GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 30 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 SIXTEEN)

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 everybody. Mr Kark, a quick bit of housekeeping, if I may. This Friday a member of the Panel needs to be away by about 3.30 in the afternoon. If there is any danger of that impacting negatively on the schedule, then the Panel would be perfectly prepared to sit longer hours in the run up to, and I will be guided by you as to when and if that is required.

MR KARK: First of all, I am sure in terms of overall impact that is not going to have a significant effect at all. It is a timely point at which to mention next week and Professor Ford. Today we have a fairly full schedule. Mr Fitzgerald is going to be calling the first witness Mr Redfern, and I may slip out of the room at that time while that is done. Then we are going to be hearing from Dr Reid. Dr Reid is a fairly substantial witness. You will recall that he was one of the consultants. Then tomorrow we may still have Dr Reid to finish. I do not know how long we will be with him. Then we have got Dr Tandy and others. Now, so far as Thursday is concerned, we certainly may start Professor Ford on Thursday, but you have heard Mr Langdale's suggestion, which I fully support. Mr Fitzgerald has done a huge amount of work on the chronologies and the defence are going through those at the moment. They have done some of them but not all of them, and are adding some details, I think, to those they have seen. Next week we have one, as I understand it, non-sitting day, which is Wednesday, because we are being moved out of here because it is required, I think, for a Council meeting. Then I ought to mention that Thursday, my current instructions are that Professor Ford is not available. He has some prior commitment. I have known about that for some time and perhaps I should have revealed that earlier. I am sure there will be other things that we can do and read, but we are losing two days in the middle of next week. Professor Ford is available, I think, until Monday the 13th. So we have got Friday, Monday and Tuesday of next week, Friday the following week and Monday the week after that, so we have got five full days to deal with Professor Ford's evidence, and, although he is a very substantial witness, I am reasonably confident that we will be able to finish in that period.

MR LANGDALE: May I just mention one other thing which may affect the order of events. At some stage before Professor Ford gives his evidence my learned friend I know is going to put in evidence the statements made by Dr Barton, which include a general statement of her position and individual statements with regard to each one of the patients. I am not suggesting that he calls a policeman, or whoever received the statements, to read them all out, but it is going to be very important for the Panel, before hearing Professor Ford, to have in mind the content of Dr Barton's statements, because, apart from anything else, I shall be putting certain matters from them to him. He, of course, has read them all, but I just think we ought to allow, in terms of the timetabling, for that to take place. It is not a matter of a half hour read.

THE CHAIRMAN: You are absolutely right, Mr Langdale. One of the unusual features of this case so far has been that we have not had the sort of gaps that often occur and which enable a Panel to keep up with its reading. I know there is a general feeling that we would welcome some reading time, just keeping up with the transcripts themselves. Normally, Mr Kark, it has to be said that GMC scheduling is not as efficient as yours has been, and your team are to be congratulated on that because you have kept it coming with no real gaps.

MR KARK: Well, perhaps there is advantage to inefficiency sometimes.

THE CHAIRMAN: Sometimes.

MR KARK: One of our difficulties is that because we have known of Professor Ford's time slots, as it were, we have had to keep things moving to get to the point where we can call him. Thereafter, I suspect, we can if necessary slow down a little because we still have a long time before the scheduled end of the case, but we will just have to deal with Professor Ford as best we can. I entirely accept Mr Langdale's point. You will need, I would suspect, at least half a day realistically reading Dr Barton's statements.

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THE CHAIRMAN: It sound as though towards the end of this week that time is going to be available to us. Even if we were to start the Professor a little later, at least we would be properly prepared for him, and I think Mr Langdale is absolutely right, we need to be in a state of readiness or else the first wave washes over us and we have not really taken it on board in the way we should, if I can mix the metaphor.

MR KARK: I accept that.

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THE CHAIRMAN: Good. Thank you. So, Mr Fitzgerald, you have a witness.

MR FITZGERALD: Sir, I do. Just before he is called, could I hand out, please, copies of the revised chronology for Patient I, Enid Spurgin, which is the patient the next witness deals with. (Same handed)

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THE CHAIRMAN: Mr Fitzgerald, we will just add these to the patient bundle without the need to give it a separate exhibit number. It will simply go in at the beginning of the bundle.

MR FITZGERALD: Thank you. This is the revised and agreed version which sets out almost all, if not all, of the relevant entries from the notes.

THE CHAIRMAN: I can see you really have done a great deal of work and we are most

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grateful for that. Thank you.

MR FITZGERALD: Certainly, sir. The next witness is Daniel Redfern, who is a consultant orthopaedic surgeon, who reviewed the notes relating to Enid Spurgin and provided an opinion. He did not deal with her himself. What I was going to suggest is that maybe the most efficient way of dealing with this is for he and I, and therefore the Panel, to go through this document briefly when he is called and familiarise the Panel with it in that way, rather

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than giving time at the outset for the Panel to just review it.

THE CHAIRMAN: We are in your hands absolutely.

MR FITZGERALD: Thank you very much. Could I just explain something about the chronologies in terms of the colour coding. The colour coding has only been used in terms of the drugs prescribed and administered. For example, if one looks at page 12 at the top, one

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can see that there is an entry on page 12 relating to Oramorph and co-dydramol. Entries in red relate to prescriptions and entries in blue relate to drugs administered. So that is designed to be helpful. Could I call then, please, Mr Daniel Redfern.

H

DANIEL REDFERN, Sworn
Examined by MR FITZGERALD

(Following introductions by the chairman)

Q Is your name Daniel Redfern?
A It is.

Q Is it Mr Redfern?
A Mr Redfern.

Q You are a consultant orthopaedic surgeon at the Royal Preston Hospital?
A I am.

Q You have been in that post since 1999, is that right?
A Yes.

Q Just a little more about your background: you qualified originally from Oriel College, Oxford, is that right, in 1980?
A Yes.

Q Where did you do your further medical training, please?
A St Bartholomew's Hospital Medical College in London until 1988.

Q What qualification do you hold, please?
A An MA, MBBS, FRCS and the FRCS Orthopaedics.

Q So a Fellow of the Royal College of Surgeons for Orthopaedics?
A Yes, two Fellowships: one is the standard Fellowship, and then there is the intercollegiate Fellowship, which is taken at the end of training.

Q You did your basic surgical training at St Mary's Hospital in London?
A Yes.

Q Then moved on for higher surgical training to the Hammersmith and Charing Cross Hospitals?
A I did.

Q Then, as you say, you have been a consultant surgeon, orthopaedic surgeon, in Preston from 1999?
A Yes.

Q Is it right, Mr Redfern, that you were asked in 2006 by the Hampshire Police to provide an expert report into the care provided, from an orthopaedic point of view, in relation to Enid Spurgin?
A Yes.

Q You produced a report dated 22 January 2006, having been provided with the medical records and reviewed them, is that right?
A Yes.

Q Would you find it helpful in giving your evidence to the Panel to be able to refer to your report?
A Yes.

MR JENKINS: There is no objection.

MR FITZGERALD: Sir, I am sure that for large parts of Mr Redfern's evidence he will not need to do that, but there may very well be points where it would be helpful, so I am grateful for that.

THE CHAIRMAN: In the absence of objection from the defence I see no difficulty with that.

MR FITZGERALD: Thank you. Mr Redfern, you have also been provided this morning with a chronology, have you not, about what happened in relation to Enid Spurgin?
A Yes.

Q Have you had some time to look through that?
A I have.

Q For your benefit the Panel also have that, and what we will do in a moment is just to go through it to look at the relevant entries from your point of view.
A Okay.

Q You were asked in 2006 to consider a number of different issues, some of which are relevant for us and some of which less so, but so the Panel are clear on the exercise that you have performed were you asked to address, first of all, whether or not Enid Spurgin suffered after her admission to the Haslar Hospital in this case from something called compartment syndrome?
A I was.

Q As a result of the operation that took place to her fractured neck of femur?
A Yes.

Q That was an issue that really related to her treatment at the Haslar Hospital?
A Yes.

Q Could you just help the Panel immediately with what compartment syndrome is?
A Compartment syndrome is a condition which arises most commonly after trauma or surgery. The segments of a limb are bound within a tight containing structure called fascia, which binds the soft tissues and the bones together under the skin. If you develop swelling within that tight fascia, then the pressure within that area builds. If the pressure builds sufficiently, then the return of blood from that segment of the body is obstructed. As a consequence, the blood coming in is also secondarily obstructed at the point of the micro circulation, which is where the blood vessels become very small. If that happens, then the tissues in that area lose their oxygen supply and the cells will swell. This worsens the

problem because it increases the pressure in the compartment. If left untreated this condition can lead to muscle and nerve death within the compartment and loss of function in the limb, or compartment of the limb. I hope that is reasonably clear.

Q I suspect it is. You make your point in your report in terms of why this really is an issue that is more relevant to the treatment at the Haslar Hospital. This is something that would arise in reasonably short order after an operation?
A Either after trauma or after an operation, yes.

Q And so for the Panel's benefit, it is not such an issue when we come to her treatment at the second hospital, the Gosport War Memorial Hospital?
A The issue would have been only the sequelae of a compartment syndrome rather than the diagnosis of the compartment syndrome itself.

Q Very well. By that point the damage from compartment syndrome is done?
A Is done.

Q Also for the Panel's benefit, I think it is right to say that from your analysis of the notes, you are unable to say that this patient did have compartment syndrome but it was a possible diagnosis?
A Yes.

Q You were also asked, though, to consider other issues. Firstly whether in your view it would have been reasonable to expect a doctor – one of the doctors who were treating this lady – to refer her for further orthopaedic review after her operation in the light of the symptoms that she showed?
A Yes. I was.

Q You were asked to comment on the possibility that the pain that Mrs Spurgin suffered was due to any reversible post-operative complication?
A Yes.

Q And you were also asked to comment on the antibiotics that were used to treat Mrs Spurgin and whether they were sufficient in your view?
A Yes.

Q Those are issues which are relevant to both hospitals but certainly relevant to the treatment at the Gosport War Memorial Hospital. When you were looking at the records of Mrs Spurgin to inform you in making your report, is it right that you were concerned particularly to see, first of all, the details of the operation she went through and then also signs of further pain, discomfort, swelling – matters of that nature – after the operation?
A Yes.

Q What I will ask you if we can do is to go through this chronology now, to just look at the relevant points. There may be one or two moments while I just ask for your comments and refer you to your report. To run through the most relevant points from the chronology, we can see from the first page and the first entry that it was on 19 March 1999 that Mrs Spurgin was admitted to the Royal Haslar Hospital following a fall. It caused a right subtrochanteric femur fracture.

We know, moving on to page 3 – do you have page 3 of the chronology?
A Yes.

Q At the top of page 3 we see that surgery was carried out. This was the next day, the 20th, under spinal anaesthetic with the insertion of a right dynamic hip screw. There was a blood transfusion that was given. Then there was a post-operative review that day by a senior house officer that there was a lot of ooze from the wound, that the thigh was about two times the size of the left thigh, and there was an issue of whether there was a haematoma, and the patient was complaining of discomfort in the leg and pain on palpation. I think you made a point in your report, that it was quite a complicated fracture and quite a complicated operation that this lady underwent?
A Do you wish me to expand?

Q Please, yes.
A In the scheme of fractures around the neck of the femur, which is the hip, the subtrochanteric fracture is probably the most difficult of the three sub-types to deal with. It is difficult to reduce. It is difficult to fix and the fixation has a higher propensity to fail than standard fractures.

Q This may be relevant to the point we will come onto, but when you say "a propensity to fail," what does "fail" mean in this context?
A Failure would usually involve some breakdown in the interface between the implant and the bone, so that the plate may pull away from the side of the bone to which it is fixed. May I stand up?

Q Yes, if you are more comfortable, I am sure. (The witness did so)
A It is fixed down the side of the femur here (indicating) and then there is a screw that passes up into the hip bone itself, so the plate can either pull off in *this* direction (indicating), or alternatively the screw can cut out through the femur superiorally, going towards the head. So those are the two commonest modes of failure. (The witness sat down)

Q So literally the fixation between the bones is ---
A It either pulls away from the bone, or it cuts through the bone.

Q That will have inevitable consequences in terms of pain and mobility?
A Yes.

Q Moving on, we can see that on this day – the day of the surgery, at the bottom of the page – paracetamol was administered and also morphine for pain relief?
A Yes.

Q Unsurprising on the day of operation?
A Perfectly standard.

Q Moving over to page 4, it is now 21 March. The first entry deals with the morning: "Seen by doctor today" – the X-ray was checked and was okay.

"Mrs Spurgin able now to get into chair. Please give morphine before moving Mrs Spurgin – a lot of pain on movement."

We can see at the bottom of the page that again morphine was being administered that day. Again, this is the day after surgery. Would that level of pain be unusual?
A That would not be unusual.

Q You make a point in your report about the reference to an X-ray being checked and being okay. First of all, in terms of the fixation, in terms of the surgery, what does that reference tell us about at that stage?
A It states that the doctor reviewing the X-ray was satisfied both with the position of the implant construct on the bone and also with the position that the bone had been put into, which is termed its reduction. So the bone had been satisfactorily straightened and fixed.

Q You make a point in your report about this being on your analysis of the notes, the only reference to an X-ray actually being checked in relation to this patient?
A Yes. There were no X-ray reports and I did not have the opportunity of reviewing any X-rays personally.

Q The Panel will know that there is later at Gosport War Memorial Hospital a request by a Dr Reid for another X-ray to take place, but on your analysis of the notes that does not seem to have been followed up. Is that right
A I could not find a record of that X-ray having been taken or reviewed.

Q Moving on with the notes, in the middle of that page, page 4, I would just point out that the last three lines of that entry say that the right hip is painful +++, no ooze, but thigh enlarged, possible bleed into thigh but no evidence of hypovolaemia. The hip was still painful but that was not very surprising given how recent the operation was?
A It is not surprising. If you read the contents of my report, I was concerned that the issue of compartment syndrome was raised but not acted upon.

Q This is relevant to the criticism that arose in your report of the treatment at the Haslar?
A Yes.

Q That this should have put people in mind of ---?
A Compartment syndrome.

Q Very well. Particularly in light of the pain and the swelling that was occurring?
A Yes, and in the light that one doctor had actually made that diagnosis.

Q Yes. That is a note that has not been included in the chronology because it is not so relevant from our point of view but it features in the notes from the Haslar. Moving on to page 5, the next day, 22 March 1999, in the middle of the page, the second entry:

> "Sat out by physios. Drinking and eating much better today. Oral fluids pushed."

And it is paracetamol that is being administered that day.

The next page, 23 March, a couple of lines down, a.m. –

> "Moved patient to chair with 2 assistances. Patient has difficulty and pain ++ with mobility."

Then the last couple of lines at 19.53:

> "Transferral and mobilising not well. No ooze on wound on hip."

Still it is just paracetamol being administered.

We move on over the page to the next day, the 24th. There is a review by Dr Reid, consultant, who also saw the patient at the Gosport War Memorial Hospital. Dr Reid pointed out:

> "Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful."

He wanted to be reassured that all was well from an orthopaedic viewpoint. He was saying if it was, he was happy for transfer to take place to the second hospital.

If we move on over the page, again just paracetamol that day that was being administered. The next day, the 25th, there is a note on the ward round that the right leg had increased swelling, the skin was fragile. A haematoma had developed and broken down.

Go over the page, please, to the top of the page. This is the last day the patient was at the Haslar Hospital. From the nursing notes, the patient was mobilised to the commode with two staff. The last line there is that she was very reluctant to mobilise. "Needs encouragement." Still just paracetamol being given though.

Then it was the next day, the 26th, that we can see that the transferral took place to Dryad Ward at the Gosport War Memorial Hospital. There is a note in the transfer letter there saying that the patient was now –

> "... mobile from bed to chair with 2 nurses and can walk short distances with a zimmer frame."

It also pointed out that the right lower leg was very swollen and there was a small break in the skin. The only medication is analgesia PRN. On the 26th she was transferred.

Going over the page to page 10, that day three was a review by Dr Barton. Dr Barton noted effectively she was not weight bearing, and that there was a plan to sort out analgesia. In the second entry on that page from the nursing notes, it is pointed out that transfer had been difficult since admission.

> "Complained of a lot of pain for which she is receiving Oramorph regularly now, with effect."

The legs are swollen. The last few entries relate to the night time:

> "Requires much assistance with mobility at moment due to pain/discomfort. Oramorph ... given...".

Over the page:

"Oramorph given for pain in hip
Experiencing a lot of pain on movement"

We can see from the entries relating to the drugs that were given that there were four doses of Oramorph given that day.

Over the page to page 12, the 27th, Oramorph continued and also co-dydramol prescribed and the nursing notes states:

"Is having regular Oramorph but still in pain.
... In some pain, needs 2 nurses to transfer at present."

The next day, the 28th, Oramorph and co-dydramol both given. Moving through the next few pages quite quickly, page 13 on the 29th March, co-dydramol only given.

On the 30th, over the page to page 14, again co-dydramol given. In the nursing care plan it is observed that both wounds are redressed.

"Steri-strips from surgery removed. One small area near top oozing slightly...".

The next day, the 31st, Oramorph given again, a small dose and co-dydramol and MST – so slow release morphine – then prescribed for the first time and two doses administered.

We go over the page to page 15. At the top there is a nursing entry that the patient was now commenced on the MST.

"Walked with the physiotherapist this a.m. but in a lot of pain."

The next day, 1st April, the second entry is from the nursing care plan. There was a wound in the right hip oozing large amounts of serous fluid and some blood, and a hole was noted in the wound. Still having pain on movement.

You made a comment in your report about what this sort of oozing of serous fluid might indicate. Can you help us with that, please?
A I will just refer to my report.

Q It is page 11 of your report, just a few lines down from the top.
A Sorry – just to check. Leaking from a wound at this time following surgery would suggest that there was either a clot that had formed within the leg – and I differentiate this from a venous thrombosis. It is a different kind of thing. This is a post-surgical collection of blood. What happens is that over the course of a number of days after surgery it will liquefy, and then it will drain through if there is a patency in the wound. The alternative is that there was an infection on the implant and that this was discharge from that infection.

Q You have described that as a potential deep infection?
A Deep infection.

Q Because not just on the surface of the wound but actually inside?
A Inside, presumably right down to the level of the implant.

Q Just moving on, it was the most that was given that day, on 1 April. Then going over the page to page 16 on the 2nd, the next day, again MST given, and on the 3rd. There is a nursing entry for the 3rd, that the patient was still continuing to complain of pain on movement. Then on the 4th, there is a nursing entry that the wound on the right hip was oozing serous fluid and blood, as before, it would seem. MST was again administered.

Going over the page to the 5th, again MST administered. Then the next day, the 6th, there was a review by Dr Barton. That entry in itself is not particularly relevant to us, other than that the MST dose was increased to 20 mg. The next entry relates to swabs being taken from the suture line on the right hip and the right calf. Then there is a microbiology report coming back. The fact that swabs were taken would indicate that that was action being taken in respect of the potential infection. Is that right?

A Yes. It would suggest that there was suspicion of an infection.

Q The microbiology report is our page 57. It might be helpful to look at it briefly. Next to you there are a number of files on your left. Can you take out the file marked "I" – which is different from the filed marked "1".

A Yes.

Q Would you turn to page 57. The pagination that we are using is the one at the very bottom of the page with a dash either side. That is the microbiology report. That seems to have been the result of these swabs being taken. Does that seem to make sense to you?

A That would fit. Date received, 6th of the 4th.

Q So that would fit?

A Yes.

Q Date reported, 9th of the 4th. Does that mean the date that this report was actually made?

A The date that the microbiologist made the report was the 9th of the 4th.

Q Can you help us with the infection that was found? You made a point in your report about whether this would be considered a particularly serious or dangerous infection.

A There are two organisms. May I just check my report on that?

Q Of course.

