients?
A Yes, we will have shared patients.

D Q At the War Memorial Hospital?
A At the War Memorial Hospital.

Q And would you have had discussions or contacts with Dr Barton about patients who were treated at the War Memorial Hospital?
A Yes.

E Q When you were both working there?
A Correct. We would have done.

Q And have you also, as a consultant, dealt with patients of Dr Barton's for whom she was the general practitioner?
A Correct. I would have done that as well.

F Q And in that role would you have seen referrals by Dr Barton?
A Yes, I would.

Q And possibly have had discussions over the telephone or face to face about patients?
A I think fairly regular discussions with Dr Barton. I did a clinic in her surgery and regularly met Dr Barton and other GPs of that practice every month.

G Q Although you cannot give us the year when you first came across her, have you had sufficient time to form a view of her skills and abilities as a doctor?
A Yes.

Q Tell us what you think of her?
A My opinion is that Dr Barton has always been a really very accomplished doctor. She has in terms of managing her patients always for my service made very timely referrals, very

H

appropriate referrals. She has asked pertinent questions about intervention and care. Like any consultant/GP interface there was always discussion about what would be an appropriate course of action. I know that I have had discussions with Dr Barton on occasion when we did not always see eye to eye, but she has changed her views, changed her opinion, and we worked on together with patients, but in a very positive fashion. Certainly, within her practice she was the most psychologically minded and able of the GPs.

B Q Tell us what you mean by "psychologically minded"?
A Able to see that people had a psychological component to illness, and understood people as individuals rather than, I suppose, just bodies to do something to. She was very aware of people as individuals. She was quick to pick up on depression and was generally timely with interventions. In terms of our interface at Gosport War Memorial we shared many patients, even before the move to Dryad on Redclyffe Ward, which then became my continuing care unit. The referrals made by Dr Barton to myself on Dryad or Redclyffe ward
C – I cannot think of an inappropriate referral. Obviously it is difficult to search the total memory bank, but I cannot recall anything that was not appropriate for my assessment or my intervention, or for my team's intervention. We worked very hard on some really challenging cases. She was very pro-active at getting people home and certainly Dr Barton was very supportive of those management plans on Dryad ward. I think we achieved very many successful discharges home, or to residential or nursing home care.

D Q Perhaps it is time for a question.
A Sorry. Yes. Does that ---

Q It is all right. What would you say about her level of commitment towards patient care?
A She was phenomenally committed. She was always in there first thing, even before me, so she was in there first thing and I knew that I could catch her first thing in the morning
E when I arrived. If there were problems, all the nurses had to do was to call her, and I knew that she would turn up. So if I had a problem with somebody, or we had agreed to meet she would come in. She was very committed to providing the care on Dryad ward.

MR JENKINS: Thank you very much.

THE CHAIRMAN: It means we have come to the stage when members of the Panel may
F have questions of you. I will look to see if any do. Yes. Dr Roger Smith is a medical member of the Panel.

Questioned by THE PANEL

DR SMITH: I am a physician. Can we go back to creatinine.
A Ah!
G
Q Your reaction was...
A Yes, go on. It still is.

Q It is not a viva.
A No.

H Q Just a flavour, if you would.

A Okay, fine.

Q Because Mr Jenkins did bring it up.
A Yes.

Q A level of 301 is raised?
A It is raised. He also has a raised urea, has he not, of 28.

B

Q Can you think of any reasons why a creatinine may be higher than it normally is in a patient?
A He could be dehydrated.

Q Any other reasons?
A Some renal impairment. Probably medications.

C

Q Could infection cause it to be high?
A Okay. Infection – I am sure you are right.

Q So a creatinine of 301 may be a temporary thing. It may get better than that.
A Okay.

D

Q Would you agree with that? In some cases, a raised creatinine may go down with some treatment of some conditions?
A Correct.

Q And, secondly, is a level of creatinine of 300 something that you would equate with near death?
A No.

E

Q No? Anywhere near death?
A Do you know, I just do not quite know actually so I would prefer to say I would not be one hundred per cent certain.

Q I only ask these questions because the rest of the Panel are lay.
A No, sure. That is very reasonable.

F

Q That is very helpful. In a similar vein this gentleman had pretty bad bedsores, sacral sores?
A Correct.

Q From immobility from Parkinson's disease. A month before that he had not been as ill. You had felt he was well enough to go back to a rest home, a nursing home. Again, with Parkinson's and immobility, the fact that you develop bedsores: what in your opinion would that equate to? Is that a situation which may be easily remediable in some people?
A I am sorry. The thoughts that go through my mind are that he is spending a lot of time in bed, and either not moving or not being moved.

G

Q But may the situation improve under certain circumstances?
A Improved nursing care could improve it.

H

Q And ---
A I am sorry. I am not quite....

Q Okay. We will leave it there because that is sufficient for the question I am asking. With Parkinson's, may immobility sometimes improve as well?
A Yes.

B Q Sorry – mobility improve.
A Mobility can improve.

Q In general terms, then, faced with a patient with a known background like this man, who develops a sacral sore and immobility and a raised creatinine – I am sorry, it does sound like a viva and I do not mean it to be.
A It is like a viva.

C Q I am very sorry. Speaking as a physician – you speaking as a physician – what would be the general principles of management of his physical problems if you are faced with a man on your doorstep like that?
A Let us make an assessment to start with, if there is any underlying cause for this, or deterioration. Then it is about management of his Parkinson's, his bedsore and his mobility.

D Q So it is "make an assessment"?
A Yes.

Q Get to know the patient?
A Yes.

