GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 1 July 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 SEVENTEEN)

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. Good morning, doctor, welcome back. Please take a seat. I remind you, of course, that you remain on oath and we broke yesterday when Mr Langdale was about to turn to the matter of individual patients.

MR LANGDALE: That is correct.

B

RICHARD REID, Recalled
Cross-examined by MR LANGDALE, Continued

Q Dr Reid, I am not going to trouble you with any matters relating to Patient E, Gladys Richards, whom you spoke about – the one contact you had with her. There is nothing I need to ask you by way of fleshing out what you said, so I am going to turn right away, if I may, to the position with regard to Patient I, Enid Spurgin. I just want to deal first of all, please, with the sequence of events. I do not know whether you have at the beginning of that file a chronology?

C

A Yes.

Q I do not know whether you have the up to date one, the full one. Does your start with an entry on the 19 March?
A Yes.

D

Q Then various bits in italic print?
A Yes.

Q Then I am sure we are looking at the same document. Wherever possible I am going to try to use this for assisting us getting through this quicker than we might otherwise do. Would you look, please, in that file at page 374, using those numbers that have a little dash either side. We can see there the notes you made on page 374.

E

A Sorry, is this in the ---

Q Yes, sorry. I will indicate when we are going to the chronology. We need to actually look at the document itself.
A Yes, thank you.

Q You have already covered this.

F

> "A delightful 92 year old lady... She is still in a lot of pain which is the main barrier to mobilisation at present – could her analgesia be reviewed?"

A Yes.

Q Can we take that as being that you thought she perhaps needed to receive more analgesia than she was currently receiving?

G

A Yes.

Q Would you then look, please, at page 301, bearing in mind the date of your seeing her in hospital was 23 March.
A Yes.

H

Q You are writing there to Surgeon Command Scott later on in the month, on the 26th – all right?
A Yes.

Q And you say in the first section of your letter that you had visited Mrs Spurgin at Haslar on 24 March. Now, maybe it is a mistake on the date, but it is one visit only that we are talking about?
B
A Yes.

Q So really it appears to be a typo in the letter, the 23 March. Your note says the 23rd?
A Oh, yes. I beg your pardon.

Q You see what I mean?
A I beg your pardon, yes. I understand what you mean.

C

Q I just want to be clear that it is not two visits. It is you seeing her once?
A That is correct.

Q It looks as if it is sensible to go on the date as being the 23rd? All right?
A Yes.

D
Q Could we go to the chronology that is at the front, if you would, and go to page 6. We can see the date, 23 March, is there but what is recorded in the history column, as it were, is from nursing notes and therefore not from your review. If we move on to page 8 in that same chronology, if you would, at the top, which appears to be in the section involving 24 March, we have the little note in summary form that I have just drawn your attention to. What we have to bear in mind – Sir, I am sure this can be corrected on a different version of this document – but we need to bear in mind that the chronology appears to be inaccurate. It should be the 23rd that you are seeing. It is not your fault, Dr Reid, of course, so we can get it in context. We can just note, looking at the chronology, if you go back to the 23rd, page to page 6 of the chronology which is 23 March, to save you looking through all the documents to check these things we are assuming it is correct, on page 6 we can see that on the 23rd, half way down the page, she receives paracetamol.
E
A Yes.

F
Q The same amount that she had been on before. It does not look as if the hospital acted on your suggestion?
A Yes.

Q It appears, if you go over the page to page 8 again, that on the 24th she is still on 1 g paracetamol. They have not done anything about it and, over the page at page 9, again the same amount?
G
A Yes.

Q Is that perhaps an illustration of the kind of thing I was asking you about yesterday, about hospitals in this situation perhaps tolerating greater pain levels than you would in a continuing care ward?
A Yes, and certainly if one were wanting to attempt rehabilitation, it would be vitally important to get pain under control.

H

Q You indicated that where your letter is at page 301, if you go back to that which we looked at a moment or two ago, you talk about mobilisation not only in that document but elsewhere, but as I think you indicated to us in your evidence when you said "hopefully remobilisation" at the end, it would depend entirely on Haslar having checked out her post-operative condition to make sure she was suitable for transfer?
A Yes.

B

Q And you were indicating, although you did not spell it out in black and white, because one tries to look on things in the best light in reality that meant you had considerable doubts that she would get back on her feet?
A Yes. I had some doubts about whether... Yes.

Q I think the description you gave in the statement you made was "... meant I had considerable doubts"?

C

A Yes. That is correct.

Q What there is between the two may be debatable, but that is an expression you used in the statement to the police and obviously the concerns, you say, that the hip was very painful? Yes?
A Yes.

D

Q Can we go, please, to page 23 in so far as this patient is concerned?
A Is that the summary document or ---

Q I am sorry. It is my fault. The main file itself, page 23 – the document you looked at in the course of your evidence in chief. This is from the nurse, Captain Ranking, I think it is?
A Yes.

E

Q This is the transfer letter. You have already indicated to us that that was quite at variance with what you had found a couple of days before?
A Yes.

Q And you indicated that you would be very surprised if that lady could be properly described as "weight-bearing" unless she had, I think you said, great assistance?
A Yes.

F

Q That means – what – nurses supporting her?
A Yes. It would probably mean two nurses to support.

Q And a zimmer frame?
A A zimmer frame, possibly, yes.

G

Q Thank you. If you look back to the summary at the beginning of the file, I just want to use that as the quickest of dealing with the drug administration history. Perhaps you would turn up in the chronology document or history document, page 9, where we have the date of the transfer to Dryad. Do you see that?
A Yes.

Q Then over the page, the transfer having set out the position, you have Dr Barton's review. We have already looked at that. There she says, "Plan sort out analgesia."

H

A Yes.

Q Obviously a sensible thing to do with the patient in this condition?
A Indeed.

Q The chronology goes on. If you look at page 11, there is a prescription for Oramorph by Dr Barton, and we can see the stages at which it was administered. I need not trouble you with the detail of that. Perfectly sensible course to take. Agreed?
A Yes.

Q Any time I ask you about a situation like this, when you were not the person who is actually dealing with the patient at the time, we have to bear in mind the most significant thing is the view of the person who actually is examining the patient, who has the patient there in front of them?
A Yes.

Q Over the page to page 12, we can see that Oramorph is administered, together with co-dydramol – all right? In the top left section – Oramorph?
A Yes.

Q The particular drugs are given little bullet point or a bullet spot, as it were. The 28th, the next day, Oramorph and co-dydramol – all right?
A Yes.

Q Then over the page to page 13, in terms of analgesia, we are looking at the 29th, co-dydramol. She is not receiving Oramorph at that point. All right – on 29 March?
A Yes, yes.

Q Over the page, page 14, co-dydramol, and then by the 31st, at the bottom of that section, Oramorph is administered again, and then there is co-dydramol and then MST. All right?
A Yes.

Q She is still in pain, as we can see on page 15 at the top. In a lot of pain. Again, nothing that you would criticise in terms of the opiates that were being administered at that stage?
A No.

Q But may I just ask you this in the light of something we heard from the witness? We have here a patient who has been treated on Dryad with co-dydramol, but also opiates in the sense of Oramorph and MST. All right?
A Yes.

Q Can I put it as bluntly as this? It would be complete nonsense to suggest that patients when they arrived at Dryad were immediately put on a syringe driver?
A As far as I am concerned that is complete nonsense.

Q We heard that said by a witness, and I would just like you to deal with that. On 1 April, looking at page 15, MST. Taking it pretty rapidly, page 16, MST on the 2nd, and the 3rd and on the 4th. All right?

A Yes.

Q Then we come to the 6 April, when she is reviewed by Dr Barton – all right?
A Yes.

Q Then over the page, page 18, on the 6th, MST – all right?
A Yes.

B

Q Then antibiotics are mentioned on the 7th, and we have the history of pain. The 7th, 8th and 9th on page 19, MST?
A Yes.

Q Your note, which we can see mentioned on page 18, which you dealt with in your evidence – your note of seeing her on 7 April?
A Yes.

C

Q Asking for an x-ray to be taken?
A Yes.

Q As you said, there was clearly a continuing problem with the right hip. All right?
A Yes.

D

Q And you, of course, would be aware of the drug history up until that point. All right?
A Yes.

Q You had indicated that an x-ray should be taken. Would you look, please, at page 134 in the main body of the file?
A Yes.

E

Q If you look about half way down that page, dated 7 April, where it says, "[Seen by] Dr Reid. For x-ray tomorrow at 1500 hours." It looks as though an x-ray had been arranged?
A It does.

Q I am going to go on the basis that an x-ray in fact, for whatever reason, was not taken. All right?

F

A Yes.

Q I can only put this to you as a possible situation. The following day, if an x-ray had been arranged for the 8th, if the patient was unable to be moved safely or properly in terms of their care for x-ray, would it be proper to make a decision not to take an x-ray?
A I think that would depend on the whole situation at the time.

G

Q Yes, but there might have been circumstances where, in the view of the nursing staff. The patient was not well enough to be moved to x-ray, or is that something we can rule out?
A I think that would be very unusual.

Q Thank you. Then can we look, please, at the drug chart at page 178 in that same main body of the file. Again, you have been asked about that and I am not going to go over that with you. We can see the various drugs that are set out, including morphine, MST and so on,

H

and obviously in terms of seeing this patient on 7 April, you would have indicated if you had any concern at all about the drug administration up to that point. Right?
A Yes.

Q Then your next note is when you saw her on 12 April. That is on page 27, if we can turn to that, please. On 12 April:

B

"Now v. drowsy ...
Diamorphine infusion established"

So when you saw her she was on the syringe driver. Correct?
A Yes.

Q Which had been commenced that day, and you took the decision, because she
C appeared to be very drowsy, that the appropriate thing to do was to reduce the diamorphine down to 40?
A Yes.

Q And you obviously had in mind the fact that it was a real possibility, if not a likelihood indeed, that pain would recur?
A Yes.

D

Q And that therefore if that did happen, the nursing staff should increase the dose to 60?
A Yes.

Q No doubt if it had continued, they would be justified in increasing it further?
A Yes.

E Q It is clear that the midazolam that the patient was also on, administered subcutaneously, was in fact increased, albeit not by an enormous amount, but it went up. I am not suggesting for a moment, Dr Reid, that that was something that you asked to be done. Indeed, Dr Barton was not present when you saw this patient that day. She had been in the hospital in the morning, but this patient was seen by you in the afternoon. It appears that a nurse – and the initials, I think, are Lynne Barrett's initials – it looks as if the nurse got it wrong?
F A I did not know.

Q You did not ask for it to be done, and the dose in fact, midazolam, was put as the same as the diamorphine?
A Yes.

Q Which involved an increase. Can we just look, please, at page 174 in the same file. It
G is clear, obviously, that this is something you would have seen?
A Yes.

Q Indeed, it would be important for you to take note of it in terms of your examination of the patient, and your decision as to what was appropriate?
A Yes.

H

Q And it obviously is plain as a pikestaff that the diamorphine had been prescribed at the dose range 20-200?
A Yes.

Q That would have registered with you, would it not?
A I think that what... I just cannot remember. What it certainly registered with me is the patient was receiving 80 mg, which I felt was too much.

B

Q I fully appreciate that. We can see at 1640 in the section dealing with drug administration, that is when the dose was reduced.
A Yes.

Q Because LB, who I think is Lynne Barrett, is the nurse doing that. Perhaps we can just take note of the point I made about midazolam. Lower down the page, midazolam was 20 and it was increased to 40, matching the dose which you prescribed for the diamorphine.
A Yes.

C

Q For whatever reason. You have told us about your approach as to how you would have established in terms of what she had been on, in terms of MST and how you would, as it were, take into account the amount that she had been on prior to the administration of diamorphine.
A Yes.

D

Q Which in fact was 45 in 24 hours. To make a direct comparison, a direct conversion with diamorphine, you would halve it, bringing you out at about 20 to 25, you have said, subcutaneously.
A Yes.

E

Q But because the patient's pain control needed to be greater, you therefore thought an appropriate initial dose in terms of the situation as you found it was 40. That is the process you adopted in working out the figure.
A Yes.

Q You have told the Panel that your reduction would have an effect on the patient, in other words, the reduction would come into play within about an hour.
A I emphasise that I am not an expert in pharmacology, but that is my understanding.

F

Q Obviously on that occasion, you did not ask what had happened with regard to the x-ray.
A No, I did not.

Q I am not criticising you for a moment, but just so we know. You did not say, "Why has this patient not had an x-ray?" Why not say on this occasion, "She should be given an x-ray, as I asked"? I am sorry if the answer is obvious, but would you like to deal with it? Why not say, "I did ask for an x-ray earlier. It does not appear to have been done. I think she should be x-rayed."
A I suspect that I felt at this stage this lady was terminally ill.

G

H

Q I would just like to ask you about that in general terms. Somebody in that state, why not refer them back to the Queen Alexandra? Again, the answer may be obvious, but I would like to hear you explain.
A Because I think this lady's prognosis was awful in terms of recovery at all and certainly functional recovery. I thought this lady's prognosis was awful, both in terms of her life and most certainly in terms of her ability to get back on her feet.

B

Q That leads me on to ask you something in more general terms now that we have discussed the condition of this patient. Where a patient on a continuing care ward is in such pain and distress that the administration of subcutaneous analgesia is justified and that subcutaneous analgesia involves a combination of diamorphine and midazolam, which is quite a common combination. Correct?
A Yes.

C

Q Those drugs are administered to deal with pain, distress, agitation – whatever one describes the symptoms as.
A That is correct.

Q The patient is on the palliative care route. We have seen that.
A Yes.

D

Q It may be very difficult to draw the line between palliative care and terminal care.
A This lady was terminally ill and needed palliation of her symptoms.

Q It is very difficult to say at precisely what time one is talking about terminal care, but people use different expressions. The patient continues to deteriorate. Let us assume that. Is it right for us to have this in mind? The patient's deterioration may be due simply to the patient's symptoms which brought about the pain, distress and agitation in the first place, their medical condition, to use that expression.

E

A It may be because someone was dying, rather than ...

Q Their condition is just getting worse.
A Yes.

Q It may be the deterioration is due in part to the effect of the subcutaneous analgesia.

F

A Yes.

Q That is something you have to live with in deciding what the best thing to do is.
A There sometimes is a balance to be struck between the dose and symptom control.

Q When the doctor treating the patient is faced with a situation of a patient continuing to deteriorate and the continued deterioration justifies an increase in the diamorphine and the midazolam, the doctor is aware that the administration of those drugs may well be playing a part in the deterioration.

G

A It certainly – yes.

Q But a doctor cannot decide precisely what is causing the deterioration: whether it is the patient's medical condition or that in combination with the analgesia without taking the patient off the analgesia and see what happens.

H

A That is correct.

Q Is that something you would seriously contemplate?
A Not in this situation. No, I would not normally contemplate doing that.

Q Again, I am sorry if the answer is obvious, but why not? Why not just say, "Well, I'm not sure whether the patient's condition is deteriorating entirely because of the medical condition or in part because of the administration of diamorphine and midazolam" Why not just take them off?
A I think what one has to look at is someone's prognosis. In other words, what is this patient's expectation of life, what sort of symptoms have they been experiencing up to date and to make a judgment about what is the most important issue to resolve. In other words, is someone at the end of their life and the overriding priority is to keep them comfortable or might they, by reversing the effects of opiates or whatever enable them to return to a more normal state?

Q What is the risk if you take somebody off a syringe driver?
A Worsening of the pain and agitation and distress.

Q Just in relation to this patient, before we leave the situation, you have told us what you recorded – we have seen it on page 27 – you have told us what your view was of the situation. I just want to check one thing with you, if I may. If you look at page 20 of the chronology? This is not an occasion when you saw the patient, but on 10 April, before you are seeing her on the 12th, on the night of the 10th, if that is right, she is described as having had a very poor night. Do you see that?
A Yes.

Q And:

> "Appears to be leaning to left. Does not appear to be as well and experiencing difficulty in swallowing."

I am not going to read out the rest. She is not drinking, despite encouragement and help. She is on Oramorph at that time. That may well be an indication of some sort of cerebrovascular event.
A It could be.

Q Again, this is not a criticism of you. Are you able to remember whether you were aware of that when you did your ward round on the 12th and reviewed her?
A I really could not say.

Q If you had been aware of it, would that have been a further factor influencing your view as to what was appropriate in the circumstances?
A Yes.

Q You were asked questions about the cause of death. That is why I am making that point.
A I understand.