A One is staphylococcus aureus and one is staphylococcus epidermidis. Staphylococcus aureus is a typical pathogen for causing wound infection. Staphylococcus epidermidis is usually a skin commensal, as the name suggests, on the epidermis. A commensal is an organism that lives ordinarily on the surface of the skin without causing problems. It is of theoretical importance in orthopaedic implants, but here, no sensitivities have been given for it. The sensitivities for staphylococcus are typical: flucloxacillin, erythromycin and, quite surprisingly, penicillin, because staphylococcus aureus is not usually sensitive.

Q In fact, when you reviewed the issue of whether the treatment for infection that was given at the Gosport War Memorial Hospital and whether the drugs that were used were satisfactory from your point of view, your conclusion was that it may not have been the perfect solution, but that it was satisfactory from your point of view; it was not something you would criticise. So we may not need to go into that.

A I am sorry, this is why I was looking through my report. I think they commenced on ciprofloxacin, metronidazole, which is a reasonable best guess, because the patient was incontinent of urine, although not of faeces as far as I am aware. So it was a reasonable best guess.

Q If we go over the page in our chronology to page 18, we can see these drugs being commenced. On page 18, the first entry there is the drugs that were given on the 6th, but on the 7th we can see there is an entry that the fracture site was red and inflamed, she was seen by Dr Barton and that those two antibiotic drugs were commenced: metronidazole and ciprofloxacin.
A Yes.

Q Ultimately, when you were giving your opinion on the prescription of those antibiotics, it was your view that that was a satisfactory approach?
A I think I also said, however, that the antibiotics should have been changed on receipt of the report.

Q Can you help us with why that is?
A The organism staphylococcus aureus is not sensitive at all to metronidazole. The antibiotic ciprofloxacin is a broad spectrum antibiotic which is less effective against staphylococcus aureus than antibiotics such as flucloxacillin and erythromycin, both of which are very good anti-staphylococcal agents.

Q We have seen that the report was only made on the 9th.
A Yes.

Q Just moving on to finish the relevant entries from the chronology, on the 7th, the last entry is a review by Dr Reid. That is the consultant who had seen the patient prior to her transfer to the Gosport War Memorial Hospital, and his entry was that the patient was still in a lot of pain and very apprehensive. He has said:

> "For x-ray Right hip as movement still quite painful – also, about 2" shortening Right leg."

You referred to this earlier in your evidence in relation to there being a further request for an x-ray. You dealt with this at page 10 of your report. From the note about the movement still being painful and the shortening of the right leg, what concerns would that raise?
A My concern would be, given that picture, that the implant had failed.

Q Is the level of pain that the patient had been in which was registered in the notes and which seemed to be continuing after the operation and in the second hospital, and the difficulties in mobilisation, would that be normal if the fixation was working properly?
A In a sound fixation and in the absence of other complications, you would expect the analgesic requirement to diminish and the ability to mobilise to improve steadily until an end point is reached.

Q So what concerns would have been raised by continuing pain and lack of mobilisation?
A In the first few days after surgery, there was the concern of a compartment syndrome causing pain in the thigh. Compartment syndrome is a very painful condition. After 48 to 72

hours, the pain of compartment syndrome recedes and the likelihood of that being a reasonable cause for her pain recedes at that point. From then on, really at no time does she demonstrate improvement in terms of her general levels of pain as far as I can establish. There is a brief period while she is at Gosport when her analgesic requirements come down to a paracetamol requirement, but it is always documented in the case records that it is painful for her to mobilise.

B Q What concerns does that raise?
A That would worry me that the implant fixation was not adequate.

Q Is this entry by Dr Reid about the shortening of the right leg further evidence of that?
A It is quite strong evidence of that. The hip should not be short by that degree. That is about 5 centimetres. That is a long way short.

C Q By this stage, some two or so weeks or a little bit more after the operation that this patient underwent, would it be common or uncommon for the patient still to be requiring morphine?
A That would be very uncommon in my experience in the context of an adequate fixation.

D Q Moving over the page in the chronology, on page 19 we can see that on that day, when the review by Dr Reid took place, again MST was given and on the 8th MST was given again. He records:

> "Wound oozing slightly overnight. Redness at edges of wound subsiding."

On the 9th, MST was given again and it was recorded by the nurses:

E > "To remain on bed rest until Dr Reid sees the x-ray of hip."

As you said before, I think there is no sign in the notes that that x-ray was done or reviewed by anyone.
A I could not find a record of the x-ray having been taken. It would be logged initially in the x-ray department, but there was certainly no report.

F Q Over the page to page 20, on the 10th MST was given again and in the nursing notes it is recorded:

> "Very poor night. Appears to be leaning to left ... Stitch line inflamed and hard area. [Complaining of] pain on movement and around stitch line. Oramorph 5 mg given at 07.15 hrs."

G For the Panel's benefit, I should point out now that that 0715 entry would in fact be on the next morning. If it is helpful to write that in, it would in fact be on the morning of the 11th, because this is an overnight entry. Then moving on to 11 April, in the first entry there is another reference to pain on movement and Oramorph being given at 0715. She was complaining of tenderness around the wound, there is a review by Dr Barton, it seems, a reference to the condition of the patient deteriorating and:

H > "The patient denies pain when left alone, but complaining when moved at all."

Then there is a note there that the patient may be commenced on a syringe driver and that is what took place the following day. I think for our purposes at the moment, those are the relevant notes we need to look at. As we have gone through, we have already commented on a number of the significant points, but if I could just move on to the opinion that you express having looked at the records. I think it is right to say that when you set out your view in your report, you have made some points about ways in which you were hampered initially and it is right to say that you felt you were hampered by not having had sight of any relevant radiographs of radiologist's reports. So x-ray reports.

A Or preferably x-rays.

Q Or x-rays themselves. But you did of course take account of the fact that there was the initial reference to the x-rays being okay and then the fact that later at the Gosport War Memorial Hospital, although there was reference to the fact that an x-ray should be carried out, there was then no further reference to it.

A Yes.

Q You also felt limited in what you could say because of the fact that there was no post mortem examination.

A Yes.

Q Therefore is it right that in looking at what the diagnostic possibilities were, you could only give possibilities, rather than firm conclusions.

A A range of possibilities.

Q But you were able at page 14 to set out what in your view that range of diagnostic possibilities was. There are three I think. Can you just help us with what those were?

A They were an untreated compartment syndrome, a failure of the operative fracture fixation and a deep tissue infection or abscess formation.

Q You went into some depth in your report about compartment syndrome and about the failings at the Haslar Hospital.

A There is a much better definition of compartment syndrome there than I gave half an hour ago.

Q That may be the case, although for my part it was sufficient for us and in fact, as it is not a criticism that you would level at the Gosport War Memorial Hospital in any way, I am not proposing to ask you more about that. From the bottom of page 17 of your report, in the final paragraph, you did have some conclusions that may be relevant for us. What is your opinion in terms of whether it would have been reasonable for any of the doctors who were looking after this patient to have considered the issue of the failure of the fixation of the fracture?

A The fact that she remained in pain throughout the entire episode. I could understand her not being able to mobilise because of general debility – it is not uncommon in patients with femoral fractures of this kind – but for mobilisation to be painful and to continue to be painful and to fail to improve would have concerned me, certainly by the end of the first week.

Q So after that and whilst she was in the Gosport War Memorial Hospital, what is your view on whether consideration should have been given to that?

A It is consistently mentioned in the nursing records and in the medical records that she finds it painful to mobilise. Now, that really should not be happening at that point and the correct thing to do at that point would be to put her on to bed rest, take an x-ray and check that the implant fixation is sound.

Q Is that something that you suggest would be an appropriate course of action for just an orthopaedic doctor or for any doctor having the care of this lady?
A I train non-orthopaedic, non-surgical doctors at a very junior level: first and second year post qualification, and I would expect any of them to execute that course of action.

Q Would that course of action have been confirmed as necessary by the review by Dr Reid in terms of the shortening of the leg?
A It appears that – one can only surmise, but he makes the comment that the leg is shortened and requests the x-ray. So it would seem that it was fairly much in the fore of his thinking.

Q In terms of the treatment for a possible deep infection at the Gosport War Memorial Hospital, what was your opinion on ultimately whether the treatment given was appropriate or not?
A My conclusion was that the choice of antibiotics given at the beginning was reasonable, given the context of the patient as far as I could understand it from the case records. I would have reviewed the antibiotic medication on receipt of the microbiology report and at that time stopped the metronidozole and started flucloxacillin, but continued with the ciprafloxacillin.

Q You make a point in your report about appropriate secondary investigation.
A Yes. If the possibility of a deep infection or abscess were entertained, then the best investigation would be an ultrasound scan of the thigh.

Q Who would that be referring to?
A The actual ultrasound would be done by a radiologist, but it would be requested by a doctor. May I expand on that a little?

Q Yes, of course.
A I think that that is something that might not fall within the scope of a non-orthopaedic doctor.

Q In terms of evaluating it?
A Evaluating and recognising that it might come back to an orthopaedic opinion before an ultrasound would be requested. So it might have to come back to orthopaedics and at that point I imagine that investigation would have been requested.

Q That rather leads on to the next question, which is whether it would have been reasonable to expect a doctor at the Gosport War Memorial Hospital to have referred this patient back for an orthopaedic review in light of the symptoms that she was displaying?
A Yes, I think that would have been the reasonable course of action.

Q You commented in your report, and it is the bottom of page 18 and then on to page 19, about whether these possible diagnoses were reversible. Can you help us with that?
A Do you want me to comment on the compartment syndrome?

Q No, not for my purposes.
A The failure of the implant fixation is reversible. It is reversible by revision surgery. It is not common, but there are standard procedures in place for that. The deep infection is reversible as long as the infection does not get completely set on the implant. The difficulty with implants is that they do not allow blood into them, unfortunately, so you can very rarely completely eradicate an infection from an implant. You can keep it under control. So it is reversible to that extent.

Q In terms of controlling somebody's pain, or improving their mobility, is that something that can therefore be helped in that regard?
A Yes. There is a spectrum of infection from the more superficial and less serious infections which can be dealt with by antibiotic treatment, either by tablet form or intravenously, or if infection has become serious, or if abscesses develop, then surgical treatment of an infection may be necessary.

Q On page 20, your second paragraph on page 20, you make some conclusions about treatment at the Gosport War Memorial Hospital. Could you help the Panel with your view on what diagnoses there should have been, whether they are differential diagnoses or not, and what action should have been taken?
A The two possibilities that I reached for a differential diagnoses were that the implant had failed or that she had an uncontrolled infection, or indeed possibly both, which I do not state explicitly. I said that as a consequence it would have been prudent for further orthopaedic opinion to be sought.

Q Further investigation to have been carried out?
A Further investigation by way of a plain X-ray or an ultrasound of the thigh.

MR FITZGERALD: Yes. Very well. Those are all my questions, thank you, but there will be some more.

THE CHAIRMAN: I think we have reached the point, Mr Jenkins, at which we will give the witness a break. You have been on the stand for an hour.
A Have I?

THE CHAIRMAN: It sometimes passes very fast, does it not? I will try and break at about this sort of interval, but I should tell you that if at any time you feel in need of a break you only have to say so and we will adapt to your comfort and convenience, but for now you remain on oath, the Panel assistant will take you somewhere where you can get some refreshment, and we will return at 5 minutes to 11, please. Thank you. I should say please do not discuss the case with anybody. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Jenkins, I stopped you before you could start.

Cross-examined by MR JENKINS

Q You are refreshed now, Mr Redfern, so you are ready to deal with me. I have not got many questions, but can we just go back over the history for this lady.
A Yes.

Q She broke her hip on 19 March. We see that on the front page of the chronology. We know that by the 24th, this is page 7, and we see the date on the previous page (page 6) the date is given as the 24th, there is a ward round at the Haslar Hospital and a Dr Lord is being suggested as someone who can undertake an assessment. We have Dr Lord's assessment over the page at page 7, and then Dr Reid's assessment. So this is five days after her fall.
A Yes.

Q Dr Reid, we have already noted, and it is recorded in the entry on page 7, that he is asking for reassurance that all is well from an orthopaedic viewpoint; if all is well, then he would be happy for her to be transferred to the Gosport War Memorial Hospital. Your point, I think, is that this lady was not properly investigated whilst she was at the Haslar.
A In the context of what, the implant---

Q Well, I think the way you have put it in your report, which the Panel do not have, you say that it is of grave concern that no further action seems to have been taken in relation to the diagnosis of compartment syndrome, looking at page 19.
A Yes. In relation to the diagnosis of compartment syndrome?

Q Yes.
A That is why I asked in what context. Yes.

Q You say:

"In my opinion this lady had a significant bleed into her thigh in the early stages post-operatively" -

we are talking about the few days after the operation.
A Yes.

Q "and the possibility of compartment syndrome was raised. Once the diagnosis of a compartment syndrome had been considered" - in other words raised – "then it is of grave concern" – your words – "that no further action seems to have been taken in relation to this potentially serious diagnosis."

The suggestion I have made is that this lady was not investigated as thoroughly as she could or should have been at the Haslar Hospital.
A She probably did not even need to be investigated further. To explain the management of compartment syndrome---

Q Right.
A ---it is a clinical diagnosis. Really, almost once the possibility has been raised that a patient has compartment syndrome, then there is an obligation to act upon it.

Q What you have said in your report is that you would expect a basic level surgical doctor, junior doctor, to be able to make the diagnosis.
A Yes.

Q But that a GP perhaps would not be in that position?
A A general practitioner might not be in that position.

B Q The time that that should have been considered properly was when Mrs Spurgin was at the Haslar Hospital?
A Yes.

Q It is not apparent that it was.
A That would appear to have been the case, I agree.

C Q Again, Dr Reid indicates that he was seeking reassurance that everything was well orthopaedically. It was not in your view?
A That was at five days after the surgery. The issue of the compartment syndrome was a few days before that, if I could just refer back to the chronology.

Q Please do.
A Yes, it was the 21st, which is sort of 48 hours post-admission and 24 hours post-
D operatively approximately. That is when the issue of compartment syndrome was raised.

Q Right.
A The issues related to compartment syndrome would probably have blown over by four or five days after the surgery.

Q Okay.
E A That episode would have been completed and the damage done.

Q Okay. You also say, and I am just going on in your report:

"Mrs Spurgin's early failure to mobilise and the pain that she described consistently on moving her injured leg should have given the doctors caring for her at Haslar sufficient reason to consider appropriate investigation by way of a further plain x-ray
F of the hip and thigh."

A Yes, I think that is fair.

Q "This would have eliminated the possibility of fixation failure."
A Yes, at that point.

G Q You say:

"It seems from the medical record that these issues occurred prior to transfer to the Gosport War Memorial Hospital."

That, it would appear, was not really done.
A Yes, that would appear to be.

H

Q Does it follow that if you had been treating this lady you would not have been in a position to give Dr Reid the reassurance he was seeking?
A I do not think I would.

Q Now, would it be your view that this lady was transferred out of the Haslar Hospital before properly she was ready for it?
A I would say that she was.

Q Yes. Once she arrived at the Gosport War Memorial Hospital, it is clear that this lady was still reluctant to mobilise and in a great deal of pain.
A Yes.

Q We know that she was given medication for the pain and swabs were taken. We have indications of that on the notes. If you turn, please, to page 17 of the summary, we see in the nursing care plan that swabs were taken. We have got indications in the medical records that those were sent off for analysis. If I can invite you to turn to the medical records for this patient, Patient I, if you still have them, and if I can invite you to turn to page 59 we will see that this is one report, and from the bottom left hand corner we see that this is a wound swab from the calf.
A Yes.

Q It is collected on 6 April 99, so that ties in with the date that we have just looked at on the chart. We will see, as we look along the bottom line, it is reported on 8 April, and we see a stamp when it is received on the ward. That would be typical, I think, a stamp or a date to be written on?
A Either when it is received or when it has been reviewed. It depends on the practice.

Q You would expect a doctor, when they review a result such as this, to initial it or sign it to say that they have seen it?
A Yes.

Q The Panel will hear in due course that that is Dr Barton's initials, which she entered. We see that it comes back, or is seen on the 9th. This is headed "Provisional Report!" We see that the culture result shows that staphylococcus aureus is isolated but that sensitivity tests were to follow; staphylococcus epidermidis again isolated. I think we have to look at the preceding page, page 57, to see when those sensitivity tests were reported. It took an extra day for that to be reported. The stamp at the bottom of the sheet, the date reported is 9 April.
A Yes.

Q The Panel will hear, I think, that the weekend (Saturday and Sunday) was 10 and 11 April. Signed by Dr Barton, and it is stamped as seen or received on the ward on 12 April, so a Monday?
A Yes.

Q What you have told us was that the antibiotics introduced by Dr Barton, we have them on the summary at page 18, you have told us that those antibiotics – metronidazole and suprox we have called it on the summary – those were a good best guess at that stage.
A Yes.

Q We know, because we have just seen the results, that the swabs have not been reported on by 7 April.
A Yes.

Q We will see from the next entry down that:

"Commenced antibiotics as hip wound may be infected."

That was the view, I think, at that stage?
A Yes.

Q These antibiotics were brought in to deal with the infection that was probably there, but had not been identified.
A Yes.

Q What you have told us is that it might have been appropriate to review the antibiotics once the results had come in.
A Yes.

Q We know that was by 12 April. I think if one follows through the chronology, we will see that on page 20, on the night of Saturday, 10 April, it looks as if this lady had a stroke.
A I cannot comment on that.

Q All right. Her condition was very poorly on the 11th. The entry that we have in the summary, relating to page 134, suggests that she was seen by Dr Barton. I am going to invite you and the Panel to turn up page 134, because it may be that the entry needs a bit of explaining.
A This is still in file I?

Q It is still in file I. There are two page numbers at the bottom of page 134. The other number is in a rather fatter pen, 107.
A Got it.

Q What we see for 11 April 99 in this nursing summary document is an entry which would appear to be written after 7.10 p.m., because it starts by relating something that happened in the evening on that Sunday night. The inference I suggest to be drawn is that this is an entry made by night staff, and we will see the very end of what the night staff entry is, the very last thing they write is "Seen by Dr Barton". I do not know that you can comment on it, Mr Redfern, but I am going to suggest that that was Dr Barton seeing the patient first thing on the Monday morning. It is the last thing that the night staff saw at the end of their shift. Again, we have to go back to page 57 because we know that the pathology report was seen or arrived on the ward on 12 April, and that is when Dr Barton signed it.
A Yes.

Q You have told us that it would have been appropriate to alter the antibiotics once that report had come in, and I think what we see is that the consultant Dr Reid is reviewing the patient again on that day, page 136, just after the 134 that you were looking at, yes, but I think what we have is a full clinical picture of this lady, that she is in a very poor condition, and I think it may be you would agree that the orthopaedic considerations were not at the front of the consultant's mind?

A That might be reasonable, but again it is difficult for me to comment without---

Q I understand. So far as an X-ray is concerned, you have said that an X-ray was clearly sought. If we look back at the summary, page 18, swabs had been taken on 6 April. The summary, page 18, deals with the day after that. We see the entry in the clinical notes. Dr Reid, the consultant, has ordered an X-ray. If we are able to go back to page 134 of the notes, we see in a little more detail as to when the X-ray was actually booked for.

A Yes, I have that.

Q It is just about a third of the way down the page. It is the entry for 7 April. It reads:

"[Seen by] Dr Reid. For X-ray tomorrow at 15.00 hours".

A Yes.

Q Obviously the 8th. But you have not seen an X-ray that relates to the X-ray that was booked. If we go back to the summary, page 19, if you would, the bottom of the page, we see entries indicating Dr Reid wanted the patient to stay on bed rest until he saw an X-ray of the hip. You told us that was the way in which you would want to see the patient managed?

A Yes.

Q Off her legs?

A Yes.

Q Until the X-ray was undertaken and reviewed?

A Yes.

Q That clearly was the plan. That was a Friday. Dr Reid was due to come in on the Monday for a ward round and we know that he did by Monday the 12th. Again, it may be that the X-ray was not in the forefront of the mind, given this lady's condition. She was to die that night.

A We do not actually know whether the X-ray was taken.

Q We have not seen an X-ray in the records.

