GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 2 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 EIGHTEEN)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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THE CHAIRMAN: Good morning, everyone. Before the witness is called the Legal Assessor wishes to address the Panel in open session.

THE LEGAL ASSESSOR: Thank you, Mr Chairman. The position is this, that I would like at the earliest opportunity to give the Panel some formal legal advice on the proper ambit of Panel questioning of witnesses. It would be my preference to give that advice as soon as I can. I am, of course, aware that Dr Reid is outside, has been waiting for some time and would no doubt like to complete his evidence. It may equally be the case that counsel would wish to know what that advice is before the matter goes any further. So I raise it at this point, I am content to give my advice at this point, but I am in the hands of counsel and, of course, the Chairman as to whether now is the appropriate time to give that advice.

THE CHAIRMAN: Gentlemen, the position is that we are here half an hour earlier today at the specific request of the witness, who very kindly agreed to stay over last night so that counsel could have an opportunity to ask their questions of him. Mindful of that, it would be my preference that we allow the witness to answer his questions and get on his way. However, as the learned Legal Assessor has said, it is also very much a matter for counsel. If counsel feel that in some way it would assist them to hear his advice before they ask their questions of this witness then, of course, you need only say so and we will hear his advice before the questions. Mr Kark.

MR KARK: I think for my part, if there are no more Panel questions of this witness then I would be quite content to continue with the witness at this stage, and then perhaps when he has finished you could hear the legal advice so that you can assess it and formulate, as it were, upon it before we hear the next witness.

THE CHAIRMAN: Yes. Mr Langdale.

MR LANGDALE: Sir, in the abstract one would want to know the advice now, but I think in view of the circumstances with this particular witness and the reasons that you have just dealt with yourself, it would be appropriate, provided there are no more questions from the Panel for him, that we continue with his evidence and deal with the question of the advice, whatever it may be, later.

THE CHAIRMAN: Very well. As I indicated yesterday, the Panel questions are complete, so we will now call the witness, allow counsel to ask their questions and when the witness leaves then we will hear from the Legal Assessor more fully. So if we can have the witness, please.

<u>RICHARD REID, Recalled</u>
<u>Further cross-examined by MR LANGDALE</u>

Q Dr Reid, as you will appreciate from what was said yesterday, I have some further questions for you arising out of the matters raised with you by the Panel. May I just deal with one general issue, first of all? You were asked questions about the decision made by a doctor, nursing staff and maybe with relatives, the decision that a patient should go on to the palliative care route leading on to a terminal phase of the patient's life.
A Yes.

Q You gave evidence about the fact that the administration of subcutaneous analgesia with patients of this type, subcutaneous analgesia involving diamorphine and midazolam, that that really meant, barring miracles, the patient would come to the end of their life on the

syringe driver, to use that expression.
A I would say so, yes.

Q That was the reality?
A Yes.

Q And something that had to be faced?
A Yes.

Q No doubt, a difficult decision for those involved in palliative care?
A Yes.

Q Because of the consequences?
A Yes.

Q But if the subcutaneous analgesia was not administered the alternative was that the patient would be suffering unnecessary pain and distress.
A Could be, yes.

Q Is that not ---
A If someone was in pain and distress and received nothing then, clearly, they would continue being in pain and distress.
Q Would that be in accordance with medical ethics to allow a patient to suffer like that?
A No, not at all.

Q You have already given your evidence about the cases you were asked to consider that we are focussing on in this hearing that, in your view, there was, as it were, a proper course of treatment followed. Bearing in mind that approach, what do you say to anybody who would describe that as signing a patient's death warrant?
A I think sometimes very unpleasant realities have to be faced.

Q I am dealing with the expression. What do you say to someone describing that as signing a patient's death warrant? Is that the sort of expression you would use?
A No, not at all.

Q Is that the sort of expression you would use with relatives?
A Not at all.

Q Can you explain why not? Why not say, "We've signed this patient's death warrant"?
A Because I think that would be inhumane.

Q Any other reason?
A It is not true either. One would be relieving symptoms.

Q Thank you. Another general matter. You were asked about evidence that the Panel has heard from a particular nurse with regard to a complaint that she made in respect of Sister Hamlin and Dr Barton, just setting the context, and you indicated that that rang a bell with you.
A Yes.

Q But you did not know the details and it was, of course, a complaint alleging harassment. Did you know that same nurse, when she gave evidence here - because this was

asked of you in the context of the general good repute in which Dr Barton was held and the cohesion of the nursing staff - had said that in her view, this is the nurse who complained, that she found Sister Hamlin to be an excellent nurse? Do you know she had said that?
A No.

Q Did you know that that same nurse had said she found that Dr Barton was a good and experienced doctor and somebody who was caring about her patients?
A I did not know that.

Q Or that in her view, this was the nurse who complained, Dr Barton was always aiming for the best for her patients?
A I did not know that.

Q That is your view of the doctor as well, is it not?
A Yes.

Q I want to ask you, please, again about another general matter to do with what has been described as anticipatory prescribing.
A Yes.

Q When we talk about anticipatory prescribing, is this right in terms of your understanding: it occurs in a case when a doctor's view that although the patient may not immediately need the medication it is sensible and in accordance with good medical practice to write up a prescription before the need manifests itself?
A Yes.

Q That might apply to a range of medications but can also apply to prescribing, before the patient needs it, diamorphine and midazolam?
A Yes.

Q You indicated that not only was that something which occurred in respect of Dryad Ward, it was something which occurred in respect of Queen Alexandra Hospital?
A Yes.

Q The decision to do that, that is writing up the prescription before it is necessary to administer the drugs, is in the best interests of the patient to avoid them suffering unnecessarily?
A Yes.

Q Maybe the doctor is not there immediately in order to authorise the use of a syringe driver, whatever it might be?
A Yes.

Q In those circumstances a nurse would be entitled to make a decision to start the use of a syringe driver, subject to the fact that he or she should check with the doctor first?
A Yes.

Q As you have told this hearing, you were aware that in relation to patients on Dryad Ward, Dr Barton would on occasion prescribe subcutaneous analgesia, write out the prescription, before the patient actually needed it?
A Yes.

Q Your understanding was that if the situation, that is the need for the administration of the subcutaneous analgesia, arose when the doctor was not available, and no other doctor was immediately available, the nurse would ordinarily seek authorisation from the doctor?
A Yes.

Q By contacting by telephone or whatever it might be?
A Yes.

Q But if that contact was not possible, in terms of it being established, the nurse could go ahead and commence the use of the syringe driver?
A Yes.

Q Again, in the interests of the patient?
A Yes.

Q That being your understanding of what the situation was, and I appreciate you were never contacted specifically to be asked about this, it would be your understanding, would it not, that the doctor, in this case Dr Barton, would be seeing the patient, in any event, pretty soon afterwards?
A Yes.

Q Unless, of course, it was a long weekend or something of that kind. Right?
A Yes.

Q But the nurse would also have available to him or her the ability to contact an on-call doctor if they could not actually get hold of Dr Barton?
A Yes.

Q I think you should know in the light of questions that have been asked that it is not suggested on behalf of the GMC, in any one of the twelve cases this Panel is considering, a nurse without proper authorisation or in some improper way started subcutaneous analgesia. It is right that you should know that.
A Thank you.

Q Indeed, we have heard from one nurse, curiously enough, the nurse who made a complaint about Sister Hamlin and Dr Barton, that on an occasion when she actually commenced the use of the syringe driver, although it was not noted down, she felt sure she would have contacted Dr Barton to get authorisation.
A Thank you.

Q In the circumstances that people were faced with on Dryad Ward, with patients of the kind we are dealing with, did that seem to you to be a perfectly sensible and proper system to use?
A Yes.

Q You have also indicated, I think this was your understanding, that, in any event, for the administration of a controlled drug in circumstances where the doctor is not immediately there, the nurses would ordinarily act in pairs. There would be two of them?
A That is a requirement.

Q Yes. You were asked about a situation, again, there is no instance in the twelve cases the Panel are examining of this having happened, but you were asked about the possibility of

perhaps being back staff only available. They would always have access to a night sister if it was at night, would they not?
A Yes.

Q There would be a senior, properly qualified nurse. Correct?
A That would be my understanding.

B Q The key to it is this, is it not: the decision is, first of all, is it in the patient's best interest to have subcutaneous analgesia administered?
A Yes.

Q To elevate/prevent pain, distress, agitation, whatever it might be?
A Yes.

C Q The second question is who is actually going to do it physically?
A Yes.

Q That is what actually arises in practice?
A Yes.

Q It is not a case of the doctor himself or herself setting up the syringe driver. That is done by experienced nurses?
D A Yes.

Q They actually carry out the process?
A Yes.

Q The doctor need not necessarily be there when they actually do that?
A That is correct.
E

Q I am going to ask you about, I think, only two of the patients you were asked questions about by the Panel. I want to go back, please, to the case of the patient Enid Spurgin, Patient I, if we may. You were asked questions about the plan with regard to this patient. Just to remind ourselves, when the patient was admitted, if we look at page 27 again, a page we have looked at many times, in fact, I think it is actually open in front of you now, page 27, we can see what Dr Barton wrote in terms of a plan, "sort out analgesia". All right?
F A Yes.

Q Of course, to see what the plan was one also has to look further in terms of nursing notes and the care plans.
A Yes.

Q Because some questions were asked as to what had or had not happened, had anything
G been done and what the care plan was. Would you look, please, at page 96 in that same file? This is part of the nursing care plan that came into being with regard to this patient. Correct?
A Yes.

Q At the top is the date of her admission:

"Enid is experiencing a lot of pain on movement.

H Desired Outcome To eliminate pain if possible and keep Enid

comfortable, which should facilitate easier movement and mobilisation."

Does that make sense to you?
A Yes.

Q

"Nursing Action: Give prescribed analgesia and monitor effect
Position comfortably
Seek advice from physiotherapist regarding moving and mobilising"

A Yes.

Q Again, just what you would expect in the case of this patient?
A Yes.

Q We might as well just follow this through to prevent you having come back to it, because there is another point I want to make through your evidence to see whether it is a proper point when we look at this part of the history. The following day she was having regular Oramorph but was still in pain.
A Yes.

Q Obviously, somebody has to do something about that at some stage?
A Yes.

Q Next day:

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

Does that make sense to you?
A Yes.

Q "Is now having metaclorpramide"

Is that three times daily?
A Yes.

Q "and codydramorl. Vomited this afternoon".
A Yes.

Q Again, over the page,

"After using the commode. Refused supper."

Next day, 29 March: "Please review pain relief this morning." Running on to 31st.

"now commenced at 10 mg MST (twice a day) Walked with physiotherapist this am but in a lot of pain".

I am drawing your attention to that because you mentioned, do you remember, when you were asking about what you thought the situation might very well be with this patient and her

hip; you said that the physiotherapist you would have expected would have noticed or observed something. Would you just indicate as to what the significance of that was as to whether something had gone wrong with the operation in terms of the problem with the metal, as it were, in the hip, and you told us the nature of those problems, or whether it be something else.

A Could you just repeat that, please?

Q Yes. You mentioned in your evidence that you would have thought, and I may not have got the most precise note of it, my words, that with a catastrophic failure of the actual hip and metal work – and I am sorry to use that inelegant expression – you would have expected the physiotherapist would have noticed something?

A I certainly felt that if there had been a sudden dislocation of the hip, one would have expected a sudden increase in pain. Likewise, the head of the femur may suddenly disintegrate or gradually disintegrate.

Q So was that something you would expect a physiotherapist to ---

A A physiotherapist would certainly notice if there was sudden change for the worse.

Q Following through this note,

"She walked with the physiotherapist this am but in a lot of pain. Physio demonstrated how to get Enid from chair and"

– can you read that?

A "and onto gutter frame".

Q "Support round waist and hip/bottom level and ask Enid to push herself up to standing position".

Again a perfectly sensible course of action?

A Yes.

Q Then the next note is:

"Oramorph .... given for pain with not too much effect".

Then the following day, 1 April,

"Seen by the physiotherapist. To remain on bed during day over Easter holiday – to walk with ---"

A "...gutter frame once/twice a day".

Q Sorry, it is my ignorance, gutter frame, is that the same thing as a Zimmer frame?

A It is one which has arm supports; it is a higher frame.

Q So still trying to mobilise this lady?

A Yes.

Q "See Shirley Dunleavy's report.

Still having pain on movement."

The next day, if we follow it through, 3 April,

"Still continuing to complain of pain on movement."

The MST increased on 8th. I am going to come back to the next entry in a moment about the X-ray? All right?
A Yes.

Q That deals with the picture with regard to the plan and the activity and, looking at it, does that seem to be a perfectly sensible way of proceeding?
A Yes.

Q You were also asked by one of the members of the Panel about the fact that really nothing was done after her admission. I am paraphrasing. There did not appear to be any sign of anything really being done after her admission. I have drawn your attention to what happened in terms of the nursing care plan and what happened there. Would you look please in the same file in relation to material which shows what was done after her admission? Would you look at page 43? It is in fact the following page from Dr Barton's admission note. We have there the biochemistry report from the Portsmouth Pathology Service.
A Yes.

Q There is a group of them there. I would like you to look through them, They go on from page 43 to the next page, 45, next page 47, next page 51, next page 57, 59 and 61. It is a collection of these documents. Does that show that in fact, in terms of seeking to treat this lady, proper tests were carried out and the results sought?
A Yes.

Q Just in general, and we can look at each one individually if necessary?
A Yes.

Q On 26th, again, does that seem to be a sensible and proper course of action for a doctor in Dr Barton's position to ask for, to get results to try to discover what the right way of treating this lady was?
A Yes.

Q And in particular, very importantly, the question of infection?
A Yes.

Q You have told us already in your evidence about the devastating effect that deep-seated infection can have in respect of an operation of this kind. Is that right?
A Yes.

Q We can look through these reports and we can see in relation to the pages, at page 51 for example, when the report date was on a particular test; over at page 57, the date the report was made. Mr Redfern, the orthopaedic surgeon, referred to this in his evidence, so the Panel have already seen it, and in relation to the particular antibiotics and so on that were used, the date that was reported was 9 April. Right?

A Yes.

Q And over on page 59, date reported was 8th; that is in relation to the findings of those tests, and similarly on page 61, "date reported", 8 April. It is right to say, is it not, that things were being done, and perfectly proper things, in terms of seeking to treat this lady as best as possible?
A Yes.

Q I would like to deal with just one further point in relation to something you were asked about. Do you remember you were asked in relation to I think in her case it is page 169. One of the members of the Panel was asking questions about the review box, do you remember?
A Yes.

Q If we go to 169, we can see that on the front of these prescription sheets there was written, certainly at the time we are concerned with in relation to this patient, which is 1999, that there was at item 9 of the front sheet:

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

A Yes.

Q If we move on to page 174, we can see, in relation to his particular patient, prescriptions written by Dr Barton and the review date, the little box on the left hand side in the middle of that left hand column is not marked.
A That is correct.

Q And indeed I think in just about every one of the relevant patients that is the case. Were you aware of the fact that the request on these forms to tick or to put in the review date on the box only came in after a certain period of time? I am not expecting you to remember but I have got to put that to you because I am suggesting that it is clear that certainly in the early stages of some of these patients – I am not able to identify every one – and certainly in the case of Mr Pittock, Patient A, and Elsie Lavender, Patient B, the particular form in use did not have provision for that. I other words, it did not say and did not provide a review date box, but you would not be aware of that because you started in 1999. Is that correct?
A Correct.

Q But, in any event, in the normal course of events, the doctor himself or herself would be reviewing the prescriptions when they saw the patient?
A Yes.

Q Perhaps we can see how this particular feature was not confined to Dryad Ward, the failure to fill in the box. I am sorry one has to go to a different file but can we look at the file relating to Patient H just to observe the point? I would like you to look, to assist us, at page 110. That page relates to Patient H and this is a regular prescription sheet from the Queen Alexandra, all right? So it is not Gosport War Memorial; it is QAH. If we look at that, just by way of example, we can see that on the forms then applicable there was a box to put review date in but it is not filled in.
A That is correct.

Q So perhaps it is not very surprising to find that was not something that people did?
A Might I add that on reflection about this I think the purpose of this and the use for which it was really intended was for use of a short-term prescription like antibiotics to make sure that that review actually did occur and nursing staff had alerted the doctor to that.

Q Doctor, I think you may well be right because I think there was another example, maybe with Patient H, where there is in a hospital document one review date filled in for a medication of precisely that kind, for penicillin I think it was, but we can check that later. That is really the purpose of that particular provision?
A I think so.

Q I am also told, and we can check it later but you would not necessarily know, that the Haslar did not on its forms have provision for a review date. I want to follow through please, still with Patient I, the question of what happened in terms of X-ray or no X-ray. For this we need to go back to page 27 where we have two entries by you when you saw her on 7 April and 12 April?
A Yes.

Q And, as we have seen more than once, on 7 April you wrote with regard to this lady,

"For X-ray, right hip as movement still quite painful – also, about 2" shortening right leg."

A Yes.

Q It is not suggested that Dr Barton was with you in relation to that ward round when, amongst the other patients you looked at, you looked at this lady. In the ordinary course of events when a consultant such as yourself wanted a patient X-rayed, you record the fact that you wanted that done?
A Yes.

Q I want to ask you about what actually would have happened. If the clinical assistant is not with you, some form has got to be completed, has it not?
A Yes.

Q Would it normally be you as a consultant doing the ward round, if that is something you wanted to happen, who would fill in the form?
A I think in this situation if Dr Barton were not present, it would probably have been me who completed the form.