Q That is all I need to ask you about that patient. We can move on, please, to Patient J. We have the general picture set out in the chronology at the beginning of the file. It is a

chronology which is going to be updated; it is not as full as the other one which you were looking at, but it may be we can use that one to move on pretty quickly, because looking at the chronology on the first page, we can see that he was admitted to A&E on the first page on 6 August at QAH. If you turn over the page, if we look at 9 August, that is when you reviewed this patient. We have already looked at your notes. You remember this is the very large gentleman.
A Yes.

B

Q I am not going to ask you to look back at the notes, but just so we can see the history. There is a continuing history on QAH, "Reviewed on ward" and so on and so forth. On 13 August on page 3 of the chronology we see the planned transfer to Dryad. On the 15th, it is noted there is no bed available.
A Yes.

C

Q Another indication of the sort of pressure on Dryad. Correct?
A Yes.

Q On the 16th, there is no bed available. Dr Tandy, from whom we will be hearing, saw him. Then if you look on page 4, on 23 August he was actually admitted on that date and you have covered that with us.
A Yes.

D

Q Looking on the chronology and moving over to page 5, he has been admitted on the 23rd, some medication, including paracetamol, is prescribed by a doctor other than Dr Barton.
A Yes. I think that was Dr Ravindrane.

Q A blood sample was sent for analysis on the 24th.
A Yes.

E

Q Dr Barton is prescribing temazepam on that day.
A Yes.

Q Then we see on 25 August a verbal message from Dr Beasley. That is a doctor whose name you will recognise in Dr Barton's practice.
A Yes.

F

Q To withhold the clexane dose and review with Dr Barton *mane*. In other words, the following day.
A Yes.

Q Would you just help us, please, with clexane? As I understand it, that is an anti-coagulant.

G

A That is right.

Q If a patient is bleeding – and we had better look at the notes just to see the sort of thing that was operating in this case. If you go to page 63, do you see the date of 25 August?
A Yes.

Q On that date, it is recorded in the summary that he is passing fresh blood PR – per rectum?

H

A Yes.

Q Then:

> "? Clexane. Verbal message from Dr Beasley to withhold 1800 dose and review with Dr Barton mane. Also vomiting – metoclopramide 10 mg given IM … good effect.

B

Would you just help us, please, with the significance of that? If the patient is passing fresh blood and it appears that Dr Beasley had received that information over the telephone, does that make sense?
A Yes.

Q The reason, if you could just explain.
A Because clexane is an anti-coagulant and, if not the cause of the bleeding, would certainly make bleeding worse.

C

Q Then the administration in terms of vomiting of the other drug.
A Yes. Metoclopramide is an anti-emetic, in other words, an anti-nausea, anti-vomiting medication.

Q So that, so far as you can judge it looking the notes, makes sense too?
A Yes.

D

Q Then if we could look, please, at page 174, looking at the top part of that page, we can see the two medications you have just been dealing with, or certainly one of them, the metoclopramide. We can see it is verbal, Dr Beasley, in the top left.
A Yes.

E

Q Does there appear to be Dr Beasley's signature lower down that page?
A I think it is overwritten. I think that is Dr Beasley's signature.

Q What I am suggesting to you – again, you cannot possibly say, but just so we can have this picture in mind as we consider your seeing of this patient – it looks as if Dr Beasley probably came in in the evening. He must have been there to sign on the 25th. That would be consistent with him coming in, would it not?

F

A He has signed it at some stage, presumably after 1755.

Q Given the verbal authorisation. It is consistent with him having actually come in perhaps later on that evening.
A Yes. It is consistent with him having visited the hospital and signed the drug chart.

Q Just while we are on that page, because we are going to come to your seeing him on 1 November, we can see there diamorphine. I am sorry. That is in September so I need not trouble you with that. We will come back in terms of November later, the range that is there. Then would you look, please, at page 56? We can take up the picture in terms of Dr Barton, page 56 at the top of the page, 26 August is when she calls to see him. All right?
A Yes.

G

H

Q We have already dealt with this, "clammy unwell", and you have explained

the significance of that, "suggest MI treat stat [diamorphine]". In other words, an instant dose of diamorphine, a single dose. Is that right?
A Yes.

Q "Oramorph overnight". Perfectly sensible so far as you can judge it ...
A Yes.

B

Q ... in the circumstances. "Alternative possibly GI bleed but no ..."?
A Haematemesis.

Q The significance of haematemesis, please?
A Haematemesis means vomiting blood.

Q

C

"Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death"

We bear in mind, on the preceding page of that file, that Dr Ravindrane had admitted this patient on the 23rd. All right?
A Yes.

D

Q We have the date. Dr Ravindrane, can we assume, should have seen the previous notes coming from the hospital?
A Should have seen? If ---

Q I appreciate you cannot say with confidence, but in the ordinary courses of events should have done. If we look back to the previous page, page 54, that is the hospital note by - I think it may be Dr Chatterjee?
A Yes.

E

Q On 20 August, he has put towards the end of his note, "Not for 555".
A Yes.

Q Meaning?
A Not for cardiopulmonary resuscitation.

F

Q So in the ordinary course of events, if Dr Ravindrane had seen that, no doubt that would have a bearing on whether he made any decision that this patient should be referred back to the hospital?
A Yes.

G

Q I appreciate the difficulty, Dr Reid, in you trying to deal with this when you had not actually seen the patient yourself, but we are trying to piece the picture together. We can see the situation, back on page 56, after what Dr Barton had indicated, but, in her view, he was not well enough to transfer to an acute unit. He remained poorly, as the note made by her on the 28th. I need not trouble you with the next note. You, of course, then see him on 1 August. All right?
A 1 September.

H

Q I am sorry. I keep making the mistake - 1 September. It follows that you would have seen the previous history as recorded on that document?
A Yes.

Q Would have seen that Dr Barton had been raising the possibility of GI bleed. All right?
A Yes.

B

Q If we go to page 174, the drug chart, when you saw him on 1 September it would have been apparent that he was on the syringe driver?
A Yes.

Q Again, it is the same point really, Dr Reid, but I draw your attention to it: you would have seen that the diamorphine prescribed was the range 40-200?
A I can see that from the chart.

C

Q Because this is not an example of the rear part which you were dealing with yesterday, you would have been looking at the prescription position, because he is on the syringe driver; you would need to know, would you not?
A Yes. As I have said before, I cannot recollect, I have never seen this prescription, but, nevertheless, it was my responsibility to see it.

D

Q All right. I will not press you any further on that. I do not think I can get any further information on that. The view taken as to what was appropriate with regard to the treatment for this patient, back to page 56, would also depend on what you would have made of any results that had come through with regard to this patient. For example, the haemoglobin would have been available to you?
A I cannot say whether it would have been or not.

E

Q In the normal course of events it would have been?
A Yes.

Q We know that it had dropped so it would be an indication of the patient having bled quite significantly?
A Yes.

F

Q Once again, you did not query because you did not see anything wrong or incorrect about this patient being on the syringe driver by that stage?
A No, I felt this man was terminally ill and because of that I may not have looked or asked for haemoglobin results.

Q I think you have already indicated a number of factors that applied anyway with regard to this patient. Extremely unlikely to leave hospital terminally ill, as you have already indicated.

G

Q As you saw the history, and whatever other material was supplied to you, there was nothing which caused you to feel that Dr Barton had acted inappropriately?
A No.

H

Q May I turn, please, then to Patient K, Elsie Devine. I think the first document to go to, please, in the file is at page 155. Do you have that?

A Yes, I have.

Q Thank you. At the top of the page we can see, "[admitted to] Dryad", on 21 October. I am not going to read through all of that, but the plan:

> "Get to know
> Assess rehab potential",

B

- and so on -

> "Probably for rest home in due course".

Then four days later you saw this patient, because that is the note you have already dealt with. Yes?

C

A Yes.

Q As you have recorded about halfway through your note, "chronic renal failure"?

A Yes.

Q I want to ask you some questions relating to a view you have already expressed about the situation with regard to this patient and I am referring, Dr Reid, to evidence that you gave at the inquest. You may remember you were asked about this patient?

D

A Yes.

Q We have the transcript. I just want to ask you about one or two matters arising from your evidence at the inquest. I think you indicated that although, of course, you are not a renal physician, you are not a nephrologist, you indicated that it was nonetheless clear to you that there is a long list of possibilities which could account for deterioration in renal function?

E

A Yes.

Q We do not need to go through all of them, but that was the position. As you have already indicated, in terms of urinary tract infection that was an extremely common cause of deterioration in renal function ---

F

A In elderly people, yes.

Q You have already covered that topic in the evidence you gave. The time that I think you saw her the position was, with regard to 25 October, if I can just deal with that. You were asked about why you had not referred this patient when you saw her on 25 October, why you had not referred her to a renal consultant, and you gave your reasons why. Do you remember?

G

A Yes.

Q Again, I am going to take it shortly. You indicated that you felt from reading the notes, not from any personal recollection at the time, Mrs Devine was likely to have what is called a vascular dementia?

A Yes.

H

Q A series of small little strokes and so on. Yes?

A Yes.

Q In addition she had chronic renal failure. She had a very low albumen level in her blood?
A Yes.

B

Q Which you indicated was an extremely poor prognostic marker?
A Yes.

Q Would you just explain that, please, why it makes the prognosis poorer?
A Albumen is a protein in blood and what we know is that in people with chronic illnesses the lower your albumen in general the worse your prognosis.

C

Q Your feeling was at that stage that because of the multiple problems and having excluded other physical causes, like urinary tract infection, it was unlikely that anything more could be done from a renal perspective than had been done already?
A That is correct.

Q You made it clear again at that stage you are not a renal physician?
A That is correct.

D

Q You made the general point:

> "It is not appropriate ... to refer everyone on to a specialist. One has to make judgments about what [a person's] prognosis is ..."

A Yes.

E

Q In this case you felt that her prognosis was extremely poor and that was the reason why you thought it was not appropriate to refer this patient on to a nephrologist.
A That is correct.

F

Q I do not think I need to ask you any more detail because you were asked a number of questions about that at the inquest. For my learned friend's reference point, that is day eleven, the inquest, page 33. There is another reference at day eleven, page 10.

Would you look, please, at page 156, the next page on, because, Dr Reid, there is just something about your further note I want to clarify with you. At the top of the page, we are now on 1 November, "Physically independent", and so on, you set out the position, you have already told us about it, and then the last two lines:

G

> "[Therefore] try home visit to see if functions better in own home."

What was the situation then? If you had indicated in your view on 25 October there were a number of problems which made the prognosis very poor, would you help us with what the realities were when you were saying, "[Therefore] try home visit"?

H

A I cannot remember without going through the notes at what stage I would

have made the judgment about Mrs Devine's prognosis being so poor. I am not sure it was at that stage on the 25th. I think it was later but I would have to look through the file.

Q Yes. I think that was the context you were being asked in the inquest about the 25th. I will just double-check there but I am pretty sure that is right. (Pause) I think it was 25 October you were being asked about, because you were being asked about your note with regard to chronic renal failure, because you have already been asked by another advocate at the inquest whether you could have referred her to a consultant.
A Yes.

Q The coroner said:

> "In this case you didn't refer her on to a renal consultant. Why not?"

- and you gave those answers.

In that context, maybe you were meaning at a later stage?
A I think I may have been.

Q At the time, on 1 November, it seemed a possibility that it might be worth trying a home visit?
A Yes.

Q Then if we move on to the next date in terms of the entries on page 156, 15 November, this is the "very aggressive", "very restless", and so on, note which you have, again, dealt with and asking Dr Luznat to see her and so on. You indicated if it was unclear whether the patient's distress was mental or physical then you might use an opiate ...
A Yes.

Q ... in circumstances you were presented with here. Can we look, please, at the position with regard to the drugs prescribed for this patient? I think the best page is to go to page 281, please. Do you see in relation to diamorphine on that page, it is 40-80?
A That is correct.

Q That would be a reasonable range ---
A Yes.

Q --- in your view? Midazolam 20-80. We can see the administration of the diamorphine and the midazolam on the 19th. You were not prescribing that, but you were asked some questions about the fact that this lady had been on chlorpromazine, and it may be easier for you if we go back to the chronology in this case just to deal with this point. At the very beginning of the file there is another chronology. It will save you looking at different pages, I hope. Perhaps we can move on in the chronology, Dr Reid, to page 8. Do you have that?
A Yes, I have. Thank you.

Q Looking at the 19th, that is, in fact, a Friday, Friday the 19th, when she was seen by Dr Barton, she was prescribed and, indeed, it was administered

chlorpromazine, diamorphine, administered at 9.25 in the morning?
A Yes.

Q I just need to note the times because I am going to ask you something about that. Midazolam also at the same time, 9.25?
A Yes.

B

Q Chlorpromazine, would that have any bearing on what the appropriate amount of diamorphine or midazolam was to administer to the patient?
A Potentially in relation to midazolam.

Q Potentially because? If you would just explain why?
A They are both sedatives.

C

Q It has a sedating effect as well.
A. Yes.

Q If you look at the top of the page, on that same page, it in fact is the previous day, the 18th, the Thursday. Fentanyl was a 25 skin patch every three days, was administered at 9.15 in the morning?
A Yes.

D

Q If you can just take that on board in terms of what I am going to ask you. So the day before, fentanyl, 9.15 in the morning. The next day, as a result of matters which the Panel has already heard about, the drug prescription has changed. On the morning of Friday 19 November, is this generally right? The fentanyl would have just about reached its peak level?
A That would be my understanding, but to be absolutely sure I would have to check in the BNF.

E

Q I am not going to press you or suggest that you can give precise answers, but the fentanyl your understanding – just to follow through the point – is something that takes effect gradually?
A Yes.

F

Q The patch is put on, and is deliberately designed to provide to the patient ---
A Yes.

Q --- morphine ---
A --- a continuous low dose of opiate.

Q Yes. And over a 24-hour period, assuming the patch is still on, it gradually builds up?
A That is correct.

G

Q This is very, very general.
A Yes.

Q So that 24 hours after the patch has been put on, it has reached more or less ---
A Steady state.

H

Q And then it will decline?

A Yes.

Q In fact, a fentanyl 25 patch, as I understand it, means 40 mg in 24 hours. Does that make sense?
A The equivalence to ---

Q The equivalent to.... By the time the patient has reached peaked level, 24 hours later, they will have received 40 mg?
A I could not answer that.

Q I think, and I am sure you will heave a sigh of relief, Dr Reid, I think if that is as far as you can take it, I will not go through the remainder of the conversion that I was going to go through in terms of what the sensible prescription of diamorphine would have been to take over from the fentanyl. Or is that something you can ---
A No. Not really.

Q All right. You were asked about it by Mr Kark. I am not blaming him, and you gave an answer, but what you are really saying is, "I really can't sensibly answer as to what would be ---"?
A I do not have the expertise to answer that.

MR LANGDALE: Then I am not going to press you on it. I am sorry it has taken so long, but that is all I need to ask you. Thank you.

THE CHAIRMAN: We will break here, Mr Kark. The witness has been on the stand for over an hour. We will come back in twenty minutes, please, ladies and gentlemen. Doctor, I remind you, you are on oath. Please do not discuss matters. The Panel Assistant will take you somewhere where you can get some refreshment.

THE WITNESS: Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone.

MR KARK: Sir, before I ask Dr Reid any questions, may I start by mentioning that Professor Ford is at the back of the hearing room. He, of course, as an expert is in a different category to other witnesses. He is, I think, entitled to be present. He has also been receiving the transcripts of the hearing so he can comment, if necessary, on the evidence. I just thought I ought to mention that as a courtesy to the Panel.

THE CHAIRMAN: Thank you, Mr Kark. You have no objection to that, Mr Langdale?

MR LANGDALE: No.

THE CHAIRMAN: Thank you.

Re-examined by MR KARK

Q Dr Reid, I have some general questions to ask you in re-examination. Then I want to ask you just a few questions – very few, I think – about each of the individual patients that Mr Langdale has gone through with you. When you began your evidence being cross-examined, you gave evidence that your understanding was that Dr Barton spent a lot of her own time speaking to relatives, and she did a lot of counselling and that the nurses, I think, were fulsome in their praise of her?
A Yes.

Q Can I just ask where you information was coming from? You were going in one afternoon a week. Who primarily did you liaise with?
A That was from the nursing staff.

Q You say the nursing staff. I just want to see if we can tie that down a little bit. Was there any particular individual that you would tend to do your ward rounds with?
A No.