Q Their problems, and see if there is a way through?
E A Correct.

Q Having said all that, is it reasonable to sum up that you would not – let me put the word "necessarily" in if you like – you would not necessarily think that this was an end of life situation?
A It is bedsores, Parkinson's and poor mobility and a creatinine of 301 paint part of a picture, do they not? Part of the assessment is to get the whole picture. I do not know what F the rest of the whole picture is or was. I know his mood is good.

Q Let me crystallise it into this then. In such a situation there is potentially for improvement?
A Uh-huh.

Q Yes?
G A Yes. Sorry, sorry. Yes.

Q But there is also potential for no improvement or, indeed, deterioration?
A Correct.

DR SMITH: It is something you need to assess. Thank you very much.

H

THE CHAIRMAN: Doctor, I am not a medical member, as will probably become apparent. We have heard a great deal about getting the whole picture and, of course, a lot of that has to do with when you take that picture.
A Yes.

Q We have heard a great deal about deterioration. We have heard a great deal about the effects that different medications can have on physical and mental status, and their ability to sometimes mask what one might call a true picture.
A Uh-hum.

Q Indeed, you have told us today about the effect of medication that can be had with a patient suffering from Parkinson's. You indicated there was a fluctuation in their physical status.
A Yes.

Q We have also heard a great deal of evidence from others about the effect that a transfer can have on a patient, both physically and mentally, and not necessarily a transfer between hospitals; even a transfer between wards.
A Yes.

Q In the whole business of assessing the true picture, can you give us any assistance in broad terms, appreciating that every patient is an individual, of what one should be looking at in terms of the passage of time between the moment of arrival after transfer, before you can be making the sort of assessment that is going to have an impact on your decisions in terms of the long-term for the patient?
A Okay. As you rightly say, each person is very individual and not specifically talking about the two patients we are talking about today, I suppose assessment can be very short. If someone comes in, you may have known them from the past, you have known them from the day hospital, and it is very clear that they have deteriorated significantly and that assessment takes place very quickly. It may be that the underlying reasons for the deterioration are crystal clear and you can make decisions there and then. Generally it takes a bit longer than that and it may be several days. For some people, if I think about Mr Pittock, who was transferred from a residential home, for it to be crystal clear to us what was happening took a week to be clear whether he was going to get better and improve or not, for example. For some people, it takes longer than that. It is dependent on the rest home, the nursing home, the information you receive from them, the information you receive from families, how they respond to the new environment, whether they feel confident and comfortable in that environment to appreciate the process of assessment and if you have a patient who readily engages with that assessment process, then again it is so much the quicker. Does that help you?

Q That assists greatly, but just in respect of the last point, of course lack of engagement or otherwise may itself be a feature of, shall we call it the transfer effect.
A Correct.

Q So it is a matter of building in margins of safety, I guess. At which point might it become safe? I appreciate that initial assessment is vital, but that is merely for your immediate management of a patient, is it not?
A Correct, yes.

Q But suppose it is a ward where, for example, there is routinely a decision that will be made for patients whom it is assessed are coming into that end of life stage and they may be put on to a course of treatment that of necessity is a one-way street and a short street at that. What I am looking for is any guidance that you can give us as to the sort of timescale on average that one would expect to elapse before that sort of decision is made to ensure that there is no great risk of a patient being put into that final phase when in fact some of the symptoms of deterioration that they are manifesting are either as a result of the transfer mode or indeed fluctuations that may occur because of the use of certain medications or simply the side effects that might occur as a result of the use of certain medications. Maybe there is not a guideline that you can give us, but if you can, it would help me enormously.

A I am just taking a little time to think out an answer, because clearly if it was an easy answer, you would be there a long time ago. I think if you are embarking on a course of treatment, then clearly that has to be well thought through and whatever the course of treatment, it needs clear thought given as to why you are undertaking that treatment and what it is for. I think the timeframe to embark on these, as you have alluded to before, is very much about individual patient decisions, rather than a timeframe by which every patient is treated, because that would be very non-personalised, would it not, and you would feel you were just were not valued as an individual. To be honest, I really could not give you a timeframe in which you make these decisions, but when someone comes into hospital, you do have to make a decision about their treatment plan. Often prior to admission, there would have been some treatment plan alluded to. For example, for Mr Pittock and Mr Cunningham, Dr Lord had already come – I am sorry, not Mr Cunningham. I beg his pardon. For Mr Pittock, Dr Lord had already come up with a treatment plan which was for us to use on Mulberry and I would imagine that would continue to be used on Dryad ward. So there are treatment plans that should be set up at the beginning and may precede a patient into hospital. But embarking on – I forget the words you used to describe it – a one-way street of treatment, which suggests a sort of an end point that is terminal, those decisions are not I would say something that you make instantly when someone comes into hospital, unless there was good reason to do so. I cannot define "unless there is good reason to do so", but it may be that there are circumstances where that may be the case.

Q Would it follow that if the patient were to be admitted on to the ward on the basis of pre-planning which indicated, for example, that the patient was for rehabilitation, those sorts of circumstances would make it on the face of it inconsistent, if there were a rapid assessment culminating in that patient being put on to a course of treatment that completely contradicted that for which they came in, for example, rehabilitation they are coming in for, but very swiftly being put on to an end of life course of treatment that would only have one outcome.

A It sounds far too straightforward to say yes, you would surmise that would be the right outcome, that if you are coming in for rehab, you are not put on sort of end of life pathway unless circumstances have changed.