Q I am not suggesting for a minute you will be bale to recall but in the ordinary course of events you would have expected that you would have filled in a form?
A Yes.

Q If not you and not Dr Barton, perhaps the ward sister or whoever was going round the ward with you might or might not?
A No.

Q So if it is not Dr Barton, it has got to be you?

A Yes.

Q And the form, without going into all the detail, what is the form in effect saying? What are you asking or showing or dealing with ?
A Requesting an X-ray of the right hip in this case.

Q So you set out what part of the body needs to be X-rayed?
A Yes.

Q Anything else on the form?
A And provide clinical details such as "patient sustained fractured neck of femur on such a date; dynamic hip screw inserted, still in pain. Query infection. Query dislocation".

Q Thank you. To give the person who is taking the X-ray an indication as to what it is that should be scrutinised?
A Yes.

Q And who is the intended recipient of the form, first of all ? Who does that go to?
A It is the X-ray department.

Q So it goes to the x-ray department. There was no radiologist on duty at Gosport War Memorial Hospital, was there?
A Not at all times, no.

Q But there was an X-ray department?
A Yes.

Q So requests for X-rays would go there?
A Yes.

Q And at some stage a radiologist, is this right, would take the X-ray?
A It would probably be a radiographer who took the X-ray.

Q I am getting expressions wrong, sorry. A radiographer would actually take the X-ray?
A Yes.

Q There it is; it has been taken. What happens in the ordinary course of events next?
A A radiologist would review the X-ray and produce a report or the X-rya might be sent to the ward.

Q Let us take the first of the circumstances first. The radiologist looks and he will have the consultant's form indicating what it is he is meant to be looking for?
A Yes.

Q Supposing he finds nothing of any significance so far as he can detect: what does he do with his findings?
A He would dictate a report, which would be subsequently typed up and which would then find its way to the ward.

Q That would happen if things had moved in that particular way?
A Yes.

Q Whatever he had done in terms of making a report, that would find its way in due course to the ward?
A It should do?

Q Or to you?
A To the ward.

Q And ordinarily speaking when a consultant had asked for an X-ray without saying that it was urgent or anything of that kind but pointing out what the purpose was, how long would that process take?
A At that time I could not say but I certainly do not think it would be a same-day service.

Q I was going to put to you that it certainly would not be the same day and quite commonly you might not see the X-ray result until your next ward round?
A That would be correct.

Q So in this lady's case it might well have been that the X-ray result would not have come through to you until 12 April?
A That is correct.

Q Because what appears to be the case is that you did not indicate in your request for the X-ray that it needed to be carried out expeditiously?
A There is no record of my having asked for that.

Q No, but if you had thought that it was necessary to have the X-ray result that day or the following day, you could have said so?
A Yes.

Q Indeed, it would have been possible for you to have asked that the lady be X-rayed that very afternoon?
A Yes.

Q You would have the power to do that, assuming it was possible?
A Yes, assuming ether was an appointment.

Q In those circumstances when it appears you have not indicated that there was any urgency about this X-ray, it may be – we will look at some other entries – that in fact there was an X-ray which had been taken but it was not something you asked to see on 12 April?
A That is correct.

Q Is this right, or is this fair, Dr Reid, when you saw the patient on 12 April the x-ray result, if there was one, was not something that was in the forefront of your mind?
A No.

Q It is quite possible, therefore, that you did not ask for an x-ray or what the result was?
A That is perfectly possible.

THE CHAIRMAN: Mr Langdale, I do apologise for interrupting. You took us earlier to a page that I think might short circuit this enquiry.

MR LANGDALE: I am coming to that.

THE CHAIRMAN: Very well.

MR LANGDALE: I am doing these things deliberately in a certain way to get the general picture and then we are going to look at what the records show. Thank you.

(To the witness) Indeed, it is not an uncommon feature, in relation to hospital records and x-rays, for x-rays to go missing and to not make their way to the proper recipient?
A That is correct.

Q In relation to the history in this case, so far as we can piece it together, we have your request, order, whatever we like to call it, you are saying, "I want an x-ray done". All right?
A Yes.

Q I am not saying, "I want it done expeditiously", and anticipating at the time that you would see the x-ray next on your next ward round?
A Yes.

Q Then might we move, please, to page 134? On page 134, we are now on the summary, on 7 April there is a note made by, I think, Linda Barrett, that may be wrong, but made by a nurse, recording the fact that you had seen the patient. Right?
A Yes.

Q 7 April, "For x-ray tomorrow". Not just no time but x-ray at a particular time, at 1500 hours, then to commence and so on and so forth. In the ordinary course of events, and I appreciate, Dr Reid, you did not make this note, that rather looks as if an x-ray had been arranged, does it not?
A Yes.

Q Arranged for a specific time the next day?
A Yes.

Q In the ordinary course of events, somebody, a member of the nursing staff, assuming Dr Barton was not there, would have to be arranging with the x-ray department for this to be done?
A Yes.

Q They would have contact the x-ray department and fix an appointment time. All right?
A Yes.

Q We can see in that same note, after the commencement of a drug, just to follow it on, "To be reviewed on Monday" what does that suggest to you? Not what the plan was, but that the x-ray be reviewed on your next ward round?
A I could not say whether it was in relation to the x-ray or the commencement of flupenthixol or whether it is to review the whole picture.

Q It is consistent with the nurse understanding that the x-ray was to be reviewed on

Monday, is it?
A Yes.

Q All right. That would make sense because that would be your next ward round?
A Yes.

Q I appreciate you cannot say for certain because you are not the person who wrote the note.
A Yes.

Q I would like you to look, please, again, trying to follow this through, to page 98. If the 12th was a Monday, we are on the Friday, I think. 9 April, towards the bottom of the page.
A Yes.

Q Which would be, if the plan had been carried out, the day after the x-ray was taken, "To remain on bed rest until Dr Reid sees x-ray of hip". All right?
A Yes.

Q Again, you are not the author of the note but it would not make much sense unless an x-ray had been taken, would it? "To remain on bed rest until Dr Reid sees x-ray of hip".
A It does not give me a sense of whether the x-ray has been done or not.

Q What would be the sense of writing it - I appreciate it is not you - if there was not any x-ray at all?
A It may have been relayed from the ward round that this lady was to have an x-ray of her right hip and that she was to stay on bed rest until that reported.

Q We have seen what the nursing staff recorded when she was due to have an x-ray. On 7 April, two days before this, apparently an x-ray has been arranged for the 8th.
A Yes.

Q Now we are on the 9th, it makes sense, does it not, that there was an x-ray? You cannot know but ---
A I cannot know.

Q No.
A I cannot know.

Q That is all I am going to ask you about that. I think that is probably as far as we can take it, having looked at what was said. I am now going to ask you about another aspect of this same patient, still on page 27, and your note of your ward round on the 12th, if you go back to that. Page 27, your round on Monday 12 April, "Now [very] drowsy", and then that next word. I am sorry.
A "(since DIAMORPHINE ..."

Q "(since DIAMORPHINE infusion established)". I am sorry. I should have my own note about that.

"Reduce to 40 mg ...
- if pain recurs, [increase] to 60 mg.

Able to move hips, [without] pain but [patient] not rousable"

A patient who is not rousable, and I am not going to worry about quite what degree that was because some of your note suggests that, certainly, you were able to have some movement without pain was recorded, a patient may become unrousable for more than one reason?
A Yes.

B Q A patient in this sort of situation?
A Yes.

Q They may be unrousable because they are, in fact, in a terminal phase ...
A Yes.

Q ... of their lives. The fact that they are unrousable may be affected by the fact that they
C are on subcutaneous analgesia?
A Yes.

Q It may be?
A Yes.

Q It may be a combination of the two?
A Yes.
D

Q The fact that a patient is not rousable does not necessarily mean they are oversedated?
A Not necessarily.

Q I appreciate, Dr Reid, and I am not criticising you for a moment, you took the view this patient may be oversedated that dose of diamorphine. Yes?
A Yes.
E

Q I am not criticising your decision for a moment. You thought if that is the cause the sensible approach is to reduce the diamorphine.
A Yes.

Q I am not suggesting for a moment you suggested that the midazolam should go up. All right?
F A Yes.

Q The patient, as we know, in relation to page 27, died at 1.15 the following morning.
A Yes.

Q You were asked about, as it were, whether the death resulted from the oversedation of the midazolam.
G A Yes.

Q In the sense that the midazolam had been put up from 20 to 40.
A Yes.

Q The fact of the matter is one simply cannot say, can one?
A I could not say.
H

Q No. Indeed, nobody can say because nobody knows precisely what the effect on this

patient was of any added midazolam?
A Yes.

Q All that we can say with confidence, whether it is a clinical pharmacologist or anybody else, you included, is that the increase of midazolam would have had a sedative effect?
A Yes.

B Q More of a sedative effect than, in your view, would have been appropriate?
A Yes.

Q In your judgment, bearing in mind what happened in this case, it may be well be the case that this patient died as a result of the deterioration in her medical condition?
A Yes.

C Q Coupled with the effect of diamorphine and midazolam?
A Yes.

Q Which played which role in relation to the cause of death it is impossible for anybody to say.
A Yes.

D Q Just on that point in terms of drowsiness and whether a patient is rousable or not and the significance of that in relation to subcutaneous analgesia, would you look, please, back to page 134 in respect of this same patient? Dr Reid, I appreciate moving around pages and dates and that sort of activity it is sometimes difficult to follow the thread, but we keep in mind that this lady had no subcutaneous analgesia administered until the morning of 12 April, the day you saw her. All right?
A All right.

E Q Do not worry to look anywhere else, just bear in mind when I ask you about this note. The first time she has it is the morning, I think it is around about nine o'clock in the morning, of the 12th. Yes?
A Yes.

Q Let us at what the picture was the day before, before she is on any form of subcutaneous analgesia. There is an entry on the summary by a nurse, dated 11 April. Do
F you see that?
A Yes.

Q It has "PM" written beside it.
A Yes.

Q

G "Nephew telephoned at 19.10"

- so seven ten in the evening -

"as Enid's condition has deteriorated since this afternoon. She is very drowsy. Unrousable at times. Refusing food and drink and asking to be left alone. Site round wound in right hip looks red and inflamed and

H

feels hot. Asked about her pain Enid denies pain when left alone but complains when moved at all. Syringe driver possibility discussed with nephew. He is anxious that Enid be kept as comfortable as possible. He will telephone ward later this evening."

So I have gone through the whole note. All right?
A Yes.

Q We note, in relation to what is said about the site round the wound in the right hip, again, is that consistent with infection taking its toll?
A It is certainly consistent with a superficial wound infection and, quite possibly, a deep wound infection.

Q You cannot tell a deep-seated wound, but certainly superficial. Can we sensibly regard the entry in this way: there is a good example of a patient being very drowsy and unrousable at times which has nothing to do so with the administration of subcutaneous analgesia?
A That is correct.

Q Again, is that, perhaps, an indication, you are not the person who saw her on that afternoon or evening, an indication of the dying process?
A Yes.

Q We must bear in mind in relation to that as well, to cover the whole picture, that at this stage she was receiving, on the 11th, a total of Oramorph 5 mg and MST two 20 mg doses administered. All right?
A Yes.

MR LANGDALE: Dr Reid, thank very much.

THE CHAIRMAN: Thank you, doctor. Now it is Mr Kark. Mr Kark.

MR LANGDALE: I am terribly sorry. I do apologise. I need to ask something about Mr Packman. I am afraid I omitted to do so.

THE CHAIRMAN: Yes, of course. We go back to Mr Langdale.

MR LANGDALE: I am sorry, Dr Reid, but it is considerably fewer questions about Mr Packman than with regard to Enid Spurgin. This is Patient J. I will just take that file. First of all, this, please, with regard to Clexane, would you go to page 172? Just reminding ourselves, this patient was admitted to Dryad on 23 August. All right?
A Yes.

Q We can see on page 172, although the date is a little unclear, a record of Clexane. All right?
A Yes.

Q "Passing Fresh Blood PR", per rectum, and we have already dealt with that. Right?
A Yes.

Q Then on page 173, the next page, one can see the Clexane recorded there and then, as it were, stopping. All right?

A Yes.

Q If we go back to page 55, we can see there the note by Dr Ravindrane on 23 August. All right?
A Yes.

Q When, at that stage, Clexane is continuing and we know that, in due course, the Clexane was stopped perfectly appropriately, as you have indicated, as a result of the ...
A Bleed.

Q Can we just note before we move on, page 182, that is from Queen Alexandra. All right? It is not Gosport War Memorial Hospital.
A Yes.

Q We can see there, I simply draw your attention so we can take the fact, that he was on Clexane at QAH for really some time. On this particular sheet, he starts it on what appears to be 6 August, so he has quite a long history of being on Clexane.
A Yes.

Q Mr Jenkins has helpfully reminded me of the thing that was in my head when you talked about review dates. It is on this sheet. If you look towards the bottom, you can see penicillin B has a start date of 11 August and review date of 13 August, but for the other drugs on that page, there is no review date. Does that tie in with what you said you would expect in relation to these review days?
A Yes.

Q I am not going to ask you to go over the situation with regard to Mr Packman. You have covered it very fully in your evidence, but there is one further thing I just need to ask you about, please. This is on page 63 of the notes. If you would look at the date of 25 August, about a third of the way down the page, you were asked about this by one of the members of the Panel:

> "Passing fresh blood PR [per rectum]
> ? Clexane"

Obviously the nurse had taken action in terms of getting in touch with Dr Beasley.
A Yes.

Q As you would expect. As I think you indicated, in such a situation you would expect a nurse to seek the advice of a doctor.
A Yes.

Q Then – and I really assure you this is my last question, Dr Reid – something you said about midazolam. I appreciate you are not an expert, but you indicated that in terms of the death of Enid Spurgin, when you were asked about midazolam, you said that in your view, if her death had anything to do with midazolam, you would have expected it to have its effect earlier. Do you remember saying that?
A I would have expected it to have an effect within two to three hours.

Q I appreciate when we hear that from you ---
A I am not an expert.

Q I am not pressing you on it. You said, "I am not an expert, but that in my view is the sort of time period I would estimate it would take its effect, if it was playing that part."
A Yes.

MR LANGDALE: Thank you very much.

B THE CHAIRMAN: Mr Kark, the witness has now been on the stand for approximately an hour, so I think we will take a short break. Doctor, I am sorry to prolong the agony, but we will take a break now for 15 minutes. You will be taken somewhere where I hope you can get some refreshment. I remind you that you remain on oath. Please do not discuss the case with anyone, nor allow anyone to discuss it with you. Thank you very much. 15 minutes, please, ladies and gentlemen.

C (The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark?

Further re-examined by MR KARK

D Q Dr Reid, I am going to start with just some general questions and then a few questions about Patient I and then I hope we are finished. You were asked by members of the Panel about the starting of the syringe driver and whether it was appropriate for a nurse to be able to do that if she thought it was necessary for the patient.
A Yes.

E Q Mr Langdale has asked you about that as well. My understanding of your evidence is that there is nothing wrong with the nurse doing that and the nurse being equipped to do that if it is necessary to control the patient's pain. Is that a fair summary of your evidence?
A Yes.

Q You have also accepted I think that the starting of a syringe driver in these circumstances, with these patients, with these drugs, would be a significant, probably a very significant, event in the patient's life.
A Yes.

F Q Because, however one wants to couch it, it is an end of life event.
A Yes.

Q Does your answer pertain to a nurse of any level of training: state registered nurses, enrolled nurses, bank nurses? Is your answer the same for all?
A Any qualified nurse.

G Q Any qualified nurse. Does a syringe driver provide immediate relief from pain? Does the inception of a syringe driver in fact provide immediate relief from pain?
A I would have thought that you would start to see some relief within 15 to 30 minutes.

Q If a patient is in immediate pain, which I think is something that is called breakthrough pain, if they are already on analgesia, are there other ways that a patient's pain could more immediately be controlled?

H

A Did you say if they are on oral drugs?

Q If they are already on analgesia and a patient has breakthrough pain, are there other ways of providing pain relief immediately to the patient?
A One could give it in exceptional circumstances by intravenous injection.

Q Why do you say in exceptional circumstances? More exceptional than using a syringe driver?
A What I am thinking about is, say, a patient who is having a heart attack, who is in severe pain. That sort of situation.

Q Let us ignore a heart attack for a moment. A nurse is with the patient, the patient appears to be in pain. The patient is already on morphine in some form, MST, say.
A The dose could be increased.

Q Would that be as effective in the short-term as using a syringe driver?
A I think it would probably take longer. Oral drugs generally take longer to have an effect than subcutaneous drugs.

Q If a single injection of diamorphine is used, is that an appropriate method of dealing with immediate pain, or not?
A Yes.

Q You were responsible for referring patients to the GWMH on occasion.
A On occasion, yes.

Q On occasion, did you refer patients to the GWMH, whether Dryad or Daedalus Wards, who required rehabilitation or remobilisation?
A Yes.

Q When you did that, were you doing it expecting that efforts would be made to rehabilitate and remobilise the patient?
A Yes.

Q You were not doing it merely tongue-in-cheek, as it were?
A No. In the interim, though, a patient's condition may have changed between my assessment and them actually being admitted to Dryad or Daedalus Wards.

Q But you appear to have had the advantage, which some others might not have done, of both being at the QAH and also seeing what the process was like at the GWMH.
A Yes.

Q From what you have said, can we take it you would not have referred patients for rehabilitation if you had not thought it was going to happen?
A That is correct.