Q Not Sister Hamblin?
A It could be any of the senior nursing staff.

Q Did you speak yourself to any of those relatives?
A I only remember during the course of the year speaking to, well, three or four sets of relatives.

Q Over the course of the year, did you say?
A Well, I think ... Over the course of a year, oh ... It is difficult to remember.

Q All right.
A But eight sets of relatives, perhaps. It is very difficult to ...

Q All right.
A Eight sets of relatives. It is very difficult to recollect.

Q All right. You were asked about the notation "happy for nursing staff to confirm death". You indicated that you would not expect Dr Barton to talk to you before making that notation?
A That is correct.

Q But do we take it – and I think you have given us evidence already – that that is a notation effectively that the patient is expected to die in the relatively near future?
A I would anticipate... In general terms, yes.

Q In terms of a move to palliative care ---
A Could I just clarify that a little?

Q Yes.
A Obviously there may be some patients who are extremely frail and for whom one recognises that they are unlikely to improve in their condition, but death need not be---

Q Absolutely ---
A --- perceived to be happening next week, not today or tomorrow.

Q If there was a decision, however, to move to a palliative care route, rather than a treatment route, do we take it that equally you would not expect to be consulted about that in relation to each individual patient?
A That is correct.

B

Q And how would you expect that to be written up in the notes?
A I would expect there to be a note to the effect that the care plan had changed from, if you like, trying to get someone back on their feet to trying to keep them comfortable.

Q Try to keep them comfortable. Or your notation, which we have just been looking at, I think, TLC?
A Yes.

C

Q You were asked about Dr Barton's resignation in the year 2000 and you told the Panel that your understanding was that she would be replaced by, I think, a full time clinical assistant?
A She was.

D

Q And ultimately did you say, I think, there were two and a half doctors? We understand what you mean by that – two and a half doctors looking after, did you say, 30 beds?
A Yes. That is the current position.

Q You knew, I think, in 199 that there was a police inquiry into one of the deaths on the ward?
A On Daedalus Ward that was.

E

Q Yes.
A I was aware of that.

Q At the GWMH hospital?
A Yes.

F

Q Were you also aware of the CHI investigation?
A Yes.

Q Did those events, so far as you are aware, have any effect on staffing levels at the hospital ?
A Not that I am aware of.

G

Q Why did it change?
A I beg your pardon?

Q Why was there a change in the staffing levels?
A I am not aware that ---

H

Q You just told us there was a change in staffing levels?

A Yes, in terms of the medical staff.

Q Did you find out why management might have thought that was necessary? Do you know what the thinking behind it was?
A I think, certainly by that time, I had felt that the situation certainly from the point of view of medical cover was untenable. I had previously worked in Southampton where we had a GP, who was a clinical assistant, providing cover to our wards. Eventually the
B demands just outgrew the ability to keep pace. So I came to the view, as did my colleagues, that the model of cover we had just was not sustainable, just was not enough.

Q When did you come to that view?
A I think I came to that view during 1999, early 2000.

Q You also agreed with Mr Langdale when he suggested to you that missing notes were
C a common feature?
A On transfer.

Q Again, can I just ask you about your source of evidence about that. We have heard some evidence, for instance, from the nurse manager of Daedalus Ward, Mr Beed, who told us that they used to come late in 1 in 10 or 1 in 20 cases.
A I certainly remember that it was a recurring theme that notes were incomplete, X-rays
D were missing, et cetera.

Q Does that mean that they came but they came late, or they did not come at all?
A Usually came late.

Q Again, just dealing with the general questions, you said I think in answer to Mr Langdale that Oramorph was the first choice for strong opiates. Yes?
E A Yes. Yes.

Q I am not challenging that or doubting that. I am just seeking to clarify it with you. Co-codamol and co-dydramol – are they on the next level down?
A Yes.

Q In terms of the analgesic ladder?
F A Yes.

Q They are not opiates?
A They are.

Q They are opiates, but they are weaker opiates?
A Weaker opiates.

G

Q So is there perceived to be a jump between co-dydramol and co-codamol and that sort of drug, and an opiate-based drug? Sorry – a stronger opiate?
A Yes, but opiate… Morphine and diamorphine are stronger opiates.

Q Co-codamol and co-dydramol are drugs which I think are given relatively regularly by GPs?
H A Yes.

Q I just want to try to understand what your evidence is, and Mr Langdale spent a bit of time trying to understand, I think, what your evidence is, about these variable prescriptions. Do you still have one of the examples of the prescription sheets which you can open out?
A No.

Q Could I ask for you to be given one for a patient. Sir, we are just going to pass one to the witness, to use by way of example. (Sheet handed to the witness)
A Thank you.

Q Can you open it out?
A It is only the one sheet.

Q Can we get another one? (Sheet returned to counsel) I just want to understand when you were giving us evidence about the opened out sheets, and you were talking about a blue plastic folder that they came in.
A Yes.

THE CHAIRMAN: Mr Kark, whilst we are looking for that ----

MR LANGDALE: The example is Ruby Lake in the file.

THE CHAIRMAN: While we are looking for the document, I wonder, Mr Kark, is there any chance that one of these blue plastic folders could be obtained?

MR KARK: Yes. I do not know if they still exist, but I will explore this with the witness. (Further sheet handed to the witness)
A Thank you.

Q Just fold that out. Which one do you have there? Is that Ruby Lake?
A Yes.

Q In our bundles we have in that particular file, just so we can try to follow the evidence, we have page 368A. That is marked "Prescription Sheet" with a big "B" in the corner. That is the front page, is it?
A That is the front page.

Q And there are occasions, I think, when you were saying, effectively you only looked at one side of the sheet?
A That is right.

Q Would that be the same side of the sheet with prescription sheet B on it?
A No.

Q It would be the other side?
A It would be the other side.

Q Can you just help us in relation to this patient, what sheets there are on the other side? Can you just go from left to right?

A On the reverse sheet, first page on the left is the "Daily Review Prescription" sheet. The next page is for "Nursing Use Only".

Q Could you slow down? Sorry. "Daily Review Prescription", and in that version that you are looking at, does it start with diamorphine 20-200?
A Yes, it does.

B

Q And the first date is the 19th?
A Yes.

Q So that is on the far left hand – that is 368E. That is the left hand panel, as it were. What is the middle panel?
A It is headed "For Nursing Use Only – Exceptions To Prescribed Orders".

C

Q That is on page 368F. And the last one?
A Is "Portsmouth Healthcare Trust Prescription Sheet" with a "B" in the top right hand corner.

Q That is our front sheet, in fact?
A Yes.

D

Q So that is the right hand pane. And on the other side, does it start with Oramorph?
A Yes.

Q So that is in fact our page 368B. Would you regard that as the front or the back of the sheet? Perhaps it does not matter. The next middle panel, does that have digoxin?
A Yes.

E

Q That is our page 368C. Is the far right-hand side blank?
A Yes.

Q This sheet, you say, would have been opened out.
A Yes.

Q And it would have been in a blue plastic folder.

F

A Yes.

Q It slips into the folder from the side or the top and it is then attached where?
A It has a sort of hook on it and it sits on the bottom of the bed, the bed rail end.

Q I am sorry if these seem such obvious questions, but in order to write on the sheet, you have to take the sheet out of the folder.

G

A Yes. Or you can partially pull it out to write on it.

Q How would you write on it?
A It is retained by a strip of cellophane along the top and a strip of cellophane along the bottom and there is a split in the cellophane at the join lines, so you can just pull the page out like that. That is my recollection.

H

Q Is there any regularity about which side faces you? If you are standing at the foot of the bed, which side do you say would be facing you?
A As you approach the patient?

Q These sheets were at the foot of the patient's bed.
A Yes.

B

Q They are in clear blue plastic folders.
A They are a blue plastic folder retained by clear cellophane.

Q They are attached to the bottom of the ---
A They hook over the rail at the bottom of the bed.

Q Which side of the sheet would normally be facing outwards?

C

A This side here, which is Oramorph and the regular prescriptions.

Q If you wanted to look at the back of the prescription sheet, you would probably have to take it out of the folder, would you not?
A Yes.

Q Did you regularly or irregularly review prescriptions?

D

A I thought that on most occasions I did review prescriptions.

Q Which prescriptions did you think you were reviewing?
A I would certainly open the chart like this and look to see what was being prescribed.

Q How would you know whether a patient was on a syringe driver or not?
A Well, usually it would be pretty obvious when one approached the bedside.

E

Q Why?
A Because you could see the syringe driver.

Q Where?
A It would usually be on a bedside table or locker.

F

Q Were syringe drivers ever put under the pillow of a patient that you can recall?
A I cannot recall. It might even be on top of the bed.

Q It is just that we have heard some evidence about that. The other way, I suppose, of telling if a patient is on a syringe driver is if you did look at the chart.
A Yes.

G

Q You cannot help us as to how often you looked at the back of the prescription sheet.
A If a patient were on a syringe driver, I would look at this. Sometimes I recollect that Dr Barton actually wrote syringe drivers on this part of the chart, but if it was not in that part of the chart, then I would take it out and look at what was on the reverse side. That would be my normal practice.

Q If a patient was on a syringe driver, but it was under the covers or under a pillow,

H

would you still, do you think, have realised if a patient was a syringe driver?

A Absolutely. The nursing staff would have reported it to me.

Q So that would have caused you, would it, to have looked at what was going into the syringe driver?
A On most occasions it would have done, yes. It should have done.

Q It seems to follow from that – and I think you have already given this evidence – that you must have seen these prescriptions.
A Yes.

Q But did nothing about it.
A I certainly do not recollect them and I did not do anything in particular about Mrs Spurgeon's.

Q Do you know if the same system is used now, the blue plastic folders?
A No, it is not.

Q Do you still work ---
A I am not working on Dryad Ward any longer.

Q I appreciate that, but you are still working in a hospital environment.
A Yes, but not in a ward environment at the moment. I am not usually in a ward environment.

Q You were shown a defence document. The first document I think you were shown is the document we have marked D4. At the bottom of this note, which is entitled "Learning Points from the Wilson Complaint" dated 27 October 1999, we can see it is an agreed protocol that Jane Barton, clinical assistant, writes up diamorphine for syringe drivers with doses ranging between 20 and 200 mg a day.
A Yes.

Q I just want to understand your evidence about this. Were you then aware of any such protocol?
A I was not aware of any such protocol.

Q If you had been aware of any such protocol, would you have done anything about it, do you think? Would it have disturbed you in any way, or would you have been content with it?
A I think it would depend on what the content of the protocol was.

Q If there was a protocol which indicated that when a syringe driver with diamorphine in it was being started, it would be appropriate for the clinical assistant to write up a prescription for a dose range of between 20 and 200 mg of diamorphine, would you have thought that was acceptable, or not?
A I think it depends on your interpretation of what is being – because it says "doses ranging between". So what I interpreted by that was that it could be a dose of 20 to 40, 20 to 80 and not just 20 to 200.

Q I understand. So you would say that is ambiguous?
A Yes.

Q The next document that you were shown, D5, is your document. You wrote this up, did you? You devised this.
A Yes.

Q In December 1999.
A That is correct.

B

Q First of all, can you help the Panel why this was written up?
A As I said yesterday, I think the principal reason was in relation to the Wilson complaint, where we had had an independent medical review from a consultant in Southampton, Dr ---

Q I am not going to ask you to go any further than that. That is why you ---

C

A Yes. She commented on the wide prescribing range.

Q Did this in fact come into effect, this protocol?
A Not as laid out.

Q What was changed about it?
A What was an acceptable prescription range. This is a draft document prepared by me.

D

I have previously said that I was not an expert in palliative care. My understanding certainly in relation to smaller doses of diamorphine was that the correct approach was to double the dose if pain had not been controlled. So I prepared this document on the basis of that. That document was then circulated for comment to members of the Medicine Prescribing Committee, which reflected a lot of disciplines, including palliative care, and I immediately got feedback from consultants in palliative care, saying that what I had suggested would not be an appropriate ...

E

Q Before you devised this document, did you actually take any advice, or was it really a draft?
A It was a draft to start a discussion.

Q You not being an expert in palliative care, where were you taking your basis of knowledge from for even starting this document?

F

A I suppose it was my belief that it was appropriate to double the dose.

Q Where had you got that from?
A Just my early experience in Southampton, but it was very limited.

Q Then you took advice and the advice that you received was that this would be wrong.
A That is correct.

G

Q And so it was changed.
A Yes.

Q Do you remember what it was changed to?
A I think, as is now the conventional wisdom, the wisdom is that if pain has not been controlled by the current dose, then it is permissible to increase the dose by up to 50 per cent

H

the following day.

Q Under the heading "Prescription" – and again, we now I think appreciate that this was written without the benefit of advice – you write:

> "Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80, 60-240 mg …"

B

Did that also get changed?
A Oh, yes.

Q Because you appreciated it was wrong?
A Yes.

Q The very last line:

C

> "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 pervious 24 hours dose."

All of that again – I know it follows from what you have just said – presumably was changed.
A Yes.

D

Q And the table that follows on the next page is not how it was eventually published?
A That is correct.

Q We can put that away. Can we just now look relatively briefly at the individual patients you have been asked about? The first was Enid Spurgin. I think the first thing I want to do is to clear up what I think has been thought to be an error in the chronology. If you have a look at these original notes. (Same handed) In our chronology, I am looking at page 6. This is Patient I. This is a very minor point perhaps, but I think it may be important to get it right. If we go to pages 373 and 374 and the chronology at page 6, do you see an entry for 24 March, "Ward round MMS"?

E

A Yes.

Q Then:

F

> "Skin very thin and fragile lower legs
> Needs to elevate"

That is not your ward round. Then underneath that, do we see a note saying:

> "Dear Dr Lord
>
> Many thanks for reviewing this pleasant 92 year old lady …"

G

A Yes.

Q Over the page, that note continues:

H

"She has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult."

Then we have a note from you dated apparently 23 March.
A Yes.

Q And then over the page from that, we have a note dated 25 March.
B
A Yes.

Q Do you think you have got that date right, or do you think you may have made a mistake?
A I honestly have no idea. Given that it was the 24th, yes, I think it must be a mistake on my part. I am sorry.

C
Q It looks, does it not, as though it must be the 24th?
A Yes.

Q It may just be worth us making a notation on the record itself at page 374. Indeed, when you wrote your letter at page 301, you wrote about seeing the patient on 24 March.
A I did, yes.

D
Q So that would seem to be consistent.
A Yes.

Q If we stay with the clinical records, this was the lady for whom you recommended an x-ray.
A That is correct.

E
Q It does not look as though that x-ray was ever performed.
A That is correct.

Q I think you confirmed this to Mr Langdale that it would not be for nursing staff to take that sort of decision.
A About whether someone should have an x-ray or not?

F
Q Yes.
A No, it should be medical staff.

Q Once a doctor has written that a patient should have an x-ray, nurses have quite a lot of power but they would not normally have the power to overrule that direction?
A Not normally.

G
Q It is right to say that that request for an x-ray does not appear to have been followed up by anybody.
A That is correct.

Q That decision, that direction, recommendation, call it what you will, took place on 7 April 1999. Yes?
A Yes.

H

Q It is in the clinical notes, I think, at page 27. Can we take it that if you are asking for an x-ray at that stage you are still regarding this patient as poorly but treatable?
A Potentially treatable.

Q Had you taken a decision at that stage that, in fact, this patient was for purely palliative care?
B
A I do not think so.

Q By the time you next come to see her, or at least there is a note to that effect on 12 April. Yes?
A Yes.

Q You describe her as being, "Now [very] drowsy".
C
A Yes.

Q No x-ray has been taken and she has been started, by the time you see her, on a high dose of diamorphine via syringe driver.
A She was on 20 mg BD of MST prior to that.

Q Yes, she was.
A Her pain had not been controlled by that dose. I think we worked through
D
the conversion factors, and the conversion yesterday, in my understanding, was at that time to halve the dose of morphine to convert to diamorphine and my limited understanding at that time in palliative care would have been to double the dose to get the pain under control.

Q Yes. I am sorry. All I asked you was that on 12 April when you next came to see her she was now very drowsy.
E
A Yes.

Q You did not review your previous decision about an x-ray. Did you just not notice that or did you, by this stage, form a different view?
A I cannot remember, but my feeling was that on 7 April when I last saw her I felt that this lady's prognosis was extremely poor in terms of functional recovery and, indeed, of life. It is likely that this lady had a deep-seated wound infection.
F
The British Orthopaedic Association produced a booklet in 2007 which talked about complications related to fractured neck of femur.