THE CHAIRMAN: That is very helpful. I appreciate those were very difficult questions to try to answer, but it certainly assists me as a non-medic. We have reached the point now where the Panel have asked their questions and it is open to the advocates themselves to ask questions which arise out of the questions asked by the Panel. I am going to ask Mr Jenkins if he has any questions arising.

Further cross-examined by MR JENKINS

Q Coming back to Mr Cunningham, if you would. You checked yourself. You said Mr Pittock had been assessed by Dr Lord and you stopped yourself from saying that Mr Cunningham had been as well. If you look at page ---
A You are right. I beg your pardon. You are absolutely correct. I did not mean to contradict myself.

Q --- 644. When Mr Kark asked you questions, he stopped the chronology on 18 September and told you that three days later, Mr Cunningham was to be admitted to the War Memorial Hospital.
A Yes.

Q What we know is that on 21 September, he was assessed at the Dolphin Day Hospital, which is part of the War Memorial complex, assessed by Dr Lord and we have her assessment there. At the bottom of page 644, we have six numbered points. To the left of the number 1, we have a triangle, which is medial shorthand for "diagnosis".
A Yes.

Q I do not think I need to take you through them, but it is clear that Dr Lord has written up a plan. That is the first word she has written on the next page, page 645, and she sets out five numbered points. Again, the detail of them perhaps does not matter. She is suggesting that Oramorph should be prescribed as required, if he is in pain. She has assessed the extent of the pressure sore on the previous page and at the end of her note, she has written, "Prognosis poor".
A Yes.

Q We can turn over two pages to page 647, where we will see that Dr Barton, underneath a photograph of the sacral sore, has made an entry that Mr Cunningham is to be transferred to Dryad ward.
A Yes.

Q In those circumstances, would you expect the clinical assistant to pay high regard to the plan drawn up by the consultant arranging for the admission?
A Yes. If it were my clinical assistant, I would expect them to follow the plan.

Q You were asked questions by the Panel about pathways that patients might be placed on and you were asked if, say, a patient was admitted to the ward for rehabilitation, whether rehabilitation is what they should get by way of treatment.
A Yes.

Q We have to assume for these purposes that rehabilitation is realistic as a basis for admitting a patient to the ward, rather than something written on a piece of paper.
A Correct.

Q Any doctor, on seeing a patient, either at the time of admission or just after, would you expect them to undertake an assessment both of the history and of the patient's then condition. Yes?
A Yes.

Q You were asked questions about pathways for patients. Do you really need to assess the patient yourself in order to be able to decide what is appropriate for this patient at this point in time?
A Sorry, when you say "you", are you talking about ---

Q For you or for anyone to make a decision appropriate for this patient, do you need to be able to review not just the history, but the present position?
A I think what I replied to the Chairman was that if there was an intention to rehabilitate, then you would assume that someone would be going into the unit to be rehabilitated, but situations change and I very clearly said that. That is the plan, but when someone gets to the ward, that is not always how the situation is. Does that answer your question?

Q It does mostly. The way in which one might know that the situation had changed is because the doctor and/or nursing staff are continuously assessing the patient.
A Yes. You make an assessment, which I think I said should be taking place.

MR JENKINS: Thank you.

Re-examined by MR KARK

Q I have only one matter to ask you about. I just wanted to try and follow what you just said. I am not going to ask you about creatinine.
A No, please do not ask me about creatinine!

Q Still with Mr Cunningham, page 645 of file G, is that the plan set out by Dr Lord for this patient?
A I believe that to be correct.

Q Then you said – I just tried to note it quickly: "I would expect a clinical assistant to pay high regard to the plan set out by the consultant."
A What you are saying is, I am contradicting myself, I think.

Q No, I am not suggesting anything.
A All I am saying is that if, as a consultant, you make a plan for a patient you have seen in the community and then they are admitted to a ward, a clinical assistant or a junior doctor, you would expect them to follow the plan. But part of the junior doctor's role or the clinical assistant's role is to make an assessment of that patient when they come into hospital. If there is a significant difference, then you have to look and change the plan. You cannot stick with the plan regardless.

Q I entirely understand that. If there is a significant difference between what you read as the consultant's plan and what your assessment of the patient is, would you in normal circumstances make any note about that?
A I would expect my junior doctor to make a note about that. What you are saying is, if I thought there was going to be a significant difference ---

Q If you read a consultant's plan for a particular patient, the patient gets wheeled round to you and you take a look at that patient and think, "Hold on. This is an end of life patient", would you make a note about that and the reasons for your decision?

A I would expect my junior doctor to do that. If I am the consultant and I make a plan and then, when the patient gets wheeled round to my junior doctor for admission, they think, "What's up here? Things are not quite what they seem to be", I would expect them to think about the plan and either contact me or do something about it and not necessarily follow the plan.

Q This patient on page 645 who is being assessed on 21 September is where?
A From what I understand, this person is in Dolphin Day Hospital, having come in from the nursing home. When Dr Barton has written her comment, I cannot tell you.

Q I think it is accepted that when Dr Barton saw the patient, the patient was still in Dolphin Day. That is what is being suggested.

MR JENKINS: Mr Kark knows what Dr Barton said to the police.

MR KARK: Let us imagine that for the moment. The patient has not even been moved yet. The patient is still lying in the same ward where the consultant has just assessed him. The consultant has suggested that the patient is for a high protein diet and Oramorph if in pain. You, as the clinical assistant, go and see that same patient and you make a decision at that time to put the patient on a syringe driver on that day, on 21 September. Is that something you would communicate to the consultant?
A Generally. I have slightly lost track of where you have gone with your thinking and your position.

