GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 7 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 TWENTY-ONE)

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.
Tel No: 01992 465900)

INDEX

THE CHAIRMAN: Good morning everybody. Mr Kark, Mr Fitzgerald, before we have the witness back in, I should say that the Panel have taken the opportunity to read the statements from Dr Barton in respect of Patient B. We have gone through the Patient B bundle again and, of course, the updated chronology. In so doing, we have noted on page 5 of the chronology references to correspondence on pages 242 and 244. Our bundle contains a page 242 but does not appear to contain a 244. We are wondering if we are missing something or if there is a typo?

MR KARK: First of all you are quite right.

MR LANGDALE: I think, but I may be wrong, the answer is to be found at 935 and 936 which gives the whole letter.

MR KARK: I think it is worth putting on 242 that there is a better copy at 935 and I think we had better check. We have our original files next door and we can check to see what 244 was.

THE CHAIRMAN: That does sound familiar.

MR KARK: That may be the answer, but I think we had better check it. Was that the only thing?

THE CHAIRMAN: That is was the only thing we had.

MR KARK: We are ready again for Professor Ford. I was going to make a suggestion for the Panel members to consider whether, instead of breaking and doing one patient at a time, it might speed the process up if we were to do two patients because I think one can probably keep two patients in mind and then let Professor Ford continue for a little longer. It is merely a suggestion.

THE CHAIRMAN: Your confidence is welcome. I will see what the view of the Panel is, whether you would prefer to continue as we have been, keeping one patient in mind at a time, or whether you think it would be reasonable to read two in and keep two in mind, any particular views?

MR KARK: It does not have to be decided now in any event. Perhaps we will raise it later and see whether we can move on.

GARY ASHLEY FORD
Examined by MR KARK, continued

Q Professor Ford, turning to Patient B, I think you have also have the chronology for Elsie Lavender, is that right?
A Yes, I do.

Q The Panel will have looked through that but, in essence, she was admitted to the Royal Hospital Haslar. She had a fall and apparently there were x-rays conducted of her skull and shoulders that took place on 5 February 1996. She was then placed on coproxamol and dihydrocodeine. There is a note on 14 February 1996 that she is still not able to do much

for herself because of pain in her arms. On 16 February 1996 there is this note, the patient having been since by Dr Tandy:

> "Since the fall, patient had had weakness in both hands and has been a unable to stand."

We will look at this again in due course, but I think you took a view as to whether in fact this patient had had a stroke or not?
A I thought it was unlikely on the basis of the information presented in the notes that she had had a stroke. This lady, from the description of the admission to the Accident & Emergency Department, had very probably fallen down the stairs and had a significant injury. She was found at the bottom of the stairs. The symptoms she has, pain in the arms and weakness in both arms, are not typical of a stroke at all. In the context of that fall, it is much more likely she had sustained a fracture of the cervical spine with some cervical cord injury or had some cervical cord contusion. The symptoms are really not at all typical for a stroke. It would be much more typical for a cord injury and she presented in the context of somebody who could well have had a cord injury. I think that was recognised as a possibility by Dr Tandy because she refers in one of her entries to, I assume, the writing is that she assumes that the patient has had cervical – she had her neck x-rayed, I assume it was normal.

MR KARK: I do not think she had the report or the x-ray.
A She obviously did not and she was asking the team who at that point were looking after her to check that she did not have a neck fracture, a cervical spine fracture. Ideally, with these symptoms, one would have gone on to do an MRI of the neck, but one would certainly have wanted to get an x-ray of the spine. I could not tell from a review of the notes whether that x-ray had been obtained and there was nothing in the medical notes at the Royal Hospital Haslar to indicate a result of that x-ray.

Q In any event, on 22 February 1996, she was transferred to Daedalus Ward. We have the clinical notes at page 975. I am not going to refer to much of the notes at all. It may be worth having the clinical notes, 975, for Patient B. The note made by Dr Barton:

> "Fell at home top to bottom of stairs."

That is under her past medical history:

> "Lacerations on head, leg ulcers
> Severe incontinence needs a catheter
> Insulin dependent
> Regular series BS
> Transfers with 2
> Incontinent of urine."

We know what that means now, it means the help of two nurses to get out of bed.

> "Help to feed and dress
> Barthel 2
> Assess general mobility
> ? suitable for rest home if home found for cat."