MR KARK: Yes. Can we just stop there for a moment? That is not knowledge that you would have had in 1999.

MR LANGDALE: (Speaking off microphone)

G

MR KARK: I want to know what your thinking was in 1999.

MR LANGDALE: Sir, with respect, I wonder if the witness could just finish what he was saying by way of explanation? Then if he has not answered the question, he can be asked to deal with it.

H
THE CHAIRMAN: Mr Kark, let the witness finish and then you can ask your question.

MR KARK: (To the witness) What were you going to tell us about something published in 2007?
A What I was going to say was the overall mortality from fractured neck of femur is about 25% a year. If you have a complication such as deep-seated wound infection the death rate approaches 50% and that booklet specifically says that few of those who recover will ever walk again, and that certainly has been my experience over the years of dealing with patients where the operation for a fractured neck of femur, that there have been complications.

B

Q I want to go back to your state of mind on 12 April 1999.
A Yes.

Q You record that the patient was, "Now [very] drowsy".
A Yes.

C

Q Can we take it that you would then have looked at the prescription sheet to discover why?
A Yes.

Q You found that the patient was on a high dose of diamorphine.
A Yes.

D

Q Which you reduced by half.
A Yes.

Q Was the fact that the patient was now on a syringe driver relevant to your decision as to whether it would be worth pursuing an x-ray, as you had advised five days before?
A I do not think so.

E

Q What had changed?
A I felt this lady was now terminally unwell. There was constant reference throughout her notes, in the nursing records in particular, to this lady being in pain and my view was that this lady had gone through three weeks of real suffering where the pain had never really been properly controlled and I felt her outlook was pretty hopeless and the overriding priority by that stage should be to keep her comfortable.

F

Q At the time that you saw her, the time of this review, we can take it, I think, that you could not speak to the patient, or if you could speak to her she could not answer you?
A That is correct.

G

Q Because she was not rousable?
A That is correct.

Q Did you consider then that whether you made the decision or not a decision had been made to treat this patient palliatively?
A I think that was the correct decision.

H

Q I did not ask you that. I asked you whether you thought that decision had

been made.
A Yes.

Q Thank you. You were also asked, and I think this was as a generality - it was put to you, I think, you cannot find out what will happen to a patient unless you take them off opiates.
A That is correct.

B

Q I just want to explore that with you for a moment. If you have a patient who is unconscious, unrousable, you are not going to be able to find out what is going on with the patient in terms of their sensation, et cetera.
A That is right.

Q Why cannot you simply reduce the opiates until they become rousable?
A I did reduce the opiates.

C

Q I understand that, but the answer you gave to Mr Langdale was you cannot find out what will happen without taking the patient off opiates. Is there a distinction between taking them off opiates and reducing the opiates?
A Yes, there is.

D

Q You can, presumably, reduce the opiates?
A Yes, or stop them.

Q You spoke early on in your cross-examination about the experience of the nurses?
A Yes.

E

Q Your impression was that they were, in general, no doubt, very experienced nurses.
A That is correct.

Q Did you know what their training had been in the use of either syringe drivers or opiates?
A No.

F

Q In this case we know that a nurse called Nurse Barrett decided, after your intervention to half the dose of diamorphine, to double up on the midazolam.
A Yes.

MR KARK: Which I think you described yesterday as astonishing.

G

MR LANGDALE: Sir, with respect, my friend cannot put that she made a decision to double up because he does not know why she did. It may be a mistake.

THE CHAIRMAN: Yes. Mr Kark, all we can say is that she did double up.

MR KARK: I accept that correction. (To the witness) We know that she did it. Yes?
A Yes.

H

Q You describe that, as I think you said yesterday, as astonishing?

A Yes, given what I had found.

Q If that were a deliberate decision, it would, in your view, have been quite wrong?
A Yes.

Q If it is a mistake, is it a serious mistake?
B
A Yes.

Q You were asked about indications that this patient had had a CVA?
A Yes.

Q We know that the patient was leaning to the left.
A Yes.

C

Q Was that what you took to be the prime indicator of the CVA?
A From that note it is possible the patient could have had a CVA.

Q Yes, well, all sorts of things could have happened.
A Yes, it could.

D

Q The fact that the patient was leaning to the left, did you take that as being a possible indicator that she had had a CVA?
A A possible indicator.

Q Yes. This patient had a painful right hip. Might that cause a patient to lean to the left?
A Indeed it might, but it had not been commented on before.

E

Q No. I want to move on then, please, to Patient J. I have not very much to ask you about that, but you commented on the earlier annotation, "not for 555".
A Yes.

Q You indicated, as I understood it, and I want your help about this, that that would potentially indicate non-referral back to hospital for treatment. Is that what you were saying?
F
A What it would indicate is that that decision, I think, would indicate that one would have concerns about their overall prognosis.

Q One has to be careful, of course. This is an annotation made by another doctor.
A Yes.

G

Q At a particular point in that patient's illness.
A Yes.

Q Are you saying that once "555" is written into somebody's notes, that every doctor thereafter is likely to follow that and that it may have an effect on their future treatment, not just for resuscitation but for other treatments as well?
A Decisions about CPR are complex decisions and decisions about the appropriateness of being for resuscitation or not can be a fluid one. In other
H
words, there will clearly be patients who have incurable illnesses who are likely to

die and their resuscitation status will not change. On the other hand, there are patients who may be extremely ill at a point in time and they will be deemed inappropriate at that time for resuscitation, but when they improve it is appropriate to review their resuscitation status and change it if that seems appropriate.

B

Q So far as other treatment is concerned, and this patient may be a good example, it seems he had a GI bleed?
A That is correct.

Q The fact that "not for 555", or not for resus, whatever is written in the notes, is written into his notes is or is not an indication that his gastrointestinal bleed should not be treated?
A It is not an indication that it should not be treated but it may not be appropriate. It depends on the ---

C

Q That would be for the doctor ---
A Reassessing.

Q It would require, would it, a reassessment?
A Yes.

D

Q If we go to the clinical notes at page 56 and the page before, page 55, he had been seen by Dr Ravindrane. Yes?
A Yes.

Q I think among other things, it seems as if it was he who prescribed Clexane. Yes?

E

Q I am not going to go through the notes, but I think the evidence will probably demonstrate that he did. Then on 26 August the patient is seen by Dr Barton and she decides he is not well enough to transfer to?
A Acute unit.

Q Then we see these two notations:

> "Keep comfortable
> I am happy for nursing staff to confirm death"

F

A Yes.

Q Is that an indication at that stage, on 26 August, that the patient was for treatment or for palliative care?
A For palliative care.

G

Q The decision to treat a 67 year old man, as I think this patient was ---
A Yes.

Q --- for palliative care would require what sort of assessment?
A It would require an assessment of what the underlying prognosis for this gentleman would be and the seriousness of the illness which had developed and, therefore, will it be appropriate to actively manage or not.

H

Q We know that on 30 August syringe driver was started, so by the time you see him on 1 September you found him to be, "Rather drowsy, but comfortable".
A Yes.

Q We see:

> "Remains confused
> For TLC ..."

B

So that is another annotation that this patient is for palliative care?
A Yes.

Q At the time that you made that notation did you take it that that was already the course that this patient was on?
A Yes.

C

Q Finally, I do not think we need to turn up any notes for Patient K, I just want to ask you about your understanding of fentanyl – what a 25 microgram patch means. What is your understanding of what a 25 microgram fentanyl patch would convert to? Let us take it 24 hours into its life, as it were.
A Right. Could I say that I think there has been a change in the *British National Formulary* about what the equivalence in morphine or the fentanyl patch has been between 1999 and now.

D

Q Right.
A I would have to reference ---

Q You said to Mr Langdale, and I did not catch quite what you said, I think you said it is the equivalent of 40 mg?
A No. Mr Langdale put that to me.

E

Q That was being suggested to you?
A Yes.

Q I thought you accepted that, or you ---
A No. I said I could not be sure.

F

THE CHAIRMAN: Mr Kark, perhaps the witness could finish the answer he started a moment ago when he said "I would have to have reference to…" and then you interrupted him.

THE WITNESS: To a *British National Formulary* before 1999, and a current one. I think ---

G

MR KARK: I was not ignoring that. I was just about to take the witness to it, but I wanted to know what your evidence was before you referred to the *BNF*. Are you saying that you would not have been sure what the equivalence was?
A Not without looking at the *British National Formulary*.

H

Q I am not criticising you for that for a moment, but I just wanted to understand what your evidence was. Would you take out Panel bundle 1, which is to your left, and turn up tab 3 and go to page 12. Just to help you, this is a *BNF* for September 1998. Yes? So we are going back to at least the right ---
A I cannot see a date on it, but ---

B

Q If you look at the first page, you probably can.
A Thank you.

Q Yes? Okay. Then if you go to our page 12 – it is page 201 within the book – do you have that? Look at the page numbers with a line outside, the far right hand side at the bottom of the page.
A Yes.

C

Q The heading is "Fentanyl"?
A Yes.

Q We can see that the contra-indications and side-effects are those for morphine salts?
A Yes.

Q We can see under "Administration":

D

> "Long duration of action. In view of the long duration of action, patients who have experienced severe side-effects should be monitored for up to 24 hours after patch removal."

That is because the effects of the patch wear on?
A Yes.

E

Q Is that the brand name, "Durogesic"?
A Yes.

Q But it is fentanyl by a brand name. If we look underneath that, do you see "Administration"?
A Yes.

F

Q In rather small writing. It tell us doctors where to put a patch. Then do you see these words:

> "Patients who have not previously received a strong opioid analgesic, initial dose, one '25/micrograms/hour' patch replaced after 72 hours; patients who have received a strong opioid analgesic, initial dose based on previous 24-hour opioid requirement (oral morphine sulphate 90 mg over 24 hours + one '25 micrograms/hour' patch…".

G

A Yes.

Q So that gives us the conversion, I think. It is the equivalent of giving somebody 90 mg of Oramorph?
A Yes.

H

MR KARK: That is all that I ask you.

THE CHAIRMAN: Thank you, Mr Kark. Dr Reid, we come to the stage now where the barristers have completed their questions, at least for the moment, and it falls to the Panel to consider whether they have any questions, then, to ask them of you.

B

We have already taken the opportunity as a Panel in the last break to discuss, Mr Kark and Mr Langdale, what sort of time scale we would need before we would be ready to put our questions. I can tell you for the time that we have now reached, that we would not be ready to put any questions to the doctor before lunch.

C

It is now ten to twelve. We would need all of that time to have any prospect for one o'clock. What I am going to say is that we will not be in a position to put questions before two o'clock. I very much hope that at two o'clock we will be in such a position. We will take a shorter lunch to try to ensure that. Clearly the doctor has given some important testimony and it is very important the Panel consider carefully those questions they would wish to ask of him now so that we do not find ourselves having to ask him to come back on another occasion.

D

Doctor, I am afraid that means that you are now going to be released this side of lunch, other than, of course, you are free now to go and take a longer lunch. Could you please be back here for two o'clock? What will happen is that the Panel will put their questions, and I hope they will be shorter than they would have been if we did not take the time; there will not be a repetition, I hope, of questions. When we have asked our questions of you, the final hurdle is that then the barristers are entitled to ask any questions which might have arisen out of our questions. That, then, will be it. If you would return at two o'clock I would be most grateful. I remind you that you remain on oath. You should not discuss the case with anybody and you should not allow anybody to talk to you about the case.

E

THE WITNESS: Thank you.

THE CHAIRMAN: Thank you very much. Two o'clock, please, ladies and gentlemen.

(Luncheon adjournment)

F

THE CHAIRMAN: Welcome back, everyone. Doctor, I sorry that we have kept you out for so long. As you will appreciate, your testimony raised a lot of issues that are of particular interest to the Panel. If it sweetens the pill slightly, I think as a result of our discussions, we will now be asking fewer questions than we would have been if we had just gone straight into questions from the Panel.

THE WITNESS: Thank you very much.

G

THE CHAIRMAN: We are going to start with questions from Mrs Pamela Mansell, who is a lay member of the Panel.

Questioned by THE PANEL

MRS MANSELL: I think some of my questions might reflect that I am a lay member, so would you bear with that. I would like to first have a look at Enid Spurgin. I understand you

H

to say that there was some difference between when you assessed this lady and when she was actually admitted to the Dryad ward and there was some incongruency in between the letter from Haslar to Dryad and what the lady was actually like. When I actually looked at these two, your initial assessment and the letter from them, I actually had difficulty in seeing that incongruency – that there was not a consistency there. Does that make sense? Obviously not.

A You are saying there was not an inconsistency between ---

B

Q That is right. That is what I understood you to say. It was not entirely consistent between how this patient appeared when she got to Dryad Ward and when you saw her, and the letter from Haslar to Dryad?

A There would appear to be an inconsistency between my assessment when I saw Mrs Spurgin in the Haslar Hospital and the letter which accompanied Mrs Spurgin from Haslar Hospital. That is Captain Rankin, I think, who wrote that letter.

C

Q Right. Could we just explore that inconsistency a little bit because when I looked at it, I thought, "I can see there is a lot of consistency actually there, rather than the inconsistency", so I think I have the letter on page 23 in bundle I. That was the letter from the ward. I have a feeling – I think if we go to 301, that was your actual letter. Am I right? I am not very good with these references.

A Shall I ---

D

Q You see. I can see that what you are saying, the main problems are the pain in the right hip ---

A Yes.

Q -- and a swollen right thigh, and even a limited range of passive movement. When you actually saw her you were saying that there was a limited amount of movement. In a way, they are actually saying here that she can only move aided with two nurses and a zimmer frame. They are also saying there is not a lot of movement there, are they not?

E

A Yes. Perhaps it might be important to say there is a difference between active movement and passive moment.

Q Right?

A So when I saw this lady, I would deduct from my letter that she was not capable of lifting her leg of her own volition because of the pain.

F

Q Right?

A And when I saw her, even passive moment – that was me lifting her leg for her – even a limited range of movement, that was very painful for her. I find it just a little bit surprising that in the transfer letter from Haslar it says that she is now mobile from bed to chair with two nurses, when I found that even just lifting her leg a little of the bed was extremely painful.

G

Q Painful for her. So that might be around this whole acceptance of pain, et cetera. That could be an explanation or --- ?

A Sorry?

Q It may well be that whatever the pain, this person was got out of bed and ---

A Yes. I am not disputing ----

H

Q Okay. There could be a lot of explanations for that. That takes me one path, but I am under the impression that she was very with-it?
A Compos mentis, yes.

Q A compos mentis, quite with-it lady, so she was actually coming to Dryad for treatment in terms of mobilisation. She was not a palliative care?
B
A Not at that stage.

Q Can I then take you to Dr Barton's assessment on page 27?
A Sorry? Dr --- ?

Q I can see that Dr Barton's assessment here on page 27 is consistent with yours, that you want the plan to sort out the analgesia?
C
A Yes.

Q Okay. But this also tells me that this lady is not continent.
A Yes.

Q And my understanding was that this lady was continent but had some accidents – incontinence of urine because of the immobility, the lack of getting out of bed. We have
D
heard from another witness that that can actually be quite transient. It is not necessarily a symptom of old age, of the systems breaking down.
A The lack of continence.

Q The lack of continence in this particular lady.
A I think if someone were having what you describe as "accidents", I describe that as not being continent.
E

Q Right, okay. A lot of your patients are actually palliative?
A Yes.

Q Who are incontinent?
A Yes.

F
Q Then this lady was different, in that it was occasional, not continuous?
A Yes. It is certainly recognised that if you are immobile, you are more likely to be incontinent.

Q Because you cannot get to the bedpan, or whatever else?
A That is right.

G
Q Absolutely. But how would this initial assessment by Dr Barton enable me to understand those differences in this lady, to another lady who is coming in for palliative care?
A In Dr Barton's assessment she says that Mrs Spurgin is not weight-bearing.

Q Yes?
A So that clearly could be an influence on her continence.

H
Q Yes. Yes?

A I think recording someone is being incontinent is just recording a fact. It is not making a prognosis or indicating that someone should only be for palliative care or whether she is for active care. I do not think it is saying that.

Q Right. Okay. But in this is suggesting to me or to the nurses that there is a treatment programme here that we may have to look at?
A What is in it is Dr Barton's statement "Try and sort out analgesia".