A So we do not know whether the X-ray was actually taken.

Q No. I think that notes that we have do not indicate that it was or was not taken, or if it was not, why it was not. Can I ask, if this lady was to be reviewed by an orthopaedic surgeon, you would anticipate in a community hospital she would have to be transferred back to a hospital such as the Haslar?

A I do not know what the local arrangements are at the Haslar. There are two ways of doing this.

Q One way is to ask a surgeon to come in?

A Yes.

Q What I am going to suggest is that in practice she would have had to be transferred?

A What – as an inpatient?

Q That surgeons from the Haslar would not have wished to come over to the Gosport War Memorial Hospital to review a patient.
A Then she could have been seen as an outpatient or in an outpatient clinic.

Q I understand. At the time that would have been on 12 April?
A There is ample opportunity before that for her to be seen. This process began long before the end of April.

Q I understand. What would have happened if this lady had been sent back to the Haslar Hospital? Would it have required a re-exploration of her hip?
A On the assumption that there was a failure of fixation, then there would have been an evaluation of her general fitness to go revision surgery.

Q Yes?
A And had she passed that assessment, which is usually done by the anaesthetist who is schedule to do the surgery, then she would have undergone revision surgery.

Q That evaluation is very important?
A Yes.

Q Because decisions have to be made about what is in the patient's best interest?
A That is correct.

Q If a patient is elderly, in poor physical shape, it may well be thought this is not in the patient's best interests to undertake surgery under general anaesthetic?
A Yes. There would have to be considerable co-morbidity though. We have a very low threshold for operating on people with fractured neck of femur, because they commonly carry considerable co-morbidity. The bar is set fairly low.

Q I understand. It is well recognised that general anaesthetic itself carries risks?
A It is.

Q And one would want to evaluate whether it is generally in the patient's interests and that they will survive the insult that general anaesthetic involves?
A Death under anaesthesia is extraordinarily uncommon, even in very frail patients.

Q Under anaesthesia?
A Yes.

Q The patient has to be fit enough to undergo it?
A Yes.

Q And be able to come round afterward?
A Yes.

MR JENKINS: Thank you very much.

Re-examined by MR FITZGERALD

Q Mr Redfern, there are just two matters. Forgive me if they seem obvious, but I just want to clarify them. The first is that you agreed with the suggestion that in your view the transfer from Haslar Hospital to the Gosport War Memorial Hospital took place too soon?
A In my opinion.

Q Because there were other things, other investigations, that you thought should have taken place there first?
A Looking at the case file in its entirety, it looks as though that is the case.

Q The question is therefore – and forgive me, as I say, if it is obvious – with that fact in any way remove the need for later doctors to consider an orthopaedic referral?
A No.

Q The second point is simply this; you were explaining to Mr Jenkins a moment ago that there was ample opportunity before 12 April for the orthopaedic referral to happen, and that the process started long before then. Could you just explain what you meant by that?
A Again, on my review of the case records, problems with mobilisation were present from the day that she was transferred which was the 26th, I think she was eventually transferred over. The 26th March.

Q Yes.
A There is assessment on the 24th and she was transferred on the 26th. Right the way up to the weekend immediately before she died. At any time there the consideration ought to have been given that there was something amiss.

MR FITZGERALD: Thank you. Those are the matters I wanted to clarify.

THE CHAIRMAN: Thank you very much indeed. Mr Redfern, we have reached the stage I mentioned at an earlier point this morning. The barristers have completed their questions and it is now open for members of the Panel to ask questions of you, if they have any. I am going to turn now to see if we do have questions. Yes. Dr Roger Smith is a medical member of the Panel.

Questioned by THE PANEL

DR SMITH: I am a physician. Just thinking about your evaluation of this lady at the beginning of her third week, the 15th day – this is 9 April. This is about the staph aureus swabs coming back and she is described as ill and not drinking. "Irritable. Leave me alone." From what you know of this lady, can you thinking for the lay members of this Panel, of any possible medical causes for that condition?
A As far as I understand from the documentation prior to her fracture she was independent, living alone and mobilising without assistance. She was not on any medications as far as I am aware. So her pre-morbid state was reasonable. It is very difficult to say but it would fairly exclude, say, any dementing process for example. She presents as somebody who might have a derangement of her electrolytes. Most commonly in my experience the derangement of her electrolytes or an infection would cause similar features as you describe.

Q Indeed, one of your concerns is that she may have had a deep infection in the machinery that is in there?
A That is right, yes.

Q Forgive the physician's view of your world. Such an infection can be severe, can it not?
A It can.

Q And cause very important systematic effects on the patient, on the whole patient?
A Yes. It is well recognised as a cause of alteration in demeanour. I am struggling for the right word. Confusion. That is the word. It can cause confusion.

Q What I am coming round to and asking is, as an orthopaedic surgeon with such an ill, old lady is the situation irremediable?
A What?

Q If it is an infection.
A What? The condition of upset that she had?

Q Yes.
A No. It is absolutely remediable. You run a standard set of tests, a standard set of sources of infection are looked at, including the wound, the urine, if necessary the chest. The chest is listened to – not necessarily X-rayed – but there is a standard set of things that you do in those circumstances.

Q At this late stage when she is really ill?
A Well, yes. I would. I have done that, yes.

Q Going back to what Mr Jenkins was asking you about, operating on frail old ladies, is it not a kind of dictum in your world that if you do not operate on some people they die, so it is worth operating on them on the chance that they may survive.
A This is part of the reason we set the bar so low for the threshold for proceeding to surgical fixation. It is recognised that fracture of the femur represents a biological state as well as a pure fracture. Some of what we do is actually to a degree palliative but it is well recognised that if we do not operate on people with hip fractures and get them fixed and mobilised, then it shortens their life expectancy.

Q Would you expect a physician to have that similar view as a general physician?
A It has been a dictum for 25-odd, 30 years now, so...

Q Would you expect a general practitioner to understand that?
A I have to say, I probably would these days because... I probably would. I think it is that well known.

Q Would you expect nursing staff, whose job it is to receive patients from an orthopaedic unit, to know that?
A I would expect them to know. In the rehabilitation unit I would expect them to know that.

Q If there was proper liaison between the two units?

A Yes.

Q And the scene was set for safety?
A If they are regularly receiving patients, then they ought to be aware of that.

Q In your opinion should this lady have died in Gosport War Memorial Hospital?
A It is very difficult for me to answer that.

B

Q In your opinion might she have had a better chance if she had been reviewed by an orthopaedic surgeon?
A I think she would have had a better chance had she been reviewed.

Q And that such a review is not a difficult thing to arrange, one way or another?
A No. It is fairly standard for patients to be sent to rehabilitation units and then sent back if there is something amiss.

C

DR SMITH: Thank you very much.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

D

MS JULIEN: What I am trying to clarify is, if you can, what weighting you would give to the fact that in your opinion she was transferred too early and the seeming lack of review. What had a great impact, if that is a fair question?
A The answer to that depends on me surmising that her fixation had failed. Had her fixation not failed, then it is difficult to say whether it would have had an effect or not. If the fixation had failed, then I think it would have been picked up earlier at the Haslar Hospital. Does that help?

E

Q Yes. It would have been picked up earlier, and so the outcome would have possibly been ---
A Earlier intervention.

Q Resulting in ---
A Resulting in the fracture healing and her being able to mobilise.

F

MR JULIEN: Thank you.

THE CHAIRMAN: Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Dr Redfern, I am not certain whether this is going to be really significant or not. There is something I did not quite understand. When you were talking about the microbiology report you said, or I understood you to say, the drugs were reasonable best guess, and I understood you to say "particularly as the lady was incontinent"?
A Yes. My best guess as an orthopaedic consultant would have been an anti-staphylococcal agent. I would have used a flucloxacillin and erythromycin or something similar.

G

Q As a lay person, could you break that down so that I can understand?

H

A The bugs that were growing the staphylococcus and different bugs are sensitive to different types of antibiotics, so one antibiotic is particularly good at treating one bug, fairly good at treating another and no good at all at treating another.

Q Right?
A So the commonest infection that occurs in orthopaedics by a street is staphylococcus infection. It is your number one suspect. If I was doing something on an empirical basis – best guess basis – I would have an anti-staphylococcal agent in there like flucloxacillin, which is probably the best. The antibiotics that were chosen: one is ciprofloxacin, which is a very broad spectrum. It will pick off a lot of bugs, but its direct action against staphylococcus is not as good as flucloxacillin. The other antibiotic that was chosen was metronidazole, and metronidazole is good against what are called gram negative bacteria, which are things that are found in the earth or in faeces, for example. So if a patient were faecally incontinent, then they might contaminate a hip wound, it being close enough proximately. So it was reasonable for those two antibiotics to be chosen.

Q But how would it have been different if the person had not been incontinent?
A I do not think there was ever... I did not find anything in the record that she was faecally incontinent.

Q No. That is right. I think there is a slight anxiety for me that this elderly lady had not been incontinent and then had gradually become, or there were indications of incontinence. I was trying to work out in my own mind, is that because this lady was actually incontinent, or is it because of the poor mobility and the worries, et cetera, of actually getting out of bed, because there was not previously ---
A Incontinent of urine.

Q --- incontinence of urine. Yes – incontinence of urine.
A It is quite common following hip surgery. Quite common.

Q So when you talk about incontinence, I have to link that to the faecal incontinence, not the urine incontinence?
A Excuse me. As far as the metronidazole is concerned, that is anti-faecal so in my book it is anti-faecal prophylaxis.

Q So the incontinence that we are saying may not necessarily be a sign of deterioration of the patient per se, but rather the incontinence of the urine, or can be a symptom of the fact that they are less mobile because of the pain?
A It is a transient feature commonly of people who have hip fracture.

MRS MANSELL: Thank you. That has helped me to understand that.

THE CHAIRMAN: It is just me now, Mr Redfern. I am also a lay member of the Panel. Can I ask you to address your minds to the time when this patient was first admitted to Gosport and, in particular, was assessed by Dr Barton. There is reference to it in the schedule on page 10 referring to the clinical notes on page 27 in the bundle, although they are quite helpfully produced for us in the first column in the schedule if you have difficulty in reading the handwriting in the bundle.
A Yes, I have those records.

Q Given what you have already told us about your misgivings as to the status of the patient at the time that she was transferred and the fact that in your view this should have been spotted at Haslar, I need to ask you specifically about the assessment that took place when she arrived in Gosport. From what you can see of the notes and what you know that the patient would have been exhibiting by way of symptoms at the time that she would have arrived, are you able to make any comment on the adequacy of the assessment that was made on her at that time?

A It seems a fairly sparse assessment at first glance. There is not an examination of the wound, for example, there is not an examination of – it is stated that she is not weight-bearing and that is the only assessment of the hip fracture that I can see in that record. Other than that, it does not appear that the patient's hips or legs have been examined.

Q Do I take it that is something you would regard as essential for the discharge of one's duty of proper assessment or not?

A Well, she has been transferred to a rehabilitation hospital. That is the difficulty I have with answering that, because I do not operate in that sphere. I operate in the sphere of orthopaedic acute admissions. That is probably a question that should be asked of a consultant who has a special interest in the care of the medical elderly.

Q The adequacy of the assessment is a specific question that this Panel is going to have to decide at some point in the future. If you do not feel that you are the appropriate person to comment on that, then I will not press you further on that point.

A This assessment was made in the rehabilitation unit, so I think it is probably not appropriate for me to comment on that.

Q Can I ask you a more general point from your experience of hospitals and records? You appeared to be expressing some surprise or perhaps concern that so far as the x-ray which had been ordered was concerned, there was no apparent note one way or the other to indicate whether the x-ray had actually been taken.

A I am surprised that there is no record of the image anywhere. In fact, there are no x-rays available for any of her orthopaedic episodes as far as I am aware. They are unretrievable.

Q One point then is the retrievability. No doubt that is something that counsel on both sides have explored already. The other is the note that we have ourselves is the nursing note. Would you expect there to be a reference to, "Patient sent off for x-ray"?

A Yes. I would expect it to be in the nursing record, "Patient went for x-ray today at X, Y, Z. Returned at A, B, C."

Q Where there is no such indication, are you able to make any inference?

A My inference is that the x-ray was not taken.

THE CHAIRMAN: Thank you. That is all from me. Now we are at the point where I have to ask the barristers whether they have any questions arising out of the questions that were asked by members of the Panel. I am going to turn first to Mr Jenkins.

MR JENKINS: I do not, thank you.

THE CHAIRMAN: Mr Fitzgerald?

MR FITZGERALD: No, thank you.

THE CHAIRMAN: So I am pleased to be able to tell you that does complete your testimony. We are most grateful to you for coming to assist us today. It is only through the presence of witnesses such as yourself that this Panel is able to get a clearer picture of what happened often months, even years, in the past and for your assistance in that regard we are extremely grateful. You are now free to go.

(The witness withdrew)

MR KARK: The next witness is Dr Richard Reid, please.

RICHARD REID, Affirmed
Examined by MR KARK

(Following introductions by the chairman)

Q I think it is Dr Richard Reid. Is that right?
A That is right.

Q Dr Reid, so far as your involvement in the various inquiries into what happened at the Gosport War Memorial Hospital is concerned, I think you have made a number of statements – is that right? – the first starting in 2000 in relation to Gladys Richards and then you were making statements in 2004.
A That is right.

Q Then in 2006, you were interviewed by the police in July and August I think over a period in excess of 20 hours.
A That is right.

Q So you have said a great deal about the events particularly concerning three patients. I am going to ask you some questions about that period in your life. If you find it difficult to remember, please just say so and if you need to have reference to material, then we may well be able to assist you. You will be able to have the patient notes in front of you when you are referring to them. Can I ask you first about your own medical background, please? I think so far as your own qualification is concerned, you qualified in Glasgow in 1974.
A Yes, that is correct.

Q You became a member of the Royal College of Physicians in 1978, a Fellow at Glasgow in 1988 and a Fellow of the Royal College of Physicians in London in 1990.
A That is correct.

Q As far back as the late 1970s and early 1980s, I think you were then beginning to consider a career in geriatric medicine.
A That is correct.

Q You became a consultant in geriatric medicine at Southampton General Hospital in August 1982.
A That is correct.

Q Did you remain there until about March 1998?
A That is correct.

Q Then I think you took up a role in April 1998 as a consultant in geriatric medicine and also medical director of the East Hampshire Primary Care Trust.
A First of all, it was Portsmouth Healthcare Trust.

B Q That was its former name, as it were.
A Yes.

Q Then it evolved into the East Hampshire Primary Care Trust.
A Yes. I had a similar role with Gosport Primary Care Trust.

Q I want to deal, please, with your occupation since April 1998 as a consultant at
C Portsmouth. Where were you based?
A When I first started, I was based at Queen Alexandra Hospital.

Q Is that in the Portsmouth area?
A Yes. That is in Portsmouth. At that time, there were two district general hospitals in Portsmouth: the Queen Alexandra and St Mary's, and we had beds in both hospitals.

D Q I think in early 1999, you took on the responsibility of one of the consultants at the Gosport War Memorial hospital.
A That is correct.

Q How many other consultants were there who were looking after patients at that hospital?
A One: Dr Lord. That is inpatients I am talking about.

E

Q How did you take on that role? How did it evolve that that hospital required a consultant?
A There had always been, as I remember , one consultant who oversaw Daedalus Ward and one consultant who oversaw Dryad Ward and our responsibilities were rotated every now and again.

F Q I think you remained in position from early 1999 to about March 2000.
A That is correct.

Q That was as consultant specifically for the inpatients on Dryad Ward.
A That is correct.

Q In that role, did you come across Dr Barton?
G A Yes.

Q Had you had dealings with Dr Jane Barton prior to that?
A Not to the best of my recollection.

Q You were aware no doubt that she was a local general practitioner.
A Yes.

H

Q And she had taken on the job of clinical assistant at Gosport War Memorial Hospital.
A Yes.

Q Were you aware that prior to the move to the Gosport War Memorial Hospital, she had worked in the same position at the Redclyffe Annex?
A No, I was not aware of that.

B

Q Were you aware that prior to you arriving there, she had been in post for quite some time?
A Yes.

Q Did you understand the position to be that when Dr Barton was not available, her work would be undertaken by locums, effectively partners at her practice?
A That was my understanding.

C

Q So there was an agreement of cover by the partners at her practice in relation to both Daedalus Ward and Dryad Ward.
A That is my understanding.

Q What role did you have in a supervisory context in relation to Dr Barton?
A Well, as the consultant in charge of the ward, I am ultimately responsible for the
D medical practice within that ward. At that time, I conducted a weekly ward round. My colleague, Dr Lord, also conducted a weekly ward round. Both ward rounds I think were on Monday afternoons, which meant that – in an ideal world, one would wish the clinical assistant to accompany one on the ward round. To try and overcome that problem, Dr Barton would attend my ward round on a fortnightly basis and on the alternate Monday would attend Dr Lord's ward round.

E

Q So you would be going along to Dryad Ward once a week.
A Yes.

Q That was Monday afternoons, was it not?
A Monday afternoons.

F

Q Dr Barton would join you on your ward round once a fortnight?
A At best.

Q At best. Does that mean there were occasions when she was not able to make the ward round?
A That is correct.

G

Q How long would your ward round normally take and what would you do?
A It was about three hours long and I would, with the senior nurse on duty and Dr Barton if she were there and with the senior registrar if one were attached to me at the time, take the notes trolley and do a ward round. In other words, look at every patient.

Q If there were patients causing Dr Barton particular concern, would you discuss those with her, or would you expect those to be raised with you so that you could discuss those
H with her?

A Dr Barton, if she was there, would raise issues with me. If Dr Barton were not there, then the nursing staff would point me in the direction of the patients who were causing concern.

Q Tell us something, please, about your understanding of Dr Barton's experience and seniority?
A She was a very experienced general practitioner who had been functioning in that role at the War Memorial Hospital for I think ten or 11 years before I arrived there.

Q Did you come across Sister Hamblin when you were there?
A Yes, I did.

Q Would she on occasion accompany you on ward rounds?
A Yes.

Q Were there occasions when both Dr Barton and Sister Hamblin accompanied you, or would it be one or the other?
A There would always be a senior member of the nursing team there, and Dr Barton if she was available.

Q In general terms how would you say that the ward was run?
A Very well.

Q Your appraisal of Sister Hamblin?
A I beg your pardon?

Q Your appraisal of Sister Hamblin? What would you say about her?
A I thought she was a very kind, caring ward sister.

Q By the time you arrived in 1999, as you have already indicated, I think, both of those individuals would have been at that hospital for a fairly considerable period of time?
A Correct.

Q How easy did you find it coming into your post and having to take charge, as it were?
A Well, I do not recall encountering any sort of great difficulty. I felt that the nursing staff were very mature, sensible nursing staff, and I found in general it was a pleasure to work in that ward.

Q We have heard a certain amount about how full the ward was at various times.
A Yes, that is correct.

Q You were able to get through all of the patients in an afternoon, were you, or not?
A Yes.

Q Did the occupancy of the beds vary from time to time?
A Not greatly. I would say most of the time the beds were one hundred per cent occupied.

Q In that respect, can you remember whether you had any conversations with Dr Barton about how busy she was?

A I recollect having a conversation, I think it would be in early 2000, about the pressures of the job.

Q Can I ask you a little bit about the sort of patients that were occupying those beds on Dryad Ward? What sort of patients did you deal with?
A Well, largely they were continuing care patients, in other words patients who were going to be there for the rest of their lives. That was a little bit different from my previous post in Southampton, where most of the type of patient who were in Dryad Ward at that time would actually have been in a nursing home. So that was slightly unusual. I said in statements that over the course of that year, I think that because of the move of patients who would formerly have been NHS long term continuing care patients out into nursing homes, we started to have beds become free on the ward, and at that time, even as there is now, there is always huge pressure at the front door of the hospital to move patients on who can be moved, and we were sort of put under pressure to take patients who might not be continuing care, in other words the sort of patient who I would describe as they have not made a full recovery from their illness, not quite clear in what direction this patient is going to go; are they going to get better or might they become a continuing care patient.