Q We have seen in some of the notes that we have just been looking at that whatever the staffing levels of physiotherapy were like, there was clearly physiotherapy at work on Dryad Ward.

A There was. What I could not be sure of at this distance in time is whether – my feeling was when I started on the ward that there was no routine physiotherapy at all.

Q Did you do anything to change that?
A That was not important if patients were being admitted there for continuing care, but as the nature of patients changed and we were transferring some patients who needed physiotherapeutic input, I remember having a meeting with managers to discuss how could we do that.

Q What was the answer?
A As I remember, I think the physiotherapy department in particular said that they would be unable to provide physiotherapy on a sort of continuing basis, but would be prepared to undertake assessments of patients with a view to giving guidance to nursing staff as to how to move them, mobilise, et cetera.

Q We were looking at an example of that a little earlier I think: how to get a patient out of safely and things of that nature.
A Yes.

Q I want to go back, I am afraid, to Patient I. You have spent a long time looking at these notes. Could you take up your bundle I, please? This is Mrs Enid Spurgin of course. Could you go to a note you are becoming extremely with, I expect, at page 27? This is your note in the middle of the page of 7 April.
A Yes.

Q Leading up to this visit by you, the patient had apparently – and although there is no note in the clinical records, there is a note about this in the nursing records – this patient had been seen by Dr Barton.
A Yes.

Q And the MST had been increased. You have made a note of that, "MST [up]" and then what follows after the arrow?
A "Increased to 20 mg bd".

Q So that is 20 mg twice a day?
A Yes.

Q Then you suggest adding another antibiotic.
A No, it is not an antibiotic. It is a sedative, a tranquilliser.

Q What is it called?
A Flupenthixol.

Q The pain that you describe the patient being in, did you at this stage have any diagnosis for that? What was causing this patient's pain?
A I think, given that I have noted there has been a two-inch of shortening of the right hip and that I requested an x-ray, my concern would be, why was Mrs Spurgin still in so much pain?

Q A deep-seated infection, bearing in mind the two-inch shortening of the leg, would or would not be your primary diagnosis? What was your primary diagnosis?
A I think this lady had a deep-seated wound infection.

Q How is that going to cause a two-inch shortening of the leg?
A I think it is recorded after the operation that this lady had a lot of swelling in her leg, a wound haematoma. We know that wound haematomas are likely to become infected, but it is also possible that the head of the femur could have crumbled, either associated with infection or on its own.

Q I am sorry? You would have associated it with infection or – ?
A The head of the femur could also have crumbled and that would cause shortening.

Q Or conceivably there could be some displacement within the ball of the hip, where the operation has actually taken place?
A Yes. The metalwork may have pushed through.

Q When you next attended on 12 April, it does not look as if you saw any x-ray.
A It does not look as if I did.

Q If you had, would you have made a note about it, about what the x-ray revealed?
A I would have thought so, if I had seen it, yes.

Q Because here was a patient presumably still with a two-inch shortening of the right leg.
A Yes.

Q That had not been fixed.
A No.

Q That could only be fixed presumably if she went back to orthopaedics.
A Yes. Well, potentially fixed.

Q You found a patient who was very drowsy with a diamorphine infusion established. When you found that nothing appeared to have happened, or you certainly did not see an x-ray report or an x-ray, did you take that up with anybody?
A Well, I cannot remember, but my feeling would be that at this stage I thought this lady was terminally unwell and that following that up was pointless.

Q You had directed an x-ray to be taken.
A Yes.

Q There was no sign, as far as we can see, that an x-ray had been taken, that you knew of.
A That is correct, yes.

Q Would you have thought – I appreciate you probably cannot remember specifically now – but would you have thought it would be appropriate to take that up with Dr Barton?
A I do not think that in this situation it would have crossed my mind to do it, because I felt that this lady was terminally ill and the utility of an x-ray was nil.

Q Would it have concerned you that no x-ray report was available to you?
A If I had been aware that the x-ray had not been done, then I would have wanted to know why that had not happened.

Q Who would you have asked?
A I would have asked the nursing staff.

Q I want you to have reference, please, to two pages: page 134 and page 98. Page 98 perhaps first, at the bottom of which we see that on 11 April the patient was given an extra dose of Oramorph in the morning at 7.15.
A Yes.

Q The patient is already I think on 40 mg of MST, which is the slow-acting, slow-release morphine.
A Yes.

Q We see on page 134 that the patient is described as being "very drowsy, unrousable at times".
A Yes.

Q Can you help the Panel with this? Is the MST likely to be having that sort of effect upon her?
A It could be.

Q When you came to reduce Dr Barton's prescription from 80 down to 40, that was still in effect a doubling of the dose that she had been on, was it not?
A Yes.

Q Bearing in mind that she was already very drowsy and unrousable at times, can you explain your thinking?
A Because there has been constant reference throughout this lady's admission to her being in pain. In the note of 11 April, it does say that whenever Mrs Spurgin was moved, she was continuing to be in pain, despite being drowsy, and therefore to attend to her basic nursing needs, in my view she required more analgesia.

Q When you reduced the dose, as you did, is that something that you would have spoken to Dr Barton about?
A I should have spoken to Dr Barton about it but I do not recollect doing so.

Q Can you help us as to why you would not approach Dr Barton about that sort of thing?
A I would only see Dr Barton once a fortnight. I was very busy and I suspect that by the next time I came round I had forgotten about that episode.

Q May I ask you this in that context? Did you have any reluctance to approach Dr Barton?
A No.

Q On that theme, you were asked by Ms Julien about your supervisory role.

A Yes.

Q You were, in a sense, in a supervisory role, were you?
A Oh, yes.

Q Was Dr Barton in a training post?
A No.

B

Q I want to just look at the issue of the blood tests. Can we go to page 43, please? It is just to clear up a potential ambiguity. This is a document which shows that the specimen date, if we look at the bottom left hand corner, was 26 March.
A Yes.

Q And that in fact is the date of transfer from QAH to Dryad Ward for this patient?
C A Yes.

Q Can you confirm or otherwise that this, nevertheless, would have been a report ordered from the Gosport War Memorial Hospital?
A Yes, I think I can. In the top right hand corner underneath "Accredited Laboratory", there are two boxes, one a hospital number and the other is report destination which has GWM and GWDR and that is the code for Dryad Ward at Gosport War Memorial Hospital.

D

Q GWM would be presumably Gosport War Memorial and GWR Dryad?
A Yes.

Q To the left of that we see "Requesting Clinician Dr Reid" and we see that all the way through the rest of the reports as well but does that actually mean that you were the requesting clinician or would it be done under your name?
E A It was done under my name.

Q You are the expert in this; we are not. Was there anything either in these blood reports or from the clinical records that you can discover that apart from having a possible infection at the area of the hip, this patient had a general blood infection?
A Is there anything to indicate that on this?

F Q Yes?
A No is the straight answer to that.

Q You were asked by Mr Langdale most recently about the effect of the increase in the midazolam?
A Yes.

G Q I just want to ask you this: if it was not that which caused the patient's death, what are you saying this patient died of?
A I think she died of the complications of a fractured neck of femur; in other words, a deep-seated wound infection.

Q A local deep-seated wound infection
A Yes, in the right hi.

H

MR KARK: That is all that I ask. Thank you.

THE CHAIRMAN: Thank you, Mr Kark.

Doctor, I am delighted to be able to tell you that that brings your testimony to an end. It is a very important part of our work to try to build up a clear picture of situations that occurred sometimes years before, certainly in this case. It is impossible for us to do it without the assistance of witnesses such as yourself who are prepared to come before us, subject themselves to long hours of questioning and give us their own individual testimony. We appreciate that it is a stressful experience and in your case, with the amount of time involved, particularly gruelling, and we are most grateful to you for your patience in sticking with the process. Thank you very much indeed, Doctor. You are free to go.

(The witness withdrew)

THE CHAIRMAN: I think we will now hear from the Legal Assessor.

THE LEGAL ASSESSOR: Thank you, Mr Chairman.

I now formally advise as to the questioning of witnesses by a panel. It will have become apparent to the Panel I am sure that all counsel in this case are very experienced and able. Each knows what his case is; each asks of a witness those questions he needs to ask in order to seek to establish his case. Counsel know more about the facts surrounding this case than we do or ever will, given the wealth of background material which exists and which they have gone through.

The primary role of a panel is to make fair and reasoned decisions based on the complete evidence and submissions presented to it by counsel. It is of course entirely for the Panel to decide what it makes of the completed evidence when it goes into camera to begin its deliberations.

It is proper that a panel may, after a witness has been examined by counsel, ask succinct factual and open questions to clarify the evidence of that witness. When a panel asks such questions, it should bear in mind the following. Firstly, a panel is acting in a judicial capacity. It should ask any questions in a fair, impartial and judicial spirit. Those questions, as I have previously advised, should be asked in an open manner, just as the Panel has requested of the defence in this case. It is inappropriate for a panel in effect to give evidence through questioning. It is inappropriate for panel questioning to take the form of a persistent and prolonged line of cross-examination, which might be interpreted as being intended to support a point of view already held by a panellist. It is inappropriate for the form of a panel's questioning to disclose what might appear to be a fixed point of view in a panellist's mind. Such an impression might be given by the tone of the questioning, by the use of leading questions or by accompanying comments, such as "I have difficulty in accepting that". It is inappropriate for a panel's questions to take the form of an extensive and lengthy recitation of a witness' evidence back to that witness, followed by an invitation to that witness to agree with the panellist's interpretation of it.

In conclusion, a panel must bear in mind at all times its absolute judicial duty to act fairly and impartially. It must keep an open mind about the evidence until it begins its deliberations and it must make it apparent to all that that is what it is doing.

I have before today advised the Panel as to the way in which questions should be asked. It is not appropriate for a Legal Assessor to intervene repeatedly thereafter in order to provide advice already given. Of course, a panel does not have to accept my advice. A panel is the judge of both fact and law but Mr Kark, Mr Langdale and most importantly Dr Barton are entitled to know at this stage whether this Panel accepts my advice or not, and I advise as follows.

Counsel should be asked whether they dissent from or wish to add to what I have said. The Panel should go into camera now to discuss the implications of this advice and to specifically decide whether or not to accept it. Having done so, the Panel then should come back into open session. If the Panel has concluded that it accepts my advice and will abide by it, it should announce that fact. If, as it is perfectly entitled to do, the Panel declines to follow any part of my advice, it should announce that fact and give reasons.

Mr Chairman, that is my advice to the Panel.

THE CHAIRMAN: Thank you very much indeed, Legal Assessor.

Mr Kark and Mr Langdale, do you have any observations on the advice just tendered?

MR KARK: I have nothing,

MR LANGDALE: I do not.

THE CHAIRMAN: The Panel will now accede to the advice of the Legal Assessor and go into *camera* to consider what he has said. We will call you back as soon as we are able.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

D E T E R M I N A T I O N

THE CHAIRMAN: Welcome back, everybody. I should say, before I go on to deal with the matter of the advice just given, that the Panel are very conscious, Mr Kark, of the house-keeping concerns that you will have. There is a witness waiting to come before us now who was here yesterday, there is a specific window of time booked for video link evidence to be presented later in the afternoon and it is for that reason that I am going to attempt to respond to the very detailed and helpful advice from our Legal Assessor in an extemporary fashion rather than taking time to reduce it into writing and then read it to the parties.

I should say at the outset that the Panel entirely accepts the advice of the Legal Assessor. We have taken the opportunity to have that advice printed off for us so that each of us have our own individual copy and that has enabled us to study the advice with greater care and accuracy than would have been possible just by referring to our own notes and it also gives us a helpful template for the future. The hope is that each and every one of us will use it to assist us when we are formulating potential questions in our own mind as to whether the question is appropriate or whether the form of that question is appropriate and, if not, to

attempt to make the necessary changes, even to the extent that that might mean not asking the question at all.

In particular, the Legal Assessor in his advice drew our attention to certain matters that a panel should bear in mind when asking questions and the first was that it should ask any questions in a fair, impartial and judicial spirit, and I would like to say here and now it is the intention of this Panel always to do just that. This is not a Panel of professional questioners and there may be times when the form in which a question is put is less than ideal, but behind it we would wish all parties to feel that whilst our questions may at times be probing and sometimes demanding, they are, nevertheless, coming from a spirit of enquiry.

We are required in this case in particular to look at the situation as it was on two wards a number of years ago so that we can form a view in respect of matters, prescriptions, that have already been admitted as to whether the actions in prescribing those was, for example, inappropriate or not in the best interests of the patient and to do that requires us to have a clear, or as clear as we can get it, view of customs, practice and the general flavour of how things actually worked on the individual wards.

We, as I say, recognise and accept that, nonetheless, the way in which we ask those probing questions should always not only be in a fair, impartial and judicial spirit, but so far as it is possible not give an impression to the contrary. We fully accept that it is not appropriate for a Panel member, in effect, to give evidence through questioning. It is sometimes objected to in counsel's so it would be quite wrong for it to be permissible in Panel members'. Those who wish to give evidence should go on the witness stand and that is something that we fully accept and endorse.

The Legal Assessor has advised us that it is inappropriate for Panel questioning to take a form which might be interpreted as being intended to support a point of view already held by a panellist. That is something that we endorse absolutely. It may be from time to time that when particularly challenging or probing questions are put that they will inevitably be put from a particular point of view, but it should be absolutely clear to all parties that no member of this Panel has at this stage made a decision in terms of having a fixed point of view. Rather, we are enquiring and what we very much hope is that at the end of the process it will be seen that all parties are subject to the same level of probing and challenge and that it is absolutely not reserved for one particular side or another. That would be absolutely wrong and, as I have indicated, it would not be an accurate reflection of the views of this Panel.

The next point is really somewhat similar in that the advice was it is inappropriate for the form of questioning to disclose what might appear to be a fixed point of view in the panellist's mind. Particular reference was drawn to the use of accompanying comments such as, "I have difficulty in accepting that", and that is a comment that was used yesterday. Again, the Panel fully accept and endorse that and we will each of us make efforts to ensure that so far as we are able we avoid the use of such phrases.

Finally, the Legal Assessor advised us that it was inappropriate for Panel's questions to take the form of extensive and lengthy recitation of a witness's evidence with an invitation to the witness to agree. We have to absolutely endorse that. It has been a matter of criticism when counsel has engaged in that particular practice and we take it on board. We need to be very careful in our own questioning to ensure that we do not go in that direction.

The Legal Assessor advised in conclusion that a Panel must bear in mind at all times its absolute judicial duty to act fairly and impartially. It must keep an open mind about the

evidence and it must make it apparent to all that that is what it is doing. In so far as any of the questions that we may have asked so far have not made it apparent that the Panel retains an open and enquiring mind, then I can only apologise and assure all of you that this Panel is still very much engaged in active enquiry and no minds have been made up. We are hearing evidence from one particular side at the moment and it would be wholly inappropriate to reach conclusions before we have heard all of the evidence from both sides and it is our intention to do just that.

I should say that the Panel would also invite counsel to continue with the practice that they have adopted with members of the Panel and with each other throughout, in that if anybody at any point asks a question, or starts to ask a question, which somebody find objectionable they should do exactly what they have so far done and that is object, and I hope in every case so far where a Panel's question has been objected to, that objection has been listened to, taken account of and, where appropriate, the line of questioning has desisted. We wish to make it very clear that we do rely on both our Legal Assessor and the professional parties themselves to feel absolutely able to object at any point, just as they do to questions on occasion asked by their opposite number.

That concludes what I would wish to say at this point. Are there any observations, Mr Kark, from the GMC team?

MR KARK: No, we are grateful for that determination and for that insight into your approach.

THE CHAIRMAN: Thank you. Mr Langdale?

MR JENKINS: I have no observations to make. Thank you.

THE CHAIRMAN: Thank you very much. Then we will proceed, Mr Kark, with your witness.

MR KARK: Yes. May I just mention in terms of timing that, as you have properly mentioned, we have a video link set up for this afternoon at, I think, two thirty, with Dr Luznat. We have abandoned the hope of calling Dr Ravindrane today, so he will now be giving evidence tomorrow. We are going to start with Dr Tandy. I do not in fact think she will be nearly as long as Dr Reid, but it is conceivable that we will get to the point where we would have to apply to interpose Dr Luznat. I do not foresee that that will cause anybody any difficulty but that might happen.

MR JENKINS: Sir, can I just indicate now, if that were to happen there would be no concerns on this side.

THE CHAIRMAN: That is extremely helpful, Mr Jenkins. Thank you. Yes, Mr Kark, we will have the witness, please.

MR KARK: Thank you. Dr Jane Tandy, please.

JANE TANDY, Affirmed
Examined by MR KARK

(Following introductions by the Chairman)

Q Is it Dr Jane Tandy?
A Yes.

Q Dr Tandy, I want to ask you a little bit, please, about your experience. There came a time when you worked for a period as a consultant on Dryad Ward. Is that right?
A That is correct.

B

Q In particular, in relation to any patient that we are dealing with you worked there from 1994 to around September of 1996 when you then went off and did various other things.
A That is correct.

Q I just want to deal, please, with your experience prior to taking up that job. You became a consultant when?
A In June, I think, 1994.

C

Q Your speciality was?
A I am a geriatrician.

Q I think you had been a consultant geriatrician since June 1994?
A That is correct.

D

Q Prior to that, can I ask you if you had had any particular interest in geriatric work or palliative care?
A I had no particular palliative care experience other than you get working in a busy general district hospital, but I had worked, I think, for three or four years as an SpR, a senior registrar as it was in those days, in geriatrics.