B

Q That is right; that is right. But you have already indicated in your letter that you are not entirely satisfied that there is not actually – excuse me if I get this wrong – an orthopaedic problem. It is not actually a problem with the operation.
A I asked for some reassurance in my letter that all was well orthopaedically with Mrs Spurgin's hip, and there is an entry from the orthopaedic surgeon the day after I saw her which does not make any reference to that. I find that not to be an unusual experience and I have tended to work from the basis that if it is in the notes, if they have said nothing, then they are happy with how things are orthopaedically.

C

Q Right, okay. But the pain continues in the hip?
A Yes.

Q What is the risk from this of actually the focus becoming on the analgesia and actually controlling the pain through analgesia rather than looking at whether there is another problem?
A Yes. Normally one would expect pain after a hip replacement, and that the pain would gradually ease with time.

D

Q Absolutely. That is right.
A If that does not appear to be the pattern, that is clearly the stage at which one should be thinking about or further assessing what is actually going wrong with this lady's hip.

E

Q Right?
A I think the question for me is, at what stage following the operation does one make that assessment, and that may be different for different doctors. Some may have a much earlier threshold for investigating than others. That is just human behaviour.

F

Q So when you are looking at an initial assessment like this and you are setting out something for the nurses, what else might you expect to see in there that tells you there has to be a period of review? You are saying that really, when you are dealing with it it might be a matter of a period ---
A --- of time.

Q --- and see how the pain is decreasing?
A I think what one would expect to see is a progress report, in terms of, is the pain settling and is the patient now starting to mobilise and if not, then initiating further investigation. But I think the overriding priority at the time of transfer was pain control.

G

Q That is fine, but you see the reason why I am asking questions around this is, when we actually get to the 6 April this patient is, I understand, seen by Dr Barton and Dr Barton addresses the analgesia and increasing the dosage. Okay?
A Yes.

H

Q But does not actually address what is causing that pain not to be going away?
A Yes. Well ---

Q So it indicates a certain mind-set, or perhaps does it indicate that certain mind-set, that the focus is more on the analgesia rather than it is that this patient is in here for mobilised treatment, et cetera?
B
A I saw the patient the following day and felt that investigation was appropriate.

Q That is right.
A As I have said before, I think we have different thresholds for at which time we should do that, but I would have thought that by that time it was appropriate to investigate, because the pain was not settling.

C
Q But it is arguable that the same pattern is then progressed because the patient does not go for the x-ray? As far as we know, nothing is actioned. The patient does not go for the x-ray and then, of course, by the time you next see the patient the patient is then on the syringe driver?
A Yes.

Q And is drowsy, and unrousable?
D
A Yes.

Q And so dehydrated because they are not getting fluid, et cetera.
A Well ---

Q So has that focus on the analgesia prevented any addressing the treatment plan?
A I do no think so. Certainly from my perspective, when I saw this lady on the 7th,
E
I was clearly concerned about what was going on in her right hip. Without going into all the detail, I think that the most likely thing is that she had a deep-seated wound infection.

Q Infection – yes.
A What can one do about that is then the next question. An x-ray is the first step in that. An x-ray may show absolutely nothing. Either way, one would then consider, "Is this lady well enough to refer back to an orthopaedic opinion?" What I would say is that if this lady
F
did have a deep-seated infection, the consequences of that are fairly awful, in terms that it usually requires going back to theatre. This is already a lady who was very frail, so there would be risks simply from the anaesthetic. Also, the operation that is carried out leaves someone with considerable shortening of the leg and that can often make mobilisation very difficult. We know that developing a deep-seated wound infection carries a very poor outlook, so even with referral onto the orthopaedic surgeon, I would have been very pessimistic about this lady's prospects for surviving, let alone for walking.

G

Q But the alternative to that is to accept that the patient is just going to relapse into death, is it not? Move towards death?
A Unfortunately we recognise that is a complication of ---

Q That is assessing the risks, is it not? I am not certain how.... I can see what you want to initiate here – the x-ray ?
H
A Yes.

Q But I am not certain how those risks were actually assessed by Dr Barton and by the nursing team?
A There is no record of that having been done that I can see.

Q So you come in after, and find out that the x-ray has not been ---
A --- done.

B

Q And that the patient has moved to being on a syringe driver and unrousable and imminent death is near. What should we have expected a reasonably competent consultant to actually have initiated at that point to ensure the protection of patients?
A When I saw her on 12 April?

Q Yes?
A I think it is to look at what has happened and to review what has happened to this lady up until that point.

C

Q Right?
A I have outlined what I felt the likely prognosis would be and then to make a decision about do we actively intervene, or do we treat this lady palliatively? I believe that is what I did.

D

Q I am not certain that you actually did make the decision to treat palliatively, the patient is already on the syringe driver and ---
A To continue the treatment.

Q There was no alternative, was there, at that point? You are saying once they are on a syringe driver you do not actually take – and he is unrousable – you do not take people off that?
A It would be unusual to do that.

E

Q That is right.
A But this lady, having had her operation on something like 19 March and three weeks later she is still in severe pain and, in fact, if anything in more pain that she was at the start.

F

Q Exactly. That is ---
A That indicates to me a very poor prognosis.

Q Is not the pain because the cause of it had not been addressed again?
A What I have said, even if ... I just think that the odds were really stacked against a good recovery for this poor lady.

G

Q I can hear that, yes, but I am not certain as to how that balancing act was actually carried out. Then, if you say there was a review at the end – a review of this lady's decline and the failure to take up the x-ray – I am not certain what the outcome of that review actually was?
A I felt by that time the x-ray had become irrelevant.

Q Obviously, yes.

H

A That is why I did not pursue it, because I felt this lady's prognosis was so poor that it was just right to treat her palliatively because she had been, as far as I can see, in a lot of pain since day one, and in increasing pain.

Q Yes. Yes. Okay.
A But the outcome is from trying to... It is a very difficult complication to manage – deep-seated wound infection after fractured neck of femur. The outcomes are extremely poor. I mentioned earlier some of the figures that are associated with that. Those are figures, if you like, across the board. This lady was 92, so her outcome is likely to be worse than the average outcome simply because of her age.

B

Q Yes, yes. But having heard from an earlier consultant giving us evidence, there is certainly the view that you would move to looking to actually rule out whether or not further surgery was necessary or further treatment of the hip would have been necessary?
A I can only speak from my experience, which is that such patients do very badly and, as I said, there is a document the British Orthopaedic Association published just two years ago which affirms that.

C

Q Can I move on then slightly, and look with you around palliative care. What does a good assessment – what should a good assessment – in relation to palliative care look like? What would you expect to see in there?
A First of all, what is the patient's diagnosis and, resulting from that, what is their prognosis for quality of life, et cetera. That is going to be the starting point.

D

Q Yes?
A Then, if a patient develops an intercurrent illness, depending on the severity of that, whether it is appropriate to treat that or not in the context of someone with a poor prognosis. In that situation, I think that often we are aiming to relieve symptoms rather than looking to curing or to treating very serious illness arising in someone who already had a poor prognosis.

E

Q Right, right. So in a case like Mrs Spurgin, is that what you would have expected to have seen here? This lady moves from coming in for mobilisation treatment and we see here drift – if I use that word – or move into not just palliative care but end of life care. Where is that? What assessment?
A As I have said, the patient with fractured neck of femur is in an extremely serious condition. We know that across the board, with all patients with fractured neck of femur, there is a 25 per cent mortality rate at one year. So although someone may appear to be fit, well and going to have a simple operation, it is a marker of poor outcomes. It is not infrequent to see people who have previously been well who die from complications of fractured neck of femur.

F

Q But when I read the guidelines about palliative care, it talks about bringing together all the relevant people to decide on the prognosis, the outcome. Why would you not have sought the view of a consultant from the acute ward or someone who deals with the orthopaedic side to actually come and review this lady?
A That was the thinking behind asking for the x-ray, to try and find out what is happening, with a view to them seeking orthopaedic review, because the first thing an orthopaedic surgeon would ask me, if I had referred a patient to him, is, "Well, have you re-x-rayed the hip?"

G

H

Q But that did not happen here.
A No, it did not happen.

Q It went from one to the other without that detailed assessment, this person's prognosis was so poor, moving into palliative care. In fact, we moved from the one to the end of life care.
B
A Yes. I am sure that was an appropriate ...

Q Also when I look at the palliative care guidelines, it advises that you have to take account of the fact that to constantly make sure that the drugs are not making the patient worse than the actual cause or problem for the patient. So how did you see that the controls were put in so that constantly was being reviewed within palliative care?
A There is nursing documentation to support the fact that this lady was really in pain for
C
almost the entire length of her stay in hospital, both Haslar and at the War Memorial Hospital. Drug charts and the nursing documentation show that Mrs Spurgin was needing increasing doses of diamorphine to try and control her pain. Now, in most situations, when one is aiming for palliation, one does manage to – what one is aiming to achieve is pain control and someone being alert, conscious, but sometimes it is not possible to achieve that and the level of pain control or sedation needed to control patients' symptoms is such that it makes them drowsy. I wish it were thus that one could always palliate and leave people alert
D
and orientated, but sometimes unfortunately it just does not happen.

MRS MANSELL: I will leave it there. Thank you very much.

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

MR PAYNE: Good afternoon. If I could turn you back to Patient I, page 27. You had seen
E
this lady prior to entry on to the ward.
A Yes. I saw her in Haslar Hospital.

Q You had known that she was in pain then.
A Yes.

Q Just before we go any further, on page 27, I think it is Dr Barton's note, can you tell
F
me what date that is? I thought it was the 26th.
A I think it is.

Q It is the 26th. Yours is the 7th.
A Yes.

Q If you turn back to page 23, can you tell me where the date is there, because I am
G
struggling to find that. I cannot see a date. Can you?
A No, I cannot see a date.

Q But it talks about "she was admitted on the 19th".

THE CHAIRMAN: It has just been pointed out to me on page 23, above the extension number, there is the number 260399. There are no full stops or slashes, but it looks like a
H
date.

THE WITNESS: It looks like a date.

MR PAYNE: So that was written on the same day as this.
A Yes.

Q 26.3.99 is a Tuesday and you see the patient the following week on the Wednesday.
B
A Yes.

Q You have said that she is still in a lot of pain.
A Yes.

Q But you still think on the 7th there is still reason to look at it positively, because you want him to do an x-ray.
C
A I think I would have been looking at it negatively.

Q But you want him to do an x-ray, you want him to find out the cause, et cetera, et cetera.
A Yes.

Q I should think that is more of a positive than a negative, but fair enough. If those
D
types of things had taken place on the 26th ----
A I do not think it would have been appropriate to do it at that stage. This comes back to the question of at what stage, if someone is in continuing pain, does one then start investigating. Some people will mobilise on day two after a fractured neck of femur, some very elderly ladies. Some people may take ten days, two weeks to really get going, simply because of pain. So it is unpredictable.

E
Q But you have told us that when you first saw this lady, the mobility, you showed us lifting her leg with your hands and she was in a lot of pain.
A Yes.

Q So surely the closer you are to trying to reverse the problem, nearer to the actual operation would give a better prognosis of the final outcome, would it?
A I think the other thing to say is that x-raying someone in this condition often does not
F
tell you very much. The x-ray can be completely normal with a deep-seated hip infection. The longer time goes by, the more likely the x-ray is to become abnormal. What an x-ray could tell us was the collapse of the head of the femur, that the femur had dislocated. I think that both of these are much less likely than a deep- seated wound infection. To come back to your question, it is a matter of judgment at what stage you think it is appropriate to investigate. I would not be thinking of x-raying someone let us say if they were still in pain after a week after their first neck of femur. I would still be thinking that this could still be
G
natural recovery.

Q It would still follow that the closer from the operation that you identified, for instance, the infection, the more chance you have of stopping that infection getting bigger, curing that infection quicker.
A My guess would be yes, is the answer to that. I am not an orthopaedic surgeon, but often these deep-seated wound infections are extremely difficult to treat.

H

Q I see no note from the 26th to the 7th within this. There is no record of any deterioration or action being taken. You go to the nursing notes and I have tried to read through those and it talks about "still in pain", "still in pain", "still in pain", but no-one is trying to find out what the cause is. I am right in thinking that you visit once a week.
A That is right.

Q But Dr Barton visits every day.
A That is right.

Q And there is no record.
A That is right.

Q Then on the 7th you instigate a plan of some sort with regard to x-ray.
A Yes.

Q Then you visit again the following Monday, which is the 12th, and nothing has been done.
A There are records in the nursing notes about some (inaudible) which has recurred. I acknowledge that there is not anything written. In an ideal world, one would have wanted that to be happening.

Q You see, earlier in your evidence you said that they knew more about it than you and you thought that the nursing staff and Dr Barton, you had the utmost confidence in them and those types of things.
A Yes.

Q Yet here we have a situation where you actually instigated a plan and nothing has been done, nothing is carried out. I am not from your industry, but in my industry, somebody would be wanting to know why.
A On my ward round, I would be gathering information from the nursing staff about what had happened since ...

Q Because you would not be able to take it from here, would you?
A No, I would not. Definitely not.

Q So there is something amiss with the recording. I am moving away from that now, doctor. Could I just take you to page 169? It is the front page of the concertina sheet, the drug sheet. If you go down two-thirds of the page, under 9:

> "Put date prescription needs to be reviewed in 'review' box of regular prescription section."

If you turn to page 174, I think that sheet is all Dr Barton's signature and there is no review date.
A No, there is not.

Q On any of it. This is Patient F and there is no review date on any of those. Surely a review date is exactly what it says.
A Yes.

Q Therefore if there is no review date, these prescriptions are never-ending.
A There should be a review date.

Q Can you remember bringing that to ---
A No, I cannot remember.

Q Do you think that is an ideal situation, to have no review date?
B
A No.

Q One of the allegations against Dr Barton is that she did not keep clear and accurate and contemporaneous notes on a number of things and one of them is the drug regime.
A Yes.

Q Would you say that that is a failing on Dr Barton's part?
C
A Yes. There is clear instruction on the prescription sheet to complete a review date.

Q Initially you told us – correct me if I am wrong – that you thought that Dr Barton and Sister Hamblin had more experience in the use of these opiates.
A They did have more practical experience of using them.

Q I think you also said that if you had come to something outside the normal, you would
D
have referred to the BNF.
A Yes.

Q Where they may have more experience than you, in 1999 you were a consultant.
A Yes.

Q You were a very experienced person in your field.
E
A Yes.

Q You have said to us that if you would have seen the prescriptions for 20 to 200, that wide range, you would have done something about that.
A Yes. It was my responsibility to do something about it.

Q When you saw that – and you reduced one from 80 to 40.
F
A I did not recollect seeing prescriptions for 20 to 200 mg until the police interviewed me and produced a prescription sheet which demonstrated that.

Q With the greatest of respect, doctor, I have difficulty accepting that, because you told me that the sheets are there, you are reviewing the patients, you are on a ward round with people that you say have more experience in this than you and, before you can make a judgment, you must review all the facts.
G
A I accept that I must have looked at this prescription, but I have no recollection of it. I should have done something about it. I fully recognise that.

MR PAYNE: Thank you very much indeed. That is all.

THE CHAIRMAN: I am going to introduce Ms Joy Julien, who is also a lay member of the Panel.

H

MS JULIEN: Good afternoon. My question is around your supervisory role in relation to Dr Barton and also in relation to the nursing staff. Earlier on in your evidence, you gave examples, quite a few examples, of situations where you would not have expected Dr Barton to consult with you.
A Yes.

Q What my question is is whether you can give me some idea of the extent of your knowledge of the amount of discretion that Dr Barton and the nursing staff had in their day-to-day work. For example, in relation to the syringe drivers, we have heard evidence about syringe drivers being prescribed without a specific start date. Were you aware of that?
A I am not aware of it being without a specific start date.

Q No incident at all of that?
A Do you mean that it was not recorded on the ...

Q That there would not be a specific date as to when it would commence.
A I think I said that in our palliative care ward today we do admit some patients who may not be immediately in need of opiates, but I think I described the sort of patient who is perhaps recovering from a very serious operation, is very frail and one was not sure whether this person was going to get better or whether they might in fact continue to decline. In that situation, we would write up prescriptions in advance. In other words, the prescription would be dated, but there would be no start date on it.

Q Are you talking about via syringe drivers?
A Yes.