Q It is your evidence that matters, not my thinking.
A It is how the evidence has been presented.

Q If we go to page 758, which is the drug record, on 21 September, the same date as that assessment by Dr Lord, this patient is put on a syringe driver by Dr Barton.
A Okay.

Q Would you expect Dr Barton to communicate that to Dr Lord why her assessment was seemingly rather different?
A I am sorry, I am just looking for .... (Pause)

MR JENKINS: I am sorry to interrupt, but I wonder if it would be fair for Dr Barton if Mr Kark were to take the witness through the history of what happened that day. We can start at page 754.

MR KARK: I am sorry, I am simply picking up on the examination by Mr Jenkins. He was asking this witness questions and the witness said, "I would expect a clinical assistant to pay high regard to the plan drawn up by the consultant." That is all that I was asking about.
A Yes. I am sorry, I got slightly sidetracked. I did not quite hear everything you were talking about, and it sounded like you were talking to yourself and Dr Barton and not to me.

Q No, I am asking you questions.
A I thought you were having another discussion.

Q I am sorry. That is my fault. I am asking you questions. I was asking you if the clinical assistant comes to a different view, first of all would you expect them to make a note about it or not?
A I would expect if they come to a different decision that there is some recording and some discussion.

Q And the discussion would be with whom?
A With either a senior doctor or myself.

MR KARK: Thank you.

THE CHAIRMAN: Thank you, Mr Kark.

Thank you, doctor, very much indeed. That completes your testimony. We are extremely grateful to you for coming to assist us today. It is always very difficult for a panel in these sorts of situations to try to get a true picture of what happened, very often months and, indeed, years ago, and we really do rely upon witnesses such as yourself coming to assist us. In that regard, you really have been of great assistance and you go with our thanks. Thank you.

(The witness withdrew)

MR KARK: That is the last live evidence that we have. We might finally make an attempt at some reading this afternoon. I wonder if the Panel might like a short break. There is about 30 minutes of reading to do.

THE CHAIRMAN: We will take a short break. We will return at 25 minutes past the hour.

(After a short break)

THE CHAIRMAN: Welcome back everyone.

MR KARK: Sir, could we start with some housekeeping. The first piece of paper we want to give you is the death certificate for Gladys Richards which we have not had until now. At file E there is an empty tab, and perhaps that could be filed there. We are not going to give it a different C number. (Documents distributed and inserted in bundle E)

THE CHAIRMAN: For the record, the Panel have received the death certificate in the case of Patient Gladys Richards and we have added it to the patient bundle behind the appropriate tab.

MR KARK: Thank you very much. There is also one for Mrs Eva Page, bundle E. (Documents distributed and inserted in bundle E) There is a document after the death certificate which is the birth certificate. The reason for that is that the death certificate appears to reveal the wrong date of birth by a day. It was Code A and it is shown in the death certificate as Code A. I do not expect much turns on it, but that is why you have a copy of both.

THE CHAIRMAN: Thank you very much. Both of those documents have been received by the Panel and placed into bundle C behind the appropriate tab.

MR KARK: I am now going to read the statement of Sharon Barbara Ring, which is a statement read by agreement, I believe.

MR LANGDALE: Yes.

MR KARK: This is the statement of Sharon Barbara Ring.

STATEMENTS OF SHARON RING, READ

She describes herself as a care manager in social services. She made a number of statements to the police, the first of which is dated 10 November 2005. She says,

> "I am currently employed as a care manager in relation to social and home care for the elderly at Fareham Social Services.
>
> I was an E grade staff nurse in the NHS."

She gives her nursing and midwifery number.

I have just realised that we do not have a copy for the stenographer. I am sorry, and we will provide one post event, as it were.

THE CHAIRMAN: Whilst you have interrupted yourself, can I just confirm that this statement has been admitted on the basis that the defence are content for you to read it but they do not accept the contents as being fair.

MR KARK: Sir, I think this one is accepted.

MR LANGDALE: Sir, I think in this case there is no difficulty about the content. I do not think any issue is taken with what I understand is going to be an edited version simply to cut out irrelevancies.

THE CHAIRMAN: That which we hear is accepted by the defence as being undisputed fact. Thank you.

MR LANGDALE: It is not a matter of contention.

THE CHAIRMAN: Thank you.

MR KARK: She says,

> "Between May 1976 and May 1979 I trained as a student nurse. I worked at both St Mary's Hospital and the Royal Hospital in Portsmouth."

She says that she qualified as a State Registered Nurse in May 1979 and that she worked on a female geriatric ward. She deals with her midwifery training in 1981.

"During the period 1983 to 1986 I worked part time as a staff nurse on night duty at both Thalassa and Bury Lodge Nursing Homes for the elderly in Gosport. I initially worked two nights per week."

She then speaks about running her own business between 1986 and 1990. She came back to nursing in 1991.

B I am skipping parts. I know my learned friend and I have agreed, but I think he will agree that we can précis this. She says:

"In September 1991 I rejoined the NHS as a D grade Registered General Nurse (RGN) working part time at the Redcliffe Annexe in the Avenue, Gosport. This was a long stay unit for the elderly (patients over the age of 65 years). I have re-registered with the United Kingdom Central Council for Nursing, Midwifery and Health
C Visiting.

In my time at the Redcliffe Annexe I was working with ..."

and she names Sue Donne, Lynn Barratt and Gill Hamblin, who she describes as the Ward Manager.

D "As a D Grade I was a junior Staff Nurse and as such I always worked with a Senior Staff Nurse.

I received no training in the use of IV drugs and I did not administer these.