Q I think just going right back, I think you did your ---
A I cannot remember if it was three or four years. I am sorry. I would have to look at my CV.

E

Q I think you did your house officer training in 1983 to 1984?
A That is correct.

Q When you came to your post at Dryad Ward it was as the consultant, and was Dr Barton already in post?
A She was.

F

Q I think you worked there - you have made a separate statement about this and I am going to lead you, if I may, because the dates are quite complex, but we can simplify things. I think you started in June of 1994 as a consultant on Dryad Ward?
A As far as I remember, yes.

G

Q How often would you visit Dryad Ward?
A It was scheduled for once a fortnight but I was, I think, normally around a week in between, so if people wanted me to go along to the ward for any problems I could pop in on a weekly basis, if required.

Q I think there was a period between 11 July 1996 to 12 August 1996 when you were on sick leave, and I am taking this from a statement that you made ...
A Yes.

H

Q ... and I am going to lead you. I think, actually at the time you made this statement you had your secretary's assistance to tell you.
A Yes, that is from their own records.

Q All right. Then I think from 16 September onwards, effectively, you were, first of all, on sick leave and then you went on maternity leave?
A That is correct.

Q It follows that from around September of 1996 onwards you were not performing any ward rounds at the Gosport War Memorial Hospital?
A Correct.

Q Just coming back to the earlier part of 1996 and your dealings there, you were visiting the ward once a fortnight?
A That is from my secretary's records, yes.

Q If required you could go a lot more often?
A Yes.

Q Dealing with patients there, did you come across patients who were being dealt with in a palliative manner?
A At that time the functions of the ward was really for patients who were then deemed too frail to go to nursing homes, so many of the patients there were very unwell. I do not remember - I am not quite sure what you are asking. These were patients who we would generally expect would not have a very long length of life.

Q So far as the use of analgesic drugs, and particularly opiates, is concerned, you had had general training in their use no doubt.
A Of course.

Q By the time you came to be dealing with patients on Dryad Ward in 1994, when you started, what was your experience up to that point?
A In general, you mean?

Q Yes.
A On any medical ward you will have patients who are dying and patients who are distressed, so these are drugs we would use when required.

Q When you came on to Dryad Ward, was it your impression that Dr Barton had greater or less experience than yourself?
A She had worked in that setting for longer than I had.

Q Did you also come across Sister Hamblin?
A Yes.

Q What view, if any, did you form of her experience in that setting?
A Again, she had worked in that setting longer than I had. I cannot really comment beyond that.

Q So as the consultant, what was your role and relationship in relation to Dr Barton? How often would you actually see Dr Barton?

A From memory, she attended most of the fortnightly ward rounds and we would talk about all the patients on the ward round.

Q Was that in general terms the extent of your dealings with her?
A Yes. Obviously I was open to telephone advice if required.

Q So far as the use of opiates in relation to analgesia for the elderly is concerned, did you have any particular knowledge or experience of opiates specifically with the elderly, or would you yourself have had to had reference back to the BNF or similar documents?
A I problem would have been fairly happy prescribing routine doses, because most patients we see in any branch of medicine now are elderly. I have a low threshold for using the BNF to be absolutely sure of dosages for many drugs, but I would generally have felt fairly happy initiating morphine type drugs.

Q I want to turn to a particular patient. It is Mr Leslie Pittock. Do you in fact have any particular recollection of him?
A I do not remember him. All I know is what I have read in the medical notes.

Q I think it is right to say that you have made two statements and, as a result of those, you were asked to go through Mr Pittock's notes and translate various things and also comment on your own role.
A I cannot remember the order in which things happened. I think the police interview was the first time I looked at the notes, as I recall.

Q Could I ask you, please, to take up the file to your left which is marked A? I am not going to ask you a great deal about this patient, but I just want to see if you can assist us, please. If you turn to page 196, this patient, as we can see, had come from Mulberry Ward. Where was your regular hospital?
A At that time, I was largely at QA: Queen Alexandra.

Q Your job at Queen Alexandra was what?
A I think at that point my acute ward was Mary Ward, which was a stroke ward –no, it was not. I think at this point it was Anne Ward, which was a general medical, elderly care ward. I did other things as well.

Q Does that mean that were occasions when you yourself referred patients to Gosport War Memorial Hospital?
A Absolutely.

Q When you were referring pots to the Gosport War Memorial hospital, would you on occasion refer them for rehabilitation?
A The patients I would send down – I was very careful who I sent down – and again, this is from memory, I had I think one or two patients whose care I could write down very clearly what I wanted done and when I wanted to do it and if patients were medically unstable, it would quite inappropriate. These would be patients perhaps I think some who had bad cardiac failure who would take a long time to get better and would require meticulous weighing, keeping an eye on their blood tests and on the acute ward, sometimes patients were fighting for attention from very, very unwell patients and from memory patients I sent down did well. But patients who need a large amount of rehab input would not be suitable for transfer.

Q It follows I think that you would have to be fairly satisfied that the patient was in a relatively stable condition before you could transfer them.
A Absolutely. It is not an acute medical unit, nor a rehab ward. It was not set up to be.

Q You would have known at the time that you were referring patients to the Gosport War Memorial Hospital that they presumably would get limited medical input?
A Yes, absolutely.

Q Can we just look at this particular patient briefly? We can see that he had been admitted on 5 January, transferred from Mulberry Ward and his essential problems were immobility, depression, a broken sacrum, he had a small superficial area on his right buttock, heels were suspect, he had been catheterised, transferred with a hoist and we can see at the bottom, "Long standing depressive on lithium and sertraline."
A Yes.

Q Underneath that, we can see an entry for 9 January. The writing I think is that of Dr Barton. Then underneath that, do we see a review by yourself?
A That is correct.

Q Your review I think was on 10 January.
A Correct.

Q If you just keep a finger in there, please, and go to page 208, just to lead you into the 10th, as it were, do you see the entry for the 9th?
A Yes.

Q That reads:

> "Small amount of diet taken. Very sweaty this evening but is apyrexial. Has stated [something] that he has generalised pain. To be seen by Dr Barton in the morning."

That is a nursing note. Then we can see the following day there is a reference to:

> "Condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on Oramorph 4 hourly this morning. Mrs Pittock seen and is aware of poor condition. To stay on long stay bed."

That just I hope helps you a little with the background. Can you take us, please, through your note and the relevance of it to this patient?
A I have summarised the problems. He had depression, I think it was resistant depression, and it was a chronic problem. He had a catheter in situ, he had ulceration. His Barthel at that point was zero, which meant he could swallow, he could eat and drink a little if he was fed, but he could not actually do anything for himself at all. He would have been incontinent. Having reviewed the notes, I have written "for TLC". Clearly he had spent a while in hospital. He had not really improved. He was distressed and he was in pain. I had spoken to his wife; I have written "Discussed with wife", because sometimes when you speak to a family you get a very different picture than you get from reading the medical notes, but from what I have written here, clearly she did not say anything to make me feel that he was not likely to survive; it was doing very badly.

Q When you write, as you do, "for TLC", we have heard quite a lot about that expression. We all know what it means: tender loving care. Is it a euphemism for ---
A It is not an expression we would use today.

Q It is not an expression you would use today?
A It is not in current use today, no. When I wrote it then, that would mean that the focus should not be on prolonging life, but on making sure that he is comfortable. If he had something like a urinary tract infection and that gave him discomfort, then you would treat that. So it does not mean you do not treat, but it means the focus of what are doing is on making sure the patient is comfortable.

Q If you could just read the words underneath, please.
A Yes.

"Discussed with wife. Agrees in view of very poor quality [something scribbled] for TLC."

I should think that is probably meant to say "of life", but I agree it is not well written.

Q If you go to page 202, you will find a drug chart. Do you see towards the bottom that Oramorph has been written up?
A Yes.

Q Would that have been consistent with your understanding of what was going to happen for this patient?
A Yes, and also if somebody is a little bit confused and is uncomfortable, sometimes if you just take the edge off the pain, they actually respond to you much better and are much more settled and able to do more.

Q So far as the Oramorph is concerned, the prescription that is written I think is for 10 mg in 5 mls. Is that right?
A Yes.

Q 2.5 mls to be given four-hourly.
A Yes.

Q Then if you look underneath that, do you see a further prescription for Oramorph, 10 mg in 5 mls, 5 mls to be given *nocte*.
A Yes.

Q That would be to give the patient a restful night.
A Yes. That would be the hope.

Q Could you just help us, when you left this patient, would you have taken a view that Oramorph would be sufficient to settle him?
A I think I would not have known at that point. You do not know. You start. I think he had complained on a couple of occasions and so you treat what you can and then see what happens. It is not a known. It is not something you know at that moment.

Q But at that moment, with the patient in the state that he was then in, what did you think he needed?
A It was written up during the ward round by the looks of it, so I am sure I suggested a small dose of opiates to see how he was if we took the edge of his pain and then review.

Q Could you have a look, please, at page 201? You can see that this is under the heading "As Required Prescription".
A Yes.

Q I think this is Dr Barton's writing and it is written up as a variable dose.
A Yes.

Q We have seen other forms of variable doses much wider than this. Were you aware that Dr Barton was writing up variable doses, first of all?
A Yes.

Q Had you come across variable doses before?
A Yes.

Q Can you just give us some sort of context?
A All sorts of drugs, not just palliative care drugs, in terms of care units, you often use variable doses of vaso active drugs and the nurses then review them. I have been asked to write up as a junior doctor large doses, variable doses of opiates for palliative care wards.

Q Can you give us an idea of the sort of acceptable range?
A I cannot absolutely remember, but I do remember being asked I think to write one up to 150, because I remember being quite taken aback as a junior doctor.

Q Can you remember what sort of patient that was;?
A It was on a palliative care ward, but I have absolutely no memory. It was a routine thing that I was asked to do.

Q Did you know at this stage, as a consultant, something about conversion rates between oral morphine and intramuscular?
A I cannot remember exactly what was known then. I clearly know what the advice is, but whether it was the same information then as now, I honestly do not know. I am quite sure I would have started at – diamorphine is more potent than morphine, it was known then, as it is now.

Q Would you have known how much more potent? Would you have known ---
A Yes. You double it.

Q Would you say that again, please?
A Yes.

Q You said something about doubling it and I did not quite catch it.
A You used to halve the amounts of diamorphine from Oramorph, depending on what drugs were around.

Q May I ask you this? If you had yourself been converting from Oramorph to diamorphine, is that something – you said you had a fairly low threshold for the BNF – you would have checked, or would you simply have written it out?
A I suspect I would have known.

Q Without recourse to the BNF?
A It is 13 years ago, but I think so.

B

Q If that is right, then your understanding would have been to halve it in order to obtain the same degree of analgesia.
A Yes. It is different advice now, but I would probably have halved it, yes, if the current dose was adequate.

Q Would you have known anything of the particular sensitivity of prescribing opiates to
C the elderly?
A Of course, yes.

Q You say, "Of course, yes." You have been working in geriatric care. It is not obvious to all perhaps, but you had a particular expertise.
A I thought you were asking me rather than ...

D Q We can see at page 201 that in fact it looks as if this prescription was written on the day after your ward round.
A Yes.

Q Your next visit would have been scheduled for two weeks later?
A Correct.

E Q It is pretty obvious and I am sorry to ask such an apparently stupid question but can we take it you did not see this prescription?
A I cannot see any way I could have done, no.

Q And you can see that this patient was in fact started on I think 15 January on 80 mg of diamorphine – 80 mg being the minimum dose that a nurse could administer within this prescription?
F A Yes.

Q Is that a prescription that you think you would have written?
A I might have used the variable dosage range, but I would have used a lower starting dose.

Q Where would you have started, do you think?
G A I had not seen the patient at this time, so if his pain as adequately controlled on I think he was on about 30 mg of morphine, then I would have used a lower dose than this, but presumably the pain was not adequately controlled on that lower dose, so a straight-forward conversion probably was not appropriate.

Q If you had simply been converting from 30 mg, which I think we have seen the patient was on, according to your formula, hoping to achieve the same rate, it follows that
H you would have written a prescription for 15 mg?

A 10 to 15.

Q 10 to 15?
A Well, that is current day. Yes.

Q In terms of increasing a dose of diamorphine, what was your understanding then, if you are able to recollect it, of the incremental nature of the increase?
A Well, on the wards generally in an acute hospital we would write a baseline diamorphine dosage and we would have "as you need it" top-ups and then as it was then, you could review the patient a few hours later and easily change the dosage.

Q Can you just take us through that because this may be important? When you talk about "as you need it" top-ups, would this be for somebody on a syringe driver?
A Yes.

Q When you talk about "as you need it", are you talking about what we have heard about as break-through pain?
A Exactly.

Q So how would you deal with break-through pain and how would you titrate the dose? What would you do?
A Normally we have a baseline diamorphine dose and on a drug chart there is an "as you need it" PRN section and you would have additional doses of diamorphine that could be given as required.

Q How would that extra diamorphine be given?
A Sub cut usually. If it depends on a syringe driver. I think they tend to use a second needle actually but I do not know what was done then.

Q I am trying to take you back, though to 1996.
A I really cannot remember but we would have used additional dosages as needed.

Q Can you give us any idea about the sort of additional dose you would have used?
A Again, my mind is full of what we know and what we do now and it is now standard practice but clearly if you have a patient on a fairly small dose, then you use a fairly small top-up; if you have a patient on a much larger dose, you would use a larger top-up, so it is not a fixed number.

Q In trying to use a comparison, and say you had somebody on 40 mg of diamorphine through a syringe driver, when you talk about a top-up dose what sort of dose are you thinking about in your brain?
A 5 to 10.

Q And see how that worked?
A Yes.

Q How long would you give the patient to see if that did work or not?
A It is usually after about four hours; if the patient has had the syringe driver going through at a steady dose, unless they are in a lot of pain and particularly if they do not like additional injections, then you would go back and review your baseline dose.

Q In addition to the diamorphine, if we go back to our page 201, we can see that midazolam was written up. Would you have been aware then of the effects of midazolam?
A Did I know about the drug? Yes.

Q Not only would you know about the drug, you would have known the effects that it would have?
A Yes. Did I know it was written up here? No.

Q And you did not know that it was written on this prescription?
A No. Sorry, I was not sure what you were asking me.

Q You would know that it would have a sedative effect?
A Yes.

Q Again, just looking at the sort of dosage when coupled with the diamorphine, is this a prescription that you would have written?
A No.

Q Why not?
A That is a high dose of midazolam.

Q We are calling an expert to deal with what happened with this patient and I am not going to ask you about the other increases, which I think you know that there were.
A Yes, I have been through the statement.

Q At the time, you were not aware that these increases were happening?
A I cannot see how I should have been.

Q If you had been aware of the initial dose, of the prescription, and the increases, would you have done anything about it?
A If I saw the patient at the time and it looked like the dose was too strong and they were very, very drowsy, I would suggest that they were cut back, but if the doses happened to be about right for the patient, then I would not necessarily cut them back. It would depend entirely on how the patient was.

Q How often did you get a request, can you remember, from Dr Barton in this relatively brief period for assistance in terms of prescribing?
A I do not remember very many. I do not remember being called out of hours, so to speak.

Q Do you remember any? You say "I do not remember very many".
A I actually do not, no. That does not mean it did not happen. I just do not remember.

Q I understand. Finally this in relation to your approach to prescribing at the time: your normal practice in relation to the use of opiates would be what? What would your aim be with any particular patient?
A It depends why you are giving the drugs. Sometimes for breathless patients, you are just aiming to help with breathlessness. For a patient in pain, you are aiming to relieve the pain as best as you can, but there is a ceiling dose which varies from patient to patient

because of the side effects. So you have to compromise sometimes between pain and side effects, if that is what you are asking me.

Q But the side effects that you have been looking out for would be what?
A Respiratory depression, some patients get very sick on it; constipation; some patients get very muddled on it and do not like that feeling. With some patients you can actually discuss what you want to do.

Q Did you find some patients, just dealing with Oramorph for a moment, of yours did actually have a bad reaction to Oramorph?
A As in?

Q They did not like it or it gave them ---
A Yes, the same with codeine; some patients are very sensitive to very small doses of opiate drugs. That is common.

Q We can put that file away for a moment. I do not think you had any other dealings with this patient?
A No, not from the notes and I have no memory.

Q Just two other patients very briefly to deal with: can you take up file B which is that of Elsie Lavender? Please turn to page 242. I think we have actually got a second page of this elsewhere in the notes. Stupidly, I have not made a note upon it. It is at the back of the bundle somewhere. We have found it. If you go to later in the bundle, to 935, this patient had been admitted to your hospital having had a fall I think back on 5 February.
A No, I saw her in Haslar. She was under a medical team, I think.

Q Why were you seeing her at the Haslar?
A Patients who were felt suitable for rehab were always seen by a consultant or senior medical member of the team before they were transferred over.

Q You are absolutely right that she was at the Haslar. The notepaper is from the Queen Alexandra. You see the patient at the Haslar?
A Yes, but we dictate a tape and then it is typed up by our secretaries back at QA.

Q Just reading through this briefly,

> "Thank you for asking me to see this 83 year old lady, who was admitted under your care some 11 days ago following a fall. .....she's had weakness."

You talk about her being a bit battered and she feels that her mobility is starting to improve in her hands and she stood with physios.

> "Examination confirmed atrial fibrillation. I could not hear any murmurs."

Over the page:

> "I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron-deficient anaemia. Upper GI investigations might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here."

You are reluctant to consider Warfarin.