Q So you would consider that appropriate?
A What I cannot be sure of, because I do not work in the palliative care ward, is whether that is a syringe driver or whether – I think that is written up as Oramorph, such and such a dose, three to four-hourly as required. That is from memory of what we do on a palliative care ward today, but I do not work there, so I cannot ....

Q If that were the position would you consider it appropriate for a syringe driver without a specific start date? That level of discretion, would you consider that appropriate?
A I think it would come back to the clinical condition of the patient. In other words, if it was someone who was very frail, let us say might be having difficulties in eating and swallowing, one might in these circumstances consider it appropriate to be considering subcutaneous drugs rather than oral drugs but I am not sure of whether a syringe driver would be appropriate at that stage.

Q Is that because, do you think, of the risk involved in that way of management?
A Syringe drivers are applied when patients are no longer able to swallow or where you feel that a patient would be caused a lot of distress by repeated injections.

Q Are there risks involved? I am not sure I understand what you are saying.
A I do not think there is any greater risk than giving orally. It is just I think we should be giving drugs orally where we possibly can.

Q Let us suppose there was a syringe driver prescription without a specific start date. Would you consider that that would be operating in the patient's best interests, working within that format?
A It would depend on the individual patient and their circumstances.

Q You saying it could be in the patient's best interests?
A I think it could be, if, again, the situation is someone who is very frail, having difficulties swallowing, or let us say a very thin skin and you knew that repeated injections were likely to be painful, then in these circumstances it might be appropriate to prescribe a syringe driver.

Q Yes, but my question does not really focus around prescribing syringe drivers *per se*, it is about the flexibility regarding the commencement, if you see what I mean? There is a slight difference.
A I think if you reasonably anticipate that the patient may become distressed within the next few days then I think it is reasonable to prescribe in an anticipatory way.

Q What about from the nursing staff's point of view? We have heard that some nursing staff, they have actually told us that they have the flexibility to initiate in certain circumstances the syringe drivers. How do you see that?
A I am sorry. Could you repeat that?

Q The nursing staff could initiate the syringe drivers off their own volition, without having to consult with Dr Barton or any other doctor.
A I cannot say I was aware of that.

Q If that were the case, what would be your view on that?
A I think it would depend on the individual situation. If Dr Barton had assessed the patient and felt that a syringe driver might become appropriate because she is not available, I do not feel it is unreasonable for nursing staff to commence that syringe driver because she is immediately available.

Q I think you said earlier on in your testimony that you were not really aware of the level of training that the nursing staff had had.
A No, I was not.

Q So even taking that into consideration you would still consider it appropriate?
A When I came onto Dryad ward the nursing staff seemed to be very au fait with syringe drivers and I made the assumption that they knew how to manage this, but I did not enquire as to what the specific training was.

Q Do you think there were any potential risks, that way of operating?
A Administration of opiates has to be undertaken by two qualified nurses and so I think that there was some safeguards in that. There was not one individual nurse could go to the drug cupboard and look at the prescription and just decide off her own back what was the appropriate - so there had to be two nurses as far as controlled drugs were concerned.

Q Again, would that way of operating be in the patient's best interests?
A In terms of relieving a patient's pain and distress yes, I think it would be,

given that there was not a doctor immediately available on site.

Q Are there any situations where you think it may not be in the patient's best interests?
A I cannot.

THE CHAIRMAN: You are looking a little tired. Would you like to take a break now before we continue?

THE WITNESS: No, I am fine, thank you.

THE CHAIRMAN: You are quite sure about that?

THE WITNESS: Yes, thank you.

THE CHAIRMAN: If at any time you do feel it is all getting a bit much and you need a few minutes to get yourself together, please just say so. This is your testimony and we will take it at your pace.

THE WITNESS: Thank you very much.

THE CHAIRMAN: I am going to pass you now to Dr Roger Smith, who is a medical member of the Panel.

DR SMITH: Can I just take you back briefly to the same case that both of my colleagues opposite each other talked about, and this is Mrs Spurgin, that is Patient I?
A Yes.

Q The first question to a geriatrician is this: does age in itself matter?
A No. It should not be a barrier to receiving treatment if treatment is deemed to be appropriate.

Q Aunty Enid, said a witness, was a very independent old lady of 92 who drove her car until she was 90, and this poor old lady was pulled over walking her dog.
A Yes.

Q Fractured her neck of femur. It is an important context. Do you agree?
A I did.

Q Let me then go, just leaving that aside, to the issue that you raised in your note. You were clearly concerned that there might be an orthopaedic problem.
A Yes.

Q Both before she left Haslar ...
A Yes.

Q ... and later when you saw her, I do not know, about a week after she came into Dryad.
A Yes.

Q You noted shortening.
A Yes.

Q I think I heard you say to Mrs Mansell that you thought this was due to deep-seated infection?
A Yes.

B

Q About which you would be very pessimistic in terms of outcome?
A Yes.

Q But could there be another explanation of shortening? What would a junior doctor think if you said, "Shortening of the leg, doctor, what do you think?"
A The other diagnostic possibilities would be dislocation of a hip. That could produce shortening.

C

Q For the lay members, is that something that is remediable?
A Yes, it is, but I think it is unlikely in this clinical context, because usually when a hip is dislocated and there is a sudden increase in pain and not the gradual increase in pain which seems to have happened. Also this lady had been seen, I think, by the physiotherapist who did not report any concern with the hip, and physiotherapists are often quite good at picking up orthopaedic problems. The other possibility is that her femoral head had collapsed as a result, because just osteoporotic and soft and metal work, and, again, that presents a major challenge from an orthopaedic perspective to sort that.

D

Q Indeed, the orthopaedic surgeon who independently gave us his witness on that said that there was a chance in osteoporotic old people that the metal work might come apart.
A Yes.

E

Q Is that potentially remediable?
A My understanding is that when you have metal work in place it is extremely difficult to eradicate infection and that the only chance of getting that infection to resolve is actually to remove the metal work.

F

Q What we seem to be agreed about is that when there is shortening there are different possibilities and there is, perhaps, some potential for treatment?
A Yes.

Q You say that was not going through your mind, that you were being pessimistic, not optimistic, I think you said to Mr Payne?
A Yes.

G

Q So Aunty Enid, who was very independent, pulled over by a dog, might she not have had the chance of an orthopaedic opinion?
A As I said, when I requested the x-ray that was at the back of my mind, because the first thing an orthopaedic surgeon would ask is, "Have you x-rayed the hip", but I would still come back to my view that even though this was an independent fit lady beforehand, her prognosis at this stage when I saw her on the 7th I think was looking distinctly guarded.

H

Q That is to say the least, is it not, but is that not because nothing has been

done? I am sorry, I am probably repeating on what my colleagues have said, but is that not because nothing has been done?
A Having seen such patients in the past, my experience is my patients do extremely badly.

Q We will leave it there. Just going back to the general situation. You came to Dryad and there was you and there was Sister Hamlin and her staff and there was Dr Barton, the clinical assistant, daily, Monday to Friday. I think you mentioned a senior registrar?
A Yes, Dr Ravindrane occasionally.

Q So there was a registrar on occasion. So if Dr Barton needed advice, on a day-to-day basis if she needed someone to refer to with a problem, would she go to you?
A Yes.

Q There would not be another way she could go to your registrar, for instance?
A No, that would be unlikely.

Q How available were you?
A I may not always have been immediately available but Dr Barton would be able, if she was not able to contact me directly, to leave a message with my secretary and I would try to get back to her.

Q So there was a contact point that could easily be used?
A Yes.

Q Forgive me for asking this question: were you amenable to being contacted?
A Well, I would like to think so.

Q Glad to be contacted?
A Yes.

Q Would the staff have known that?
A I think so, yes.

Q Did they ever?
A I think I remember a couple of occasions. Well, I certainly remember being down seeing relatives of an evening at the request of staff, either Dr Barton or the nursing staff. I think I recollect being there on a weekend once when I was not on call to sort out a problem. So I would like to think that - I think it is really important that consultants are available.

Q Thank you very much for that. Let us think about Patient J, Mr Packman. Mr Packman was this very obese gentleman who came from - I have forgotten now. I think it was the QA?
A Queen Alexandra Hospital, yes.

Q He came for a chance at remobilisation.
A Yes.

Q I think there was somebody, it might have been you, who said there was a

good assessment on the day of admission and that was by Dr Ravindrane?
A I am not sure. I do not think it was me that said it, but there was a good assessment by Dr Ravindrane.

Q That was the kind of note you would expect a hospital doctor to make?
A Yes.

B

Q He started this gentleman on Clexane.
A I would have to ---

Q Okay. We will take our time on that one. It should be page 55, I think, in J.
A I am sorry.

Q It is 55. It has "54" in bold.

C

A Yes. I am just trying to find the reference to Clexane. I have the prescription sheet on page 173.

DR SMITH: Good.

MR KARK: Clexane is mentioned on page 172.

D

DR SMITH: Page 172. (To the witness) I do not recognise that as Dr Barton's writing.
A No, I think that is Dr Ravindrane's signature.

Q I think we established that earlier. So he started Mr Packman on Clexane. Would it be a reasonable assumption then that starting him on Clexane, which is to prevent problems ...
A Yes.

E

Q ... firmly does not put this gentleman in the end of life category at this stage?
A Yes, that is fair comment.

Q So he is still for mobilisation, if it is possible.
A If it is possible, yes.

F

Q Then the next day he has, "Fresh blood [per rectum]".
A Yes.

Q As a physician, what would you take that to mean?
A He was having bleeding from his gastrointestinal tract. Probably the lower part of the gastrointestinal tract. Is that what you?

G

Q Fresh red blood could come from the lower. Could it come from the upper GI tract?
A If it was a very profuse bleed my understanding is it could, but I think that is unlikely.

Q But it could?
A I would prefer to defer to a gastroenterologist on that particular question.

H

Q I am asking you as a general physician geriatrician.

A I think someone would have to be having a very severe gastric bleed before that would happen.

Q It could be a severe GI bleed?
A My feeling is ---

Q Put it at that level. It could be?
B
A It could be.

Q What would you expect a nurse to do if she saw that in the bed? If it was in your ward in QA, what would you expect a nurse to do?
A Call the doctor.

Q Why?
C
A Because gastrointestinal bleeding is a serious condition.

Q What do you expect the doctor to do?
A Make a judgment about what treatment is felt - well, to examine the patient and make a judgment as to what treatment is felt to be appropriate.

Q The doctor having thought it was a GI bleed of some significance, what would you expect that doctor to do before he then left that patient?
D
A I think it depends on the individual patient, but in normal circumstances one would expect someone to check a blood count, check pulse, blood pressure, et cetera, and ask, perhaps, for blood to be cross-matched.

Q Would it be unreasonable to expect a junior doctor to put up a drip?
A Oh yes, yes.

E

Q It would not be unreasonable?
A It would not be unreasonable.

Q What would you expect a houseman then to do? Sorry – we call them something else now. F1, or something, is it not?
A Much the same. Much the same.

F

Q Yes. But what else would you expect them to do?
A Call a senior.

Q Yes. Why?
A Because that would represent a significant change in someone's condition which they might potentially not be able to deal with on their own.

G

Q It is a serious situation? A potentially serious situation?
A Yes.

Q This did not happen?
A No.

Q That is not good.
H

A I think that in this situation what one has to look at is what was this patient's prognosis, outcome, what was wrong with them, and this man clearly had very significant medical problems in that he was immobile. It was unlikely that he would ever regain his mobility. He had extensive pressure sores in his sacrum and the back of his legs. This man was never in my view going to get out of a bed. He is never going to mobilise again, and I think his life expectancy was extremely poor. In that context ---

B

Q Wait a moment. He had been sent because there was some potential for mobilisation?
A I would disagree with that, fundamentally.

Q Okay.
A As I say, he had no prospect of rehabilitation.

C

Q Let us backtrack a moment. Let us stick to where we were going, in a ward in the QA. If a man had an acute bleed, a sixty-something year old man had an acute bleed and he was in for something else, is there some potential for assessment at a reasonable risk?
A I think what we are coming down to is, what is this man's prognosis ---

Q No, no. You said that. But is there some potential ---
A Yes. There is potential for assessment ---

D

Q At a reasonable risk?
A There is potential to intervene.

Q And if he was in the QA might he have had an endoscopy?
A He might have had.

E

Q If he had not, if he had not had an endoscopy in the QA under your care, what would be written in the notes?
A Just ask me again.

Q See if I can put it a different way. If somebody had decided – if you had decided – that this man, who is not in Dryad, is in the QA, and you see him on your ward round the next day?

F

A Yes.

Q If you decided that he was not for endoscopy ---
A Yes.

Q --- what would you have done?
A I would have written in the notes.

G

Q How much would you have written?
A I would have written the reasons why I thought that he should not be for endoscopy.

Q Why would you have written why he should not?
A So that other people who followed on would see that and would know that that was the plan of care.

H

Q You would be very careful to write down the reasons, because it is a big decision, is it not?
A Yes.

Q Apart from covering your own back, there are many other ramifications?
A It is a big decision.

B

Q And that did not happen either?
A No.

Q So I am still left with that same problem. Why is a 67-year old man, although he has multiple problems, why is he not given the chance of a reasonably easy investigation and, through that investigation, therapeutic endoscopy to tie off a blood vessel, to put adrenalin round a blood vessel that is bleeding?

C

A Because I think the important thing is, "What is this man's prognosis" and in the light of the events that are happening to this gentleman, how appropriate or otherwise is it to intervene.

Q But you are not there?
A No.

D

Q Somebody else is there?
A Yes.

Q Somebody else is making those decisions?
A Yes.

Q On an intercurrent event?

E

A Yes.

Q In the progress of this man of 60-something?
A Yes.

Q Do you not think it might have been reasonable for somebody to telephone you and say, "What should we do here"?

F

A I had confidence in Dr Barton and her decision making.

Q So you are happy that your patient did not get the chance?
A In the nursing record, and speaking to the nursing staff ---

Q Are you content with that not being in the record? Are you content that your patient did not get the chance?

G

A Yes, in this situation I am.

Q Are you content that the decision – a major decision – that you would have written in the notes if it was in the QA was not taken to you?
A Yes. Dr Barton was a very experienced doctor and she had been in that role for eleven years.

H

Q I am sorry, in what role?

A In her clinical assistant.

Q In what kind of a ward?
A Rehabilitation and continuing care ward. She was also an experienced GP.

Q On a what kind of ward?
A Continuing care.

B

Q Continuing care ward?
A Yes.

Q That was changing?
A That was changing. She was also a very experienced GP. She could have encountered this problem in her general practice.

C

Q Okay. I am going to move to a totally different area very briefly. That touches upon that last interchange we had there. Patients were now coming. The situation was changing. This continuing care ward was becoming a place to which patients were sent by orthopaedic surgeons post-op and by others for some... We know that the chance of mobilisation was not good because the staff were not there to do it. There were no physios and so on.
A Yes.

D

Q But that was what was happening?
A Yes.

Q Do you think it is possible that such patients, that this team was not used to dealing with, might have been reclassified in their minds into continuing care patients and not given the management that was meant for them?

E

A When my colleagues and I saw patients on the acute wards, potentially to be transferred to our wards, we would in general write the diagnosis, what the prognosis would be and a management plan.

Q "We" being?
A The consultants. Sorry; if I was asked to see someone, have a word, and my colleagues were asked to see someone on the orthopaedic wards in Queen Alexandra Hospital, there was always a letter written to the patient's general practitioner after every such ward consultation.

F

Q So they did not get to Dryad except through your hands?
A That is right. So when we started with the bed pressures and there were fewer continuing care patients, what happened was, if you like, the waiting list for Dryad Ward would evaporate at times, but there would still be a waiting list of patients for transfer to Daedalus Ward. What would happen is that one of the secretaries who maintained the waiting list would then take the names of the top two or three patients out of the waiting list, board, along with an accompanying letter, speak to a consultant who was available in the offices, and say, "We have an empty bed in Dryad Ward. There are these patients here who are on the waiting list for Daedalus. Do you think they might be suitable for transfer to Dryad Ward given the circumstances that exist?" And so, if I were there, I would look through that and try and identify the most suitable, in other words, the patient who was not like to need intensive rehabilitation.

G

H

Q Yes. But nevertheless, you and your colleagues have formulated a plan by writing something down before the transfer?
A Yes.

Q And that might be, as we have seen, to give them a chance for remobilisation, and so on?
B
A Yes.

Q But we have not seen in the cases that we have dealt with today "for continuing care"?
A No.