We know that in the nursing notes there was reference to a probable brain stem CVA. That was obviously being considered. Do you think it may have been wrong?
A I think almost certainly it was wrong.

Q We know that this patient was then prescribed dihydrocodeine. As far as that is concerned, is a PRN prescription not unreasonable?
A No, I think that was reasonable. I think there are various reports of pain in her hands, there is possibly pain in her shoulders – I do not think there was pain in her neck – and also pain from a pressure sore she was developing, or certainly her bottom was very sore, was referred to at one point.

Q There is a note of the 24 February, I am taking this now from the chronology at the bottom of page 8. This is from the nursing notes reviewed by Dr Barton:

"Pain not controlled properly by D.F.118."

Is that dihydrocodeine?
A Yes.

Q

"Seen by Dr Barton – for MST 10 mg BD?",

meaning twice daily. We have that prescription, if anybody wants to turn it up, at page 997. We will run through the prescriptions first and I will ask you to comment on them. She was put on slow release morphine tablets at 10 mgs twice daily and those are administered. Looking at the chronology at the bottom of page 9, there is a note in the nursing care plan that the patient appears to be in more pain, "screaming 'my back' when moved but uncomplaining when not". She is reviewed again by Dr Barton on 26 February and a further prescription is written up. We are now looking at page 11 of the chronology. As we can see, the prescription, which we can find if anybody wants to turn it up at 995 and 997, was that the MST at 10 mg was discontinued, 20 mg was commenced at night time but then she was written up for diamorphine between 80-160 mg by syringe driver, midazolam between 40-80 mg, obviously also by syringe driver, and hyoscine. We will come back to look at those in a moment. Then the MST is continued. The patient is noted, on 4 March, to be complaining of pain and having extra analgesia. We can see that the MST dose was increased to 30 mg twice daily. At the bottom of page 13 we can see:

"Pain uncontrolled – patient distressed".

We have heard reference to pain uncontrolled in the evidence and, as we have understood it, it means essentially not necessarily that the patient is screaming in pain the whole time, but that the pain is not being controlled by the analgesia that the patient is receiving. Is that your understanding?
A Yes, that is my understanding from the previous witness statements.

Q We can see at the top of page 14 that the diamorphine is prescribed at a higher dose, 100-200 mg, and on 5 March the syringe driver is started with 100 mg, the lowest dose – sorry, the chronology is shown as being on 5th?
A I had it as the 5th.

MR KARK: We can check that.

MR LANGDALE: On page 14, I am sorry to interrupt but I want to be clear, on page 14 of the chronology for 6 March I have "SC analgesia commenced".

MR KARK: Yes, that is right, but that is a nursing note which may be relating to a historical event.

B

MR LANGDALE: I think it is Dr Barton's note, but I may be wrong.
A May I comment. My interpretation when I reviewed the prescribing charts was that I understood that the diamorphine had been commenced on 5 March.

MR KARK: If we look on at page 991, and we heard about this from Mr Beed, I think, we can see the prescription for diamorphine written up by Dr Barton for 100-200 mg and we can
C see an entry under 5 March. I am afraid we are working on microfiche for this.

MR LANGDALE: If I can short cut this, no dispute, that is what is shown on the chart, therefore it may just seem a little misleading if you have "SC analgesia commenced" on the 6th.

MR KARK: The note on 6 March is relating to the historical, the fact that SC has already
D started, so I think it started on 5 March, although it is difficult to read exactly when it started. It looks like 09.30 in the morning. That is also confirmed by the nursing notes. I think we are there, 5 March it is started. I am turning to your report, which the Panel do not have, at paragraph 7 where you deal with the issue whether in your view there was good evidence of a brain stem stroke. How could this in fact have been ascertained?
A I think, as I mentioned earlier, Dr Tandy rightly commented that a CT scan would probably not have been helpful in diagnosing a brain stem stroke, so you would really want to
E do a magnetic resonance scan of the brain and also the neck because there was a clinical question of whether she had a neck injury or fracture or displacement of the cervical spine. It has to be said that MR access for patients like this was quite hard, difficult, in the early 1990s so I am not critical of them not going ahead with that. I do think that the cervical spine x-ray should have been done, which is what Dr Tandy had asked to be checked and it is not clear whether that was done or not. You would have wanted to have excluded a cervical spine fracture in this lady.