"Alas, I don't think her brain stem stroke would show up particularly well on a CT and we're now 11 days post-ictus."

A That is after the event.

Q "I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and X-rays could go with her."

First of all, do you have any independent recollection of this patient at all?
A I am sorry, no.

Q Can we take it from your earlier answers that you would have considered this patient was stable enough for transfer to the Gosport War Memorial Hospital?
A I think at this point Daedalus was up and running as a rehab unit. The hospital was being used slightly differently. So the first patient was on Dryad Ward, at which time it was purely a long-term care ward. I did take one or two patients over there who actually did very well.

Q Can you keep your voice up, please?
A I took one or two patients outside the normal parameters who actually did very well there but they were only patients I knew. But at this point as I recall Daedalus was a rehab unit, so its function was different.

Q It still would not have had any acute facilities?
A No, so somebody who went off, medically speaking, you would have to transfer up to QA or back to Haslar.

Q In transferring her over to Daedalus, would you have expected her to receive such rehabilitation as possible?
A Yes. It is supposed to be a rehab unit. I was not working on the ward but I assumed that is what it did.

Q That is dated 16 February. It is dictated on 16 February. Is that when your visit would have taken place?
A Yes. It was dictated at the same time.

Q Can you just go back in the notes, and I should have shown this to you previously, to page 148? I think it may explain your involvement, as it were, with this patient. I think I see you nodding. This is a note of 13 February '96 to Consultant in Elderly Medicine:

"Thank you for seeing this elderly 83 year old woman."

I am not going to read through the whole of this. At the bottom we can see these words:

"She has been slow to mobilize and need help to walk."

Something "herself, feed and wash herself. (Bartel score 5)."

Is this effectively the referral to you?
A That would have been a referral which I may or may not have seen when I saw the patient, but, yes.

MR KARK: I think we can put those notes away

MR JENKINS: I am sorry to interrupt but Dr Tandy's own note is two pages on at page 151.

MR KARK: I am grateful. Page 151 is the clinical note that you made. Is this reflected in the letter that was ultimately written?
A Yes, absolutely.

Q Just looking at the middle of that, I think you reflect a history and underneath half-way down do you say, and can you read out your own writing for us?
A "Since fall, pain arms and shoulders. Walked a few steps with physio. 2 to transfer. No problem eating or drinking. Complained of being unable to use fingers since admission but improving. Stress incontinence – not new."

Q Over the page, does your note continue?
A "Denies any other problems. No obvious source of blood loss".

I was worried about the anaemia. "Mixed diet" because I was worried about the anaemia. "On examination, sensible, cheerful...."

Do you want me to carry on?

Q I do not think we need to unless it adds to your letter.
A No, I do not think so.

Q Can we just look at the bottom? I just really need help reading your writing?
A "Probable brain stem stroke (she has had her neck X-rayed)"

I could not find the X-rays. I assume it was normal. So that was really back to the team to check she had not done any damage to her neck.

"Iron deficiency, anaemia. Diabetes on insulin, immobility. Sounds as though just managing at home prior but she would like to get back."

Q Meaning she would like to get back home?
A Yes, so she needs a trial of rehab.

Q Then "To Daedalus GWMH".
A "? Had enough amoxil?" I must have looked at her drug chart and perhaps she had already had more than I was expecting. I go on: because I was concerned about the anaemia, I have asked them to repeat her bloods and look at her iron levels.

Q You end,

"I am not sure whether we will mange to get her home but we'll try."

A Yes.

Q So that was the plan, as it were?
A Yes, trial and rehab. She was only just coping before.

Q Could you put that file away, please, and take up file J and turn up page 52. This is Mr Packman.
A Oh yes.

Q There is a glimmer of recognition.
A Yes.

Q It is rather later on, I think, in your career, as it were?
A Yes.

Q We are now in 1999. Is this a note that you would have made at the Queen Alexandra Hospital?
A Yes, from memory I think he was at one of the acute wards at QA at one point.

Q Do you have any recollection of him, in fact?
A He has been talked about in the corridors more recently, but I do not remember whether I really remember him or not. These patients are thirteen years ago.

Q There is no criticism of you at all.
A Sometimes we have discussed patients before the trial and so sometimes you are not quite sure what you really remember.

Q It is important, obviously, that you stick to what you think you can remember.
A I cannot talk outside of what I have written down here.

Q All right. If we go to page 51, first of all, that is 13 August. Is that a note by - is it Dr Chatterjee?
A I am sorry. I do not know. I do not know handwriting.

Q All right. We can see at the bottom there, "Transfer to Dryad Ward on [16 August 1999]".
A The top writing is mine.

Q It is yours?
A Yes. Underneath is somebody else. This is the 16th and there is the 18th.

Q I am sorry. Stop for a moment. Page 51 with a line either side of it.
A I am sorry. I am on page 52. I do apologise.

Q That is all right.
A Yes, I have it now.

Q That is the first note I am looking at. That I do not think is yours, is it?
A No, that is not my writing.

Q We can see right at the bottom of that, this is the only thing I wanted to ask you about this, "Transfer to Dryad Ward on [16 August 1999]", and then, "Not for 3555". That is a notation we have seen.
A Yes.

Q We understand what it means. Is that a notation that you used on occasion?
A Yes.

Q We understand that it means not for resuscitation ...
A Correct.

Q ... in the event of a cardiac arrest. Does it mean, in your view, not for further treatment?
A No. It is completely different.

Q Could you now go over to page 52 to your note and can you just help us through it?
A

"Obese
Cellulitis
Pressure sores - buttocks/sacrum
thighs
exudate"

I assume what I mean is that there is some exudate coming out from the pressure sores.

Q Meaning what?
A Possibly infection. Sometimes wounds just leak, even without being infected. "Swabbed", because I was obviously worried about infection, and I have talked about Intrasite dressing:

"... change daily
faecally [incontinent]
legs - much better

Dryad when bed available"

Q Did you think at that time, or does this reflect that you would have thought at that time, that this patient was stable enough to be transferred?
A Yes.

Q He, plainly, had problems.
A Yes.

Q You were giving advice or, indeed, direction as to how to deal with those problems?
A Yes. At that point I do not think there is anything - from what I remember he was very, very obese. From what people told me anyway. No, I am going to have to stick with what is written there. Nothing there has indicated that I was concerned about him, other than, obviously, he had a lot of problems, yes.

Q Yes. The note underneath, is that yours or not?

A No, that is not my writing.

Q At this time in your career you were no longer working at the Gosport War Memorial Hospital at all.
A No.

Q So once this patient had left your care and gone to the Dryad that would be it, as it were?
A Yes, I would not expect to get involved again.

MR KARK: That is all that I ask you. Thank you.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Mr Langdale, the room is going to be used in a few minutes for the first test for the equipment, but it is in the time that we would normally be breaking for lunch, in any event. Can I ask, without holding you to it, how much time you would anticipate needing for this witness for your cross-examination, or Mr Jenkins, if it is you, to be cross-examining?

MR JENKINS: Mr Langdale will not be very long. I will be a little longer. I think I will be at least 40 minutes.

THE CHAIRMAN: So everybody knows what the situation is, the window booked, assuming the test works okay, is for two thirty. So it is a matter of whether we take a slightly shorter lunch so that we can start earlier and embark on the witness and then go in at two thirty or thereabouts, or whether we go part-heard, as it were, or do not even attempt. Do you have any views yourself as to how you would wish to approach it?

MR JENKINS: No.

THE CHAIRMAN: Very well. Mr Kark.

MR KARK: Unusually, for me, I prefer a shorter lunch, because the next witness could be a little while and I think it would be fairly unattractive for this witness to have to potentially come back tomorrow. She has waited already a whole day and she has been very helpful so far.

MR JENKINS: I do not think Dr Luznat will be very long.

MR KARK: We are much more in the hands of the defence. I thought she might be a little while.

MR JENKINS: I do not think Dr Luznat will be very long at all. I will not be asking her about episodes of patient care.

MR KARK: I see.

THE CHAIRMAN: We started at nine o'clock today so I am conscious of the fact that it is, potentially, a long day. However, if we accede to Mr Kark's request, and I am going to check that everybody is willing and able to do that, and take a shorter lunch, if it turns out that Mr Jenkins is correct that the video link witness is not going to be so long then it would simply mean that we would finish earlier and I guess that would not be unattractive either after a long day.

What I am going to suggest then is that we break for half an hour, which would have us coming back at twenty-to two, with the caveat, as the Panel Secretary has reminded me, that if there is a problem with the video link test things may change anyway. So what would happen is we would all of us be individually informed of any change, but unless you hear to the contrary we would like to try and get started again at twenty-to two, please. Thank you very much.

(To the witness) You remain on oath. Please do not discuss the case with anybody else, and I hope that is going to give you sufficient time to get some lunch.

THE WITNESS: Thank you.

(The Panel adjourned for lunch)

THE CHAIRMAN: Welcome back, everyone.

Mr Jenkins, before you start with your questions, I have just been given a message from the Panel Secretary and it is this: the witness has just spoken to her and indicated that she has been thinking over a previous answer that she had given and would wish to say something before we proceed.

MR KARK: I think it is probably best that I clarify that, if I may. (To the witness) Tell us what you want to say.

A I really am terribly sorry. You asked a very clear question. We were talking about swapping Oramorph to diamorph and you asked me very clearly would I be as certain in my knowledge back thirteen/fourteen years ago as I am now. I was thinking outside, many of the things we consider that are routine practice, and I qualified in 1983, are absolutely outrageous by today's standards and I cannot imagine not knowing all this. Looking back on this, I cannot be absolutely certain I did, which is not very helpful and I am terribly sorry.

Q It is difficult for you to distinguish from the knowledge you had then from the knowledge that you have now gained?

A Yes.

Q We are looking at 1996, of course.

A Yes, thirteen years ago. I am terribly sorry.

MR KARK: That is all right. Thank you for that clarification.

THE CHAIRMAN: Thank you. Mr Jenkins.

Cross-examined by MR JENKINS

Q Can I just explore that comment? Many things that happened would be considered absolutely outrageous by today's standards?

A This was in 1983, when I first qualified.

Q You are not talking about 1996?

A No, 1983 when I first qualified.

Q Then I had misunderstood. Can you take us back to your role? What you told us was

you were the consultant for Dryad Ward in 1994 to 1997. Yes?
A Yes.

Q You had many other responsibilities as well, I think?
A Yes.

Q You were based at the Queen Alexandra Hospital. Were you responsible for several wards there?
A I am sorry. I have not looked through that. I did not expect to be asked.

Q Do not worry. I was not going to go through the detail of it.
A Yes.

Q But you had responsibilities in a number of other ...
A Areas, yes.

Q ... areas on the Queen Alexandra Hospital. Were you dealing with patients anywhere else as well?
A I think at some point I had a day hospital, which is a type of outpatients, at St Mary's, if my memory serves me correct. I am not absolutely sure.

Q I have a document which talks of Anne Ward.
A Yes, that was the acute ward.

Q That was the acute ward at the Queen Alexandra Hospital?
A Correct.

Q Elizabeth, is that another ward?
A That was a stroke rehab ward. That was at QA.

Q You were seeing patients in outpatients at the Queen Alexandra Hospital as well?
A Probably at St Mary's.

Q OPD is what your diary suggests.
A That is outpatients, yes.

Q Then Guernsey Ward?
A That was also straight rehabilitation.

Q Where was that?
A That was definitely down at St Mary's Hospital.

Q Dryad Ward, clearly, you did ward rounds once every two weeks?
A Yes.

Q Then there is mention on a document I have seen of your job plan of F3 Ward?
A Oh yes. I had responsibility for six acute stroke patients up there. They were patients over the age of 65.

Q Then, in addition, I have "ADH/DDH", which may be the Dolphin Day Hospital?
A Yes, that is correct. I am sorry.

Q That was part of the War Memorial Complex of buildings?
A Yes.

Q What is the ADH?
A Amulree Day Hospital, which was a similar set up but based at St Mary's.

Q So you were dealing with three different buildings?
A Yes.

Q You must have had scores of patients for whom you were responsible at any one time?
A Yes.

Q What you told was that you had periods of sick leave during 1996 and, as a result of that, together with maternity leave, I think you were not doing ward rounds at the Dryad Ward from September 1996 onwards?
A That is correct.

Q I think there was no full-time consultant for Dryad Ward until Dr Reid started in February 1999.
A I do not know.

Q It is in your statement that he started in February 1999.
A Okay.

Q That is where I have been taking it from and if it is in your statement ...
A It will be true.

Q ... that will be right. Were there some locum doctors employed during the time of your sick leave and maternity leave from July 1996 until August 1997?
A Correct.

Q There is a statement that I have seen from you which sets out various locum doctors and I think there were four locum doctors whose names were given, where some locums were for five days, others for several weeks, and I think the longest locum was a period of four months from the end of April 1997 until the end of August 1997. Those locums, would they have covered the full job plan that you and I have just gone through, the three different ---
A I honestly do not know because it is not something that I had any input into. I was off sick and on maternity leave, and we are not responsible for organising our own cover.

Q I understand. It follows from the dates you have agreed with me that certainly from the summer of 1996 there was no full-time consultant to support patients on Dryad Ward until Dr Reid started in February 1999.
A Correct.

Q During the time that you were working until you stopped work in the summer of 1996, can you tell us how much communication you had with Dr Barton on a regular basis?
A I think, as I already mentioned, I did a fortnightly ward round and Dr Barton, as often as she could, came. From memory, I think mostly Dr Barton did attend. Particularly when I was doing Dolphin Day Hospital, I would be there if somebody wanted me to pop in in

between weekly sessions. I think occasionally I was asked to go to the ward, but there was no other direct communication.

Q During the time that she was the clinical assistant at Dryad Ward and you were the consultant and working, in other words, up to the summer of 1996, what would you want to have been told by Dr Barton about the day-to-day care and decisions in relation to patients on the ward?

B A We would have gone around with the notes and looked at every patient together with the notes and talked about what had happened since I last saw them.

Q You would deal with patients with Dr Barton as and when you were both together?
A Otherwise, if she was not with me, one of the nurses would come with me and I would look through the notes on my own.

C Q What about communication with Dr Barton when you were not present for a ward round? What you have told us is that there may have been phone calls, but you do not recall any.
A No, I do not.

Q If you were not there and a decision was reached to start a patient on a syringe driver, would you have expected a phone call from Dr Barton to tell you that?

D A No. Only if it was something unexpected or there was some concern over whether that was the right thing to do. I would not routinely have expected to be informed.

Q What about if a decision was made to increase the dosage of any form of medication that a patient was receiving? Would the same answer apply?
A Yes.

E Q Essentially, is this the position? You were familiar with Dr Barton's practices and her experience and her ability to make decisions?
A Yes.

Q I think you also will have come across Dr Barton during the time that you were working as a consultant and dealing with some of her GP patients. Would that be right?

F A Not large numbers. Only those that – we are a huge district, so I am sure some of Dr Barton's will have got referred to the hospital, but I do not think I saw large numbers.

Q I understand. I am simply asking, would you have had the opportunity, both through working as a consultant at Dryad and through seeing other patients of Dr Barton's, to form a judgment about Dr Barton's skills and abilities as a GP?
A Yes. Not as a GP, no. That would not be appropriate for me to make that decision, I do not think.

G Q But you had the chance to see her abilities as a clinical assistant?
A Yes.

Q How did you find her?
A I was very happy with her care. As I think I have mentioned, I did bring one or two patients over who were going to need a protracted period of time in hospital and for whom I

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could flowchart very carefully what I wanted to be done and it was and these patients did well.

Q Coming back to Dr Barton, how did you find her as a doctor when you dealt with her on the ward rounds?
A My memories are good. I do not remember any particular concerns at the time.

Q What would you say about her level of conscientiousness?
A She knew the patients, which is – because of the way we work at the moment, with junior doctors coming and going, that in itself counts for quite a lot and I always thought she cared about the patients and put their interests first. I thought the decisions she made were generally sensible from memory.

Q Would you have been aware of any time pressure on her?
A Yes. I did know she was time pressured.

Q What did that mean in practical terms, Dr Barton being time pressured?
A I think the thing I remember most was that I did not feel the note keeping was of a high standard, but I felt it was probably more – well, it was more important – she saw the patients than wrote a large amount in the notes. From patients referred in from other community hospitals, the standard of note keeping did not seem to be out of the ordinary.

Q Can I just explore that? You said you thought it was more important that she should see the patients than write large amounts of notes.
A Yes.

Q Was it apparent to you that the constraints on Dr Barton's time were such that that was a choice that needed to be made? She could either write notes or spend time with the patients.
A I think that is what I must have thought, yes.

Q What you have just told me is that the notes that Dr Barton wrote were equivalent to that which you might have seen in other cottage hospitals.
A More than some, yes.

Q More than some?
A I remember seeing one patient in outpatients who came from another district hospital and the only reason I knew they were an inpatient was because they had a wrist band on; there was nothing written in the notes at all. And that was not unheard of at that time, which does not mean it is good, but it is what was happening.

Q I am grateful. So it follows that the level of note keeping by Dr Barton was equivalent and better than ---
A From my impression of other ---

Q Better than other equivalent units.
A Yes.

Q Would it be fair to say that you were aware of the way in which Dr Barton prescribed to patients?

A Generally we would look at the drug charts on the way round. We would discuss things as we went round.

Q How were the drug charts kept, if you can recall, for ward rounds when you were at Dryad?
A I do not remember having any particular concerns.