I do not recall the term the Wessex Protocols.

E With regards to the use of a syringe driver, I am aware that it can only be used on the authority of a prescription written by a Doctor. The use of which is only authorised after discussions amongst the medical team and the nursing staff have reviewed the patient's pain relief/control and the analgesic ladder had been followed; ie, beginning with simple paracetamol, distalgesics, co-dydramol, a codeine based analgesic, and then morphiates would be the next consideration.

F Once the authority for a syringe driver was given; ie, it was written on the prescription chart and normally in the clinical notes, there should also be an entry in the nursing notes which would state what controlled drugs were to be administered to a patient and what quantity and dosage. The period of time the dosage was to be administered was usually over a 24 hour period.

G These drugs would be taken from the secure drugs cupboard after the amount/dosage of the drug was checked against the prescription sheet. The appropriate amount withdrawn would be then recorded in the controlled drugs book, which should be witnessed by the two nurses who had withdrawn the drugs.

The drug solution containing the prescribed drug(s) was made up in sterilised water.

H

In the case where it was a mixture of drugs, then the compatibility of drugs would be checked in the British National Formulary (BNF). On occasions the pharmacist would be contacted for advice.

Once satisfied that the drugs compatibility was correct then the driver would be taken to the patient, where a further check would be made to ensure it was the correct patient.

A small butterfly needle would have been inserted below skin level (subcutaneous) and the syringe driver applied, which delivers a set quantity of drugs over a 24-hour period.

With regard to training it was purely on a one-to-one basis and on the job learning. We were given handouts and there may have been a course, I am unsure.

My understanding of the term the named nurse is that this person is responsible for the care of the patients allocated to them. The relatives of that patient would also speak to them if the named nurse was on duty.

The time and date of all entries would vary from patient to patient; they may be completed at the time, but normally completed at the end of the shift.

My shifts were from 0730 to 1330 and from 1230 to 2100 hours.

The Redcliffe Annexe closed and all patients and staff transferred to a new ward at Gosport War Memorial Hospital known as Dryad Ward. At this time I was an E Grade Staff Nurse.

My responsibilities at this time were deputising in the absence of the senior staff nurse or ward manager, supervising staff and delegating work loads. Also assessing, implementing and evaluating individual patient's care. Further to this I would accompany doctors and consultants on their ward rounds. I would also order drugs and arrange for their safe storage and then dispense safely to the patients.

The ward rounds were completed before surgery by the GPs, usually between 0730 and 0800 hours. These would consist of a meeting between them and the staff and opinions from us sought and the GP would visit the patient if necessary.

The consultants rounds would usually be once a week and would take all morning, and all patients would be visited by them.

The following terms can be written in the nursing notes.

ANC means All Nursing Care and means all care that is required for the individual patient, in relation to care plans such as Hygiene, Nutrition etc.

TLC means Tender Loving Care, which in my opinion indicates that the patient is in the terminal stages of life and should be treated with dignity and respect.

'I am happy for staff to verify death', would be written by a Doctor and means that the patient is expected to die in the near future. To verify death then two trained members of staff would check the patient for vital signs, (there was a policy to follow for this) and as such the eyes would be checked for pupil reaction, along with the pulse and the heart. The patient may also be pinched to see if pain registers.

I have been asked about Shirley Hallmann, a nurse at GWMH, expressing her concerns regarding syringe drivers to me. I cannot recall any conversation with Shirley regarding this topic at all.

I was on Dryad ward from September 1997 to October 1998 and in that time I believe I worked with Shirley Hallmann for approximately 6 months before I left.

If there had been any such conversation with Shirley I think I would have documented this and spoken to other members of staff. I don't recall doing either of these."

She then makes a statement dealing primarily with Patient A, Mr Pittock. It is dated 25 October 2004. She repeats, frankly, a vast amount of the same material. Then she says – and for my learned friends I am now on page 4, half way down:

"I have been asked to detail my involvement in the case and treatment of patient Leslie Pittock."

He is now Patient A. She refers to a photocopy of the nursing notes. She confirms that she has written the following entry for 21 January 1996. I am going to give the references for the purposes of the transcript. If you want to look them up then, of course, I will pause but she actually reveals what she says in her notes in any event. It is our page 212 of Patient A. She says:

"I can confirm that I have written the following entry for the 21/1/1996 (21/01/96).

Condition remains unchanged, Mrs Pittock phoned, driver recharged at 1745 Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200 micro grams, Nozinan 100 mgs, one syringe running at 50mms per 24 hours the other at 58 mms..."

That must be "mls", I think.

"... appears comfortable."

It actually says "mm" which is millimetres but I am not sure that makes sense.

"This entry has been signed by me."

She says:

"Firstly I do not recollect this patient Mr Pittock or remember the subsequent care given.

With regards to the above entry the patient's condition has not changed during my shift. Mrs Pittock has phoned because she is obviously aware that Mr Pittock is very poorly, ie, prognosis is poor.

The syringe driver has been set up and commenced prior to my shift. I have recharged the syringe driver as per the prescription chart written by Doctor Barton clearly shows that this doseage and mixture of drugs can be administered to the patient.

However if as trained nurses we felt that the amount of drugs was no longer required, ie, there were signs of improvement then I would not administer these drugs. I would firstly phone the doctor on duty for advice.

In my experience contacting a doctor for advice in these circumstances was a rare experience.

With reference to the different rates that I have recorded – both syringe drivers were set to run over a 24 hour period.

With reference to where I have written 'appears comfortable' I understand this to mean that there were no obvious signs of pain or discomfort.