F

Q I want to deal with the issue of Dr Barton's plan of treatment. If you turn back to 975, and I think you comment on this in your report at paragraph 9, what if any view do you have of the initial assessment and the plan provided for this patient?
A I think it was reasonable. I would not have expected Dr Barton to question the diagnosis that had been made by Dr Tandy. I think, as I comment in my report, that the continuing pain two weeks afterwards, in my view, should have raised a question as to what
G the cause of that was when this was not a lady, as we understand, who complained of pain before she was admitted, so you would expect pain from musculoskeletal injuries to be subsiding by this point. One thing that is not clear to me from reviewing the notes at various points, is the location of the pain from either the medical notes or the nursing notes. There is an entry, for example, referring to the physiotherapist which refers to neck exercises. This is on the bottom of the chronology, page 12, which might suggest she may have had some neck pain and stiffness. Although there is a mention about the sore bottom in the beginning, the

H

location and nature of the pain is not clear to me. I think that, ideally, one would have liked to have seen a reassessment or more description of pain and possible causes.

Q The patient was started on slow release tablets for morphine. That followed on from her dihydrocodeine. So far as the conversion from dihydrocodeine to MST, do you have any particular views about that?

A We do not usually convert from dihydrocodeine. It is a very mild opiate. As I commented in my report, you would usually you start on oral morphine, not a sustained release, if you decided that opiates, more powerful opiates, are the appropriate treatment and see the response.

Q Why?

A Because of the problem that we discussed yesterday that, when you start sustained release tablets they are very slowly absorbed and you do not know whether you are going to get the right dose, you may leave the patient not controlled with their pain or it may be too excessive a dose, so those are the sort of reasons. It is recommended that you start with oral morphine, work out the dose that controls the patient's pain and convert to a sustained release preparation.

Q If we go to page 11 of the chronology. You will find the drugs charts if you want to turn them up – we just looked at them – at 995.

A Can I just comment?

Q Yes.

A I think the use of morphine may have been appropriate but I am critical that there was no assessment of the location of the pain or which might have led to using other strategies such as non-steroidal anti-inflammatory drugs or further investigation.

Q Does this come back to the point that you were raising yesterday, that the first step is to find out what the source of the pain is rather than simply trying to relieve the pain by analgesia?

A Going to opiates, using morphine may have been appropriate, but there is not a clear and strong justification, or assessment of the cause of the pain.

Q Can we then have a look, please, at the prescriptions that are written up for diamorphine. If we work from the chronology, top of page 11, the patient at this time was being administered at 10 mg twice daily, I think. Then, that is increased on the 26th to 20 mg twice daily. So that is the prescription that is commenced and at the same time Dr Barton prescribes 80-160 mg of diamorphine, coupled with 40-80 mg of midazolam. Do you have your reports in front of you?

A I do.

Q We are looking at paragraph 11 of your report. We all know now the conversion rate. At this level I think it would be one-third normally rather than one half?

A Correct.

Q And so a normal conversion, if one was attempting to achieve the same degree of pain relief would have been in the region of what?

A 15 mg approximately; 13 mg if one is being precise with a third.

Q What do you say about the prescription that allows for between 80-160 mg of diamorphine to be given and 40-80 mg of midazolam?
A It is not indicated or justified, and it is a very high dose. It is a four to five or sixfold increase, and if that had been commenced it would be highly likely to cause major adverse effects which is respiratory depression and coma, particularly with the co-prescription of midazolam at the dose range prescribed.

B Q Does that apply to the lowest dose?
A It applies to the lowest dose of 80 mg.

Q So it follows that anything above that is going to have a worse effect?
A If one was concerned that this lady was going to become unable to swallow and take the opiates which were controlling her pain, one could have written either PRN doses of subcutaneous morphine, as we discussed yesterday, which can be given four hourly, or one C could have written, if one wanted to, a subcutaneous equivalent dose but I cannot see any justification for prescribing such a greatly increased dose. That is unsafe practice.

Q You mentioned there the possibility of coma which is obviously a hazard. What is the difference between unconsciousness and coma? What is a coma?
A Coma is generally used to describe a deeper level of being unconscious, but a coma is just the lowest form of conscious level. That is all. Depressed conscious level is a better way D – it describes the fact that that is a common adverse effect of excessive doses of opiates when first starting.