Q Does that indicate that those patients required more care?
A They could be more physically dependent. What they might also warrant though is occupational therapy and physiotherapy assessment, but it is also possible that they could have been less stable medically than patients who had been previously transferred over.

Q Now, some of those patients of all groups presumably at one stage or another might require analgesia.
A Yes.

Q I want to just examine with you for a moment what your understanding at the time was. Did you know of the principles of the analgesic ladder?
A I was aware of the principles but not the term.

Q Your understanding of the principles would be what?
A That one would generally make an assessment of a patient's pain, and broadly speaking there are three levels of analgesia: paracetamol; secondly, non-steroidal or mild opiates; and, thirdly, strong opiates.

Q The principle of the analgesic ladder would be what in dealing with a patient's pain?
A To ensure that the pain was appropriately managed with the correct level of analgesia.

Q We know also that a number of patients who were looked after on Dryad Ward eventually went on to a syringe driver.
A Yes.

Q Can I ask you, please, what your experience prior to starting this job at the Gosport War Memorial Hospital had been of syringe drivers?
A Very limited.

Q What does that mean?
A Well, where I had worked before we did not have continuing care patients, and we had a palliative care ward on site to which one could refer for advice or indeed transfer

patients over, so we were not dealing with many patients who were at the end of their lives and needing palliation.

Q So previously if you found a patient did need palliation, then you would refer them over?
A Possibly. I mean, I might on occasion deal with it myself, and if I felt that I was managing the patient appropriately I would be content with that. If I felt that the patient's pain control was causing me problems, then I would refer on.

Q Okay. Prior to beginning your work at Dryad Ward, had you yourself prescribed syringe drivers to people, with opiates?
A I think yes, but I could not be absolutely sure.

Q Is that an indication that if you had done it was not a common thing for you?
A It is not a common occurrence.

Q Dealing with opiates, the various styles of morphine that there are, what experience had you had prior to coming to this job at Dryad Ward prescribing morphine?
A Probably prescribing morphine on occasion, and on occasion diamorphine.

Q For what purposes?
A Well, usually for pain control, but also for people who might be distressed in the terminal stages of an illness, where it was unclear whether the distress was mental distress or physical distress or a combination of both.

Q It may be obvious, but when you are talking about the terminal stage of an illness, these are patients who are very ill?
A Yes.

Q As you know, because you were asked about it by the police, because on some occasions at least you saw it, variable doses were prescribed by Dr Barton.
A Yes.

Q Those were variable doses of, among other drugs, diamorphine.
A Yes.

Q Had you, prior to coming to the Dryad Ward, come across variable doses of diamorphine?
A Possibly. I mean, it is so long ago and I did not see many patients in my previous career who required syringe drivers, I mean, possibly on one or two occasions, but I really could not say.

Q Can you recall an occasion or occasions when you discussed variable doses with Dr Barton?
A Yes, I remember one occasion.

Q What did your discussion revolve around?
A It revolved around the sort of, if you like, principle of variable dose prescribing. I asked Dr Barton why she was prescribing a variable dose and she indicated to me that that was because at times she herself was not immediately available, or her partners might not be

immediately available, and particularly at a weekend when she or her partners might be engaged in visiting patients at home, so as to allow a patient's distress to be relievable quickly rather than to wait for a doctor to attend she prescribed it for that reason, and I accepted these reasons.

Q What sort of variable doses did you think you were discussing with her, or were you discussing with her?
A Well, I do not have a clear recollection of actually discussing a dosage range, but my recollection was that it was in relation to a patient who had received 20-80mg.

Q You raised that with Dr Barton?
A Yes.

Q Did you ever have any discussion with her about ranges such as 20-200mg?
A I do not recollect having such a discussion.

Q Had you come across that sort of range prior to Dryad Ward, first of all?
A No.

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

Q At the time did you realise, and we will have to look at some prescription sheets in due course, that those sort of prescriptions were being written by Dr Barton?
A No. I was certainly aware of variable dose prescribing, but I cannot recollect seeing prescriptions for 20-200.

Q If you had seen such a variable dose, is that something you would have potentially raised, or not?
A I should have raised that with Dr Barton.

Q Now, we are also I think in due course going to hear something about anticipatory prescribing.
A Yes.

Q Have you heard that expression before?
A Yes.

Q Is that something that you have come across elsewhere or only on Dryad Ward?
A I have come across it elsewhere, and in fact we practise anticipatory prescribing on our palliative care ward in Queen Alexandra Hospital today.

Q Just give us examples, please, of the appropriate ways that anticipatory prescribing can be performed, in what circumstances.
A Well, as I say, it is on the palliative care ward and it is usually the type of patient who again has been very ill, it is not really clear which course their life is going to take, in other words are they going to recover from this illness or might they soon become terminally ill; in other words, the timescale I am thinking of is becoming unwell within the next few days.

Q What sort of anticipatory prescribing would you then expect, or might you find?

A In terms of, what, the range of drugs, or dosages, or---

Q First of all, drugs, and dosages.
A Well, I am not involved with the palliative care ward at the moment, but diamorphine is obviously one. I think midazolam and haloperidol, and there is a fourth, and I am not sure off the top of my head what the fourth drug is.

B Q The sort of dosages that you come across in appropriate patients would be what?
A I honestly cannot tell you---

Q You cannot assist.
A ---what the current practice is in the palliative care ward.

C Q All right. What would you say about the concept of anticipatory prescribing of opiates for patients who were not then in pain?
A Well, I think in the circumstances I have just described, if somebody is very frail, been seriously ill, in whom one did not know which direction their course were to take, I think it is not unreasonable, in fact good practice, to think about anticipatory prescribing, because I think it is better that doctors who are experienced in doing that do it during nine to five, in other words the patient has been seen by someone who is practising every day in palliative care rather than leaving the prescribing to out-of-hours junior doctors who may
D know very little about informed palliative care prescribing.

Q If the doctor is going to write out an anticipatory prescription of that nature, what sort of instruction, if any, would it be necessary to go with that sort of prescription?
A I think on the prescription chart there is a sort of small square for indication for pain, for distress, usually an indication about how frequently the drug may be administered, and obviously the dose.

E Q That would be an instruction to whom?
A For the nursing staff.

Q In terms of the ability to increase a dose, and I am sticking to opiates for the moment, again what was your understanding of the incremental nature of the increase in doses of morphine?
F A Well, at that time, and I would have to confess it reflects my sort of inexperience of palliative care prescribing, but I would have thought that doubling the dose every day would have been appropriate, but I had very limited experience of palliative care prescribing. That would have been my understanding at the time.

Q You are referring to palliative care prescribing, palliative in those circumstances meaning in your mind---
G A Well, I think I am talking about any, sort of – where a patient is in significant pain and distress for whatever reason, they may be palliatively unwell or in pain or distress for some other reason.

Q If you had at that stage been required to prescribe opiates, would you yourself have wanted to check in the *BNF*, or not?
A Almost certainly.

H

Q Now, the *BNF* of course is a guide.
A Yes.

Q It is not a protocol. It does not require you to stick, as it were, to it, but to what extent would you have followed the guidance in the *BNF*?
A I think if it was any departure from normal, or if I encountered a patient on a preparation with which I was not familiar, then I would certainly look at the *British National Formulary*.

Q Did you also have an understanding of conversion rates from oral morphine to subcutaneous morphine?
A I think perhaps you mean subcutaneous diamorphine.

Q You are quite right, I do mean diamorphine. I am using morphine as the generic term.
A I mean, my understanding at that time was a conversion factor of 2 to 1, although that has since been amended to sort of 3 to 1, in other words you would half or third the dose of morphine to convert to diamorphine.

Q At the time in 99, when you were at Dryad Ward, your understanding would have been one half, would it?
A That is correct.

Q Does that reflect – and I do not mean this rudely – your training? Is that how you were trained or does that simply reflect inexperience?
A That was my understanding of what the conversion ratio was.

Q In terms of the prescribing and use of these sort of drugs, how would you compare your experience with that of Dr Barton and Sister Hamblin?
A They had much more experience of dealing with this than I had.

Q And did that reflect itself in your discussions and your relationship with them?
A I am sure it did.

Q In what way?
A I felt they had much more experience of using these drugs than I had and I was happy to rely on their advice.

Q I want to have it clear. There is one occasion that we are going to look at when you overruled something---?
A Yes.

Q --- that Dr Barton had done, but other than on that occasion are you saying that you deferred to their opinion?
A I was aware that Dr Barton and Sister Hamblin had a lot of experience of managing palliative care more than I had, and I would just say, I was happy to rely on them.

Q You spoke about a conversation that you had had about a variable dose with Dr Barton?
A Yes.

Q And you described her explanation for why it was necessary?
A Yes.

Q You may have said this already, but did you at that time accept the explanation that was given to you?
A Yes, I did.

B

Q In terms of the use of syringe drivers you told us already that your own experience was limited?
A Very limited.

Q Very limited. In terms of the use of syringe drivers at Dryad Ward the experience of Dr Barton and Sister Hamblin – would that have been greater than yours?
A Oh, yes.

C

Q And again in terms of the use of syringe drivers and whether it was appropriate to utilise them or not, is that something you would have deferred to their opinion or not?
A One generally looks to using a syringe driver when someone will not be able to take oral medication or it may be distressing for them to have repeated injections. That is the sort of situation in which one would be looking to employ a syringe driver.

D

Q I understand that. But if you felt that a syringe driver had been set up with a patient by a doctor as experienced, as you have told us, as Dr Barton or potentially, I suppose, by Sister Hamblin, is that something in normal circumstances that you would query or challenge?
A I would certainly ask why a syringe driver had been commenced.

Q Did you actually do that in this case? When you were on Dryad, did you ever ask about that, can you remember, or not?
E A I am sure I would have done.

Q I want to move on, please, to some patients that you dealt with. You have explained, of course, that you did not start there until 1999. So far as we are concerned, the patients that I think you dealt with directly would be Enid Spurgin, Geoffrey Packman and Elsie Devine?
A Yes, and there is also Sheila Gregory.

F

Q We are not dealing with Sheila Gregory in this case. I think also you wrote a letter in relation to Gladys Richards. Do you recall that now or not?
A This was after assessing her in Haslar Hospital, was it?

Q Yes.
A Yes.

G

Q I think we shall start with her because I think your dealings with Gladys Richards were very limited.
A That is correct.

Q You will see on your left there are a number of bundles. Could you take up bundle E, please. Could you have a look at page 24, please. I think we have now added a second page

H

to this, 24 and 26. I am not going to ask you a great deal about this at all, but is this effectively your letter to Surgeon Commander Scott?
A Yes.

Q At the Royal Haslar. Why were you reviewing this patient?
A Because one of our roles as consultants in geriatric medicine was to review elderly patients on non-elderly medicine wards where it was felt that our involvement would be appropriate, either in terms of giving advice or taking over the patient's care.

Q If we go to the second page, I think you summarise, helpfully, your findings. You say:

> "When I saw Mrs Richards she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely although not able to actively lift her extended right leg from the bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that her daughters intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care but would be happy to arrange care in another nursing home."

When you talk there about giving her the opportunity to try to remobilise, first of all can you recall this patient now?
A Very vague recollection.

Q Is there any reading that we should do between the lines here when you use that expression? What are you saying about Gladys Richards?
A I think I felt her prospects for remobilising were not good.

Q Why is that?
A We know that patients who are confused and have dementia, it is often difficult for them to assimilate instructions, so often when they are seen by physiotherapists they are unable to remember what they have been instructed to do the day before. So it is quite difficult to make progress.

Q Nevertheless, you were arranging for the transfer of this patient to Gosport War Memorial Hospital?
A Yes.

Q For what purpose?
A Because I felt she should be given the opportunity to.

Q This patient, in fact, was admitted to Daedalus Ward on 11 August 1998. Was there any distinction between Dryad and Daedalus Ward in terms of rehabilitation?
A Yes.

Q Tell us about that, please.

A Daedalus Ward was a rehabilitation ward, and Dryad Ward had been designated as a continuing care ward. There was, as I recollect, no routine physiotherapy or occupational therapy available on Dryad Ward whereas there was on Daedalus Ward.

Q Did that change? Did you begin to get more rehabilitation patients on Dryad Ward as time went on?
A Certainly patients who were not clear continuing care patients.

Q And how did that change come about?
A It came about, I think, because of the move of what formerly have been NHS long-stay patients into private nursing homes, and so that created capacity within the continuing care ward. Because of pressures at the front door, one looked to see who would be the most suitable patients to transfer to Dryad Ward, in other words, ones who were not likely to need significant amounts of input from physiotherapy or occupational therapy.

Q I think that was your only dealing with this particular patient?
A Yes.

Q She was transferred to Daedalus Ward as we know and, of course, that was not your sphere at that hospital.
A Yes.

Q We can put that away. I want to turn, please, to your dealing with Enid Spurgin, who is our Patient I. Could you take out Patient I's file, please. We are going to start just by reviewing her history, I hope, because I think you saw this patient first of all at the Haslar Hospital?
A Correct.

Q Could we start, please, at page 356. You will have to get used to this, but the page numbers to concentrate on are those with a little line either side. This is not your note, but I think it may just help you to bring the patient back to mind. We can see that she had had an accident. She had been pulled over by a dog, apparently, and landed on her right hip. It is described as a direct blow. She had a fractured right subtrochanteric fracture. Is that right?
A That is correct.

Q If you go to page 374 – in fact would you look at the page before that, 373. Your note appears on page 374, I think. Is that right?
A Yes.

Q Let us just look at the note before that. This is a note made, I think, after the lady had been operated upon. We can see that there is a note to Dr Lord.

> "Many thanks for reviewing this pleasant 92 year old lady who was admitted on the 18th March having sustained a sub-trochanteric fracture to the [right] femur ... She was previously well, with no significant past medical history, living alone and independently with no social service input. She was transfused with 3 units of blood, but otherwise made an unremarkable post-op recovery. She has proved quite difficult to get mobilised, and her post-op rehabilitation may prove somewhat difficult. Additionally the quality of her skin, especially her lower legs is poor and at great risk

of breaking down. Surgeon Commander Scott would appreciate your advice regarding her rehabilitation and consideration of a place at GWMH."

That is written by a house officer to Surgeon Commander Scott. Could we look at your note, please, of 23 March and could you just take us through that?
A You mean just read it?

B Q Yes
A

"Thank you.

A delightful 92 year old lady, previous well, with sub-trochanteric fracture of the [right] femur. She is still in a lot of pain which is the main barrier to mobilisation at present – could her analgesia be reviewed?

C

I'd be happy to take her to GWMH provided you're satisfied that orthopaedically all is well with the [right] hip.

Please let me know."

And there is a telephone number.

D

Q I think at that time, and you can have a look at some drug charts from the Haslar if you wish, the patient was on paracetamol. The drug charts are at 328. Yes?
A Yes.

Q Together with that note that we just looked at, could we now go to page 301. This is a note from you, again to Commander Scott, dated 26 March 1999. You referred to seeing her
E on ward E6 on 24 March. The last note we looked at was 23 March. Is it likely to reflect the same visit?
A Yes.

Q You say in the third paragraph down:

F "When I saw her she was fully orientated and able to give a good account of herself. The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement of the right hip was still very painful. I was concerned about this and I would like to be reassured that all is well from an orthopaedic view point. If you are happy that all is well, I should be happy for [her] to be transferred to the War Memorial Hospital ...".

So the purpose of this, perhaps, is obvious. You wanted to make sure that she was all right
G for transfer?
A Yes.

Q The pain and the swelling in her right thigh would be an indication of what, if anything – or is that just post-operative?
A You may get some bleeding post-operatively and I would suspect that is the most likely reason at that time for her thigh to be swollen. Another possibility is she could have
H had a deep venous thrombosis, but I think if it was centred around ---

Q Could you say that again? A deep venous ---?
A A deep venous thrombosis. It would really depend on clinical examination at the time, but if it is centred around the wound then the most likely thing would be that it would be a wound haematoma bleeding into the wound.

Q I do not think that we have any response from Surgeon Commander Scott. This patient was transferred on the day that this letter was written on 26 March to Dryad Ward. If we go to page 23, is this a transfer note effectively?
A Yes.

Q Written by whom?
A It looks like the signature is – is it – Rankin?

Q And it is addressed, "Dear Sister". Would that effectively be addressing it to Sister Hamblin?
A Yes.

Q We can see the note that is made. It describes what has happened to her.

"Post operatively, she is now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame. She has no urinary catheter and although she is continent during the day she has been sometimes incontinent at night.

The skin on her lower legs is paper thin so she is not to TED stockings."

Those are those tight stockings to prevent a DVT. Is that right?
A Yes.

Q

"Her right lower leg is very swollen and has a small break on the posterior aspect. This has been steristripped. Her consultant recommends they be elevated.

She needs encouragement eating and drinking but can manage independently.

Drugs have not been included as her only medication is analgesia (paracetamol) PRN."

Does that reflect the position on her transfer?
A It certainly reflects what Sister Rankin... Presumably it reflects what she observed.

Q Is this a patient who in your view was appropriately transferred to Dryad, or more appropriately would have been transferred to Daedalus Ward?
A I think if at the time there was no physiotherapy or occupational therapy available on Dryad Ward, it would have been more appropriate that she should be transferred to Daedalus Ward.

Q Can we go to page 27, please? Do you see a note there by Dr Barton at the top?
A Yes.

Q We see on 26 March:

"Transfer to Dryad ward
Fracture of neck of femur
Previous medical history – nil of significance
Barthel"

B But there is no Barthel score. Then:

"No weight bearing
Tissue paper skin
Not continent

Plan – sort out analgesia"

C Can I just ask you to help us with this? That does not seem quite reflective of the note that has gone before by the previous assessor. Help us with this. If there is a difference between the state of the patient when they arrive on Dryad Ward and the state as it is described in the previous notes or in the transfer letter, what, if anything, would you expect to be done?
A A number of things could be done. One could contact – the nursing staff could contact the ward to speak to Sister or Captain Rankin. It would also be important to examine
D the patient and see if there is any obvious reason for the apparent change. Might I say something?

Q Yes.
A Captain Rankin's note was really quite at variance with what I found two days before.

Q Just keeping a finger where you are, let us go back to the letter that you wrote at page
E 301. You say that she is fully orientated and able to give a good account of herself.
A Yes.

Q And:

"The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement ... was still very painful."

F Yes?
A Yes.

Q Does that indicate that she is not weight-bearing?
A I would be very surprised if this lady were able to weight bear without very significant help and support.

G Q When you talk about somebody weight-bearing, does it mean walking on their own or walking with assistance?
A I would say standing in the first instance.

Q The purpose of this transfer, if it were possible, was to mobilise the patient.
A Yes.

H

Q Let us go back to page 27 and let us see what happened. First of all, the plan is described as "Sort out analgesia".
A Yes.

Q Help us. Would you expect to see any other sort of plan written out by the assessing doctor, or not?
A I think it is difficult, because one cannot remember the patient, but clearly if Dr Barton has written "Nil of significance" in terms of past medical history, I said this lady was alert and orientated or words to that effect, so I think the most important thing would be reviewing her analgesia and then – after a hip operation, it is very common for people to be in pain and discomfort. The issue then is, one would expect that pain and discomfort, if all has gone well orthopaedically, to gradually lessen with time.

Q If it does not, what is that an indication of?
A There would appear to be a problem somewhere.

Q Would you expect that problem to be assessed?
A Yes.

Q And hopefully diagnosed?
A Yes.

Q And a plan written up to deal with it?
A Yes.

Q The next note is I think some 12 days later. Whose note is this?
A That is mine.

Q Could you read it through for us, please?
A Yes.

"Still in a lot of pain and very apprehensive.
MST [increased] to 20 mg bd yesterday
Try adding flupenthixol
For x-ray right hip as movement
still quite painful – also about
2" shortening of right leg."

Q Again, it may be obvious, but what does that indicate to you?
A There is clearly a continuing problem with the right hip.