Q So I come back to that. Do you think that the nursing staff, or the team in general in Dryad, might perhaps have taken a more pessimistic view, despite what you have written?
C
A They could have done. But to me, I think the staff in Dryad Ward were aware of the pressures, and certainly Sister Hamblin did speak to me about the pressures on the ward, and I made it clear that what we were trying to do was transfer the most suitable patients, and the reasons for them being transferred. Then a letter from me and my colleagues would always or should have accompanied the patient.

Q Were you aware at any time that some of your nursing staff had used the word "dumping" when talking about such patients?
D
A I was not specifically aware, but in the context of Dryad Ward, certainly often ... I think what would sometimes happen is that between the time of assessment and transfer to Dryad Ward, which might be up to three weeks sometimes, a patient's condition could have changed and we were left with a problem that was not that which was in the referral letter.

Q I think we all understand that, but the pejorative word "dumping" has connotations, does it not? About the way people think about the patients coming to you?
E
A You mean in the sense that if people feel they have been dumped, they might not want to behave as they should do? I am not quite clear what you are suggesting.

Q Let me turn your question back to you. What do you think?

THE LEGAL ASSESSOR: Could I just intervene here? If the witness is not aware of the word "dumping" being used, my advice is, it is pointless to ask him what it means. His view to what it means is no different from anybody else.
F

THE CHAIRMAN: Yes, I think that must be right. If the position, doctor, is that you were not aware of nurses using the word "dumping" or "dumped" in relation to patients who were incoming onto the ward, then there is really no value in exploring that particular point further with you, so we will desist.

G

THE WITNESS: Thank you.

DR SMITH: Then finally, and again very briefly, touching on opiates. You said that you are not an expert?
A No.

H

Q And that Dr Barton and the nursing staff were much more experienced in the practical use of drivers and diamorphine?
A Yes.

Q With sedatives. But it would not be unreasonable to say, would it, that opiates such as Oramorph and MST are pretty much ordinary drugs to most physicians?
A Yes.

B

Q And we have been looking at some of the doses, and I think that you were fairly happy with the doses of Oramorph, for instance, that were being used?
A In particular situations.

Q I think that you said that in 1999 you were not aware of the existence of any guidelines or protocols for the use of opiates or sedatives in the unit?

C

A That is right.

Q But that there was the *BNF* if you needed a reference?
A Yes.

Q I am just wondering if you are aware of what the *BNF* says about opiates in the elderly?

D

A I have certainly read it in the past and at various times in the past when I felt it has been appropriate to do so.

Q Can you tell us what your understanding of that is, or rather what your understanding in 1999 was?
A I could not tell you what the *BNF* said in 1999 about prescribing opiates in the elderly, but in general the theme was exercising more caution in elderly patients.

E

Q Would it surprise you to see that it says that in the elderly, perhaps you should start at 50 per cent of the dose in another adult?
A That does not surprise me.

Q That does not surprise you?
A No.

F

DR SMITH: Thank you very much, Dr Reid.

THE CHAIRMAN: Thank you, doctor. I am very conscious of the fact you have been on the stand now for one hour and twenty minutes. Would you like to take a break before you move on to questions from myself?
A I feel fine, thank you.

G

THE CHAIRMAN: I am encouraged to hear that you feel fine. There are, I think, at least one or two persons in the room who would appreciate at least a comfort break. I am going to say five minutes for a comfort break. Then we will resume, please.

(The Panel adjourned for a short time)

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THE CHAIRMAN: Welcome back. Doctor, the good news is you really are coming towards the end now, and I am the last member of the Panel. I am afraid I am a lay member too, with all the difficulties that that throws up. What I am going to attempt to do is to pull together the picture that I think you have been presenting in the course of your evidence.

I should start by saying, I absolutely understand that at the time that you went onto Dryad in 1999 the situation was in a state of flux, and clearly from what you have told us there were a number of elements that were far from satisfactory. It was very much a matter of all parties doing the best they could in the circumstances they were faced with, and with the resources that were available to them. I understand that. What I want to do is to make sure that I have understood clearly exactly what that means in terms of what the situation was. We start off with the fact that it was a ward that was going through change. I think you told us yesterday that it had been effectively a continuing care ward, and you said that at that time that meant not so much strain on the medical staff, but considerable strain on the nursing staff.

I think you said that the change that came, bringing on to the ward persons who were not simply for continuing care, but for whom additional elements of care were required, such as various therapies, I think you said that the significance of that was that it actually increased the strain and pressure on the nursing staff who were required to do even more than had already been the case?

A Yes.

Q In those circumstances we had a consultant, yourself, who was coming onto the ward once a week to do a full ward round, and I am not sure whether you said you would see every patient or only those that you were asked to see?

A No. I saw every patient.

Q Every patient. So we have a situation where there is a consultant coming on once a week for a ward round. We have a clinical assistant, a GP from a local practice, who is coming in Monday to Friday, every day, and we have heard certainly in the mornings, very often in the afternoons and even in the evenings as well, in your view going above and beyond what you might expect for one individual?

A Yes.

Q And you have nursing staff. You have told us candidly that you were not aware of all of the training that they would have had, in particular with regard to the use of syringe drivers?

A That is correct.

Q But you were confident that not only did you have a first class doctor on the ward, but you also had good and experienced nursing staff?

A Yes.

Q Your view was that the doctor and, to some extent even, the nursing staff had more experience of some of the areas of activity that would be required on this ward than you had hitherto had?

A Yes.

Q You have also candidly accept that notwithstanding that, you were the consultant and to that extent you ultimately were responsible for what went on on that ward?

A Yes.

Q Part of your duty of care was to ensure that on your weekly ward rounds you properly inspected the notes. That would be the clinical notes?
A Yes.

Q And the nursing notes?
B
A No, I would not normally look at the nursing notes.

Q You would not normally look at the nursing notes?
A Because there is usually a member of the nursing staff on hand who is able to tell me what was happening. There might be occasions when I did have to conduct a ward round for a short period on my own and I might then look at the records if the nurse was not available.

C
Q So there you were, with a doctor in whom you had great confidence and, so far as you were aware, a doctor in whom all the nursing staff also had great confidence.
A Yes.

Q You have told us that they were fulsome in their praise of this doctor.
A Yes.

D
Q You have also helped us to understand the system that had developed on this ward to cope with the particular pressures that the ward faced.
A Yes.

Q You have told us that this was a ward where the clinical assistant would write up variable doses on some prescriptions.
A Yes.

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Q You explained the rationale behind that. In broad terms, you were happy with that.
A Yes.

Q We were shown exhibit D4, which was, you may recall, the memorandum dated 27 October 1999 headed "Learning Points from the Wilson Complaint".
A Yes.

F

Q This of course was a document that would have been produced at a time when all of the patients with whom we are concerned in this case, with the exception I think of Patient K, Elsie Devine, were actually dead.
A Yes.

G
Q As it happens, the document refers to what was called "an agreed protocol" that you tell us at the time you were not aware of.
A I was not aware of any protocol.

Q But that document tells us that there was an agreed protocol that specifically allowed Dr Barton to write up diamorphine for a syringe driver with doses ranging between 20 and 200 mg a day.
A Yes.

H

Q You have told us there may be some potential for misunderstanding within that phrase, but be that as it may, so far as you were concerned, (a) you did not know that there was such an agreement.
A That is correct.

Q And (b) you had, until it was pointed out to you some years later, no recollection of ever having seen doses of that large a range.
A That is correct.

Q It was pointed out to you by Mr Langdale yesterday that these kinds of ranges were not limited to the one example that had been brought to your attention some years ago.
A That is correct.

Q In fact, there were many.
A There were three I think in total.

Q That is something we can refer to the records on in due course. Your understanding at the moment is that there were three of those?
A Yes.

Q None of those you recollect having seen?
A That is correct.

Q Although you accept that you must have seen them?
A I accept that I must have seen two of them.

Q But it did not necessarily register in your mind at the time that this was rather a wide range?
A That is correct. I do not recollect that wide range. What I was saying was, the third one, when I was explaining the blue fold-over drug chart, I accept it was my responsibility to look at the reverse side, but because the patient was not on a syringe driver, I may well not have looked at that chart.

Q What is clear about the agreed protocol that is referred to in this document is that it only extends to the issue of the variable dose. It says nothing about the sort of circumstances alluded to by Ms Julien where you have the doctor writing up a prescription for the mixture of opiates to be delivered by syringe driver without a start date being recorded on the prescription.
A Did you say that it does not record a start date?

Q The document says nothing about a start date.
A No, it does not.

Q So far as you were aware, whenever a syringe driver with this mixture of opiates was prescribed, there would always have been a start date recorded in the note of the prescription.
A Yes.

Q If there had not been and you had seen it, that is something that would have excited comment from you?

A That would usually be something that would be picked up by the nursing staff, because nursing staff are not allowed to administer against a prescription that has not been signed and dated, with the exception of verbal orders, for which there is a separate policy.

Q But of course in the event that ---

MR LANGDALE: Sir, I am sorry to interrupt, but it should be made clear to the witness that these were signed and dated. There was not a signed date, but a signed and dated prescription.

B

THE CHAIRMAN: Thank you for pointing that out. (To the witness) As Mr Langdale has said, we are not talking about a prescription that is not dated in terms of when it has been written, but rather, an open-dated prescription. If I can put it in this way to you. It is very crude language, as you might expect from a layman. We have been given to understand from a number of witnesses now that the process of being on a syringe driver with the sort of mixtures of opiates that we have been talking about is in effect a one-way street, end of life regime, that will not go on for very long. Once you have started, in effect, within the context of this ward, there was no going back; it was death.

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A I think that would often be the case, if one was clear that someone's symptoms were for palliation.

D

Q Can you recall a single instance in your year on Dryad Ward where a patient was put on to a mix of opiates on syringe driver who did not die?

A No, I cannot.

Q So on the one hand we all understand and agree that that is the end game. When you start on that, that is death. But that is an action. Somebody has to start you on that particular road.

E

A Yes.

Q Before you get to there, somebody in effect has to sign the death warrant, somebody has to prescribe that.

A Someone has to make a decision that this patient is for palliation.

Q And they are going to indicate that, in terms of the syringe driver, by prescribing the syringe driver with the opiates.

F

A In the first instance, one would expect that to be recorded in the medical notes, that someone's symptoms was for palliation.

Q But even if they did not use some of the words we have heard and I know you have agreed with today: "Make comfortable", "TLC" and so on, these are all euphemisms for a change of status to palliative care, end of life, the patient is going to die.

G

A Yes.

Q One of the ways in which we can see that decision illustrated is when a patient is actually prescribed that mixture of drugs to be delivered in that manner, but there are two stages to the process. There is the writing-up of the prescription and then there is the administration of the prescription.

A Yes.

H

Q You have been asked about the dangers and the risks that are attendant upon a situation where the prescription is written out, but where no start date is indicated on the prescription.
A Yes.

Q Do you accept that the principal risk there is that, for whatever reason, a patient might be administered at an earlier stage than would be appropriate?
A Yes.

Q That must be the risk. So the situation that we have on this ward is that you have nursing staff who ultimately are going to be the persons who will in effect press the button, set up the syringe driver and administer the prescription from which there is no return.
A Yes.

Q We have heard evidence that under the system that developed – and clearly it developed long before you had come on to the ward and was in place when you arrived – it was possible for nursing staff of their own volition to decide, "Now the time has come. We will administer the syringe driver and the drugs therein and therefore ultimately end the life of this patient."
A Can you just repeat that for me?

Q You came into the ward at a time when this structure was in place.
A Yes.

Q The structure was one which enabled nursing staff, not qualified doctors, nursing staff of their own volition, without a doctor telling them, "Do this now", to administer the syringe driver and the mixture of opiates therein.
A I would have expected the nursing staff to have contacted the doctor, but in the event that a patient was in distress and a doctor was immediately available, in that situation, that is the situation I would have envisaged, not it happening as a routine without consultation with Dr Barton.

Q Do you see the risk that is attendant in a ward where we know nursing staff are under great pressure? Do you see the risk in such a situation for putting into the discretion of the nursing staff as to when administration should happen?

THE LEGAL ASSESSOR: Chairman, may I interrupt here? It is simply to advise the Panel that a warning should be given in relation to self-incrimination. This specific line of questioning, it seems to me, raises the question of a link between the action or inaction of Dr Reid, the consultant on the ward, and the fatal outcome for the patients. The reason I mention it is that a suggestion has been made that the nurses were effectively put in charge, were given a discretion.

I advise at this stage that Dr Reid should be warned that he is entitled to claim privilege against self-incrimination in respect of any evidence he gives which might be relied upon in a criminal prosecution either to decide to prosecute or to establish his guilt.

In other words, in less legal words, if Dr Reid is asked questions which are directed towards or are clearly relevant to his possible guilt of a criminal charge, he should be told that he is not obliged to answer that question. I advise that we have now reached that point and he

should be warned that he need not respond to any question, not just this specific question, if the answer may tend clearly to incriminate him.

I do emphasise that my intervention is made simply because of the line of questioning being pursued. It implies no view on my part whatsoever as to Dr Reid's culpability or otherwise and neither does it imply any criticism of the line of the Panel's questioning.

B

THE CHAIRMAN: Thank you very much, Legal Assessor. I of course fully accept the advice. I want to check to see that the doctor understands the advice that I have just been given by the Legal Assessor.

THE WITNESS: That I would not wish to answer these questions without having ---

THE CHAIRMAN: Let me say a little bit further. First of all, this is not the first time that this warning has been given in this case and it may not be the last time, but it is absolutely the right of any individual who comes before us not to answer any questions which they feel might in the answering put them in a position where they themselves could find themselves answerable in a criminal court. As the Legal Assessor says, because the line of questioning could have that effect, it does not mean that it is delivered in an attempt to point a finger, but it is absolutely your right, and you should be aware of it, that you do not need to answer any question which you feel could in the answering put you in a position where you could be brought before a court of criminal law.

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THE WITNESS: Thank you.

THE CHAIRMAN: I will continue with such questions as I have, on the understanding that at any time, if there is any question you do not want to answer, you simply say, "I do not wish to answer that" and it will not go on.

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The point that I had reached was that at the time you came into this ward, there was already existing a situation in which nursing staff were able of their own volition to determine when to administer the syringe driver with the opiates on board, where, and only where, the prescription itself was open in terms of start date. That was the situation when you arrived.
A Yes.

F

Q Was that a situation that you were aware of?
A That the staff could start it at any time?

Q If they had a prescription which did not have a start date.
A My view, as I said before, is that I would have expected them to have consulted Dr Barton before taking that step.

G

Q I understand that, but the question was directed to your state of knowledge only. At the time that you came on to the ward, did you know, were you aware that in the circumstances outlined, they could of their own volition start the syringe driver?
A I am not really sure that I was aware of that.

Q Is the first that you have heard of this during the course of this hearing, or have you heard of this at an earlier stage?

H

A I just do not know.

Q Very well. You cannot be expected to remember everything. Even sometimes very significant points can go by the board. You have told us, however, that you had great confidence in both Dr Barton and indeed the nursing staff.
A Yes.

Q You were asked some questions by Mr Kark about whether that confidence in Dr Barton and the nursing staff was shared by all members of the nursing staff.
A As far as I am aware, it was.

Q We have seen – you have not up to this point – another defence document that has been put in. I am referring to exhibits D1 and D2. There was in fact in 1999 and 2000 a difficulty involving one particular nurse, Nurse Hallman, concerning problems that she had with Nurse Hamblin and Dr Barton. Are you aware of that, or were you aware at the time?
A I think I can remember Nurse Hallman.

Q She was complaining that she was being harassed by Nurse Hamblin and Dr Barton.
A I think, now you have mentioned it, I was aware of that, but I am not sure I was aware of any details surrounding that.

Q Were you aware that one of the areas of difficulty, if I can put it neutrally, between the three parties was the prescribing of opiates, in particular in relation to syringe drivers?
A I do not think that I was aware of that.

Q We will put that into the camp of something that you were not aware of at the time that you were on this ward.
A I do not think so.

Q Very well. So the picture we have is that whilst you had great confidence in the doctor and the nursing staff, your belief was that the nursing staff, because of the fulsome praise that had been communicated to you by at least some, was indeed unanimous.
A My recollection was of all of the nursing staff being full of praise for Dr Barton.

Q Going on to things that you were or were not aware of at the time that you were on the ward, we have also been shown, and I think you have seen, exhibit D5 which was headed, "PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION". That document, in fact, was written by yourself.
A Yes.