Q If we come back, please, to the chronology, that particular prescription was not administered except in so far as the MST, and we can see on page 11 of the chronology that the MST was administered 20 mg twice daily. Then over the page we can see that the patient is still complaining of pain in her shoulders on movement but refusing medication. It took a E while to persuade her to take them. Then on 2 March there is a comment about slight pain in shoulders. On 4 March the patient is complaining of pain and having extra analgesia "PRM" – is that meant to be "PRN"?
A I think that is meant to be PRN.

Q "MST dose increased to 30 mg ... by Dr Barton." At this stage, if the patient is continuing to have pain, is an increase in the dose of the MST the appropriate approach in F your view?
A I think at some point one would have wanted to see an assessment of cause of the pain, whether it was earlier at the beginning or now. The problem is, one would assume it was being treated as arthritis or musculoskeletal pain but in the context of somebody having had a major fall, I think one would have wanted to review what the cause of the pain was. It may not have responded well to opiates if it was neuropathic pain, for example, relating to nerve entrapment. There are a number of different approaches one might have taken, G depending what the cause of the pain was.

Q If one was in the position at this stage, that the doctor still does not have the x-ray from the previous hospital, or at least an x-ray report, what steps in your view could the doctor properly have taken?
A The start would be to examine the patient and see if there are any obvious signs of injury or particular problems. There is no record of that. I think it is not unreasonable to H

increase analgesia but the problem is, we do not at this point have a clear diagnosis of exactly what is thought is being treated – at least recorded in the medical records.

Q If we go to 5 March, page 13 of the chronology,

"Reviewed by Dr Barton
Has deteriorated over last few days. In some pain therefore start sc [subcutaneous] analgesia. Let family know."

Then there is a nursing note:

"Patient's pain uncontrolled. Very poor night. Syringe driver commenced...".

Just pausing for a moment, this patient by this stage, I think, is on a total of slow release morphine of 60 mg daily?
A Yes.

Q That is being taken orally and so according to the BNF certainly the equivalent dose would be 20, and one could of course increase it from that starting point?
A Yes.

MR JENKINS: Forgive me. Can I just interject? Look at page 975. We have left out one line that perhaps should be included: "Not eating or drinking".

MR KARK: I am grateful.

MR JENKINS: That is in Dr Barton's note.

MR KARK: Very well.

MR JENKINS: On the chronology it should come after "Has reviewed over last few days. Not eating or drinking". Page 975.

MR KARK: I think it is probably worth adding that to our chronology. I see it now. It is the second line. If we go to 975, it is the second line down on that entry. It is under the words "Has deteriorated over last few days. Not eating or drinking." I think the time has come, probably, when we need to stop sending these back for reprints, perhaps, and just make annotations as needed.

THE CHAIRMAN: I agree, Mr Kark.

MR KARK: The patient is then prescribed a variable dose by Dr Barton of between 100-200 ml of diamorphine and 40 mg of midazolam. That is begun at 9.30 on 5 March. What, if anything, do you say about that starting dose of diamorphine? I am looking at your paragraphs 12 and 13 of your report?
A Just to discuss the deterioration first, the first issue is why is this lady deteriorating at this stage. It should not be related to her stroke per se. It is possible it was an adverse effect of the opiates. It is difficult to tell from the information in the medical and nursing notes, but it is not clear to me why this lady at this point is not eating or drinking, but that could be related to her opiates. Also you have the issue again of what is the cause of this continuing

pain. That said, she is taking 60 mg of oral morphine, which is the equivalent of 20 mg prescription of subcutaneous infusion of 100 mg, is five times higher than the current equivalent she is taking. That, again, is – like the first prescription – not justified. It is an excessive increase. One would want to give the equivalent and possibly a little bit more of, say, 30 or 50 per cent. That would take it to the equivalent of around 30 mg over 24 hours. Again, I would judge that prescription to be very risky and likely to lead to, as the first prescription if it had been administered, adverse effects, with particular concerns about depression of respiration and conscious level.

Q In the middle of that sentence you said "likely to lead to". Was it likely to lead to the respiratory depression?
A Yes.

Q And depression of conscious level?
A In a lady of this age that increase in dose would be expected to be very likely to cause significant adverse effects.

Q We see from the chronology there is a review by Dr Barton on 6 March. The day after that has started, the syringe driver has started. There is a comment:

> "Further deterioration. SC [subcutaneous] analgesia commenced. Comfortable and peaceful."