Q What did you think the nature of that problem might be?
A There would be a number of possibilities. The hip could have been dislocated, there could be a deep-seated wound infection, a superficial wound infection. Given that this lady is 92 and she has had a fracture, it is likely that she has osteoporosis. I think she had a dynamic hip screw inserted and if the bone into which that insert is very soft, then the head of the femur can collapse and that can cause shortening of the leg. That was the purpose behind requesting an x-ray, to see if we could get to the bottom of what was going on.

Q If Dr Barton had formed the same view when she reviewed this patient, would she have been able to ask for an x-ray? It does not take a consultant to ask for an x-ray, does it?
A No.

Q You also note that there is a two-inch shortening of the right leg.
A Yes.

B

Q How would you have ascertained that?
A From examination of the patient's leg.

Q Standing?
A Oh, no. It would be lying on a bed. I cannot say for sure, but almost certainly. We generally measure leg shortening with people lying in bed.

C

Q The last note was on 26 March and this note is now 7 April 1999.
A Yes.

Q Does that surprise you in any way, or not?
A If the patient had been in a lot of continuing pain, then I think it would have been appropriate that an assessment be made of the patient.

D

Q What we do know from the drug charts – and I am just going to use the chronology that we have for the moment – is that this patient had been administered 20 mg of MST since 31 March.
A Yes.

Q Prior to that in fact she had been prescribed and administered Oramorph.
A Which page is this?

E

Q If you go to page 178, do you see the prescription for MST, "Morphine MST", dated 31 March halfway down the page?
A Yes.

Q You have told us obviously that Dr Barton had considerably more experience than you prescribing certainly diamorphine. What about opiates?

F

A Diamorphine is an opiate.

Q I am sorry. What about MST?
A Again, it is an opiate. It is morphine.

Q Who had the greater experience, would you say?
A Of prescribing MST?

G

Q Yes.
A Probably Dr Barton. Probably.

Q Where a prescription like that is written, would you necessarily expect to see anything in the clinical notes?
A I think that in general terms when one is introducing opiates, there should be a note in the clinical record.

H

Q Why?
A Because opiates are controlled drugs and they are controlled for a reason.

Q Did you expect this patient to go off for x-ray?
A Yes.

B

Q Who, following your note on the 7th, would actually have had to arrange that?
A I am not clear whether – I might have written the x-ray card on the ward round or, if Dr Barton was there, she might have written it. I could not say.

Q We have a nursing note at page 134. Do you see in the middle of that page:

"7.4.99 Seen by Dr Reid. For x-ray tomorrow at 100 hrs."

C

A Yes.

Q When you write a note like that in the clinical records, who would you expect to read it?
A The medical staff and possibly nursing staff too.

D

Q The medical staff in this case would be - ?
A Dr Barton or if there was a senior registrar or one of Dr Barton's partners who were covering.

Q The next clinical note that we see is written by who?
A By me.

E

Q Does that surprise you in any way?
A One would have expected by that time that the x-ray had been undertaken and a note made of the result.

Q Let us have a look at what had happened on 12 April. Could you read through your note, please, first of all?
A Yes.

F

"Now very drowsy (since diamorphine infusion established)
reduced to 40mg for 24 hours
if pain recurs, increase to 60mg.

Able to move hip without pain
but patient not rousable."

G

Q Can we just deal with the necessity of making notes? You have made notes in relation to both of your assessments of this patient at this stage.
A Yes.

Q How important do you regard it to make a note?
A I regard it as very important.

H

Q Again, I am sorry to ask such obvious questions, but why?
A So that there is a clear record available, both to me when I might see the patient next or to any other medical practitioner who is called or for the nursing staff.

Q Can we have a look, please, keeping a finger where you are, at page 174? Again, it is the drug chart. Do you see at the top there a prescription has been written out by Dr Barton?
A Yes.

B

Q For between 20 and 200 mg of diamorphine.
A Yes.

Q If we look below that, we can see a prescription for hyoscine.
A Yes.

C

Q And if we look below that, a prescription for midazolam, between 20 and 80 mg.
A Yes.

Q The effects of midazolam are what?
A Sedative.

Q Does midazolam have an effect on either the heart rate or the respiration rate?
D
A I am not a pharmacological expert, but I would imagine it would have an effect on your breathing, but not on heart rate.

Q The diamorphine has an effect on what?
A Breathing, consciousness.

Q There we have an example of what I asked you about as a generality before: a variable
E dose of between 20 and 200 mg.
A Yes.

Q You have told us I think that you had never seen that before.
A Well, I did not recollect that prescription.

Q Do you have any view about it?
F
A I think, as I said before, the dosage range is very wide. When I talked before about variable dose prescribing, if I remember correctly, it was in the context of over a long weekend, where Dr Barton or her partners might not be available and we can certainly see that over a course of a long weekend it might be necessary for someone's diamorphine to be increased from 20 to 80 mg, but I could not see that with 20 to 200 mg.

Q Do you think it is an acceptable prescription or not?
G
A No, I do not.

Q The starting dose appears to be 80 mg.
A Yes.

Q You reduced it by I think half.
A Yes.

H

Q Tell us why you did that.
A Because I thought that was too large a step up in dosage.

Q What effect do you think it was having on the patient?
A Over-sedation of the patient.

Q If this patient had been up to this stage on MST – and MST, we know, I think is an oral dose.
A That is correct.

Q Is it a tablet?
A Yes.

Q We know I think from the drug chart that MST – I am going in fact from our chronology, but if we look at page 178, we can see that there is a dose of morphine MST at 10 mg.
A Yes.

Q Prescribed on 31 March. Then on 6 April, a new dose of 20 mg bd. Is that twice daily?
A Yes.

Q Those are regular prescriptions to be given at eight o'clock in the morning and eight o'clock at night.
A Yes.

Q We can see, if we go along the row, that those were indeed administered.
A Yes.

Q If you keep your finger at 178 but also go to 160, please, we can see, I think, that on the day before – you came along on the 12th – on 11 April the patient had been given, in addition to her MST, some Oramorph.
A Yes.

Q That would appear to have been, I think it is, 5mg.
A Yes.

Q Because it is two and a half millilitres and there is 10mg in 5ml.
A Yes.

Q So on the day before that syringe driver was started, the patient appears to have been on 45mg total of morphine, whether it is MST or Oramorph?
A Yes.

Q You told us earlier about your own understanding of the conversion rate, which I think has been reviewed since these events?
A Yes.

Q But at the time your understanding of the conversion rate would have been to halve it?
A Yes.

Q Which would mean a subcutaneous dose of between 20 and 25mg?
A Yes, but I think it is perhaps important to say that at this stage this lady's pain was still not controlled.

Q Now, is that an explanation for the 80mg dose, or is than an explanation for why you only reduced it to 40?
A It is an explanation of why this lady needed a higher dose of opiates than the 20-25 she suggested.

Q We have to add to that, I suppose, your understanding at the time that you could double up the dose---
A Yes.

Q ---as your incremental increase.
A Yes.

Q So first of all we start off with your understanding that you should halve from oral if going to subcutaneous---
A Yes.

Q ---but then your understanding that you should double up if an increase was required?
A At that time that was my understanding.

Q Is that how you got to 40?
A Yes.

Q Well, you tell us, how did you arrive at the figure of 40?
A I think that would be the way I would have done it.

Q Using your own figures would that have been a substantial increase, or as much of an increase as you would want to allow, or would you have gone higher than that?
A Than 40?

Q Yes.
A No. I think 40 was the right dose in these circumstances.

Q What was the danger, if any, for this patient of the dose that she was then on, of 80mg?
A Over-sedation and respiratory depression.

Q What is the danger of that?
A Well, if patients are sufficiently over-sedated, respiratory depression can result in death.

Q If we just follow this through, back to your clinical note, please, page 27, you have recorded:

"Now [very] drowsy (since diamorphine infusion established) -- reduce to 40mg/24 hrs -- if pain recurs" –

and then that is an arrow up, I think, to 60mg, is that right?
A Yes, that is right.

Q What is the note below: "Able to move hips"?
A "without pain but [patient] not rousable".

Q "patient not rousable" perhaps we all understand. What efforts would you make to rouse the patient?
A Well, first of all speak to the patient. If they do not respond to speech, then touch them, perhaps shake an arm. In extreme circumstances what one can do is give the patient a painful stimulus, for example squeezing a toe, squeezing a finger, earlobe, or, in someone who has been in pain from the hip, then moving the hip would be---

Q You were unable to get any response from the patient?
A Yes.

Q What was your understanding of how long it would take for your reduction to have effect?
A I would have thought that would have been having an effect within an hour of reducing it, but I am not an expert in pharmacology.

Q We can see from the clinical record that on 13 April at 1.15 in the morning the patient was confirmed to have died.
A Yes.

Q Now, I just want to look at timing, please, so I am going to ask you to be given the original – we have now created a file with all of the originals that we have got in it, and I am going to ask for the original prescription sheets for Patient I to be handed to you. (Same handed) It is difficult for us to read, on page 174, but can you just help us with the timing: I think the original 80mg was started at eight o'clock in the morning, is that right? Sorry, you will have to find the right page first.
A Yes. Well, it looks like eight o'clock or nine o'clock in the morning; I think probably eight o'clock.

Q I see what you mean, yes. The midazolam, I think perhaps that is a bit easier to read.
A Well, that looks like nine o'clock.

Q So that appears to be when the syringe driver was initiated.
A Yes.

Q What have you written underneath?
A I beg your pardon?

Q Have you written anything underneath when you have reduced the dose?
A On the drug chart you mean?

Q Yes, on the drug chart, which I thought you were looking at.
A I do not think I have written anything on the drug chart.

Q Can you tell us, please, at 16.40 what happens?
A Oh, "Dose discarded 40mg 16.40".

Q Would that be as a result of your intervention?
A I presume so.

Q So at 16.40 effectively a new syringe driver is started?
A Yes.

Q With your reduced dose. Did you give any consideration to the midazolam?
A I do not recollect doing so.

Q You do not recollect it?
A No.

Q Just looking at that sheet in front of you, Dr Barton had prescribed, concentrating on midazolam, 20-80mg, and when the syringe driver was restarted it looks from our copy as if the midazolam was increased to 40 from 20.
A It does.

Q Can you help us as to how that happened?
A I have no idea.

Q Would you have directed the increase?
A I would find that astonishing if I directed that increase.

Q Why do you find it astonishing?
A Because when I saw the patient I thought the patient was over-sedated, and it would seem totally counter-intuitive to increase the dose of midazolam.

Q You have directly brought about the reduction in diamorphine?
A Yes.

Q Now, just stepping back from the drugs, and then we will take a break, this patient had continuing pain from her hip.
A Yes.

Q You had directed that an X-ray take place in your clinical note of 7 April.
A Yes.

Q What did you want to happen with this patient?
A At what stage are you talking about?

Q On 7 April when you intervened.
A Well, to have an X-ray to find if we could get to the bottom of why this lady was having so much pain.

Q An explanation of the two inch shortening of the leg?
A Yes.

Q That does not appear to have happened.
A No.

Q By 12 April, when you come across this patient, you have found an unrousable patient.
A Yes.

Q Can you recall if you made any enquiries about what had happened about your note?
A I cannot recall.

MR KARK: Sir, I think that is all that I need to ask about this patient, but I will review my notes, if I may, over the short adjournment.

THE CHAIRMAN: We are going to break now for lunch. We will return at 5 minutes past 2. In the interim period, please remember that you remain on oath in the middle of your testimony and you should not discuss the case with any person nor allow any person to talk to you about the case. Thank you very much. 5 past 2, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Kark.

MR KARK: There was just one more question I wanted to ask you about the previous patient. Do you still have the bundle in front of you, bundle I? We have seen what happened with this patient: the problems with the hip; the diamorphine that was prescribed, and then your reduction, yes?
A Yes.

Q We know the patient died the following day.
A Yes.

Q If we go right to the back, please, to the death certificate, and you will find a little tab, and if you just turn over the final interlever, the cause of death is given as?
A Cerebrovascular accident.

Q Where does that come from, as it were? What is that based upon, do you know?
A No.

Q Is there any indication of that that you have seen in this patient's terminal stage?
A No.

Q Let us move on to the next patient. If you can put that file away, please. I want to ask you about Mr Geoffrey Packman. If you could take up file J. This gentleman we know, just to remind everybody, if we go back to 6 August, this is prior to you having any dealings with him, I think, the first note we have got for this gentleman, the easiest place to find it is page 47, we know that this gentleman was admitted to accident and emergency at Queen Alexandra Hospital on this date, 6 August.
A Yes.

Q We can see that the problems are set out, and he has got cellulitis. Is that actually an infection?
A Yes, it is an infection of the skin and subcutaneous tissues.

Q Cellulitis in the left leg. He has got chronic leg oedema, poor mobility, morbid obesity, TBP?
A No, I think it is increased BP, which is increased blood pressure.

Q Oh, sorry, arrow up?
A I think so.

Q Then "AF", is that atrial fibrillation?
A That is correct.

Q Then if we go on to page 49, are either of those notes made by you?
A Yes, the first one.

Q The top one, 9 August.
A That is correct.

Q Can you just take us through that, please?
A Yes. "Cellulitis of [left] leg settling – switch to oral fluclox" – that is flucloxacillin.

Q Which is what?
A It is an antibiotic. "Oedema [left greater than right] foot – continue frusemide", which is a water tablet. "Arthritis of knees [left greater than right] +++ Arthritis of hips – mild [left greater than right] CNS intact Apyrexial BP [satisfactory] – continue felodipine but [reduce] to 2.5mg ([because of] oedema)".

Q I am sorry, what is that last entry all about?
A Felodipine is an agent which is used to control blood pressure, but one of its side effects is it causes swelling of the legs, and I have recorded in the third line of my note that Mr Packman had oedema with both feet, more so on the left side, so it was trying to get rid of that, because you are more at risk of having cellulitis if you have got edematous, swollen legs.

Q Below that we can see an entry which, I think, is not yours but we can see that the patient is described as being well.

"Cellulitis improving on antibiotics"

He is awaiting physiotherapy?
A Yes.

Q Over the page, page 50:

"Patient well.
Cellulitis improved on [antibiotics]
Continue physio
Apyrexial"

Apyrexial?
A Yes.

Q Meaning no temperature?
A No temperature.

B Q Then again, just glancing through this quickly, the next entry is the same day:

"Clinically brighter.
Leg looking better marginally
Pressure sores being dressed

...

C

Continue nursing care as now and try to mobilise."

A Yes.

Q Over to 13 August, please. I do not think this is your note, is it?
A No. It is Dr Chatterjee.

D

Q I do not think we need to go through this in any detail. We can see much better than on admission; carry on with antibiotics, take them 10 days. That is on the middle of the page. Then, right at the bottom, do we see:

"Transfer to Dryad Ward on 16/8/99"

E A Yes.

Q Page 52, the following page. I do not think he did get transferred on the 16th?
A No, I do not think he did.

Q I do not think your notes appear. Would you just look through the next couple of pages. I think it is most Dr Chatterjee?
F A Yes.

Q Is that right?
A Yes, and my colleague, Dr Tandy.

Q Can we then go, please, to page 55. This is 23 August. This is a note which we think is made by Dr Ravindrane?
G A That is correct.

Q Dr Ravindrane worked where?
A He was a senior or specialist registrar who would be based at Queen Alexandra Hospital but at that time he was working with me and he would on occasion come out to Gosport with me.

H

Q Are you able to help us. This is a note by him. Do you know where this assessment took place?
A I think it was at Gosport.

Q I think that accords with Dr Ravindrane's statement as well. It is just that the letter-headed paper, I do not think we have seen as coming from GWMH before.
A Sorry?

Q This is page 55.
A Yes.

Q Do you --- Sorry, go on.
A I was just going to say on the previous page it says "for Gosport" on the 23/08.

Q That would seem to indicate that although Dr Ravindrane was working at the QAH, this was an assessment which actually took place on the ward. That is Dryad?
A Yes.

Q Just looking through this, what is happening here? What is Dr Ravindrane doing?
A He has outlined the patient's problems and conducted an examination. Then he has written a plan at the bottom: repeat haemoglobin; I think it is urea and electrolytes, and liver function tests on Friday.

Q In terms of a note, just by way of example, you presumably have made many such notes in your time?
A Yes.

Q Is this an acceptable note of an assessment and examination?
A Yes.

Q And is that the sort of note that you have seen many times before?
A Yes.

Q And it describes what the patient's problems are. It describes what his present position is, and we see in the middle of the page is it "MTS"?
A "MTS = very good", I think it is. "No pain." I cannot read what ---

Q I think it is "Better in himself"?
A "Better in himself". I think the next bit is "0 JVP", which is jugular venous pulse, which is a clinical sign that we look at to tell whether someone might have heart failure.

Q And that would indicate that he is or is not in heart failure?
A Not in heart failure. Then the next line, I think, is "CDs [tick]", which means he thinks the cardio vascular system is unremarkable on examination. The next thing is "Rs", which is ticked.

Q "Rs"?
A Respiratory system.

Q So he is checking all the functions?

A Yes.

Q Vital functions.
A Then I think "PA" is the next thing.

Q Then we see "Obese"?
A It says "obese", and then, "Legs slightly..."

B

Q Oedematous?
A Oedematous, yes. "Chronic skin change. Ulcers dressed yesterday."

Q Do you have a recollection now of this patient?
A No.

C

Q No.
A Not really.

Q We have heard that he was a very large gentleman?
A Yes.

Q With very bad ulcers, but that does not ring any bells with you?
D A I have a vague recollection of a patient who when he was admitted to Ann Ward at Queen Alexandra Hospital, who was extremely obese and, if I remember correctly, and if it is Mr Packman, the nursing staff had to put two beds together to accommodate. That is the only real memory I have – if my memory serves me correctly.

Q I think we go to some drug charts towards the back. Start at page 179, and then go backwards, as it were. We can see that the patient had been on paracetamol, which he
E declined at the Queen Alexandra Hospital on a number of occasions?
A Yes.

Q Then could you go to 173. There is an entry in the middle for something called Clexane?
A That is correct.

F

Q We can see, I think, that all of these drugs were prescribed on 23 August?
A Yes.

Q Do you see?
A Yes.

Q It seems to be that these were prescriptions by Dr Ravindrane?
G A Yes.

Q Do not say "yes" if you are not sure about it. Do you recognise this signature or not?
A The first three certainly look like Dr Ravindrane's signature. I am not sure about the fourth.

Q In the middle of that page, we can see that a drug called Clexane was prescribed?
H A Yes.

Q Do you know what Clexane is for?
A Yes. It is what is called an anti-coagulant. It is used to prevent and treat deep venous thrombosis and pulmonary embolism.

Q That seems to have been prescribed for this patient and at some stage certainly administered?
A Yes.

Q The other drugs that we can see are doxazosin?
A Doxazosin, which is for high blood pressure.

Q Frusemide?
A Which is a diuretic, or water tablet.

Q And paracetamol?
A Pain killer.

Q And then, is that a cream?
A I think it is 50-50 cream. I am not sure what that is.

Q And the very last entry there?
A Is magnesium hydroxide, which is a laxative.

Q Again, I am afraid we are going to have to do this thing of keeping a finger where you are from the prescription charts and then going back to the clinical notes. Could you go back to page 56?
A Yes.

Q There is an entry right at the top there which I think is Dr Barton. Is that right?
A Yes.

Q

"Called to see"

is it –

"pale, clammy, unwell.
Suggest ? MI..."

Can you read the next words?
A Yes. It is –

"Treat stat diamorph and Oramorph overnight.
Alternative possibility GI bleed but not haematemosis
Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death."

Q In what circumstances would you expect those words to be used, the last sentence: "I am happy for nursing staff to confirm that"?
A I think if you felt that someone was terminally ill.

Q The suggestion of "MI" – myocardial infarction. What is a myocardial infarction?
A It is a heart attack.

B

Q Are there circumstances where diamorphine can be an appropriate drug?
A Oh yes, indeed.

Q The reference to a GI bleed?
A Yes.

Q Is that what you would call a differential diagnosis?
C A Yes.