Q It was written in December of 1999.
A Yes.

Q By which time all of the patients with whom we are currently concerned were dead.
A Yes.

Q It is also the draft of a protocol but that draft was never brought into being. It was changed.
A That is correct.

Q The reason it was changed was because a number of the points contained within it, namely those which dealt with the upward progression of doses, was, in fact, ill-conceived.
A Yes.

Q Wrong.
A Yes.

B

Q That was information that while being wrong does accurately reflect what you understood to be the medical clinical position at the time?
A Can you just repeat that again?

Q Yes. Although you have accepted that there were elements within your draft that are wrong, it is your evidence, is it, that you nonetheless at the time believed them to be right?

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A With a caveat that in terms of the doubling up of dose, my experience had been that was much lower doses than are in that document, so this document was used as, if you like, a starter for ten for other people to comment on.

Q One of the reasons why you did not object when you saw on the prescription notes, one of the reasons why you did not object to these rapid successions of doubling up was because you actually believed that that was the correct and appropriate way to act?

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A That is correct.

Q But you were wrong.
A I was wrong.

Q Had you referred to the current *British National Formulary*, current at that time, at the time you were on the ward, you would have known that?

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A I would have to go back to the *British National Formulary* and look.

Q You will recall that, very briefly, Dr Smith ran through the list of areas that were covered at the time within the *British National Formulary*.
A I am sorry. Could you repeat that?

F

Q You are aware that when Dr Smith was asking questions of you he did take you, albeit quite fast, through the main subject areas that were covered by the *British National Formulary* in terms of dosage for opiates.
A Yes.

Q Very well. It is just a matter of establishing that clear picture of what you did know and what you did not know. So far as this is concerned, what you knew turns out in some cases to have been ill conceived but does explain why you might not have questioned the doctor or nursing staff when you saw examples of that wrong action.

G

A Yes.

Q Because you too took the view that it was correct and appropriate. We have looked at some length at the case of Patient I, the unfortunate Mrs Spurgin. I think you said that the odds were stacked against a good recovery for this poor lady?

H

A That was my view at the time.

Q Yes. The timing is quite important there because, of course, that phrase might apply at different stages in her progression through the system, but what we have clearly established, I believe, is, first of all, that you had written up a note on 7 April indicating that you wanted this patient to be x-rayed?
A Yes.

B

Q We have heard already from another consultant that when a consultant says that something should be done in terms of action to be taken forward, this is not a suggestion or a request. The consultant told us that she expected that it would be done.
A Yes.

Q Is that the same with you, the way you operate?
A Yes.

C

Q This was not a fanciful suggestion, this was an order.
A Yes.

Q So far as we are able to tell now, looking at the documents that are before us, it was an order that was not followed?
A Yes.

D

Q You gave the order on 7 April. We have already heard that within these clinical notes there was no further entry until 12 April and that entry was made by yourself?
A Yes.

Q You came back, you presumably looked at the clinical notes and saw what you had previously ordered?
A Yes.

E

Q You quickly realised that nothing had been done about it?
A Yes.

Q Did you cause enquiries to be made at that point as to how it was that an instruction given by yourself had not been carried out?
A No, I do not remember enquiring.

F

Q If you had enquired, would it be reasonable to assume that whatever you had learned you would have noted on the clinical notes?
A Yes.

Q May we take it then that by the total absence of any information there you may not have enquired at all?
A It is certainly possible.

G

Q I have looked at the note that you have made and I wonder if you can help me. It almost appears to me as if it may have been made into stages in terms of time, because the first part of it reads, "Now [very] drowsy", and we know, of course, that by this stage the poor lady was already on the syringe driver, she had been put on to that the day before, and so was on that final journey, but when you

H

wrote, "Now [very] drowsy", that would imply to me that, although sleepy, the patient was still conscious. You should have a look at it. It is on page 27 of bundle I.
A Yes.

Q Where you have written, "Now [very] drowsy", would it be reasonable for me to assume that by that you meant the patient was conscious?
B
A Yes, they would still be responding in some way.

Q Yes. The reason I ask is because you deal with that point and you indicate that there should be the reduction in the diamorphine. Presumably, to make her able to be more responsive. I think you told us you felt it was clear from your examination that she was over-sedated?
A Yes.

C

Q We then have the next paragraph, as it were, "Able to move hips without pain", which is clear enough, "but [patient] not rousable!", with an exclamation mark.

Q What did you mean by that and what is the significance of the exclamation mark?
A I think it meant that she had been over-sedated.

D

Q If the patient was not rousable, would that be an indication that at the time you wrote that she was unconscious, or, merely, you could not get her out of the state of drowsiness to get any sensible response?
A I cannot say.

E

Q No. Unfortunately, neither can I, which is why I was asking for help, because on the face of it it appears to me that there may have been a gap in time between the writing of the first and the second.
A I would not have thought so.

Q Very well. The purpose of the exclamation mark was really to make the point then that you may have cured the pain, but if the patient is non-rousable then they are clearly over-sedated?
F
A Yes.

Q You have told us what the danger of over-sedation is.
A Yes.

Q That it can depress the respiratory system to the point that the patient stops breathing altogether and dies.
G
A Yes.

Q That is why you reduced that dose?
A Yes.

Q Here is an example where you do note a prescription level, you do apply your oversight as a consultant to look at that, question it and say that is not appropriate, it is causing this patient to be over-sedated, and you give an order that that be reduced.
H

A Yes.

Q We heard that, unfortunately, one of the nurses, and she was named, Nurse Barrett, unfortunately, for whatever reason, and it was made very clear to us by Mr Langdale that we have no information as to what that reason might have been, but the fact is that that nurse, when she made up the replacement syringe driver, whilst following your instruction to reduce the dose of diamorphine, for one reason or another, doubled the dose of - I am sorry, you will have to read it for me.
A Midazolam.

Q Yes, midazolam, and I think you told us that that astonished you?
A Yes.

Q Because the consequence of that increase in dose did what?
A It could lead to further over-sedation.

Q With the potential consequence of?
A Respiratory depression and death.

Q Indeed, we see that the very next entry in the clinical notes refers to the very next day, early in the morning, in fact, at 1.15, the patient in fact died?
A Yes.

Q You told us that part of the rationale here was pain and you certainly, on 7 April, have noted pain. You recorded, "Still in a lot of pain".
A Yes.

Q There are no other clinical entries before your own on 12 April where you have indicated fairly clearly, in that final paragraph I referred you to, "Able to move hips without pain". So, presumably, that was you manipulating the hips?
A Yes.

Q I think you told us in extreme circumstances, where a patient is unrousable, you would do something that would trigger the pain mechanism to see whether the patient was capable of experiencing pain.
A Yes.

Q You moved that patient's hitherto painful hips without response.
A Yes.

Q You said that you did not routinely read the nursing notes. Had you done so, would it surprise you to learn that on 11 April, that is, the day when the instruction was given by Dr Barton to commence syringe driver, that the nurse on duty ---

MR LANGDALE: Sir, I am sorry to interrupt. I do not think that is right. The syringe driver was commenced on the morning of 12 April at eight o'clock, or nine o'clock.

THE CHAIRMAN: I think I said when the instruction was given and the notes, if you would like to refer to page 134, would indicate that the instruction was given on 11 April.

MR JENKINS: No, we dealt with this.

MR LANGDALE: This is Nurse Hallman. I think that is first thing on the Monday morning is what she said. Nurse Hallman gave evidence about, "[seen by] Dr Barton to commence syringe driver", and she said that, in her view, was given on the morning of the 12th, and if you look at the administration of it, it was indeed on the morning.

B

THE CHAIRMAN: I am looking at the note on page 134 and the last date entry is 11 April 1999.

MR LANGDALE: Yes.

THE CHAIRMAN: Are you telling me that that note, down to but not including the final line, is not the note of Nurse Hallman?

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MR LANGDALE: That is right. The final line is that she – it is very difficult because there are a couple of squiggles, but the last line is her and her alone, above that it is not her, and she indicated in her evidence that that was, "[seen by] Dr Barton", meant not seen at night but seen on the morning when she, in other words, was going off duty.

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THE CHAIRMAN: Seen on the morning of?

MR LANGDALE: Of Monday the 12th, and she said first thing Monday morning. The drug chart shows that the diamorphine was administered subcutaneously on the morning of the 12th and I think the time is, off the top of my head, eight o'clock.

E

MR KARK: It is page 174.

MR LANGDALE: Thank you.

THE CHAIRMAN: Thank you. (To the witness) So far as the nursing note on 11 April is concerned, the nurse had noted there, "Enid denies pain when left alone". It is fair to say went on to write, "but complains when moved at all". Does that sound, at that point in time, whenever it was actually written, different to the position on 7 April, "still in a lot of pain"?

F

A I could not say for sure.

Q Very well. In any event, the next entry in the nursing notes, which, as you have told us, you would not have seen, so you would not have known this anyway, is that, "[seen by] Dr Barton, to commence syringe driver", we know that it was commenced and the next item in the nursing note for also 12 April was seen by yourself and then your instruction to reduce. When we look at the progression of actions over that period, you are coming in on the 12th and saying, "reduce that dose because the patient is over-sedated", that does being reduced but, unhappily and for whatever reason, the midazolam being doubled at the same time, with the same potential consequence of over-sedation which leads to depression of the respiratory system which can therefore lead to death, and we find that the next morning, at 1.15, the patient died peacefully.

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You were asked by Mr Kark about the entry in the death certificate and when he asked you, you indicated that you could not see, from what was in front of you at this point, how there could have been a recorded course of death as cerebrovascular accident. Would this be the reality of the situation: this patient died as a result of over-sedation?
A I do not feel qualified to comment on that.

B

Q Who would be qualified to comment on that?
A Someone who has experience in clinical pharmacology.

Q So you, as a consultant, you are not a junior doctor who is just starting out, you have been attending deaths on numerous occasions: it is not within your area of expertise?

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A As I remember, the change in the syringe driver was at 15.40 or 16.40. I cannot remember the exact time, and Mrs Spurgin died eight, nine hours later. I would have thought that if it had been the midazolam – the midazolam which had been responsible for it – it would have happened at an earlier stage. But I am not an expert on that.

Q For the backdrop that we have is difficult situations all round; the ward is changing in its focus; there are patients being sent to the ward who do not fit the traditional profile and who require an even higher element of nursing. There is, besides yourself coming in once a week, Dr Barton whom you see, I think you said, at best once a fortnight ---

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A Yes.

Q --- because she was not always able to attend these fortnightly ward round?
A Yes.

E

Q A situation in which you give instructions which are not followed? It is a situation ---
A You are talking about the X-ray?

Q For example, yes.
A That is the only example I can think of where something I asked to be done does not appear to have been done.

F

Q The only example that you can think of of a time that you have asked for something to be done on that ward and it was not done was that time?
A As far as I can recollect.

Q If we were to look through the notes, just of the few patients that we have before us and look to see what are the things that you have asked to be done, on every occasion we are going to see they were in fact done?

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A Without going through them again, but that is certainly my feeling.

Q You said this was a ward where you had great confidence not only in the doctor, but also in the nursing staff. You have told us that certainly on this occasion you had not given the instruction for the midazolam to be increased, but yet that happened?
A But .... I do not see how I can be responsible for ----

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THE LEGAL ASSESSOR: May I assist here? I think it is important that the witness is asked questions to which he can properly respond. I understand, of course, that the Panel has questions to ask him but there is a danger of matters that in a sense have been recited to the witness and for the witness then to be asked for his comments. My advice to the Panel is that he should be asked relatively open questions which he is able to answer one way or the other.

THE CHAIRMAN: Thank you, Legal Assessor. I am almost there in any event. (To the witness) On this ward you have told us about your confidence in the nurses. Were you aware, or are you aware, that there were times when bank staff would be working on the ward, particularly at night?
A I cannot say that I was aware of bank staff being used more on Dryad Ward than any other ward that I happened to come across.

Q No. And indeed, it is a common feature, sadly, in hospitals up and down the country today and, indeed, at that time, that shortfalls in staffing are routinely made up by the use of bank nurses. What is the disadvantage of bank nurses?
A People whom one does not know, one does not know what experience they have, et cetera.

Q Yes, indeed. We have heard evidence that it is entirely feasible that on occasions that might be no regular nursing staff on of a night; that it could be that you would have two bank nurses.
A I was not aware of that.

Q Does that affect your view of the degree of risk?
A Oh yes. It has to.

Q Knowing the things that you do know now, but you did not know then, as well as the things that you clearly did know then, was this ward a safe place for patients to transfer into?

THE LEGAL ASSESSOR: My advice to the Panel, Mr Chairman, is that that is too wide and ambiguous a question to put to this witness. Many people would say that hospitals are inherently unsafe places for one reason or another. No doubt many people would far rather be ill almost anywhere else other than in a hospital. My advice to the Panel is that that is not a question to which this witness can give a sensible, concise and clear reply.

THE CHAIRMAN: Was it more dangerous than the average ward in the average hospital?
A I would have said I would have been happy for my mother to be admitted to that ward than many other wards that I have had occasion to visit over the years.

THE CHAIRMAN: That is something for us to ponder on. Thank you very much indeed, Doctor. That completes the questions from the Panel. If you can bear it, I am now going to ask the members of the Bar if they have questions arising out of the Panel questions. Perhaps I could also ask for an indication from each of you as to how long that might be.

MR LANGDALE: I do have questions. 20 minutes, perhaps.

THE CHAIRMAN: Thank you. Mr Kark?

MR KARK: I would have thought I have slightly less than that, but I certainly do have questions.

THE CHAIRMAN: Doctor, there are a number of points. You have been on the stand for a very considerable amount of time now, and normally we take the view that a witness should not be asked to remain on the stand without a break for more than an hour at a time, and you have gone well beyond that point. It is also the end of a long day. The indications are that there is a fair amount of questions still to come – something in the region of half an hour to three-quarters of an hour, I would guess.

B

We are in your hands, really, here because you know what your commitments are for tomorrow and whether it would be really very difficult for you to come back to us tomorrow or whether it would be less difficult. Could I ask you, would you be available to come first thing tomorrow morning?

C

THE WITNESS: I could, but I feel I would prefer to carry on. I will leave it to you, Chairman.

THE CHAIRMAN: Mr Kark?

MR KARK: I am genuinely slightly concerned for the witness. He has had a very long afternoon. He has been cautioned, which must add to the stress, and sometimes witnesses are very loathe to indicate that they are not up to answering questions. I wholly understand he may rather finish tonight, but if we are going to go on tonight I think he should have a break, if I may say that.

D

THE CHAIRMAN: I think that is absolutely right. Mr Langdale, do you have any observations?

E

MR LANGDALE: I do not, sir.

THE CHAIRMAN: We can go one of two ways, Dr Reid. Either we can take a break now and come back at it again a little bit later, or we can stop for today and ask you to come back tomorrow morning. If it would assist, we could no doubt start a little earlier than normal with the intention, therefore, of getting you away earlier. As you know, I have myself on a number of occasions asked you whether you were feeling okay, and I have certainly had the impression on a number of occasions that you were tired. It really is absolutely wrong to press a witness for difficult answers to difficult questions at a time when they are tired.

F

THE WITNESS: Thank you.

THE CHAIRMAN: I think the Panel are indicating to me a preference for tomorrow morning. Very well. Would it assist you if we were to say nine o'clock or would you be happy with a nine thirty start?

G

THE WITNESS: I do not have hotel accommodation booked for tonight, so if I am going to go home – I can travel up in the morning.

MR KARK: May I just indicate that we will obviously speak to the witness, purely about that, but we can certainly arrange accommodation for him very locally if that would help him.

H

THE WITNESS: Can I think about that?

THE CHAIRMAN: Yes. Reflect on that, but the offer is there. We are most grateful, Mr Kark. What I will say at this stage is that we will break now and we will resume at 9.30 tomorrow morning. I am very sorry that we have kept you for so long, and I do hope that you will be away reasonably soon tomorrow. Meanwhile you do remain on oath. That means, therefore, please do not discuss this case with anybody, nor allow anybody to discuss it with you, though there will be representatives of the GMC talking to you in a moment about accommodation should you wish them to arrange it.

THE WITNESS: Thank you.

THE CHAIRMAN: Thank you very much. Thank you, ladies and gentlemen.

(The Panel adjourned until Thursday 2 July 2009 at 9.30 a.m.)

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