What is the state of this patient with that amount of diamorphine and midazolam going through her?
A There is not a formal assessment of conscious level in this lady but I would be very surprised if this lady had not had significant depression of conscious level, and that was why she was peaceful, because the drugs had significantly depressed her conscious level.

Q If we stay with the chronology on 6 March, that analgesia at that level having commenced, we can see from page 15 that death is actually recorded at 9.28 on the evening of the 6th. The cause of death is given as a CVA and diabetes mellitus. Have you formed any view as to what may have led to this patient's death?
A Because I do not think she had a stroke, obviously I do not think the stroke, referred to as a CVA, is a cause of her death. The timing of deterioration in this lady with her death – I need to work out the exact time the final prescription was administered. Within 24 hours – would suggest there temporarily that drugs are very likely to have contributed to her death. In my view she may have died from other causes. She was an older, frail lady who was very dependent, so she could have developed a pulmonary embolus; she could well have developed a pneumonia but of course drugs had induced respiratory depression. You would also often see broncho-pneumonia. I think one of the issues with any older patient with multiple pathologies is they can die suddenly, particularly if in hospital, so it is very difficult to prove beyond all doubt that one cause is the definite cause of death, but I think it was highly likely that drugs contributed to this lady's death.

Q And if the drugs did contribute to her death, what is the system? What are the drugs doing which actually cause her to stop breathing and her heart stop?
A They are suppressing the central respiratory drive so you eventually stop breathing. You die from hypoxia, low blood oxygen levels.

Q And does the heart stop first or does the breathing stop first?
A The breathing would stop first with a drug-induced respiratory arrest.

MR KARK: That is all I am going to ask you about Patient B. Sir, we are going to move on to Patient C. Mr Fitzgerald has just provided me with page 244 which indeed is the second page of the letter. I think for the sake of completeness it is probably sensible to put it in just so that we do not raise this again in three weeks' time when we have all forgotten what that page is.

THE CHAIRMAN: We can do that comfortably because it is only a single document. (Page 244 distributed)

MR LANGDALE: May I just indicate while the Panel are going to be inserting this extra page that page 242, the one that immediately precedes it – and Professor Ford can hear me saying this because I may need to ask him about it – perhaps the Panel would care to note that in the first paragraph of the letter at page 242, half way through the first paragraph:

"She tells me she's had her neck and chest x-rayed."

I will be drawing Professor Ford's attention to that as to whether there was or was not an x-ray. It may be convenient to note it now.

MR KARK: Once we have inserted that, the time has come to move on to Patient C. You will need your reading time again. We are getting through the patients a bit more quickly because the reading is being done and because we spent quite a long time yesterday dealing with the basis, as it were. Even so, you will no doubt require your 20-30 minutes, perhaps a bit longer if you are doing two.

THE CHAIRMAN: I think what we have found is, it is 30 minutes in combination because, of course, we will be looking at Dr Barton's statement as well. The two together seems to work in about 30 minutes. Ladies and gentlemen, we will formally break now so that the Panel can spend the next 30 minutes reading Dr Barton's statement in respect of Patient C and also looking at the updated chronology for Patient C.

MR LANGDALE: May I inquire with regard to Patient C, I have not received an updated chronology.

MR KARK: You should have done, Mr Langdale.

THE CHAIRMAN: I am afraid we have not received it either.

MR KARK: I am sorry. It is sitting behind me. I have it but nobody else has, so apologies. That will be sent round. (So done)

THE CHAIRMAN: I am told also that there is no statement in respect of this patient, and therefore we can reduce the amount of time that we are going to need to read. We will therefore take that down to 20 minutes, please.

MR KARK: Very well.

THE CHAIRMAN: We will re-start at 10.30, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark, before you resume, I should tell you the Panel have taken the opportunity to read through the new chronology and cross-reference it with the Patient C bundle. In that regard, page 272 of the bundle has what might very well be one of the replacement photocopy pages. It is certainly remarkably clear insofar as it has been photocopied, but the left-hand margins have been cut off and so, for example, we are unable to read the date of the prescriptions for diamorphine referred to in the upper part. Similarly, parts of the boxes on the lower part to the left are also missing. Could we either have copies that do show all or, failing that, we would be content to have a look at the original. In fact, we probably have that, do we not, in the bundle?

MR KARK: No, I do not think you will, sir, because this is Patient C and the originals do not start until D. I am afraid for A, B and C, we are relying on microfiche copies. We will see if we can get a better copy of this.