Q If this patient were having a GI bleed, as we may see in due course that is possible or even likely, is that a treatable event?
A Potentially.

Q Potentially how? What would you do?
D A By transfusion, and then investigation of the cause which would usually be by what is called endoscopy. At endoscopy it is possible to carry out specialised treatments to try and stop bleeding, if that is felt to be the appropriate thing to do.

Q Try and find out the cause of the bleed, presumably?
A Yes.

E

Q And if you could treat it?
A Yes.

Q Of itself, is it inevitably a terminal event?
A Not of itself.

Q Underneath this entry we have another entry, I think, from Dr Barton.
F

"Remains poorly but comfortable. Please continue opiates over week-end."

A Yes.

Q That entry on 26 August – can you keep a finger there, please, and then go to the drug charts at 174. Do we see that on 26 August Oramorph was prescribed?
G A Yes.

Q I am going to ask for you to be given the original prescription sheet for this please, because I hope you will find the writing a bit easier to read. (Document handed to the witness) Do you see against the entry for diamorphine "40-200 mg"? There is an entry to when it was first administered?
A First administered on the 26th.

H

Q Do you see just above the word "Dose"?
A Yes, 30?

Q It says "30"?
A Yes, yes. And then 31st, the following one, so I presume that refers to the day it was ---

Q Actually administered?
A Yes.

Q The date above that appears to be the 26th?
A The date of ---

Q The date above that?
A Yes. A lot of prescriptions.

Q And you would take that to be the date of prescription?
A Yes.

Q And the prescription there was for diamorphine between 40 and 200 mg?
A Yes.

Q And that is the sort of wide range – I will not ask you again – that you spoke about earlier?
A Yes.

Q You said you had not seen before?
A Yes.

Q Or here, or since?
A Yes.

Q That starting dose of 40 mg, do you have any comment to make about that? Did you see that at the time or not?
A I think... I am sorry. The Oramorph starting dose – I beg your pardon. That is the prescription above – the Oramorph.

Q No. The Oramorph had already started, I think.
A But it had never been given.

Q I think you are right. I think it had been prescribed on 26 August. Just give me a moment.
A I think it is over the page.

THE CHAIRMAN: It is page 175, Mr Kark.

MR KARK: I think the Oramorph had first been given, in fact, on the 27th, and it was ---

THE CHAIRMAN: Mr Kark, if you look on page 175, below the first row, there is a second Oramorph which in time is the first.

MR KARK: You are quite right. I am grateful. So there are two entries for Oramorph on page 175 and we can see that there is an initial, I think, under the 26th at 22.00 hours?
A Yes, yes.

Q Can you help us with the dosage that was actually given?
A It looks like 20 mg.

Q Thank you. In the clinical notes that we have been looking at, back at page 55, there is reference to the possibility of an MI - yes?
A Yes.

Q There is no reference to pain?
A No.

Q This patient, we know, was put onto a syringe driver?
A On the ---

Q It was ---
A On the 30th.

Q Actually administered, it was prescribed, as we have seen previously, but he was put onto it on the 30th at a rate of 40 mg?
A Yes.

Q Can you just help us with this. Treating a myocardial infarction, if that is what was being done, is there a dose, a normal dose, that one would give for myocardial infarction, as opposed to for pain?
A Depending on the size of the patient – 2.5 to 5 mg. But this was a very large gentleman.

Q Yes. So do you use what?
A It might have been up to 10 mg, an initial dose of diamorphine.

Q To treat a myocardial infarction, if that is what the concern was, would you have used 40 mg?
A Usually with myocardial infarction you would give a single dose.

Q Not a syringe driver?
A Not a syringe driver straight off.

Q Staying on page 56, underneath the entry that we have been looking at do we see an entry for 1 September?
A Yes.

Q Whose note is that?
A It is mine.

Q Could you help us with it, please?
A

"Rather drowsy, but comfortable.
Passing melaena stools
[Abdomen] huge, but quite soft.

Pressures sores over buttock and across the posterior aspect of both thighs

Remains confused
For T.L.C. – stop frusemide and doxazosin
Wife aware of poor prognosis."

Q Can you help us, please, why you formed the view at that stage that you apparently did that this patient was effectively for palliative care?
A He was a very large man who had become immobile prior to admission. I think the final precipitant probably of his loss of mobility was his left leg cellulitis, but it was clear that this man had been struggling to remain mobile without any intercurrent illness prior to his admission to hospital. I have recorded in my earlier note that he had arthritis +++ of his knees, he had grade 4 pressure sores. My view is that this man was extremely unlikely ever to leave hospital and, probably worse than that, that this man's life expectancy was likely to be extremely limited. When I saw him, he was obviously having a very significant gastrointestinal bleed – that is the reference to passing melaena stools – and I felt that he was terminally ill.

Q Had this problem been recognised earlier, could something have been done for him?
A Possibly, but I think it would be important to state that his pre-existing problems would remain. In other words, his arthritis, his grade 4 pressure sores and I think there was something else which I cannot bring it to mind.

Q On 26 August, when she first made a note about seeing this patient, Dr Barton made her notes at the top of page 56 and appears to have prescribed on the same day Oramorph, diamorphine with a variable range and midazolam.
A Yes.

Q What do you say about that sort of prescription?
A I think without having seen the patient, it is difficult. If one is considering – this man was clearly unwell on 26 August, very unwell, and I think to give diamorphine was an appropriate measure. Given his multiple problems, I would have felt that this man's prognosis for life was extremely poor and I feel at that stage that he might well have needed regular Oramorph and diamorphine in the next few days.

Q Is that the sort of prescription you are saying you would have written?
A No, no. I am talking about diamorphine.

Q What I am asking you about this prescription, this range of prescriptions on 26 August: midazolam, Oramorph, diamorphine with a range of 40 to 200. Is that a prescription you would have written?
A I would not have written a prescription for diamorphine 40 to 200 or midazolam 20 to 80.

Q You would not?
A No.

Q Why not?
A Because I think the range is too great.

Q When you saw the patient on 1 September, you described him as drowsy.
A Yes.

Q Does that indicate to you the appropriateness or otherwise of the degree of sedation?
A It may be entirely appropriate, because it is sometimes not possible to relieve a patient's distress without them becoming drowsy.

Q That depends I suppose on the degree of pain.
A Or distress.

Q Is there any reference to distress or pain?
A In Dr Barton's first note, she refers to him being "pale, clammy and unwell." Often when people are clammy, they can feel pretty unwell and distressed. Often if people are unwell, they become clammy and be feeling distressed.

Q They may be distressed presumably or they may not be distressed. Do you see any note of pain or distress?
A No, I do not see any note of pain or distress.

Q Can we move on, please, to the next patient, Patient K, Elsie Devine, and could you take up file K? First of all, can you help the Panel by telling us whether you have any independent recollection of this patient?
A Not really. I remember meeting her daughter, but I do not have a very clear recollection of Mrs Devine.

Q Could you go to page 155, please? This patient, as we see at the top of the page, had been transferred to Dryad Ward for continuing care.
A Yes.

Q She had been through Mulberry Ward, as we can see at the top, then went to the Queen Alexandra and then to Dryad.
A Yes.

Q Then there is a record by Dr Barton. Did you see the patient on 25 October?
A Yes.

Q Can you help us, please, with what you found?
A Yes.

"Mobile unaided
Washes with supervision
Dresses self
Continent
Mildly confused
Blood pressure 110/70

Normochromic anaemia – chronic renal failure.

Was living with daughter and son-in-law
? son-in-law awaiting bone marrow transplant
Need to find out more re son-in-law etc."

B Q We have heard quite a bit about this patient, but "mobile unaided" and "dresses self" seem to be an indication that certainly physically she was fairly comfortable.
A At that time, yes.

Q I just want you to help us, please, with the drugs that this lady was being administered. Could you go to the prescription charts, starting at page 279C? We can see I think that the patient was on thyroxine, which is obviously to treat hyperthyroidism.
C A Yes.

Q Frusemide.
A Yes.

Q For what?
A It is usually used for cardiac failure and sometimes used for ankle swelling.
D

Q And amiloride, is it?
A Yes. That is used for cardiac failure too.

Q Trimethoprim, is it?
A Trimethoprim is an antibiotic.

E Q Underneath that, although that is rather later, we can see fentanyl.
A That is right.

Q I think also in fact that at this time there was also a prescription for Oramorph. If we go to page 279B, do we see that on 21 October there was a prescription for Oramorph?
A Yes.

F Q Can we go back to the clinical notes? Your note was made on 25 October. The next note in the clinical notes is what?
A I think it is 1 November, which is my note.

Q That appears to be the next note sequentially.
A Yes.

G Q Can you read it through for us, please?
A Yes.

"Physically independent but
needs supervision with washing and dressing
help with bathing
Continent
H Quite confused and disorientated

Eg, undressing during the day.
Is unlikely to get much social
support at home.
Therefore try home visit to
see if functions better in own home."

Q There is no note between 25 October and 1 November. If the patient's condition had not changed, would you necessarily expect there to be any note?
A No.

Q Again, going back to the drug charts, please, a drug called chlorpromazine was issued. If we go to page 279B, we can see right at the top chlorpromazine was given.
A Yes.

Q Can you tell us, please, what chlorpromazine was used for?
A It is a tranquilliser.

Q That sort of dosage of chlorpromazine of 50 mg?
A A substantial dose.

Q If we go to 15 November, back to the clinical notes at page 156, we can see that apparently there had been something of a change in the patient's condition.
A Yes.

Q This is not your note, I do not think.
A It is.

Q I am sorry. Before we go through the note, where are you getting this information from?
A From the nursing staff or Dr Barton, if she was present on the ward round.

Q So this is not obviously based on what you have seen of her?
A No.

Q Can you just take us through your note, please?
A Yes.

"Very aggressive at times
Very restless – has needed thioridazine"

Which is another sedative drug, tranquilliser rather.

"On treatment for [urinary tract infection] – MSU sent"

That is a mid-stream specimen of urine because of blood and protein in the urine.

"[On examination] Pulse – 100/regular
Temperature 36.4
[Jugular venous pressure not elevated]
HJR ..."

This is hepato jugular reflux. It is a test of whether someone might be in heart failure. It was negative.

"Oedema +++ to thighs
[heart sounds] – nil added"

B Meaning the patient had normal sounds –

"Chest clear
Bowels regular – PR"

That means "per rectum"; a rectal examination had been done on 13 November 1999.

C "... empty
but good bowel actions since."

Then in brackets an asterisk with "MSU – no growth". What that probably reflects is that a member of the nursing staff had gone off and found the result of the specimen of urine and it said there was no growth.

D "Asked Dr Luznat to see."

Dr Luznat is a consultant in old age psychiatry.

Q The fact that this lady appears to have a UTI or consideration for a UTI, is that something that would normally be noted in these clinical notes, or not? It has been noted by you obviously.
E A Yes, ideally, but urinary tract infections are quite common and it certainly often would be my experience in the past that people have not recorded things like a urinary tract infection in the notes because it is thought to be relatively minor, but it should be in ideal circumstances.

Q If we look at the note underneath yours, is that a sort of referral?
A Yes.
F

Q It is a referral written in the clinical notes.
A Yes.

Q That is to Rosie Luznat, who I think is the doctor that you have just been referring to.
A Yes.

G Q That says:

"Thank you so much for seeing Elsie. I gather she is well known to you."

Can you read it any better than we can?
A I think it is:

H

"Her confusional state has increased in the last few days to the point where we are using thioridazine."

Q That is the sedative that you have referred to, is it?
A Yes.

Q Then there is a reference to her renal function.
A Yes.

"Her renal function is deteriorating. Her MSU showed no growth. Can you help? Many thanks."

Q The patient I think in fact continues on thioridazine. It is administered, according to the drug charts – and I will lead you on this, if I may – on 17 November in the afternoon.
A Yes.

Q Then if we go to the top of page 157, can I ask you this? We have seen your two notes on the 1st and the 15th. If a patient deteriorated, first of all, would you be available to be spoken to by Dr Barton if she required any assistance?
A Yes. I might not be immediately available, but I should be available.

Q Was that your role?
A To be available, yes.

Q And to give advice if it was needed.
A If Dr Barton felt she wanted advice, yes.

Q Then at the top of page 157, we can see:

"Elderly Mental Health

Thank you. This lady has deteriorated and has become more restless and aggressive again. She is refusing medication. She does not seem to be depressed and her physical condition is stable."

Yes?
A Yes, I think that is what it says.

Q Then I think it is:

"I will arrange for her to go on the waiting list for Mulberry Ward."

Mulberry Ward we have heard quite a bit about. It was the elderly psychiatric ward.
A Yes.

Q The next note is made by Dr Barton. You at the time did not have any dealings at this period of time.
A No further contact after that last note.

Q I just want to ask you one matter about this. If we look at the next note made by Dr Barton on 19 November:

"Marked deterioration overnight
Confused, aggressive. Creatinine 360
Fentanyl patch commenced yesterday
Today further deterioration in general condition."

In what circumstances to your knowledge is a fentanyl patch be appropriately used?
A For a patient who is in pain and/or distress.

Q Pain or distress.
A Yes. I think its licence indication is for pain, but, like diamorphine and opiates, they are often used where it is unclear as to whether the patient's distress is physical or mental or a combination of both.

Q Where a doctor has taken the decision to place a patient on opiates - and fentanyl is an opiate, is it not?
A Yes.

Q Is that something that you would or would not expect a note to be made in a clinical record, the reasoning behind it?
A Yes, I would expect a note to be made of the reason for it being started.

Q We can see that the note on 19 November finishes – I think it is "Please make comfortable. Am happy for nursing staff to confirm death".
A Dr Barton has written "Confused and aggressive", which is clearly someone who is distressed.

Q If we go to page 281 – have you got the original prescription sheet still? Have you got it?
A I am not sure.

Q If you pass the file to us we can find it for you and hand it back. (Same handed) (After a pause) You are going to have the file handed back to you. (Same handed) If you would like to take the prescription sheet out. I just want to concentrate on the drugs that were prescribed and administered on 19 November. Now, I am afraid I cannot tell you where it will be on the original, but you will find at the very bottom of one of the pages, I think, an entry for fentanyl.
A Yes.

Q We have that on our 279c. We have already looked at 279b, which is 19 November, chlorpromazine.
A Yes.

Q Then we can look, our page 281, at diamorphine 40mg and midazolam 40mg.
A Yes. Midazolam 20-80mg.

Q Yes, but actually it was 40, was it not?
A Started on 40.

Q Started on 40. So on 19 November, it appears, in the morning at least, that this patient had in her system fentanyl, chlorpromazine, midazolam, diamorphine. Is that the sort of prescribing that you would ever have written out?
A I think I would have been more cautious in my use of diamorphine and midazolam.

Q More cautious?
A Yes.

Q How much more cautious?
A Well, I am not an expert in opiate prescribing and fentanyl in particular, and what I would have wanted to do is make reference to the *British National Formulary* to see---

Q I was just going to ask you that: you have said on a number of occasions that you are not an expert in prescribing, opiate prescribing particularly.
A Yes.

Q Would you have had reference to the *BNF*?
A Would I?

Q Yes. Would you have followed the guidance?
A Yes.

Q Do you say you did not see these prescriptions? Sorry, you are shaking your head.
A Sorry. No, I did not see them.

Q If you just give me a moment, please. (After a pause) You told us about your view so far as the clinical notes are concerned of recording the use of fentanyl. What do you say about the necessity or otherwise of recording the prescription and the use of the other opiate drugs?
A I think the change should have been recorded.

Q Can I finally just ask you this: you have got the original prescription sheets in front of you.
A Yes.

Q Can you just take one up, and it may be if you use this as an example. Throughout these prescription sheets in relation to the patients that we have been dealing with on Dryad Ward, the three patients that you have been talking about, Dr Barton has prescribed a wide variable dose, yes?
A Yes.

Q Can you explain why you did not see those?
A I mean, I must have seen them, but I do not recollect seeing them.

Q If you saw them, why did you not take action about them?
A Well, I should have done.

MR KARK: I see. Would you wait there, please.

THE CHAIRMAN: I think we have reached the point where we should give the doctor a break. He has had an hour of examination in-chief. So we are going to break now. You will be taken somewhere where you can get some refreshment, and we will return, please, at quarter-past three, everybody. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

Cross-examined by MR LANGDALE

Q Dr Reid, obviously I am asking you questions on behalf of Dr Barton, you will appreciate that.
A Yes.

Q I have quite a number of matters to ask you about. What I will try to do is to ask you about general matters first of all, to seek your assistance about various points, touching upon points you may have already mentioned yourself, but I am inviting you to flesh them out and so on, and then towards the end of my cross-examination I will turn to the individual patients you have been asked about. It may be that at times we will come back to a particular topic, but I will try and keep it in that sort of order. First of all, this: you have described in your own statement, and I quoting your words, that you thought Jane Barton was a good doctor.
A Yes.

Q I would like you to flesh that out a little bit more. Why do you say that?
A Well, I felt that she was assiduous in attention to her duties when working at War Memorial Hospital. I obviously was only there for one afternoon per week, and, in situations like that, one often relies on the nursing staff for feedback about how a doctor is performing, and the nursing staff were, I would say, fulsome in their praise for the support that Dr Barton offered them. I never ever heard it suggested that Dr Barton had not attended or been unhelpful in giving advice. She was a great source of support to the nursing staff, and I felt the patients were being well looked after.

Q So I think it follows, from what you have been asked and the remark you made, that you were not somebody who had concerns about the standard of nursing care, and you were not somebody who had concerns about the standard of medical care?
A That is correct.

Q Did you also, so far as you could get the picture, whether from others or your own observations, form any conclusion about Dr Barton's attention to the needs of relatives?
A I mean, I think that is difficult to answer, because I was, as I say, there once a week, but certainly what I am aware of is that Dr Barton did come in in her own time to speak to relatives.

Q I think at one point in the voluminous records we have of things that have said, either by way of interview with the police or your evidence at the inquest, that the impression you got was that she did a lot of counselling and advising of relatives.
A I certainly know she would see relatives at the request of the nursing staff.

Q Did she on any occasion seek your advice about things?

A I would say on three or four occasions during the year perhaps Dr Barton sought my advice.

Q You have indicated to the Panel that Dr Barton was more experienced than you were in certain areas, is that right?
A Yes.

B Q It nonetheless remains the case, does it not, that she was, as it were, responsible to you?
A Indeed.

Q You were the person whom she was entitled to expect would correct her if she was doing something wrong.
A Yes.

C Q She was entitled to expect that you would advise her and guide her if you felt that she needed advice and guidance.
A Yes.

Q In general approaches to care and a whole range of other matters.
A Yes.

D Q I think also it follows from what you have already told us that if you thought something was wrong about her practice, or something which ought to be corrected or amended, you would say so?
A Yes.

Q It was not as if you hesitated to exercise your proper supervisory duties?
E A No.

Q Obviously there were a number of pressures on Dr Barton.
A Yes.

Q She was working as a clinical assistant to deal with the needs of a number of patients in two wards, Daedalus and Dryad.
F A Yes.

Q Obviously her duties with regard to, whenever she could, seeing relatives, another aspect.
A Yes.

Q Somebody who had far from unlimited time in order to carry out those duties.
G A Indeed.

Q It is not her fault; that was the fault of the way the thing was set up.
A Yes.

Q It is not obviously your fault, but would it be right to think of both of you, different roles, because no doubt you were under pressure as well, and I will come to that in a moment,
H

both of you endeavouring to perform your respective roles as best you could in the circumstances you found yourselves?
A Yes.

Q The Panel have already heard about the comparatively limited amount of time that she had in order to perform her functions - I do not think there is any dispute about it, so I need not trouble you with that – but you knew that she came in and did a morning round, or check, every morning Monday to Friday?
A Yes.

Q You knew that also she would come back, usually in the middle of the day, and hopefully also be available for you when you did your ward rounds?
A Yes.

Q Also, that she was somebody who would attend on occasion, not necessarily every day but on occasion, later on in the day perhaps to see relatives, or whatever it might be?
A Yes.