I have written under the initial entry on page 29..."

for us it is page 212 –

"2015 no change in condition – which is self explanatory.

To summarise the patient Mr Pittock at this stage was obviously very poorly, the family were aware of his condition. That during my shift the patient's condition had not changed."

She then talks about witnessing withdrawals from the drugs record which I think we both agree we do not need to go through.

I then turn to her statement dated 11 January 2005. This is for Patient Lake, and that is your file F, so we are dealing with Ruby Lake. She again reveals her training. She says that when she was at the Redclyffe Annexe she was a D grade as a junior staff. This is just addition to the preface that she gave in the first statement. She says:

"During this initial period that I was working at the Redcliffe Annex I updated my knowledge concerning nursing and healthcare by reading the Nursing Standard and Nursing Times.

Although I know I received training in connection with the use of syringe drivers I cannot remember the dates or where this training took place. However I would not have been allowed to use or set up a syringe driver without the appropriate training.

I cannot specifically remember using syringe drivers at the Redcliffe Annex."

Can I just look to my learned friends and see if they want page 3, which is in different wording, but I think is much the same sort of material. I am sorry. Yes. I am going to move on. I will give my learned friends an opportunity of having a look at that if they want any of it. I am obviously very happy to read it, but I am going to move on. Thank you. Page 4. There she says:

> "I have been asked to detail my involvement with the patient Ruby Lake ... who was admitted to Dryad Ward on 18/08/1998.
>
> I do not remember the patient Ruby Lake or any treatment administered to this lady."

She looks at the drug charts. For us it would be page 368E. She says:

> "I did not administer any drugs to Ruby Lake on the 19/081998. I believe I was off duty that day. I can confirm that I have made one entry for 3 drugs dated 20/08/1998 @ 0915 where I recorded that I have administered 20 mgs of Diamorphine, 20mgs of Midazolam and 400 mcg of Hyoscine.
>
> These drugs and their quantities were prescribed by Dr Barton who was the ward doctor for Dryad Ward at that time.
>
> On examining the nursing summary, page 394 ..., I would have checked the patient notes for the previous day where it was noted that the patient Ruby Lake was anxious and in pain, a syringe driver had subsequently been commenced.
>
> On the 20/08/1998 there would have been a verbal handover from the night duty staff informing myself and other staff commencing duty that day how each patient had progressed during the night.
>
> In the case of Ruby Lake it appeared that her condition was deteriorating and that she was still in pain.
>
> The dosage for Diamorphine and Midazolam remained the same. However 400mcgs of Hyoscine was introduced into the syringe driver at this time.
>
> I can confirm that I wrote the following entry..."

This is our page 394.

> "... on 20/8/1998 (12.08.1998) at 1215, condition appears to have deteriorated over night. Driver recharged, 1010 – Diamorphine 20mgs, Midazolam 20mgs, Hyoscine 400mcgs. Family informed of condition, daughter present at time of report."

I am just asking Mr Fitzgerald to check something.

> "With regards to this entry it would appear that I have phoned the family to inform them of Mrs Lake's deterioration in health. I would have almost certainly informed them at the same time that I had administered another drug (in this case Hyoscine) and explained to the family the reason why another drug had been introduced."

It was just slightly confusing. The note is made at 1215 but the note that the driver was recharged does show that it was recharged at 1010. She says:

> Hyoscine is normally administered to a patient when they produce excessive excretions, eg, saliva and phlegm and they find it difficult to clear these secretions.
>
> Hyoscine helps to reduce excess secretions. It also acts as an antiemetic, ie, it reduces the feeling of nausea.
>
> It is worth noting that a common side effect of Diamorphine when administered is nausea.
>
> I am unable to state when these drugs were prescribed by Dr Barton as there is no date to indicate when the entry was made on the prescription chart.
>
> I must add that prior to administering the Hyoscine the dosage would be discussed between myself and the other trained nurse where it would be decided to administer what we felt was appropriate within the prescribed guidelines as set out by Dr Barton.
>
> My understanding with regards to any controlled drug which was to be prescribed to a patient would be recorded on the prescription drug chart and recorded in the Drs notes by the prescribing doctor. Firstly I would only check the drug chart when administering drugs.
>
> I did not as a matter of course check the entries made by the prescribing doctor in the doctors notes. In the case where it was a doctors signature that I didn't recognise then I would check the doctors notes.
>
> I have checked the doctors notes in relation to the patient Ruby Lake and cannot find any reference to drugs or the reason for prescribing drugs within the doctors notes."

Those you would find at page 78.

> "These drugs would only have been prescribed if Dr Barton felt it was appropriate to do so.
>
> The normal procedure for disposing of unused syringe driver controlled drugs was that they would be disposed of by two trained nursing staff. This procedure is done when it is felt that the dosage needs to be increased or amended prior to the syringe driver finishing within that 24 hr period.
>
> The same applies when a patient dies prior to the syringe driver finishing."

She talks about being shown the drug register book but in fact we are trying to stay with our prescription charts, and the relevant document would be 368E. She says:

> "... I can confirm that I have made the following entry [in the drug register book]:
>
> 20/8/1998 (20.08/1998) 0915, Ruby Lake, 20mg...

This entry shows that I have administered the drug, that it was witnessed by S/N [Staff Nurse] Shaw ...

I have made no other entries ...

...

B I can confirm that I withdrew the drug Diamorphine out from the dangerous drugs cupboard at 0915 .... which is verified by my entry ...

.... I have shown that the syringe driver containing the Diamorphine, Midazolam and Hyoscine was recharged at 1010, 20/8/98 (20/08/1998).