B Q Would you have seen prescriptions such as the type that you were asked to look at for Patient A, Mr Pittock, prescriptions for a range of medication in a syringe driver?
A Yes. I was aware that she gave a range.

Q You have told us that you had seen that before in other units.
A Yes.

C Q Was it appropriate to do that in the circumstances in which Dr Barton was treating patients on Dryad Ward?
A I felt it was appropriate to use a range of doses, yes, because she was only there once a day.

Q So far as the nursing staff were concerned, was it clear that the range of prescription was something that the nurses could deal with competently and effectively?
D A I do not remember being concerned.

Q You did not raise any issues with Dr Barton about her prescribing?
A I do not think so.

Q You knew about the anticipatory prescribing.
A I am really sorry. I just do not remember.

E Q I am going to suggest you did not raise any issues with Dr Barton about her note keeping.
A No.

Q You have told us that on an occasion in the past when you were a junior doctor, you remember being asked to write up a variable dose for a patient up to 150 mg.
F A I am not absolutely sure. Again, this is more than 13 years ago. 15 years ago.

Q Was that diamorphine?
A I am pretty certain it was a syringe driver dose and I am pretty certain the top end was 150, because we were slightly taken aback, but we were told it was routine.

Q You were told it was routine. It would not have been a nurse that gave you the
G instruction to write up diamorphine; it would have been a senior doctor?
A No. It would probably come from a nurse, the protocol. This is what you were supposed to do. My memory is – this has to be more than 15 years ago, so I cannot be held to it – I do have a memory of being on a palliative care unit and being told this was standard procedure, the nurses would alter the doses as necessary and this is what we had to prescribe for every patient who came on the ward.

H Q Can you tell us whereabouts in the country that was?

A I am honestly not sure. I really am not.

Q Whereabouts was the unit you are talking of?
A It might even be Portsmouth. I honestly cannot remember. I did try and look back to see if we had any old protocols on the ward before the trial, but I could not find any.

Q Is this your recollection? Writing up variable doses of drugs such as diamorphine to be delivered by a syringe driver was pretty standard practice many years ago?
A I thought so, from my own experience.

Q You have told us when you were asked about conversion rates that if you were moving from oral morphine to diamorphine to be given by injection, the calculation that people would make then is that you would halve the dose.
A This is what – I did bring up again – I cannot imagine not knowing it, but then this is such a long time ago. Things that we take for granted now were not necessarily standard practice then. So I am sorry, I cannot be absolutely clear on that.

Q But doing the best you can, that is the calculation that used to be made?
A I think so, yes.

Q You have told us that you used to halve the dose to diamorphine, depending on what other drugs were around. That is my note of what you said to Mr Kark. If that chimes a bell with you, can you tell us what you meant?
A Yes. I think mostly you look at the patient really before you decided on what dose to give. If they were on Oramorph and their pain was satisfactorily controlled, then you would convert them directly. These days, you would use a third. If their pain was not controlled, then you might go a little higher than that and also write up as you need it, prn, rescue breakthrough pain medication.

Q Would you agree that it is vital to see the patient or know what their present condition is?
A Absolutely.

Q Before determining what an appropriate dose may be?
A Mostly, yes. I would not do it without having seen the patient recently at least.

Q We have heard that on occasion a doctor might be asked to make a prescription over the telephone, give a verbal order, but absent that happening, you would want to see the patient or know the patient's history and present condition.
A If I had seen the patient the day before and I had a very clear picture of them in my mind and I trusted the nurse on the other end and I was in the middle of doing something else, then I – as a junior doctor, I gave a lot of verbal orders. It was fairly standard practice, which you would not do now.

Q I understand.
A But if I had never seen the patient before or I was not happy about the person, the nurse, I did not trust the nurse on the phone, then obviously not.

Q Can I come to the nursing staff on Dryad Ward? How did you find the level of nursing that was provided for your patients on Dryad?

A In terms of if I wanted things like daily weights done, daily blood pressure measurements done, fantastic actually. Things got done much more efficiently than perhaps was done on the acute ward because of all the pressures of looking after a lot of very ill patients. They were very good at things like bed sores. Patients came in with dreadful bed sores and they healed. Quite often, we sent them down from the acute ward and I was not expecting them to get better and some of these patients did very well.

B Q Would it be fair to say that it was a well-run ward?
A I thought so, yes.

Q That requires good leadership and it requires willing nursing staff.
A Yes.

Q Was it clear that that was how things were done on Dryad Ward?
C A I was not aware of any problems.

Q As to the patient mix on Dryad, what you have been very clear about is that it was not an acute ward.
A No.

Q It was not an acute medical unit, nor a rehabilitation ward. It was not set up to be.
D A No.

Q I wonder if you can just help us with what that means in practical terms for patients who might be transferred to Dryad?
A If they are patients for whom acute medical treatment would be deemed appropriate if their condition deteriorated, then you might have to think about transferring them back to the acute ward, depending on the patient or what the problem was. If it could not be handled
E simply – because as far as I remember, we did not use even subcutaneous fluids then. If we had to re-hydrate patients, I do not think we did subcutaneous fluids or anything, as far as I remember.

Q If there was a medical problem, you would have to think about whether to transfer the patient over.
A Yes, if it was appropriate to do that. If it was not something that could be sorted out
F simply with antibiotics and just careful – getting them to drink on the ward, if it was something more serious than that.

Q Tell us why you would have to think about whether it was appropriate to transfer a patient out if there was a medical problem? Why would it not be done automatically?
A It might not be in the patient's best interests to send them on a long ambulance journey. It is quite distressing to be bumped along on a long ambulance journey if you are a
G patient who is a bit muddled and a bit confused and also if you think the chances of them doing well if given full medical treatment are poor, then you would think hard about sending them up the road.

Q What would you say to someone who said, "Well, it is always in the patient's best interests for them to be referred for assessment and investigation"?

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A No, it is not always, I do not think. For patients who are unlikely to benefit from further aggressive management. It is a decision we make every day in the hospitals. We decide where to draw the line on what treatment you are prepared to give patients.

Q Patients who are unlikely to benefit?
A Yes.

B Q What do you mean by that?
A That they are very unwell and unlikely to be made better by further medical treatment.

Q It was not a rehabilitation ward either.
A No.

C Q Again, in practical terms, what did that mean for the patients who were transferred to Dryad?
A That we were not taking rehabilitation patients I do not think at that point. I think one or two came through for whom – I mean, some patients are so frail they actually cannot cope with daily physiotherapy, so we were not offering – patients who needed daily physiotherapy, it would not have been appropriate to transfer at the time. Is that your question?

D Q It is essentially, yes. Together with, what were the facilities anyway for physiotherapy on Dryad when you were there?
A I think sometimes we sent one or two, because some patients came down who were expected not to survive and they got better. Patients sometimes do when you just leave them alone for a little bit actually and just make sure they have good nursing care, food and water. I think we sent a couple down – I am not absolutely sure – to the day hospital for physio I E think and I think sometimes we had people come on to the ward for us if they could, but my memories are hazy. I am sorry. I cannot be sure of details.

Q It is many years ago. One thing you say in your statement made for the General Medical Council – it is paragraph 14 for those who have it – you say:

F "Families had sometimes been under the impression that their relative had been transferred to Dryad for rehabilitiation when this was clearly not the case, nor appropriate."

A Yes. That was not uncommon at the time.

Q Can I just explore what you mean?
A Yes. Patients would have been seen by one of my colleagues. At this time the G criteria were such, as I have already said, we were looking at patients who were thought to be too frail for nursing homes. They were not fit for rehabilitation. These are the patients that would be sent on, but quite often nurses on the ward they had come from would say, "Oh, no, they'll be great when they get there. They'll get some rehab." So there were some communication problems and I do remember speaking to some of these families and the patient may have been in the hospital system for several months, they had been across several wards. Before they came into hospital, they were walking the dog and the relatives very H reasonably wanted to know how on earth they got where they are now and I do remember it

could take me quite a long time just to read through the notes and find out what actually happened to this person. So communication was not always appropriately done for the families when the patients were transferred down.

Q Is this patients or families who may have been misinformed as to what Dryad Ward could provide for them?
A Yes. I think it was a lack of knowledge at the acute end, because these patients were coming from all over the hospital.

Q One of the problems that that of itself might create is disappointment, resentment, complaints, about the care that the patients or relatives might have expected to be afforded at Dryad, but which could not actually be given?
A Yes.

Q How was that dealt with?
A I do not remember any complains at this time, but I do remember talking to some families and I just remember going through the notes myself and thinking, "Yes, I understand where the family are coming from", because their loved one was living independently six months ago, came in with a fractured neck of femur, they had a gastrointestinal bleed, they had a heart attack, they had one thing after another and quite often, what I really had to do was just spend quite a lot of time going through the notes myself working it out and then just taking the families through what had happened and explaining things as best I could.

Q I understand. So it is clearly the case that some families were, for whatever reason, under a false impression about what Dryad could do?
A Yes.

Q Again, you have made it plain that patients being referred to Dryad would not be fit enough to go to a nursing home?
A No, these days that is different, but that was the criteria thought to be appropriate at the time.

Q If they are not fit enough to go to a nursing home, they are not fit enough for rehabilitation?
A Absolutely not, no.

Q Can we turn to Mr Pittock, please, Patient A? It is file A. I am afraid I am going to take you through slightly more of the records than you were taken through before because I think Mr Pittock had, was it 30 years of depression?
A I do not remember, I am sorry.

Q I am not going to go through that length of time or anywhere near it, but perhaps I can take you to page 48 in the records. This is a clerking note from 14 September 1995 when Mr Pittock was admitted to the War Memorial Hospital under the care of Dr Victoria Banks. The Panel have heard from her. We know that Mr Pittock is shown as chronically depressed. A number of medical problems are referred to on that page. There is reference to his previous medical history, "PMH", two-thirds of the way down the page. It is query Parkinsonism. Can you read the next line for us?
A "Varicocele repair".

Q One member of the Panel is medical. The others may already know the answer to this but what is a varicocele?
A It is a minor procedure.

Q And "hypothyroidism" is an under-active thyroid.
A Yes.

Q No heart attack.
A High blood pressure.

Q "Diabetes." The next is?
A Chronis bronchitis or a stroke.

Q Thank you. There is reference to chronic depression for clearly some period of time; the suggestion is the 1950s. If we go on to page 51, I think the note continues. In the middle of the page we see the letters "O/E" "In wheelchair, thin" and is it "fine tremor"?
A Yes.

Q "CNS" is the central nervous system I think.
A Yes.

Q "Very immobile + Parkinsonian with cogwheeling shuffling gait". Cogwheeling is a way of walking?
A Yes, cogwheeling is more to do with ---- Certain neural conditions can give you a higher tone, make you a bit stiff and particularly in Parkinson's you get a tremor superimposed on that, so the stiffness comes and goes a bit.

Q The word "gate" should refer to walk and be spelt slightly differently?
A I think so.

Q Over the page on 52, the plan is to continue his then medication. I am sorry, we should look at the impression at the top of that page. "82 year old man with long history of depression and multiple medication". Is it "antibiotics"?
A I actually do not know what that says, I am sorry.

Q "Required ECT in the past. Mood and self image deteriorating along with physical capabilities over months, possibly since moving into a rest home away from his wife. Also very anxious at times. Deteriorating appetite and weight loss, in part due to shame at eating in public."

That is what it says. We see the plan and the question of whether he should receive more electroconvulsive therapy was raised but he did not get it. Can I take you on to page 181, which I think is Dr Banks's entry. I beg your pardon, it is a nursing entry. The nursing entry for that day, 14 September;

> "Les Pittock has been admitted from Hazeldene Rest Home at the request of Dr Banks. Les has recently become more depressed and less able to care for self – requiring assistance with washing, dressing etc."

I think what we see, if we go back to page 55, is that by 18 October, so going on a month or so after his admission, Dr Banks has recorded that Mr Pittock is "eating well, seems better and brighter – wife has noticed the improvement". The plan is formed; "no ECT. Discharge next week" is what is suggested and we will see, if we go on a page ---

MR KARK: I am sorry to interrupt but the witness is looking slightly bemused and I am wondering if there is a question at the end of this.

MR JENKINS: I am setting the scene. If there is an objection, I will give ground and the objection can be heard.

MR KARK: We know the scene. The witness knows the background to the patient and I just wonder if there ought to be a question quite soon at least that the witness can actually answer.

MR JENKINS: There will be a question. At an earlier stage in the proceedings, the Panel wanted half an hour to familiarise themselves with every patient. The Panel at this stage are juggling 12 case histories in their minds and I think it would be unfair on the Panel if I simply go straight to "This is what happened on this day", without reminding us all of the history. I do not think we have been taken through the history in this detail with this patient before. I do not apologise for doing so.

THE CHAIRMAN: Speaking for the Panel, it is of assistance to get some insight rather than just being led straight to points and their being put. That clearly we have complained about in the past. To that extent, I think we are absolutely with you, Mr Jenkins. However, we need to be conscious of whether the witness is following and I think Mr Kark's initial point was that the witness was appearing somewhat bemused as to where we were.

MR JENKINS: I apologise if that is the impression I was giving you.
A I just wondered if I was supposed to know something that I did not.

Q But you will have looked at these records before?
A I do not think I have. When I did the police interview, I did not look at any of this actually.

Q When you saw Mr Pittock, would you have had access to his medical records?
A Whether I would have access to his Mulberry Ward records, I honestly do not know because quite often departments keep their own records, for obvious reasons, in hospitals.

Q Are you saying that there may well have been occasions when you saw patients and you did not have their medical records with you?
A Oh, quite frequently and also the psycho-geriatricians' records were not with the normal medical records.

Q What about at Dryad? When patients were referred into Dryad, did you always have the medical records?
A Not always because records get lost, but if they come from a psycho-geriatric ward, I honestly have no idea whether their records came with them or not, I am sorry.

Q I am going to keep going with this exercise, if I may.

A That is fine. I just wondered if there was something awful I just did not know I had been involved with.

Q We see a discharge letter on page 57. I think the calculation as to his age is wrong; he is not 71. We have seen he was 82 a few pages ago. There is reference to the past medical history and we have looked at the clerking notes that deal with that. This covers, on the second page, 58, the physical examination that we have looked at. We see from page 58 that when he was discharged he was on a variety of medications including Sertraline and lithium carbonate, which I think are drugs for depression?
A Sorry, Sertraline is and lithium is a mood stabiliser, yes.

Q Can I take you on to page 63: we must recall that Mr Pittock was discharged to the Hazeldene Rest Home on 24 October. Here he is six weeks later being admitted again to the War Memorial Hospital and the note on admission back to the War Memorial under Dr Banks is a quotation. Putting it in a quotation suggests that that was what the patient himself had said: "Everything is horrible".
A I would assume so. I do not know better than you really.

Q There is a description of information which may be received from the rest home from RH, "Verbally aggressive to wife and self. Staying in bed all day. Not mobilising. Constipation. Not eating well." Then, "Hopeless and suicidal". "PPH", that is his previous history, "Chronic depression" and reference again to previous medical history. If we were to look at page 126, we can see in the right hand column, about two inches down from the top, the date that we have just looked at on the clerking note, it is the same date, 13 December 1995, and it is also at the bottom of the page. This is the nursing note on Mr Pittock's re-admission to the War Memorial. The reason for the admission is written there as:

> "The rest home cannot cope with him. He has put himself to bed and refuses to get up. He has become both physically and verbally aggressive towards staff at the rest home. Lack of energy and self-motivation."

I think we have another note at page 145 at the top of the page apparently in the same handwriting and to the same effect. If we go on a little bit in the history and go back to page 65, there are entries in the medical notes for 20 December 1995. The second entry refers to a ward round in which someone has written "Mobility" and then two downward arrows. Then two days later there is an entry,

> "Generally weak today. Left-basal crepitations. Chest infection."

Over on page 66, taking it on another few days, another ward round by Dr Banks. We see he is described as "chesty, poorly, abusive, not himself at all". There is reference to him being catheterised at the end of last week and a request for a geriatric review. If we go on, you will see that there is a request made to Dr Lord, on page 67, 2 January 1996:

> "Thank you for seeing Les who has been treated for many years for resistant depression. On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest is now clearing but he remains bed bound, expressing the wish to just die. This may well be secondary to his depression but we would be grateful for any suggestions as to who to improve his physical health."

We see another ward round below that of Dr Banks. "Poor food intake, fluid OK. Deteriorating. Some breaks in skin now. Query whether fit for ECT" and a reference to Fortisips, a high protein diet, and "needs more time to convalesce". There is a downward arrow on page 68 at the top with reference to diazepam, meaning reduce the diazepam.
A Yes.

Q "Watch for benzodiazepine withdrawal". Can you tell us about that?
A If you stop or decrease doses abruptly patients get a withdrawal reaction. If you decrease the dose or stop benzodiazepines abruptly, patients get a withdrawal reaction and become very agitated.

Q I am grateful. "Probably will need nursing home" is the entry just below that. Then we have an assessment by Dr Althea Lord on 4 January '96 in which she sets out a number of problems I think.

Sir, I am looking at the clock at the same time as I am doing this exercise. I have already indicated that if it were felt appropriate to interpose, I would not have any objection.

MR KARK: I have just been given a note, which I suspect comes from the Panel Secretary, that the video link is not going to be fixed. I gather they were missing a cable or had a kinked cable at the other end which they were trying to replace. That they have not been able to do. I am told that the only way Dr Luznat could give evidence this afternoon would be over a telephone. We would be content with that on this side of the room but I am very much in the hands of my learned friends and the Panel.