Q A significant number of patients to attend to on the two wards.
A Yes.

Q Patients in general terms who presented with a number of different problems.
A Yes.

Q May I just ask you, while we are dealing with that, about the state on the wards? I appreciate you can assist us with Dryad, a well run ward and all the rest of it, there is no dispute about that, but just the general nature of the patients? Do we have a picture of everybody just sort of sitting around, or lying in their beds peacefully and not doing anything? What is the general picture in terms of patients with dementia and so on?
A Well, it would be a very sort of mixed picture. There would clearly be some patients who would be extremely dependent and probably presented a heavy nursing burden, but in terms of medical attention did not require very much, and that was the predominate population, as I understand it, when the ward was established, but that gradually changed so that, as I have said before, patients of increasing dependency, and by that I mean in terms of getting someone out of bed involves more effort than nursing someone who is usually confined to bed. Also, because the patients were probably being transferred at an earlier stage than had been previously done, they would have been more likely to be medically unstable than they had been in the past, or develop medical problems while they were there. So in that sense I think the workload medically certainly increased, and I would suspect that the nursing workload did too, because what we tried to do when we were presented with patients who we felt did need some physiotherapy and occupational therapy we managed to negotiate they would at least be assessed by a physiotherapist or occupational therapist, but the nursing staff would have to try and carry out what the physios had recommended.

Q You have already spoken about the problems that might exist with patients who just were not able to cope with that, for example patients suffering from dementia and so on, but there really were not any facilities for physiotherapy on Dryad?
A No.

Q I also want to ask you about the difficulties that might arise with regard to nursing with patients suffering from dementia and so on. Might they present problems in terms of---
A Well, indeed; restlessness, confusion, et cetera.

Q Different people seem to use different expressions but I think you probably covered the spectrum in a very general sense. Can I just ask you about the pressures on you yourself?
A Yes.

Q You were under quite a lot of pressure?
A Yes.

Q You had not only your role as a consultant, which you described, but you were also, I think you told us, the medical director of the Plymouth Healthcare Trust?
A Portsmouth Healthcare Trust.

Q I am sorry – not Plymouth. Portsmouth. That no doubt took up a certain amount of your time?
A A very substantial proportion.

Q And there was a further pressure, again which you said something about but I would like you to expand on this a little, in terms of the desire of the two main hospitals we are concerned with, obviously – Queen Alexandra and the Haslar – the desire to move, and I do not mean in some frightful, inhumane sense, but the desire to move on patients as quickly as possible to free up beds on acute wards?
A That is correct.

Q No doubt a pressure felt in many other places in the country, but what is the effect of that in terms of the impact on Dryad?
A I think that it meant that patients who were not wholly suitable for transfer to Dryad Ward were transferred.

Q Can I ask you about that by way of enlargement on what you have told us. Did you find in your experience that the hospital sending the patient on to Dryad, seeking and obtaining the transfer to Dryad, was sometimes presenting a slightly rosier picture of the patient's general medical stability?
A Yes.

Q And how would that manifest itself. We have come across one example already, I think, in what you said, but in general terms how did that show itself?
A Because of the interest in moving patients on from specialty wards they would make light of, perhaps, new medical problems that had developed. So, for example, if someone was being transferred from a cardiology ward who had had a stroke, they did not necessarily say, "This patient has had a stroke." What often happened was there was a considerable delay between my colleagues and I assessing a patient on an acute ward and them being transferred – up to three weeks.

Q I am sorry. So first of all the gap between your assessment and the actual transfer - yes?
A Yes. And as a result the patient's condition had often changed in that time, but because we had accepted the patient and they are on the waiting list, the wards were only too

happy to let the patient come and perhaps not be as forthcoming as they perhaps ought to have been about the problems the patient had, at the time of transfer.

Q It would not necessarily be a surprise – I appreciate it depends individual patient to individual patient – if the assessment and view of a patient arriving on Dryad would be different from the transfer letter assessment?
A Oh, quite different on occasion.

Q I am leaving aside the question that in some patients, as we have already heard, there might in fact be a deterioration as a result of the very transfer itself?
A Yes.

Q Which is something, again, you would be familiar with?
A Yes.

Q As a possibility. I think it follows from what you have said already, that would have a knock-on effect with regard, for example, to the prospects of mobilising a patient for rehabilitation generally?
A If patients had had an intercurrent illness develop in the interim, then that could clearly prejudice any chances of rehabilitation. Also, there was a tendency for staff on other wards to say things to relatives like, "We'll transfer to the War Memorial and they will soon have her walking in no time", in the interests of encouraging the transfer and persuading the relatives to accept the transfer.

Q So an effect, is on the expectation, as it were ---
A Absolutely.

Q --- of the relatives. Are we talking about a minor problem or a real problem, or what?
A Sometimes a very significant problem.

Q How would those manifest themselves?
A Patients or relatives being told that they were coming to the War Memorial Hospital for rehabilitation when the reality would be that on assessment the chances of rehabilitation were remote.

Q How might that manifest itself in terms of the relatives feeling towards the staff?
A Dissatisfaction, concern and, not unnaturally, relatives want to listen to the more optimistic prognosis.

Q I think around 1999, and that is really the period we are concentrating on so far as you are concerned ---
A Yes.

Q Around 1999. It was not the practice to have any staff reviews or regular supervision?
A No.

Q Again, lack of resources. Is that what we put that down to?
A No. Appraisal was not compulsory at that time – the sort of appraisal I am talking about, medical staff appraisal.

Q But in terms of supervision by consultants, were there constraints upon that or not?
A In terms of time, yes.

Q May I just ask you this in a general sense, about what you would expect as a consultant with regard to a decision made by the clinical assistant, in this case Dr Barton – obviously the only real person at the time we are concerned about. Would you expect or would you not expect to be informed by the clinical assistant if the position had changed with regard to a patient?
A No. I would only expect her to contact me if she had significant concerns about that change.

Q Would you expect or not expect contact with you if Dr Barton decided the time had come for a patient to receive analgesia subcutaneously, in other words via a syringe driver?
A No, I would not have expected that.

Q Or, as another illustration, Dr Barton deciding that it was appropriate for to record the fact that she was happy for nursing staff to verify or confirm death?
A Sorry. Could you just repeat that.

Q Would it be something you would expect or not expect, for Dr Barton to contact you about in terms of her concluding that she wanted to record the fact that she was happy for nursing staff to verify or confirm – whichever word was used – death?
A No. I would not have expected her to do that.

Q I want to ask you more than one thing about prescribing practice by Dr Barton, but I am going to try and deal with it in sections. I appreciate they may slightly blur, the one into the other. What has been described as anticipatory prescribing?
A Yes.

Q What do you understand by that expression?
A It is prescribing of a medication and for someone who does not require the medication at that particular moment, but in whom one might reasonably anticipate they would need in a shortish timeframe.

Q That is something that you knew Dr Barton did?
A Yes.

Q And I may have misunderstood you. Were you also saying that Queen Alexandra, for example, anticipatory prescribing takes place?
A It does at Queen Alexandra Hospital but just, perhaps, in relation to the last question, I cannot remember a specific incident of Dr Barton engaging in participatory prescribing, but I think there are occasions when it is appropriate.

Q Was there any occasion when you spoke to Dr Barton – again, I want to make sure we are talking about the same thing – was there any occasion when you spoke to Dr Barton about anticipatory prescribing?
A I do not recollect ever doing that.

Q Because you have told us that you did have a conversation with her about the principle, I think, of variable doses?

A That is correct.

Q So we are talking about something different when we are talking about anticipatory prescribing?
A Indeed.

Q But had you been aware of Dr Barton prescribing in anticipation ---?
A Yes.

Q Assuming it is not absolutely barmy, but reasonable anticipation, as it were, you would have been perfectly happy with that practice?
A Yes.

Q Then can I turn to variable doses, as to what we are talking about, because you indicated that before you came on to Dryad, in the sense of becoming the consultant and therefore taking on Dryad, you had possibly had experience of variable doses of diamorphine, maybe on one or two occasions, but you had a discussion with Dr Barton about this topic. What was it you were raising with her?
A It was why she was engaged in variable dose prescribing – larger range variable dose prescribing.

Q What do we mean by "larger range variable dose prescribing"?
A The recollection I have was this was in the context of a patient who had been prescribed 20 to 80 mg of diamorphine.

Q So are we talking about two different things, or the same thing? I just want to make sure. Variable dose, in the sense that there is a range, or are we talking about variable doses also meaning a range which is quite wide?
A Sorry. Could you repeat that?

Q If there is a range of a dose ---
A Yes?

Q --- whether it is 10 to 20, or 20 to 200, is that what we are talking about in terms of a variable dose?
A Yes.

Q Right. The fact that there is not a set amount to be administered to the patient?
A Yes.

Q But there is a range?
A Yes.

Q All right? So by variable prescription we are talking about something where the doctor has prescribed a range for a particular drug to be administered?
A Yes.

Q And the example you had had in mind, or your recollection is ---
A My recollection.

Q When you spoke to Dr Barton – I appreciate all the difficulties remembering exactly – was that it involved a variable dose prescription?
A Yes.

Q The diamorphine?
A Yes.

B Q With a range ---?
A Yes.

Q --- which you recall as being, I think you said ---
A 20 to 80.

Q 20 to 80?
C A That is my recollection.

Q And she gave you an explanation?
A Yes.

Q And it was an explanation which satisfied you?
A Yes.

D Q Again, in general terms – I am not expecting you to remember every word she used, and I doubt very much if she could ever remember, but what in general was her explanation which she gave you?
A As I recall, she stated that at times it was difficult for her, or her partners, to be in immediate attendance and particularly so at a week-end when she or her partners could be visiting patients as part of the on-call GP arrangements. And she had done this so that
E patients would not have to wait and suffer as a result of nursing staff being unable to contact her or her partners.

Q Would you help, please, with the importance of that fact – the desire to prevent patients unnecessarily suffering?
A Indeed.

F Q Where does that rate in importance in the scale of things?
A It is the overriding priority.

Q Because we are dealing with patients who were not patients on an acute ward recovering immediately from an operation, we are dealing with a different class of patient?
A Yes.

G Q For continuing care patients, palliative care patients, would it be right to say that the relief of pain and suffering has a particular importance?
A Yes.

Q Would it be right to say in general terms that the level of pain tolerated on an acute ward would be rather higher than the level of pain tolerated on a continuing care ward?
A Sorry. I do not follow.

H

Q We have seen cases, for example, if we take the example of one particular patient, the lady with the hip.
A Yes.

Q On paracetamol, I think it was?
A Yes.

Q After her operation?
A Yes.

Q Although obviously still in pain?
A Yes.

Q Is concern about controlling the level of pain rather less on an acute ward than it is in terms of continuing care?
A I am not sure....

Q You do not see any difference or you do?
A I am not sure that I see any difference.

THE CHAIRMAN: Mr Langdale, I am sorry to interrupt at this point, but I need to say something that perhaps I should have said at an earlier stage. It is this. We, as a Panel, are acutely aware of the stresses and strains that come with the giving of evidence. We understand how very rapidly a witness can feel exhausted. It is very important that we receive evidence from you at a time when you are feeling fit and fresh enough to apply your mind fully. If at any time you feel that it is getting a bit much, and you need to take a break, or even that you have had enough for the day, you only have to indicate, and you will not be required to go on answering questions.

THE WITNESS: Thank you very much, but I feel fine.

THE CHAIRMAN: Good. Okay – thank you.

MR LANGDALE: You can feel fortunate, Dr Reid, that counsel are not allowed the same latitude, whatever they feel about the amount of questions they have to ask.

Just on that topic, I was putting that general proposition to you that in general on an acute ward, somebody recovering from an operation, there may be less attention to the problem of controlling pain – I do not mean in the sense of ignoring it – than there would be in terms of patients on continuing care ward?
A I think if you mean because in an acute ward there are some junior medical staff 24 hours a day, absolutely, whereas in a ward like dry ward, we are dependent on GPs out of hours cover. It is a different situation.

Q That again brings me on to something I wanted to explore with you as well – that different situation, and the realities of endeavouring to care for patients on a continuing care ward like Dryad – patients coming in, maybe, for continuing care; coming in, in effect, for palliative care almost from the start and that sort of category of patient. Would it be right to consider that there is a balancing exercise that has to be carried out by ---?
A Absolutely.

Q We will start off with one obvious balancing exercise, and that is the question of note-taking?
A Yes.

Q You should know that there is no dispute on behalf of Dr Barton that her note-taking was not adequate; it was not as good as it should have been.
A Yes.

Q It may be that in the 1990s the standard of note-taking by GPs, by other doctors, was rather lower than it is now in general terms?
A Yes. Before I came to Portsmouth, I worked in Southampton, where we had a four-ward continuing care type rehabilitation hospital, for which we had a GP in a similar role as Dr Barton. His notes were equally brief. I know from colleagues who worked in other community hospitals in Portsmouth – I am talking in general terms – note-keeping was much briefer than it is now.

Q In any event, you would be aware of the brevity of her note-taking, but there was no occasion on which you thought it necessary to speak to her about it by way of pulling her up about it?
A No.

Q May I just ask you this as well. Was there ever any occasion when you had any difficulty understanding what the position was with regard to a patient as a result of the brevity of Dr Barton's notes?
A Never, I would see part of my role in the ward round as not just talking to medical staff that were present, but asking the nursing staff about what was happening, because medical staff cannot be there all the time. One is heavily reliant on nursing staff for information.

Q Again, give us an idea of how important that was to you, reliance on the information from the nursing staff?
A Critical. Critically important.

Q May I ask you this in general terms, about the nursing staff on Dryad. You told us about the standard of care, and I am not going into that again, but in terms of whether you felt you could trust the nursing staff to perform their duties properly?
A Without question. I said earlier that I was very impressed by the quality of the nursing staff we had on Dryad Ward.

Q When you asked Dr Barton about the rationale or the reason for the variable dose, and she explained to you what the reason was, as I understand it, you yourself did not have any concerns that there was any real risk that a member of the nursing staff would suddenly do something absurd, and just up the dose by some ridiculous extent?
A Yes, I trusted the nursing staff.

Q Again, dealing with the problems that existed by virtue of the set-up – not Dr Barton's fault and not your fault – and the balance that had to be carried out, the balance between, "Do I spend time taking fuller notes or do I spend time attending to patients?" that is the choice, because that is really what it comes down to, is it not?

A At times the pressure can be very difficult.

Q Where do you think the balance lay between spending time writing up more ample notes or time spent looking after patients?
A Oh, it has clearly to be with seeing patients.

Q Because of that problem, with Dr Barton not being there save for the limited periods of time we have already discussed, there is a problem with what one does about making a decision as to what should be the starting dose for a particular drug. We are focusing on opiates here obviously. Would you agree?
A You have to make a judgment. There are guidelines about what the starting dose should be, but you have to make a judgment about the patient in front of you.

Q If you have a fully medically staffed ward, in the sense of somebody being available, as it were, all day, medical staff available all day, it is much easier to take an approach with regard to the administration of opiates which is bit by bit, a gradualist approach.
A Yes.

Q That luxury is not afforded if the doctor cannot be there save for limited periods of time in the day.
A That is correct.

Q So it would not be a surprise to find a doctor in those circumstances prescribing higher than might otherwise be the case if the doctor was there all day.
A Or certainly prescribing a wider range.

Q Or a wider range. But there is a difficulty, if the starting dose is too low, that the patient, when the time comes to start on the opiate, will have suffered unnecessary pain.
A Yes.

Q How would you assess the importance or the significance of the doctor's own judgment about this, the doctor who has seen the patient and knows what the situation is?
A It is critical.

Q Was Dr Barton somebody in your experience of her who made medical judgments with little or no reason behind them?
A I would have said not.

Q There therefore has to be a balance struck, perhaps with the patient in the middle, but a balance struck between nursing and medical care dealing with the problem with the patient in terms of pain control and the pharmacological approach.
A Indeed.

Q Requiring judgment. Yes?
A Yes.

Q How would you weigh the significance of experience in this field? Is that something which counts for much or little or how do you see it?
A Considerable.

Q In your experience, would it not be surprising to find two doctors, perfectly genuinely, perfectly sensibly, coming to a different conclusion as to what the appropriate dose was with regard to the administration of opiates?
A Yes, it could happen.

Q One doctor might say, "I think in the circumstances 20 is about the right starting point." Another might say 10.
A Yes.

Q Another might say 40.
A Yes.

Q As long as there is a sensible reason for prescribing a particular drug at a particular dose range or limit, then that course is justified.
A Yes.

Q Still on the same topic of pressures that people were under, you have told the Panel about the change with regard to patients, the type of patient and so on, and the increasing pressures both on medical staff and nursing staff. I think there came a time in the early part of 2000 when you had a conversation with Dr Barton about the pressures.
A Yes.

Q We know that there came a time when Dr Barton handed in her resignation.
A Yes.

Q Without going into unnecessary detail, that was because of the pressures which had been put upon her in terms of demands on her time and the expectations and the reality of the situation she faced.
A Yes.

Q Indeed – and again it was probably not your decision, although you may have been involved in discussions about it – a decision was taken by the management side that what was needed was a full-time doctor.
A Yes.

Q Again, I am not worried about all the details, but would you assist the Panel with what came into place after Dr Barton had resigned and left because of the pressures she was under?
A Yes. They appointed a full-time clinical assistant who was working 9 to 5 and Dr Barton's role then was covering 44 beds. Today it is actually 30 beds. It is covered by two junior doctors, plus half an associate specialist's time. So we have two and a half doctors looking after fewer beds.

Q Immediately after she left, there was one full-time doctor.
A That is correct.

Q It may be stretching your recollection too far, I do not know, but what was done in terms of night-time and weekends, when that doctor would not actually have been there? Was there some kind of on-call arrangement?
A Yes. There was an arrangement made I think with one of the local practices to cover all of – I cannot recall.

Q But we can think in terms of there being some sort of cover at the times when, am going to call it the 9 to 5 doctor, although that may be unfair, was not available.
A Yes. Perhaps if I might illustrate that. If I remember correctly, while Dr Barton was in post, there would be approximately about 40 out of hours calls per month to Dr Barton and her partners. After we appointed a full-time clinical assistant, I think it dropped to four.

B Q Still on the same topic, with regard to the provision of services by consultants when Dr Barton resigned, did that remain the same or did that change?
A I think that remained the same.

Q While we are on the question of consultants, Dr Tandy was not in post when you started on Dryad. Is that right?
A She was in post before. I took over from Dr Tandy.

C Q You were not there at the same time.
A No.

Q Dr Lord was of course a consultant.
A Yes.

D Q How did you find Dr Lord in terms of her ability and experience?
A Extremely capable and likeable and just a lovely person.

Q I think it is right that you – obviously not only you yourself, but also Dr Lord – were very grateful to Dr Barton for the services and work that she had provided?
A Absolutely.

E Q Was there an occasion, even if you cannot remember the exact details, when a complaint was made? I make the point now, it was nothing to do any of the 12 patients that the Panel are considering, but a complaint was made about a patient who had been on morphine tablets and those morphine tablets or the administration of them was discontinued by Dr Barton.
A That is correct.

F Q And the patient was put on less strong medication.
A Yes.

Q What did that produce in terms of the family or the relatives' position?
A It produced a complaint.

Q Because?
G A Because they felt the patient's pain was not being adequately controlled.

Q I am not going to go into any more detail of that. Do remember when about that was? Was that 1999?
A I would think it was in 1999.

Q There was another complaint relating to a patient – again, not one of our 12 – who had
H developed heart failure on a Friday – this is again from information which you have disclosed

– when Dr Barton had prescribed morphine. That was quite appropriate in your opinion in that case.
A Indeed. It was someone who was in acute heart failure.

Q But you saw the patient yourself the following Monday and you took a decision to do what?
A To stop it, because the patient was better.