C I cannot recollect the reason for the delay between withdrawing at 0915 and administering at 1010 ... There are numerous distractions on the ward especially as I was senior nurse in charge.

I am inclined to say that it is possible that the time recorded in the nursing notes is incorrect and that I actually administered it at 0915."

D She then deals with her entry at page 395 on 21 August 1998 at 1855:

". condition continued to deteriorate slowly, all care continued. Family present all afternoon and present when Ruby passed away at 1825.

This entry is self explanatory...".

E She also deals with the note that she makes about the patient dying which perhaps I do not need to go through.

Patient G: again, there is a lot of preamble which I am not going to deal with. I am turning now to page 3 of 5.

F "I have been asked today about entries in the medical records of Arthur Cunningham ..."

This is our file G. She makes reference to page 831.

"The three entries dated 26th September 1998 were written by me.

Dr Barton wrote the prescription on the form of Diamorphine, Hyoscine and Midazolam.

G All three of these drugs were put into the syringe driver by me.

The syringe driver was already in place and I would have recharged it for twenty four hours over the 26th September, through to the 27th.

H

A syringe driver is a mechanical device normally placed in the stomach. It is batter powered and functions as a device to administer a regular dose of pain relief over a twenty four hour period.

By this date I was an E Grade RGN, a Senior Staff Nurse and was fully trained in the use of syringe drivers.

B I can say by reading page 831 that Dr Barton prescribed for Mr Cunningham parameters of 40 to 200mg of Diamorphine, 800 micrograms to 2g Hyoscine ..."

I do not think it can be that much –

" .. and 20 to 200mg of Midazolam, all to be given over a twenty-four hour period.

C I can say that at 1150 hrs on 26th September 1998 I mixed 80mg of Diamorphine, mixed with water, 1,200 micrograms of Hyoscine and 100mg of Midazolam. They were all compatible to go into a syringe driver.

This was all in accordance with standard medical practice.

D As a Senior Staff Nurse I would stand in for the Ward Manager or the more Senior Staff Nurse above me in the ward. I was in effect in charge of the running of the ward and this would include the administration of medication to patients.

Each of the above entries was initialled by me."

Then she confirms the notes made by her on 25 and 26 September at page 863. I will deal simply with that made on 26 September, if I may. The rest speak for themselves in any
E event:

"'Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. Mouth care given. Driver recharged at 1150. Diamorphine 80mg, Hyoscine 1200 micrograms, Midazolam 100mgs. No phone call from the family this am. Mrs Selwood phoned to enquire on condition.'

F All medication given to Mr Cunningham was within those parameters set by Dr Barton."

Then she says this:

"Any increases in the administration of medication would be discussed between the doctor, if available, and the senior nurse. If the doctor was not available the decision,
G based on staff experience and qualifications, as well as the patient's condition, would be determined by the two trained staff on duty."

She describes again how to use a syringe driver. Then:

"Further to the above I can confirm that the notes referred to by me ..."

H She is referring to the recharging of the syringe driver, which we have just dealt with –

"I have also been asked why the diamorphine was increased to 80mg on 26/9/98 and who made the decision to increase the dosage. I assume the increased dosage was because of increased pain and the decision would normally have been the doctors, although if the doctor were not available two trained members of staff who knew the patient could have made the decision, provided it was within prescribed parameters, which it was. This increase would have been over a twenty four period and is not excessive."

That deals with the statement of Sharon Ring.

MR FITZGERALD: Sir, lastly two statements from Ingrid Dawn Lloyd dealing with patient G, Arthur Cunningham. This I think – I will be corrected if I am wrong – is a statement that is being read on the basis that it is accepted the witness is unavailable and the statement could be read, but it is not agreed evidence.

MR JENKINS: I confirm that.

MR FITZGERALD: Dealing with Patient G, firstly the statement of 18 October 2005, Ingrid Lloyd sets out her background:

STATEMENT OF INGRID DAWN LLOYD, Read

"Between 1989 and 1992 I did my Nurse training at St Mary's Hospital Paddington and at Southbank Polytechnic London where I completed by Registered Nurse and HND Nursing training."

She then goes through her employment after that, saying:

"Between 1996 and 1999 I was a night Staff Nurse D Grade on Dryad ward at Gosport War Memorial Hospital where I was in charge of the ward in the absence of a senior member of staff.

.... my responsibilities included the administration of drugs, patient care and supervising patient care.

My line manager at the time was Gill Hamblin.

I did not receive training/certification in the administration of IV drugs.

I received mandatory training in the community regarding the setting up of syringe drivers; I believe this was at the Countess of Mountbatten Hospital. I received no certificate.

I have not heard of the term, the Wessex Protocols. I do however have a good knowledge of the analgesic ladder regarding pain relief.

The named nurse is a term that is not used on night duty, but it is the nurse who is responsible for the planning, administering and implementing a patient's care plans."

She says:

> "The term TLC, 'tender loving care' I am familiar with. This would indicate to me that this patient was getting towards the end of their life, and there was likely to be no rescue efforts to resuscitate them.
>
> The term 'I am happy for staff to verify death' I am familiar with, and understand it to mean that death was expected, and that there would be no need for a doctor to be called out during the night if the patient passed away. In a larger hospital this would not occur because there would always be a doctor on duty. GWMH is basically a half way house between a larger hospital and a patient's home.
>
> Ward rounds were not conducted during a night duty.
>
> I have been asked to detail my involvement in the care and treatment of a patient on Dryad ward named Arthur Brian Cunningham ... I have no recollection of this patient ... but I can state that on page 756 of the nursing notes which is a form 'Exceptions to Prescribed Orders' I have written ..."