MR JENKINS: My experience of technology is that the lowest level of technology is usually the most likely to be successful and telephones are fine.

THE CHAIRMAN: I think a number of members of the Panel have also had experience of the telephone link-ups and they do seem to lend themselves very well. So if everybody is content with that course, we can take that.

MR KARK: I certainly think with a non-contentious witness there is no difficult with that at all. In that case, could I just speak to my instructing solicitors to see what the timing is. We are going to make some inquiries to see what time it would be best to set that up.

THE CHAIRMAN: Very well. Meantime, we will continue, Mr Jenkins.

MR JENKINS: (To the witness) We will come back to 4 January 1996, please. Again, just looking at Dr Lord's note that we have on that page, page 68, an 82 year old, "frail", she describes him:

> "Chronic Resistant Depressed -
> Very withdrawn
> Completely dependent - Bartel [score of zero]
> Catheter - by - passing
> Ulceration (superficial) of [left] buttock and hip
> Hypoproteinaemic"

She says:

"I'd be happy to take him over to a [long] stay bed at [the War Memorial Hospital]. I feel his [rest home] place can be given up as he's unlikely to return there"

Would this be typical of some of the patients that were admitted to Dryad?
A I would think so.

Q If we go on, you have been asked to look at Dr Barton's clinical note at page 196. There is a transfer document on the previous page, 195, which talks about his poor physical condition and reference to the broken pressure areas and also problems with his scrotum that were then apparent. We know there is an entry on 9 January, page 208, if I can take you on through the history. You have been taken to the entry at 9 January in the middle of that page, where Mr Pittock is saying he had generalised pain:

"Small amount of diet taken. Very sweaty ... but is apyrexial",

- and we know you saw him the next day, on 10 January, and that is the entry that we have at 196.

Oramorph was what was proposed. I think your entry at page 196, the first word is "depression". I think it might have been misinterpreted by some as "dementia", but depression is the first word.
A Yes, I am afraid it is.

Q We have seen worse handwriting than yours. Do not worry. You have told us what "TLC" referred to, that the priority at that stage of this patient's life was keeping him comfortable.
A Yes.

Q That would be the primary duty of those caring for him?
A Yes.

Q Doctors and nurses?
A Everybody.

Q Keeping someone comfortable when they have bed sores or other types of pain means comfortable 24 hours a day?
A Yes.

Q Not just for periods of time, between nursing episodes, it means comfortable whilst he is being nursed as well?
A Yes.

Q We know that from page 199 Mr Pittock had been receiving Arthrotec, which is a drug you describe in your statement for the GMC as a pain killer.
A Yes.

Q Forgive me. I said your statement for the GMC. It is not. It is a statement you made for the police. For those who have it, it is page 6 of 13. (To the witness) It is a pain killer which is a tablet which is given twice a day and is dealing specifically with his

Parkinsonism?
A No, it is a pain killer. Parkinson's is not painful, it is a disorder which affects how you move. This was for pain.

Q We know his Arthrotec was stopped. If we look at this drug chart on page 199, we see it was last given on 10 January, which was the day of your ward round.
A Yes.

Q If you remove one form of pain killer, might you think it appropriate to replace it with some other?
A We had started him on Oramorph, did we not?

Q That is what happened. I agree. We can see at the top of page 199 that Mr Pittock was receiving sertraline and lithium that he had had for many months before and also receiving diazepam but we know had been reduced at an early stage in hospital.

There is another drug chart that we have at page 202 which also shows sertraline and lithium and follows on from the other drug chart that we just looked at, at page 199, and we will see that sertraline and lithium had been stopped on 11 January 1996. These are drugs dealing with mood and, in the case of sertraline, depression. Can you confirm for us that, generally, it was thought appropriate if patients are on a lot of different medications and they have reached the final stage of their lives that it reduces the risk of complication if you reduce the number of drugs they are on?
A Yes. You look at the ones that are most likely to be of benefit to them and maintain those. It can also be difficult to persuade patients to swallow tablets so you focus your attention on the ones you really want them to have.

Q Yes. Would you approve the decision to discontinue the sertraline and the lithium in the case of a patient such as Mr Pittock?
A I find that one hard to say actually. If he was very, very depressed regardless, it may have been a reasonable thing to do. I cannot give an opinion really.

Q We know they were discontinued on the 11th. That was the day they were written up and stopped, clearly the same day because no more sertraline was given. The 11th was the same day that Dr Barton wrote up the prescription for diamorphine. If you turn to page 201, we see the diamorphine, 80-120 mg, midazolam and hyoscine to be given by syringe driver. That was when prescriptions were written up, although, of course, no medication was given for another four days.

Again, what would you say about the decision to write up an anticipatory prescription for those drugs at that stage, given that other drugs were being stopped and Mr Pittock may still have been in pain and discomfort?
A I think it was a reasonable thing to do in a functioning unit where you trust the nursing staff.

Q It is clear from your earlier answers that you trusted the nursing staff as well.
A Yes, I do not remember any concerns.

Q I wonder if we can just take it on? Mr Pittock was now receiving Oramorph on 11 January. We have seen that from page 202. We see that Oramorph continued to be given for the next few days. It was discontinued on 15 January. Clearly, shortly before the diamorphine was started on the syringe driver, on page 201, on the morning of the 15th.

Can we just look at what Mr Pittock's condition was between those dates? If I can take you to page 225, please. There is an entry for 13 January, reference to the catheter bypassing twice and the patient appearing depressed. Would it be your experience that nursing staff and medical staff are very well able to form a view of the patient's level of comfort, or the lack of it, even in a patient who may not be speaking to them?
A Not all but most.

Q If you are nursing a patient, perhaps changing dressings on bed sores or moving them on a regular basis to try and prevent bed sores developing or giving them a chance to resolve, you will get an impression in a typical patient of how comfortable or uncomfortable they are at that stage?
A Most nurses will pick it up.

Q Would it be your experience of Dryad Ward that, as a doctor dealing with patients, you depended absolutely on the feedback from nursing staff as to how the patients were progressing?
A Not absolutely, but ---

Q You undertake your own assessment when you are there.
A Yes.

Q But as to how the patients are doing when you are not there ---
A I have to listen to what they say, yes.

Q There has to be a relationship of trust between doctors and nursing staff.
A Yes.

Q That they will report to you what is relevant?
A Yes.

Q And contact you if need be out-of-hours?
A Yes.

Q Or when you are not there. I think there is an entry on page 218 as well. We have mentioned problems with his scrotum. That is referred to on 9 January on this document. The particular entry I wanted to refer you to was 16 January. It appears that another problem has arisen. Mr Pittock's right ear is very blistered and swollen. Would that be a fairly common picture, that a patient who is not eating very well has become rather withdrawn, who is bed bound with a Barthel score of nil, that the skin may break down?
A I do not know if it explains the right ear but, yes, the skin will often break down.

Q I do not know if you recall, Mr Pittock was really very wasted. Cachetic, I think, is a word that is used.
A I do not remember that word being used, but he was hypoproteinaemic and it said his intake was not great somewhere.

Q If you were to turn, please, to page 231, this is a Waterlow Pressure Sore chart used to assist nursing and medical staff to formulate plans for the patient, but in the middle of the page, under the heading "Special Risks", I think you get eight points for terminal cachexia and that, clearly, was what was thought to be an appropriate description of Mr Pittock. It means that the muscles of the body are very wasted.

A It means somebody has not eaten enough for a long time and they are wasting.

Q Yes. It is not a condition that one can suffer from as a result of not eating for a couple of days.
A No, no.

Q This is long term.
A Yes.

Q Is it appropriate, from what you have seen of the medical records, to say that Mr Pittock was clearly very unwell at this stage?
A Yes.

Q He was dying.
A Yes.

Q You can see that clearly through the records, can you not?
A Yes.

Q In those circumstances where the patient is dying, again, would it be appropriate to give a level of pain relief that those nursing him and doctors caring for him considered to be appropriate?
A Yes.

Q Again, do you really need to see the patient in front of you to make a decision as to what level of pain relief is appropriate?
A As a doctor?

Q Yes. If you were asked to say, "is 60 mg appropriate for this patient or that patient", you would need to see the patient.
A I would, yes. I am not quite sure I understood your question actually.

Q The Panel will hear from someone later on who did not see the patient and I am just asking your view as a practising doctor of ---
A There are some doses that will never be appropriate.

Q I understand that.
A You build up to them. You would not just start at them. I am sorry. I was not quite clear what you were asking from me.

MR JENKINS: Thank you very much, Dr Tandy.

Re-examined by MR KARK

Q Just dealing with those last questions. You were asked if a patient is dying is it right to give a level of pain relief which those caring for him consider to be appropriate and you agreed that was right.
A Yes, and if the patient can have an input into that decision that is often helpful too. I do not think that would have been possible here but, yes, it is not a blanket rule.

Q The aim of any such medication, can we take it, must be to provide pain relief?
A This chap was also very agitated and distressed. It was not just pain, I think, looking at

the notes.

Q Clearly, the prime purpose has to be either to deal with pain relief or, on your view, agitation. Can we just think about this particular patient? You were aware when you saw him with Dr Barton, that Dr Barton was going to prescribe Oramorph.
A Yes.

Q That was in your mind on 10 January and you believed it was in Dr Barton's mind on 10 January.
A Yes.

Q We can see from page 200 of the notes that on 10 January that is what she prescribed.
A Yes.

Q Did she say anything to you about prescribing what would have been, in effect, eight or so times that dose of diamorphine? Did she say anything to you that she intended to prescribe 40-80 mg of diamorphine at the same time?
A I do not remember her saying anything along those lines.

Q If she had said anything of that nature - I am sorry, I should not just leave it there. Together with diazepam?
A I do not remember that being discussed.

Q If she had said anything of that nature would you have raised any concern with her?
A I would not have been concerned that the drugs were being thought about, even though it would not be appropriate to give them, but I would have used the starting dose.

Q You would have raised that particular prescription?
A Yes.

Q All of the history that you have heard, with this patient we know that by the time he was started on 80 mg of diamorphine he had, the day previous, been receiving - I think we worked it out, was it 25 mg orally?
A 25 or 30 at some point, yes.

Q Whatever those caring for him were seeing, can you imagine any circumstances in which it would be appropriate to give that patient what would be, in effect, a fivefold increase in opiates?
A Not as a starting dose. You might go up to it quite quickly but you would not start.

MR KARK: That is all that I ask. Thank you.

THE CHAIRMAN: Doctor, I indicated at an earlier stage there would come a time when members of the Panel would have an opportunity to ask questions of you and I said I would introduce any of them to you at the time if they did have questions. Mr William Payne is a lay member of the Panel.

Questioned by THE PANEL

MR PAYNE: Good afternoon, doctor. This is just for clarification for me. You were asked I think by Mr Kark what the side effects for diamorphine would be and you made a list of

what they could be. I tried to frantically write it down, but did not get them all. Would you repeat them for me, please?
A Yes, of course. Some people are very sensitive to even small doses and will feel sick and nauseous on it. The other major gut complication is constipation, which is very common. You can get respiratory depression, which means you lose your drive to breathe. So sometimes somebody given a big dose of morphine will not breathe very well. In somebody who has chronic bronchitis, that could be quite a small dose to have that effect. Your level of consciousness may depress. Even on really quite small doses, some people can get quite confused, even tiny doses. Codeine can have the same effect. It can make them agitated and hallucinate. Those are the biggest effects.

Q You just mentioned that these side effects can be done with small doses?
A Oh, yes.

Q Would it therefore follow that there is a greater chance of having these side effects if the doses are quite large? Does that matter?
A Yes. All things are more likely to happen as you increase the dose, but some patients will, on a very small dose – sometimes we give them even a little dose of codeine, which is a similar sort of drug, and they will tell you the next morning, "I had a horrible night, doctor, because I hallucinated all night." So yes, it can happen in small doses, but it is more likely on bigger ones. Is that what you are asking me?

Q Yes. So it would be prudent to start on a smaller dose, just for the side effects possibilities?
A Yes. In this case, he had quite a small dose of Oramorph to start with.

Q But what about when we get up to the prescriptions for the diamorphine?
A You would tend to start on the lower dose, partly because of side effects, and you actually do not know how much you are going to need to relieve the patient's pain. So you tend to start low and build up very quickly, which is easier to do in a hospital because there are lots more people around in a big hospital like QA.

Q Would the effects of morphine/diamorphine have more – or would they react differently to somebody who is severely depressed? Would there be more likely to be side effects for someone who is severely depressed?
A I honestly do not know. I cannot think so particularly, actually.

Q The confusion would not be greater perhaps, or the agitation would not be greater?
A Well, you get some odd effects. I cannot remember all the pharmacology, but when you use very, very high doses, bigger than these, of morphine, you can get – patients can get very agitated. That tends to be much higher doses than we are talking about here. I have seen it on our palliative care ward at QA when we are using doses of 500 mg over 24 hours; much, much bigger doses. But I do not know, I honestly do not know whether very depressed patients would react differently. Anybody who is a little bit confused normally, then it would make them a little bit more confused and the effects may be more pronounced than in somebody who is not normally confused.

Q The likelihood of those things happening would be more as you increased the dosage?
A Yes.

Q My other question to you is, you also told us I think prior to the incident we are looking at, you had seen one that, you were taken quite aback that had a range to 150.
A This was as a junior doctor, yes.

Q Seriously, how many years prior to that are we talking?
A I honesty cannot remember. I would have thought probably within the last 20 years. Mr Pittock is 13 years ago, so several years before that, because I became a consultant in 1994.

Q I think you said that this rare to see a dose like that, one that went up to 150.
A I was surprised when I was asked to do it, but I was told it was standard procedure for the unit. I do not know more than that. I am sorry.

Q In your history before you got to the ward, had you seen prescriptions of this width before?
A Not on acute wards, no, we did not routinely do that. But in a way, we were in a much easier position, because there was a doctor available 24/7, so it was very easy for the nurses to get somebody to come back and review the patient's medication. There was not quite the same need to prescribe a big range of doses.

Q If someone was going to be there within 24 hours, the next day, you would not anticipate going from a range of say 80 to 120, would you?
A It is quite difficult to know how much pain relief somebody is going to need. You just do not always know. At the end of the day, you might give 5 and it does absolutely nothing and then you give another 5, it has done absolutely nothing a couple of hours later and then you start giving 10. So you may end up escalating the dose fairly quickly, because what you do not want to do is have a patient in pain.

Q That is the reason you would start low-ish?
A Start low and be prepared to build up rapidly if needed.

MR PAYNE: I think that answers my questions. Thank you very much indeed.

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

DR SMITH: Dr Tandy, you said at one point – it was when you came back in and you wanted to say to Mr Kark about what used to happen was outrageous.
A This was back in 1983.

Q Can you amplify on that? What was outrageous?
A I remember in those days, if you were over 70, quite often it was thought perfectly reasonable to give you some oral antibiotics, drink water if you are up to it and that was thought okay. I remember being told you could not treat pulmonary emboli in patients over the age of 70 because it was too risky, giving them heparin, which would be an outrageous statement to make today. We are thrombolising people up to the age of 80 for stroke. But it was of its time.

Q Is your judgment of outrageous a judgment of what you saw when you were working, or is it a judgment of the practice of medicine in general?
A I am not quite sure what you are asking me.

Q Are you drawing simply on your experience of what you saw where you worked, or are you making observations on the way in which people were treated?
A As a houseman, yes. At the time, I was of the system, but looking back a few years later, I remembered some of the patients and I thought, "Goodness, we would not do it that way now."

B Q You are not making an observation about the practice throughout the UK in that time?
A No, I cannot. I was just walking around outside and I was just thinking about what I had said and I thought, "Oh, actually, I need to qualify that."

Q You said just very recently – and again, I am not clear what you were saying – that you would want to see the patient – I think this is right and this is where I need you to put me right – if – can I put it this way; I may be wrong and that is why I want you to answer the
C question. If a decision had been made to change the track of treatment to end of life – was I right in picking that up?
A Yes. I am very unhappy making those decisions without knowing a patient, without having seen the patient.

Q The patient in your care.
A Yes. It is a decision I am asked often on the phone on the acute wards and I do not
D like making that decision unless I have actually been to see the patient. I would rather see them more than once, if possible.

Q You saw the patient I think the day before on the ward round.
A Yes.

Q Of course, you did not see her again because she died two weeks later and you did not
E go more than fortnightly.
A No, I did not see him again.

Q So would you have expected to be contacted to be asked whether you wanted your patient to be treated in that way?
A I think we had already established that Mr Pittock's outlook was very poor. My hope – a slim one, I think – was that perhaps if we just relieved a bit of his pain and his
F discomfort, he might feel happier in himself, he might be able to mobilise more, he might be able to eat and drink more.

Q Was that your understanding on that 9 April or whatever?
A But if that did not work, then I discussed with his wife, I thought the outlook was poor and I have written "TLC". At that point, I thought the treatment of symptoms was paramount.

G Q But we have established the very next day he started on subcutaneous ---
A No, no. That was a few days later, was it not?

Q A few days later. Before you saw him again.
A Yes. I think in this case, just looking at what I have written in the notes, I was quite clear, I have been very clear, more so than I normally am, that his outlook was very poor and

H

I have written, although I have written "TLC", I think that palliative care would be appropriate.

Q This is a problem that we have had with a number of witnesses – it is not a criticism – as to what is the difference between palliative care and end of life care? Is that an apposite thing to talk about with Mr Pittock, for instance?
A I am not really sure what you are asking me.