THE CHAIRMAN: If it is possible, we would be grateful.

MR KARK: There is also something else we need to do on the chronology, but we will come to that. (To the witness) Let us start, please, Professor Ford. This patient was plainly very ill when she came into the GWMH.

A Yes.

Q She had been admitted to the Queen Alexandra Hospital on 6 February 1998 and it looks like she had a carcinoma.

A Yes. There is not a tissue diagnosis, but one would not usually pursue that in a patient of this age and frailty and she had appearance on her chest x-ray from the reports which was entirely consistent with a lung cancer: a carcinoma of the bronchus. I think that is very clear that that was the underlying problem.

Q We see from our chronology the references to general deterioration, nausea, decreased appetite and feeling depressed. This is all on page 1. Could I suggest we may wish to add one matter to the chronology? If we go to page 299 of the patient notes, this is an entry at the top which actually is a continuation from the previous page of 12 February 1996. It is a review by a doctor and the last words are:

> "In view of advanced age, aim in the management should be palliative care. Charles Ward is suitable. Not for CPR."

That may be an important reference in this patient's notes. It is plain that this patient was, at her age, destined, as it were, for palliative care.

A Yes, and she would not be expected to survive for very long.

Q If the members of the Panel want to make a note in their chronology: 12 February 1998, reference page 299:

> "In view of her advanced age, aim in the management should be palliative care."

MR LANGDALE: Sir, I am sorry to interrupt, but while we are on a page, it will save me coming back to it in cross-examination of Professor Ford. Might we also note on that same page – this is mentioned in Professor Ford's report – with regard to the last paragraph on that page, "Son agrees not suitable for invasive treatment." That is three lines up from the bottom. Professor Ford at paragraph 6.2 says that that says, "Son agrees not suitable for invasive treatment."

MR KARK: I have no objection at all to Mr Langdale indicating what his additions are. I think it is helpful.

THE WITNESS: May I comment? I read that to be "investigation". I do not think it makes a substantive difference, but it is just a comment.

MR KARK: On any view, this patient was not going to be operated on at her age and she was not going to survive this cancer.
A Yes. Any intervention would have been inappropriate in terms of further investigation or treatment of the carcinoma of the bronchus.

Q She was reviewed on 25 February by Dr Lord and said to be confused with agitation and frightened, perhaps not surprisingly, although she says, "not sure why". She tends to scream at night, although she is not in pain and there is the suggestion, "Try thioridazine". You have mentioned thioridazine yesterday. Can you just remind us about that, please?
A It is an anti-psychotic drug that was used quite extensively before 2000, when there were cautions against its use because of toxicity. It was used quite extensively in older people for sedation and treatment of agitation.

Q Is that the one that was taken off the market?
A It is the one that was taken off the market, but its prescription at this time- point was appropriate and very frequent.

Q Then we can see that the patient was transferred to Dryad Ward. There is a note by Dr Barton at page 304. I am not going to go through all of that. It is in our chronology at the bottom of page 4 that the patient needed help with eating and drinking. There is a diagnosis of a carcinoma of the bronchus and:

> "Plan: Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death."

We have seen that note, or we will see that note, in relation to other patients. In relation to this patient, was that in your view appropriate?
A Entirely reasonable and appropriate. Are you referring to confirming death or to the use of opiates?

Q Both.
A The rationale for prescribing opiates was not clearly described and I think some palliative care specialists might say if she was not in pain, opiates would not be the first choice, but I think it was a reasonable prescription. Many geriatricians and general physicians in this patient, who was showing signs of distress, even if it was not clear they were in pain, if they had end stage carcinoma, would consider the use of opiates. So yes, I think it was reasonable.

Q In terms of "Happy" or whatever words one uses – there may be more felicitous ways of expressing it – but the fact that nursing staff could confirm death in this patient?
A Yes. We have not discussed that. I think it depends what the general policy of the unit was for confirmation of death in patients. One would prefer to have a policy for a unit rather than it being done on individual patients necessarily. But that is a general comment.

Q From the drug charts, if we go to page 5 of our chronology, we can see that on the day of her transfer she was written up by 2.5 to 5 ml (5 to 10 mg) of Oramorph, thioridazine and then various other drugs such as digoxin and frusemide. I do not think you have any substantial criticism of those drugs.
A No.