This is page 756 of the nursing notes –

> " ... at 2200 on 21/9/98 that Co-Proxamol, Sinemet CR and Senna were not given, the reason being that the patient was sedated. This means that the Co-Proxamol was not given because the patient was sedated on the syringe driver and the Sinemet and Senna would to be appropriate also due to sedation.
>
> On page 758 of the notes is a prescription chart written up by Dr Barton. This was for a variable dose (20-200mg) of Diamorphine and a variable dose (20-80mg) of Midazolam. I have written on 21/9/98 at 2310hrs that I have administered 20mgs of Diamorphine and 20mgs of Midazolam ... I would think that I set up the syringe driver, but Fiona [Walker] and I would have given it together.
>
> On page 861 of the notes which is a patient summary regarding Mr Cunningham, I have written on 21/9/98, 'Remained agitated until approx 2030. Syringe driver commenced as requested. Diamorphine 20mgs, Midazolam 20mgs at 2300. Peaceful following.' I have signed this entry.
>
> Diamorphine used in a syringe driver is a faster way of relieving pain than drugs taken orally. The syringe driver administers drugs subcutaneously ... and may be used if the patient is comatose, or absorption of oral drugs was impossible i.e. if the patient had difficulty swallowing, or if the patient had a slow metabolism.
>
> In my experience, and with regard to recent research based evidence I have read, Diamorphine in a syringe driver is an excellent method of pain relief. In a variable dose prescribed of between 20 to 200mgs, the 20mgs administered was the lowest possible dose that could be given over a 24 hour period.
>
> Midazolam is a sedative.

Sinemet is used for Parkinson's.

Senna is a laxative.

The exceptions to prescribed orders was documented at 2200 on 21/9/98 in full expectation that a syringe driver was to be commenced at the earliest opportunity consisting of both Diamorphine and Midazolam which would negate the need for the other analgesic."

That is the end of her first statement. She has then made a supplementary statement dated 30 November 2005, in which she says:

"I have been asked to clarify the following points: with regard to the syringe driver my entry of the 21/9/98 ..."

This is the note on page 861 –

" ... with regard to the syringe driver my entry of the 21/9/98 is followed by an entry dated 22/9/98 made by Shirley Hallman. However this is a retrospective entry. I was aware from the verbal handover which took place at about 2015 hours on 21/9/98 that the incidents that are mentioned in Shirley Hallman's note had already taken place. It was with this knowledge that together with Shirley Hallman it was agreed that a syringe driver should commence. This was done so that Mr Cunningham remained in a pain free and peaceful state.

Although I have stated in the notes that Mr Cunningham was peaceful at 2030 hours it was not certain he would remain in this state. The syringe driver was not commenced until 2310 hours as it required two nurses and Fiona Walker wasn't available until this time as she had other duties to attend to as the night nurse in charge.

The purpose of the syringe driver was to enable a pain free and peaceful state for Mr Cunningham. With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Shirley and Fiona. The drugs were prescribed to be given at our discretion.

The term 'as requested' would suggest that I had had a conversation with another member of staff, possibly Shirley Hallman, however as I do not recall this I can't make further comment.

I wish to clarify the issue with regard to the Co-proxamol. In my previous statement I have said it was not given because the patient was sedated on a syringe driver. This is not correct. Firstly Mr Cunningham was not sedated. The reason the Co-proxamol was not given was because I was acting with the full expectation that a syringe driver was to be commenced at the earliest opportunity."

That is the end of those statements.

THE CHAIRMAN: Thank you very much indeed. We are almost within the time, but not quite. Thank you.

MR KARK: Just in terms of progress, we are I think very much on track on the reviewed the timetable. Tomorrow morning, we have Mr Daniel Redfern, who is an orthopaedic consultant. I do not think he will be very long. We then have Dr Reid, and I expect that he will be a relatively lengthy witness. He may finish tomorrow, he may not. Then on Wednesday we have Dr Tandy and Dr Ravindrane, Mr Samuel, who is one of the managers now at the Trust, and Rosie Luznat, about whom we have heard. Then on Thursday we hope to start with Professor Ford. As I flagged up last week, that will slightly depend on us having had the expert's report. If we have not had the expert's report in good time, we will have to ask for an adjournment.

MR LANGDALE: Sir, may I just indicate one thing which may slightly affect that timetable? You may recall some time ago, I think it was you who asked, as a result of comments made by us, about the two sides getting together to try and produce a kind of comprehensive chronology and history.

A lot of work has been done on that I know by Mr Fitzgerald and Mr Jenkins has been kind enough to work through it. Whether we absolutely reach a final agreed version – it is not a question of dispute about facts; it may be a question of disagreement as to quite what goes in it in terms of how full it should be – but I can see we may be asking perhaps for half a day just to make sure that is straight, because I personally think very strongly, and I think Mr Kark agrees, that for the Panel's assistance as well as for our assistance, when listening to Professor Ford's evidence, it is going to be pretty useful to have a history set out. It may prevent the Panel having to constantly look at entries.

It is bound to happen. Professor Ford is bound to have to look at entries on the individual files but I think in the long run it may save time. I just mention that as a possibility. We are doing our best to see that it is all settled before we get to Professor Ford.

THE CHAIRMAN: Thank you very much indeed, Mr Langdale. Anything that can be done to make things smooth and easy for the Panel is always going to be very welcome.

We will rise now and we will meet tomorrow at 9.30 am.

(Adjourned until Tuesday 30 June 2009 at 9.30 am)