Q A further point in relation to transfers which I did not ask you about at the time we were talking about transfers. Would you assist with the question of notes being available with patients? We have seen examples of transfer letters and so on and you have told the Panel about how they might not present a very realistic picture. Not in every case, but they might not. In terms of the patients' notes, what did you find on transfer was a common occurrence?
A Missing notes, incomplete notes, no x-rays was a recurring feature of transfer.

Q I want to ask you about particular opiates. We have been talking about them in general terms, but I want to ask you about particular ones in certain circumstances. First of all, Oramorph. Was Oramorph a convenient and sensible opiate to provide, assuming of course the circumstances justified it, or was it something which caused problems?
A It would be I think most people's first choice of strong opiate.

Q In terms of opiates which we have heard mention of in terms of patients in this case, opiates such as co-codamol and co-dydramol, sometimes the choice between those two might result in the choice being Oramorph. Are there preferences for administering Oramorph compared to ---
A Co-dydramol and co-codamol are weaker opiates and I think one would look to prescribing them before prescribing Oramorph normally.

Q As you have already indicated to us, there may be circumstances where that is not appropriate.
A Exactly.

Q Oramorph again has the advantage of being flexible and of inducing a sense of euphoria to a certain extent.
A It can do.

Q It is helpful in general terms in cases involving heart failure.
A Yes.

Q Anxiety and distress.
A It is difficult at times, as I have said before, to determine whether someone's distress is physical or mental or a combination of both.

Q Then diamorphine. We need not trouble about the circumstances which justify that, because you have already given your evidence about it, but in terms of diamorphine being administered subcutaneously by means of a syringe driver, am I right in thinking that there was never any occasion in relation to any patients treated by Dr Barton where you felt the use of and the commencement of a syringe driver was inappropriate?
A I never, ever felt that.

Q Can we take it that if you had felt that, you would not have hesitated to say so?
A That is correct.

Q Did you also find yourself in terms of dealing with relatives and the pressures of time so far as you were concerned that sometimes it was a struggle for you to find the time to speak to relatives when the need arose?
A It could be difficult at times. I do recollect coming down in the evenings to speak to relatives and coming I think on one or two occasions at a weekend when I was not on call.

Q In terms of matters which might arise in terms of dealing with relatives, you have already indicated to us the problems that might arise if expectations had been raised too high, for whatever reason, but I think also it was your experience – I do not think it is something that is in dispute – that in fact the decline of patients on a continuing care ward might occur quite suddenly into what really was a terminal phase.
A Oh, yes. A patient can gradually decline or they can suddenly decline.

Q No doubt if the decline was sudden, it would be something that would be, normally speaking, particularly shocking for relatives.
A Yes.

Q I think it is right – again this is taken from something you have said yourself either in interview or at the inquest; I think in interview – you yourself in 1999 were not aware of any guidelines or protocols for the use of opiates and sedatives.
A That is right.

Q You have already told us that you were not aware of the analgesic ladder, although you would know what that would mean.
A Yes.

Q It does not mean to say your approach was not in general that, and you were not aware of the Wessex protocol.
A No.

Q I think also you have indicated in the past that it was not unusual that there were no policies in place at Dryad with regard to the prescribing of strong opiate analgesic.
A At that time I do not remember them being in place anywhere, and that applied to Southampton too, from where I had just come.

Q Yes. Well, that flows on to the next thing I was going to ask you by way of clarification, which I think you have covered; there were not any at Queen Alexandra, for example, at that time. May I come, please, to the question of the range of dose. I appreciate the difficulties of trying to remember detail back to 1999, but it may be that you have actually clarified this in the last thing you said in answer to Mr Kark, but I am putting to you that you were aware in 1999 of Dr Barton prescribing diamorphine in the range 20-200.
A No, I did not say that. I said I was aware of it being prescribed 20-80mg.

Q Yes. Well, that is why I want to clarify this. I may have misunderstood you, but at the very end of the questions you were dealing with I thought you said, when you were asked

about prescriptions in the range of 20-200, "I must have seen them and I should have done something about it".
A Indeed, I did say that.

Q So I just want to get it straight. You did see at the time prescriptions for diamorphine in the range of 20-200 or you did not?
A I do not recollect seeing them. That is what I said. I did not recollect seeing these two prescriptions.

Q Because I have to put to you, Dr Reid, that you would have seen them on a number of occasions, and that you did not at any time query it with Dr Barton. That is what I am putting to you.
A I did not query it with Dr Barton. I think I would have seen both of these prescriptions once. I did see them once.

Q I appreciate you did not have dealings with all the twelve patients we are dealing with in this hearing, but you did have dealings with a number of them, and I think with the exception of one of them they all had prescriptions which had a range of 20-200.
A That is correct.

Q So are you saying, "I might well have seen them at the time. I just do not remember it", or, "I categorically would not have seen them", or what?
A Well, certainly the one we have not discussed, which was for 20-200 as an as required prescription, where it was written on the prescription sheet I would not normally have looked. The patient was not on a syringe driver at that time, and, while I accept that it is my responsibility to have looked, I would not have done that in practice.

Q I think we had better, in fairness to you apart from anything else, just take an example of one of these drug charts, or prescription sheets, and just see what the position is. Might I have that? (To the Panel) There is a file containing a number of these and I may need to show the witness some. (Handed to the witness) I think, because some of them are now in pieces, they are not all folded together, if I could have the file for a moment I will show one example to you so we can establish what the picture would normally be. (Same handed) So the particular one I am asking the witness to look at, and I have not been through the entire file but I think it is one that is still intact, relates to Ruby Lake, Patient F. (To the witness) This is not a patient you dealt with. If I can just hold it up so that we can all see, this is the normal way in which these documents would be available to you when you did your ward round.
A Yes.

Q The first sheet has a prescription sheet, safety of the patient and all that, at the front. The inside sheet has various matters relating to the patient and so on, and has a column on the left "As required prescription".
A Yes.

Q On the inside of the first sheet.

THE CHAIRMAN: Sorry, Mr Langdale, may we at some point pass one of those around so that the Panel can be familiar with the layout?

MR LANGDALE: What I am going to suggest is if I take the witness through it so he confirms this is what they normally look like, and then I can have that handed to the Panel and they can see. (To the witness) The second page, if you are reading it through in that way, having opened up the back fold, shows regular prescription drugs.
A Yes.

Q In this particular case none of them opiates. There is then a further sheet that covers the same thing, in this case blank.
A Yes.

Q In this particular case, and it would normally be folded like *this*, back page in, cover sheet---
A No.

Q Can we go on to that in a moment. If we just deal with the content of the sheet, the last sheet, if we open it all up, has "Daily review prescriptions", regular prescription details set out on the final page of this particular case, and in this particular case on that back sheet there is diamorphine 20-200, hyoscine 200-800, I think it is, midazolam 20-80.
A Yes.

Q All by Dr Barton, with the times and dates and so on. Before we hand this to the Panel so they can see it, you were going to make a point, and you shook your head when I was showing the thing folded up. Explain.
A The drug chart was kept inside a blue plastic folder which opened out in three parts like *that*.

Q So can I just pause. It would be sitting in the folder like *this*, would it?
A No.

Q All right. How would it be in the folder normally?
A The three parts of the blue plastic folder contained a piece of clear cellophane at the top and bottom, and the whole drug chart is slipped inside that.

Q If I can interrupt you, do you mean it was sitting inside the folder like *this*?
A When you opened up the blue plastic folder, that is---

Q That is what you would see? You would see the three inside pages. Carry on.
A So unless a patient were on a syringe driver or a variable dose prescription I would not have lifted the prescription sheet out of the blue folder to see what was on the reverse.

Q How would you know there was nothing there, because it is a regular prescription on the rear sheet? It is not saying anything – it says "Daily review prescriptions"---
A On the particular patient we are talking about, she did not receive the prescription which Dr Barton had written up.

Q Yes. Again, not your fault, I am trying to take it bit by bit. So you are saying, and I will come back to that, I am just pointing out the last sheet, the one which you would have to turn over and look at---
A Yes.

Q It talks about daily review prescriptions.
A Yes.

Q What is the significance of that heading "Daily review prescriptions"?
A I think what it was designed with in mind was for using possibly with syringe drivers, with drugs like warfarin.

B Q Yes.
A So in other words where you might think of changing the dose on a daily basis.

Q I am going to pause there, and then the Panel can see it for themselves and I will ask you some more about what you were going to say. (Handed to the Panel)

C THE CHAIRMAN: Mr Langdale, while the Panel are looking at the document, if I have understood the evidence correctly, this blue folder in effect blocks out entirely a view of what is in effect the back of the form when it is opened out, so that the only thing that would be visible when it is in the blue folder would be those three inside pages, as it were.

MR LANGDALE: I am going to ask the witness about that in a moment, because he was about to say something and I cut him off, and I want to make that quite clear when we take on board the shape of the thing. A lot of the others, the pages have come apart and they are
D separate. (After a pause) (Handed to the witness) Dr Reid, you heard the Chairman's last point?
A Yes.

Q And I was going to ask you: we picture it unfolded?
A Yes.

E Q In this, we will call it, the blue cover?
A Yes.

Q Supposing you wanted to look at what was written on the back sheet. What would you do when it is sitting in the blue cover?
A I would have to take it out of the blue cover.

F Q So the back of the blue cover is not transparent, so you cannot see what is on the back of the sheet?
A No.

Q If, however, the prescription for diamorphine – and I am focusing on that for obvious reasons – was written on one of the inside pages. I am holding up an example which you will look at later on dealing with the case of Enid Spurgin, our patient I?
G A Yes.

Q I think Mr Kark asked you about this. We shall come on to the photocopies in due course. You would see the range?
A Yes.

Q And there is a range plainly, in her case – diamorphine 20-200?
H A Yes.

Q You could not have missed that, could you?
A I could not have done, but I do not recollect seeing it.

Q Really we have to conclude you must have seen it. We should conclude, should we not, that you did not take it up with Dr Barton, although you had seen it?
A I have already acknowledged that I have no recollection of it. It is my responsibility to see that, to review prescription charts and where there was an entry like that to have taken it up with Dr Barton.

Q Because it would be a considerable concern for you as the consultant to check what the patient is on?
A Yes.

Q And to see what the prescribing history was?
A Yes.

Q In regard particularly to opiates of this kind?
A Indeed.

Q It obviously would have a significant effect upon your judgment and analysis of the situation?
A Yes.

Q We may have to come back to that just to illustrate the point with regard to the patients you yourself saw, but I am going to leave that for the moment, thank you. Perhaps you could fold that up, and then somebody can put that back in the proper little plastic folder for Ruby Lake. (So done) Thank you very much. I want to ask you, please, and it is still in the same context ---

THE CHAIRMAN: Mr Langdale, I am sorry. The witness has been on the stand now for more than an hour, and I am getting indications from the Panel that they, at least, would appreciate a short break.

MR LANGDALE: Sir, of course.

THE CHAIRMAN: If that is a convenient moment, as you are about to move on – if there is ever a convenient moment.

MR LANGDALE: Of course. Just for the Panel's benefit, I am going to ask him about a couple of documents – they are not enormously long – but touching upon the same topic really, the same issue, and unless there are any other general questions I need to ask, I will be turning to the individual patients, which I will not be able to do within five or ten minutes. Those are going to take a bit of time. I imagine, depending on how long the Panel propose to sit this afternoon, that probably my questions may well run into tomorrow. I just say that to give you an indication.

THE CHAIRMAN: We normally sit until five o'clock as a general deadline. If we take a break now, then we are going to come back in in fifteen minutes or so and have not a great

deal more time. It therefore may be, if everybody is happy, we continue with the questions on this section now and then, tomorrow morning, resume and deal with the patients.

MR LANGDALE: If that is convenient to the Panel, it may certainly be convenient to me and it may be convenient for the witness. I do not know.

THE CHAIRMAN: Would that ---

THE WITNESS: Yes, that is fine.

THE CHAIRMAN: Good, thank you. Panel? (The Chairman conferred with the Panel) Yes, very well. That is what we will do, Mr Langdale.

MR LANGDALE: Thank you very much. (To the witness) Dr Reid, some further documents – not a great number of them. I would like you to look, please, at this one. First of all, I will get the witness to identify it before the Panel have it. This is a document which, as you will see in a moment – I will make sure you have a copy – is a letter from Barbara Robinson, a lady whose name will be familiar to you, in October 1999 and it is headed "Learning Points from the Wilson complaint". I am not asking you to read every word of it at the moment, but perhaps you would like to look at the last line but one where you see a Christian name. I would just like you to consider whether that would be referring, apparently, to you?

A I suspect it was.

Q It looks like it, but I think we have to confirm that with you.

THE CHAIRMAN: Mr Langdale, do you wish us to receive this as an exhibit?

MR LANGDALE: I think I have gone as far as I need to. It is October 1999, when you are still engaged, obviously, in the Dryad Ward. Does this ring any bells with you?

A I had not seen it until perhaps a couple of months ago.

Q At the time do you remember seeing it? I am going to ask for the Panel to have it, and then I can ask the questions if I need to about it.

THE CHAIRMAN: We will receive it as exhibit D4, please, ladies and gentlemen.

MR KARK: I am sorry to interrupt, but before this is handed out, I am a little troubled by this. The witness said he has never seen it, and he was not aware of it.

THE WITNESS: I saw it two months ago, just before the inquest.

MR KARK: He might have seen it two months ago, but how is that going to assist the Panel in relation to his state of mind at the time of these events, which is what he is being asked about. There may be a way of introducing this legitimately by calling evidence about it, but I do not quite understand how this witness can help you about his state of mind at the relevant events by looking at the document which he has not seen till two months ago.

MR LANGDALE: Sir, the writer of this letter will be called in due course. I think I must put it to the witness to see what he has to say about it. Apparently it refers to him even if he has

not necessarily seen the letter itself, except shortly before the inquest. I am entitled to ask him about it. It is the only way the Panel are going to make sense of the questions.

THE CHAIRMAN: Mr Kark, if the letter is coming in advance of the witness ---

MR KARK: I absolutely accept that. If the writer is being called, then I certainly accept it can be put in.

THE CHAIRMAN: Thank you very much.

MR LANGDALE: I understand the nature of my friend's objection if we were not going to call the writer of the letter.

THE CHAIRMAN: Thank you for clarifying that. As I indicated, we will now receive that in evidence and marked it exhibit D4, please. (Document marked and circulated)

MR LANGDALE: Do you still have a copy in front of your?
A I have it here.

Q We appreciate, without my reading through every word of the letter, that it is not to you.
A Yes.

Q Top right-hand corner: it is to somebody called Max Millett?
A Who was the Chief Executive.

Q The Chief Executive of the then Portsmouth Healthcare Trust?
A Portsmouth Healthcare Trust.

Q And is he still the Chief Executive of whatever the new ---
A No.

Q He is not. But he was then? All right. And Barbara Robinson was a manager at the Trust, I think?
A Yes, she is a manager in Gosport War Memorial Hospital.

Q Dated 27 October 1999, top right. "Learning Points from the Wilson Complaint". She is thanking Mr Millett for his memo and a copy of Dr Turner's letter. The first section is "Microfilming" and I am not going to trouble you with that. The next, 2b), is "Nursing Care Plans":

> "This has been picked up as part of the Clinical Governance Action Plan..."

And 3d) "Good Practice in writing up medication." That is the bit I want to focus on with you if I may.

> "It is an agreed protocol that Jane Barton, Clinical Assessment, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not

written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient.

Ian may wish to raise this at the Medicine and Prescribing Committee.

I hope this cover all the points

Barbara"

I think it may follow from what you have said, you never actually saw this letter at the time?
A I have never seen the letter.

Q Except for it was drawn to your attention before the inquest?
A Yes.

Q But the suggestion that you, Ian, may wish to raise this at the Medicine and Prescribe Committee. What happened there?
A I have no recollection of this now. I am not aware of any protocol which existed which allowed Dr Barton to write up diamorphine for a syringe driver with doses ranging between 20 and 200 mg a day. I am not aware of any such protocol.

Q This is something you did not know anything about at the time? Yes?
A Correct.

Q Nobody had said to you, "This apparently is a protocol and you may wish to raise it." Nobody asked you to do that?
A Not to the best of my recollection.

Q In the ordinary course of events, would Mr Millett, having received a message like this or a letter like this from Barbara Robinson, would you have expected him to pass it on to you or raise it with you?
A I would have expected him to.

Q All right, but you have no recollection ---
A Absolutely not .

Q Indeed, you are saying, "So far as I am concerned, that did not happen"?
A As far as I am concerned there was not an existing agreed protocol .

Q That I fully understand. I just want to make absolutely clear, in fairness to you, are you saying Max Millett never mentioned to you anything about ---
A I have no recollection of this at all.

Q All right. That is as far as I can take it with you. Do you want to add something - sorry?
A No.

Q Then there is another document which I would like you to look at, which is headed "Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion".

Take a look at it, see if it rings a bell and then I will see if you can assist us with that. (Same handed) Dr Reid, looking at that, does it ring any bells with you?
A Yes.

Q Down in the bottom left, it looks as though it is a document emanating from you.
A Yes, I was the author.

Q In that case, I think the Panel can have the document.

THE CHAIRMAN: Mr Kark, are you content for us to receive it?

MR KARK: I have just been given it. At this stage I have no objection to it going in, on the basis that it is a document about which the witness can give evidence. Can I ask if this is being produced by a witness in due course, somebody who is going to speak about it?

MR LANGDALE: This witness is going to speak about it, because it is his document.

MR KARK: I am sorry. I did not hear the witness say that.

THE WITNESS: Yes, I am the author of this document.

MR KARK: I beg your pardon. I did not hear. I accept that entirely.

MR LANGDALE: Then perhaps it can be handed to the Panel. (Same handed to the Panel)

THE CHAIRMAN: We will mark it D5, Mr Langdale.

MR LANGDALE: If you just take a moment to look through it, Dr Reid, it may be you are familiar with it. (Pause for reading) Dr Reid, I need to take you through most of this quite rapidly, I hope, and the Panel will be able to follow it as we go through it. Looking in the bottom left-hand corner, it is your reference, as it were, and it looks like the date is 3 December 1999.
A That is correct.

Q Would you just help us, please? How did this come about? Was this something you were asked to do or is it something you produced yourself by way of a protocol?
A I think where this originated from was the Wilson complaint, where we had had an independent consultant come in to review that complaint. As part of reviewing that complaint, she wrote to the chief executive, expressing concern about the range of diamorphine that had been administered or had been prescribed for a particular patient. It was as a result of that – I think principally that – that I felt we needed to have clear policies and procedures in place for the prescribing of diamorphine.

Q Thank you very much. That gives us the context. May I make it clear, the Wilson the witness is referring to is not the Wilson we are concerned with as Patient H? Can we just look at what it says:

"INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to who much analgesia (diamorphine) to administer within a variable dose prescription.

So we can see what you are talking about. Then:

"DOSAGE

Guidance from the palliative care services indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day i.e. up to 2 x 'Xmg' should be given."

You have dealt with that already.

"PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

If the previous 24 hour dose has made the patient unduly drowsy etc, the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be

adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes."

We can just take a moment to look at the Infusion and Pain Control Chart, which is attached to your document. That was, as it were, compiled by you as an illustration.
A Yes.

Q The next page is the Diamorphine Infusion and Pain Control Chart. So this was something which you were seeking to institute.
A Yes.

Q May I just ask you this, because it is obvious you stand by the content of that, because you have explained it in your own evidence. Was that something which actually did come into place? Do you remember?
A No, not in that form.

MR LANGDALE: That may not matter. Sir, that is all I need to ask about those documents and if that would be a convenient moment for us to break, then may we do so?

THE CHAIRMAN: Yes. Thank you very much indeed, Mr Langdale. Doctor, we are going to break now and we will be returning at 9.30 tomorrow morning. Is that convenient to you?
A That is very convenient, thank you.

THE CHAIRMAN: Very well. I remind you that you remain on oath. Please do not discuss this case with anybody in the intervening period, nor allow anybody to address you on the subject. Thank you very much indeed. 9.30, ladies and gentlemen.

(The Panel adjourned until 9.30 a.m. on Wednesday, 1 July 2009)