Q He is for TLC.
A Yes. At this point, symptom control is paramount. My hope was that he might actually have picked up a little bit. If we just alleviated his pain, in a nice calm ward for a couple of days, he might have picked up, in which case clearly you would change tack.

Q In your words, it was to make him not uncomfortable.
A Yes.

Q But a diamorphine pump was started on him.
A Yes.

Q At I think what you have said you thought was quite a high dose.
A Yes.

Q Would you agree that that might have implications as to where the treatment was going?
A I think I would have no question – what we were looking for was to alleviate symptoms and those are completely individual decisions made on an individual patient basis. So what he needed really – I would have started this at a lower dose, but I do not have a problem with him being started on subcutaneous diamorphine if that was what he required at that time.

Q He was started at 80 mg.
A Yes.

Q You have said you think that that is a high dose.
A Yes, to start.

Q If you think that is a high dose, would you have expected somebody to ask you if that was an appropriate stage to enter for your patient?
A I think the feeling at the War Memorial was that it was not an inappropriately high dose, therefore there was no need to contact me. I think it was done to alleviate distress and pain.

Q Could you just explain what you said then? It was a feeling at the War Memorial – ?
A I do not think anybody at the War Memorial was concerned that this was – I do not know, but I assume – that nobody at the War Memorial felt that it was an inappropriately high dose. That is all. Otherwise, I think somebody would have contacted me if they were concerned.

Q It was your patient.
A Yes.

Q Your responsibility.
A Yes, I know.

Q So nobody did contact you.
A No.

Q Does that reflect in effect that you had such a high degree of trust in them that you left it to them to make the decision?
A I think it depends what you feel the whole issue behind putting up a diamorphine pump is. It is another stage in end of life care that you move to under certain conditions, but it is not in a way particularly different than writing up a big dose of Oramorph. It should not be. As you know, you move to a driver when patients cannot swallow, when it becomes difficult or burdensome for them take medication.

Q Can I crystallise it into the same question this way? Back in 1996, did you have such a high degree of trust in the nursing staff and Dr Barton that you were content to have the situation as it was?
A Clearly, because I was not – they probably would have told me the next week that he had died and he had died on the syringe driver and I clearly was not concerned and presumably trusted them as far as I can remember.

Q Did you know he died?
A I really – this is 13 years ago. I am sorry.

Q You do not remember two weeks later saying, "Where's Mr Pittock?"
A No.

Q So there was no opportunity to discuss ---
A I do remember one person dying unexpectedly and I still remember that now, because it was an unexpected death, but this I do not remember.

Q Just one very quick point. Can I take you to that Waterlow score at page 231, because there is something I do not understand on it. If you take the second column, which is dated 22/1/96, Mr Jenkins drew your attention under "Special Risks", terminal cachexia, 8, a high score. A high score is a bad score.
A Yes.

Q But at the top it says "Build/Weight for Height – average".
A I cannot comment. The two do not tally.

Q It is incongruous.
A Absolutely.

DR SMITH: Thank you.

THE CHAIRMAN: You will be pleased to hear there are no further questions from the Panel. What we now have to do is to turn to the barristers to see if they have any questions which arise out of the questions asked by the Panel. Mr Jenkins?

Further cross-examined by MR JENKINS

Q The idea of starting a patient on a certain dose and being able to adjust that dose you say is much easier to do in a large hospital?
A It is, because there is always a junior doctor on the end of a bleep, so you can get somebody along usually within half an hour.

Q What about in community hospitals?
A Well, you have a GP who is in the middle of their surgery, so it is not as easy.

Q There are weekends as well?
A There is nobody. There is a GP on call.

Q There is and we have heard from a couple of those and we have heard from nursing staff that in this particular hospital some of the GPs may be difficult to get out over the weekend or they may be difficult to persuade to adjust the dose of analgesia?
A Yes.

Q Is it clear then that in a community hospital where there will not be a doctor 24 hours out of every day, you cannot just tinker with the dose by going a small top-up on a regular basis?
A If you best guess that what the patient is going to need is way too low, it is going to be much more difficult to get the dose up to an appropriate level, particularly over a weekend.

Re-examined by MR KARK

Q Just on a very similar topic, you were answering questions from Mr Payne and you were reminded of your evidence that earlier on in your career I think it was that the range up to 150 ---
A I think I said several times that I cannot be absolutely sure because it is a long time ago.

Q You cannot be absolutely sure that that was the level?
A No, I absolutely cannot. I remember being a bit surprised at being asked to write the dose up but what that dose was, I cannot be absolutely sure, I am sorry.

Q You also said that was a dose that you were being asked by a nurse to write up?
A Yes, as far as I remember. We do write drugs in advance of patients going to the palliative care ward just so that they are available for the nurses to give.

Q I understand that but that is anticipatory prescribing which you describe as a reasonable thing if you trust the nursing staff but do you have to put limits on your anticipatory prescribing if you are going to give a variable dose. Do you write out variable doses now?
A Me, no.

Q You do not?
A No, I do not have to because I only work in the acute unit.

THE CHAIRMAN: Doctor, I know that you were here yesterday hoping to get on to give your evidence and we kept you waiting this morning. I apologise for that but I would like to say that it is only through the attendance of witnesses such as yourself that a panel like this is able to make proper inquiry into what happened months and often many years before. We are most grateful for your assistance in helping to build up for the Panel a clearer picture of that situation in those times. You have our considerable gratitude, not least for your patience and forbearance whilst we have been going through the process. You are now free to leave.

A Thank you very much. Can I ask one very quick question, and I am terribly sorry. Am I allowed to discuss the case with other people who have already been interviewed or must I just say nothing until the ----

MR KARK: We should really ask the Legal Assessor, I suppose. There is no objection to witnesses discussing their evidence post-event. It is preferable that it does not happen just in case a witness needs to be re-called. What must not happen in any circumstances is to discuss evidence with a witness who is about to give evidence or may give evidence in the future.

MR LANGDALE: I agree with what Mr Kark says, particularly about the one thing which must not happen, but one does have sympathy with doctors who have given their evidence being free to talk about matters with a colleague who has already given evidence. I appreciate technically there is some risk that we might all suddenly decide we need to re-call Dr Tandy and other witnesses. I think the danger is probably minimal but I take my friend's point.

THE CHAIRMAN: I hope that is clear to you, Doctor. It is certainly a lot clearer than if I had attempted to explain that to you.

A Yes. I am sorry to delay you further. Thank you.

(The witness withdrew)

MR KARK: We would be grateful for some time to set up the telephone link.

THE CHAIRMAN: It is time for the break in any event.

(The Panel adjourned for a short time)

TELEPHONE LINK CONFIRMED WITH DR ROSIE LUZNAT

THE CHAIRMAN: Is Mr Kark not going to be joining us?

MR FITZGERALD: No, sir. The next witness is Dr Rosie Luznat, who is on the line now.

THE CHAIRMAN: Dr Luznat, can you hear me?

DR LUZNAT: Yes, it is not brilliant but I can hear you.

THE CHAIRMAN: I will try to speak slowly and to speak up. I am sure everybody else here will do the same. If at any stage you are not able to make out what has been said, please

indicate and whoever is speaking will, I am sure, try to repeat what they had just said. First of all, may I ask you if you have a form of affirmation in front of you or near to you?

DR LUZNAT: I do.

THE CHAIRMAN: Would you like to read that to the Panel, please?

B

Dr ROSIE LUZNAT, Affirmed
Examined by MR FITZGERALD

THE CHAIRMAN: I was not in here when there were others speaking to you earlier but may I take it that you understand who is able to hear you at this time?
A I am not entirely sure but I understand it to be the Fitness to Practise Panel, the defence and the prosecution.

C

Q Yes, the GMC Legal Team also and I should tell you two further things. This is a public hearing, so members of the public are entitled to attend and there are members who are in attendance today. I hope they can hear you, although the speaker through which we are hearing your voice is rather a distance from the public gallery. Finally of course there is a shorthand writer here who is going to help create a transcript of everything that is said.
A OK.

D

Q Other than that, we have the Panel's Legal Assessor, who is an independent lawyer who provides us with legal advice, and we also have the Panel Secretary and Panel Assistant who are responsible for matters of administration. That pretty well covers the room. I am going to pass you now to Mr Fitzgerald from the GMC Legal Team.
A Thank you.

E

MR FITZGERALD: Dr Luznat, can you hear me?
A I can hear you, thank you.

Q My name is Ben Fitzgerald and I am representing the GMC today. I am going to ask you some questions very briefly to start with and then there will be some more questions by the barrister who is acting for Dr Barton. Do you understand?
A Yes, I understand.

F

Q First of all, just a little bit about you. Is it right that you have been employed as a consultant in old-age psychiatry since 1989?
A That is correct.

Q You are also employed by the Wessex Deanery as a Director of Specialty Education?
A I am still employed but the title has changed. I am now an Associate Dean for Educational Development.

G

Q You are a Member of the Royal College of Psychiatrists?
A Yes.

Q You qualified originally as a doctor in 1980?
A Yes.

H

Q You then qualified as a specialist in psychiatry in 1987?
A Yes.

Q And, as you have already clarified, you have been a consultant psychiatrist since 1989.
A That is right.

B Q I am only going to ask you some questions very briefly to clarify an entry that you made in medical records relating to a patient called Robert Wilson. That is a patient that we are dealing with under the reference Patient H.
A OK.

Q I hope that you have been provided with a fax of just a few pages from those medical records?
C A Yes, I have received eight pages, including a letter and the entry in the notes.

Q I am very glad to hear it. I am going to ask you just very briefly to look at those and to confirm the contents?
A OK.

Q As I say, it will be very brief. If you look firstly at page 173, I hope you have a page
D of 173 with a dash either side of it at the bottom?
A Yes, I do.

Q I am just giving everybody here a moment to get that page for themselves. Do we see at the bottom of page 173 that there is a referral which starts, "Dear Psycho-Geriatrician"?
A Yes.

E Q It is a request for the psycho-geriatrician to review this patient?
A That is right.

Q Signed I think by Dr Ravindrane?
A I cannot read the signature.

Q Very well. It may be that there is going to be no dispute about it but in any case that
F was a referral that eventually led you to review the patient: is that right?
A That is right.

Q If we turn to page 176 of the records, on the bottom half of the page and just over into the following page do we see the entry that you made?
A Yes. I have that.

G Q Because it is in handwriting, what I am going to do is simply read to you from your statement how you transcribed the notes and just ask you to confirm that that is what is there.
A OK

Q This is what you wrote.

"8.10.98 Psychiatric Review.

H

Thank you for asking me to see Mr Wilson who presents with a history of heavy alcohol intake over the past few years. His current admission was precipitated by a fall resulting in a fractured left humerus.

On examination today he also presents with low mood, a wish to die and disturbed sleep."

B There is a question mark meaning possibly "secondary to pain".
A Yes.

Q "His ST memory", so is that short-term memory?
A Yes.

Q "...is slightly impaired". There is a mini mental state examination score of 24/30?
C A That is right.

Q "My impression is that Mr Wilson suffers with 1) early dementia 2) depression.

I suggest 1) sedative antidepressant to improve mood and sleep. I have taken the liberty of prescribing Trazodone 50 mg nocte."

D You put in brackets:

"(I am aware of impaired liver function but this would be a concern with all antidepressants.)"

A Yes.

E Q "I shall arrange F/U", meaning follow-up?
A Yes.

Q "...by our team once we know to where Mr W (Mr Wilson) is going to be discharged."

A That is right.
F

Q You have signed it?
A OK.

Q That is your note?
A Yes.

G Q And, just to clarify one or two things about it, please, we have already heard a little from another witness about a mini mental state examination but I think you clarify in your statement that it is a standard test of memory and general brain function?
A Yes.

Q That someone with 30 out of 30 has a good memory?
A Yes.
H

Q Someone with, say, 5 out of 30 has a very poor memory?
A That is right.

Q Mr Wilson scored 24 out of 30 and does that show that he had a slightly impaired memory and brain function?
A That is correct.

B

Q When you have written "early dementia", what does that mean, please?
A Early dementia means a degenerating process affecting the brain which is likely to be followed and probably will deteriorate further.

Q Does the use of the word "early" suggest anything about how serious it was at that moment in time?
A Yes, "early" would indicate that it is a mild form of dementia.

C

Q As reflected in the mini mental state examination?
A Yes.

Q Trazodone is an antidepressant?
A Yes.

D

Q Does that also have some sedative effect?
A It does.

Q What sort of dose is 50 mg?
A 50 mg is the lowest starting dose. It is possible to start even lower but not by giving tablets; that would require giving a liquid of the medication.

E

Q You wrote in relation to that prescription or suggestion that you were aware of impaired liver function?
A Yes.

Q Why did you write that? What is the significance when it comes to medication?
A The significance is that impaired liver function is a factor which has to be considered with most medications because break-down of medication in the liver is obviously an important part of the pathway. When you give medication, it needs to be broken down and got rid of somehow and the liver is an important part of that pathway. If there is impaired liver function, it might mean that the medication is not excreted or broken down as quickly as it would be in a person with a healthy liver and so that means it needs to be taken into account and it needs to be monitored subsequently.

F

G

Q Would that need for caution or concern apply only to antidepressants or would it apply to other medications?
A It applies to a wide range of medication, but antidepressants are know to be broken down in the liver, particular Trazodone, and therefore I felt it was important to highlight this further.

Q It may be an obvious question but how would you have been aware of the fact that this gentleman had impaired liver function?

H

A I was only aware of that through looking through his medical records and obviously having access to test results, especially results of liver function.

Q In this case, in terms of your prescription for Trazodone, I think you made clear in your statement that you were balancing the risks which come with Trazodone and someone with impaired liver function against the need to promote sleep and general well-being.
A Absolutely.

Q And your conclusion was?
A That it was an appropriate drug to use in this particular patient, and this is obviously, at the end of the day, down to clinical judgment. I think I said in my statement that in an ideal world no medication would have been the safest option ---

Q Sorry; can you just explain what you mean by that?
A I mean that in terms of liver function not introducing medication might have been the safest option, but not to treat his disturbed sleep and obviously low mood would also carry a risk with it.

Q Moving on to the last part of your entry, when you dealt with arranging follow-up, what was it that you envisaged happening?
A My plan at that point, and I knew again from the medical records that there was a provisional plan for residential placement and it would be common practice for us to follow up somebody after discharge from hospital if we have initiated psychiatric treatment.

Q That would be done by?
A Either myself or by a member of the community team.

Q Thank you. The last point is simply to identify for the Panel that at page 117, which you also have ...
A Yes, my letter.

Q ... you have, in essence, set out your findings and recommendations in a formal letter.
A That is right.

MR FITZGERALD: I am not going to ask you more about it because we have dealt with the essence of it. Those are all the questions I am going to ask you. Thank you.

THE CHAIRMAN: Thank you very much, Mr Fitzgerald. Mr Jenkins.

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

Q The same letter that you have just been asked about, on the second page towards the end, I think you make the same point about the Trazodone.
A Yes.

Q You say:

"I do of course hope he tolerates it in view of his liver and renal failure."

A Yes.

Q What you told us, as I understand it, is it is important for a doctor who is prescribing to bear in mind that a patient may have - liver failure was the one you dealt with?
A Yes.

Q But it is not an indication not to prescribe if it is an appropriate drug.
A Absolutely. It is always a fine balance between treating, potentially, at risk of causing adverse effects and not treating and the risks of not treating.

Q You, clearly, were trying to help Mr Wilson sleep better.
A Absolutely.

Q Prescribing in the hope that his mood would be elevated somewhat?
A Absolutely. My main aim at that point would have been to improve quality of life because my treatment would not have had an impact on his general physical state. I was not treating him medically in that sense.

Q I understand. Can I turn to a different topic, and that is Dr Barton?
A Okay.

Q I think you knew Dr Barton?
A I did know Dr Barton but not well. I have never worked directly with Dr Barton.

Q Have you treated patients along with Dr Barton?
A No, I have not.

Q Have you treated any patients where she was the general practitioner?
A No, I have not.

Q It may be that you cannot answer any questions I have about whether you formed a view of Dr Barton and the sort of care she provided for her patients.
A I feel unable to comment directly because, as I said, I have not had direct working relationships with her. What I did know of her at the time was that she was one of the general practitioners in Gosport and, as far as I knew, she was a well respected GP.

MR JENKINS: I am grateful, but I will not ask any more than that. Thank you very much, Dr Luznat.

THE CHAIRMAN: Thank you, Mr Jenkins. Mr Fitzgerald.

MR FITZGERALD: I do not have any further questions. Thank you.

THE CHAIRMAN: Very well. Doctor, we have completed the questions from the barristers. This is a time when if any of the Panel members have questions for you they are able to ask them. I am just going to check to see whether any of them do have questions. (No verbal response) There are no questions from the members of the Panel so it follows that your testimony is complete. Thank you very much indeed for agreeing to make yourself available to assist us today. I understand that you have been put through a great deal of inconvenience before you had the opportunity to answer the questions and I would just like to say how very grateful the Panel are to you for sticking with the process. It is only by hearing evidence from witnesses such as yourself that we are able to build up a clear picture of what happened, often at a very considerable time in the past. So we are most grateful to you and you are free to hang up. Thank you.

TELEPHONE LINK TERMINATED

THE CHAIRMAN: Mr Fitzgerald.

MR FITZGERALD: Sir, I think that is all the evidence we have for today.

THE CHAIRMAN: Very well. We will break now and resume at 9.30 tomorrow morning, please. Thank you very much indeed.

(The Panel adjourned until 9.30 a.m.
on Friday 3 July 2009)