Q She is described on 28 February and being "very distressed" and calling for help. The patient was given drugs, but they unfortunately did not relieve her. There is a reference on page 7 in the chronology to 1 March 1998, when the patient was described as:

> "Slept well but calling+. Shouting from approx 05.30. Spat out all medication."

You are nodding. We have not dealt with that in any detail, but if a patient is unable to take medicine orally or is spitting out medication and requires medication, what is the appropriate route?
A You have a number of choices. One is to give drugs by the intramuscular or subcutaneous route or potentially intravenous, but that would not be a route one would use in this setting. Or, as we will go on to discuss, there are some drugs, a few, that can be given through the skin, through a transdermal patch.

Q Let us look at that. If we go to page 8 of the chronology, this is dealing with 2 March. The clinical note is at page 305, which reveals:

> "No improvement on major tranquilliser. I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today."

Then over to the top of page 8 of the chronology, there is a reference to spitting out thioridazine and:

> "Quieter on prn ... diamorphine. Fentanyl patch started today."

If we go to the following page, we can see that the drugs which were prescribed first of all was fentanyl 25 – that should be a microgram patch, should it?
A Yes.

Q "x 3 days." So that would be one patch lasting - ?
A The patch is recommended to be in place for three days and then removed and a new patch put on.

Q We have looked at this yesterday in the BNF. The equivalent dose of a fentanyl 25, my recollection is that it was about 135 mg.

A I think it was up to 135. I think 90 mg was the standard conversion. It certainly is now. I think the 135 – I cannot remember if that was the Wessex protocol we were looking at. I think the BNF says 90 mg.

Q Just looking at this prescription, this was administered at eight o'clock that morning. So that means it would be put on the skin of the patient – where are these patches normally placed?

B A Well, in somebody who is agitated and might be pulling things off or pushing them away, you might put it on their back, so that they were less able to get it, or typically it is put on the abdomen or the chest wall.

Q I want to pause for a moment on the fentanyl patch. You dealt with this first of all in your report that you made for the police at paragraph 6.12. Do you have that?

A I do, yes. I have it open at that section.

C

Q Tell us, please, your view first of all about the appropriateness of prescribing and administering this patch in these circumstances?

A The first approach that had been taken was to give intramuscular diamorphine and the nursing notes or medical notes report that there was some improvement on that. I think two doses were given and, although it was not clear on the prescription chart that was referred to earlier, I think it became clear from the nursing notes that that was the day and these two

D doses were given at eight o'clock and three o'clock. I think that was a reasonable approach. I think the decision to use fentanyl is reasonable; I can understand the rationale for that. You have somebody who may be difficult to manage and you want to avoid having to keep repeat injections. I think using the fentanyl patch is not an unreasonable thing to do, but I think the issue, as we talked about earlier, is that it is quite a high dose of opiate that one is administering. So one has to be aware that there is a risk of adverse effects in this age group, because it is a large dose of opiate. I think it was reasonable, because the notes suggest that

E there was quite a lot of difficulty giving medication to this lady. We do not know how difficult it was to give the intramuscular drugs, but I think this was a reasonable approach to try in a patient where you have difficulty administering drugs.

Q This was a lady who was, as you have revealed, inevitably dying of her carcinoma.

A Yes. I think again you are trying to achieve palliation in somebody who is nearing the end of life and, in that context, it is not unreasonable to take some risk to achieve palliation.

F Because there was not a smaller fentanyl patch at that time, they had to use the 25 mcg patch.

Q 25 being at that time the minimum dose; it has now changed.

A Yes.

Q I want to come back to what you just said about the use of diamorphine, because I do not think it appears in our chronology and it could certainly be relevant. Your understanding

G was that this patient had received injections of diamorphine prior to the fentanyl being put on.

A Yes. It is listed at the top of page 9: 5 mg administered at 0800 and 1500 hours.

Q If we go back to page 272 of the notes, the point the Chairman raised, sir, we do not have a better copy of this, but the chronology reveals that that was in fact prescribed on 2 March. So far as the use of diamorphine, those are injections of diamorphine, are they?

A Yes, they are.

H

Q 5 mg each, one given at eight o'clock in the morning and one given at three o'clock in the afternoon. I should have dealt with those in passing. Do you have any criticisms of that use?
A No. She settled on diamorphine and there are no obvious adverse effects at that point. I think they were reasonable and appropriate. Obviously it is in the context of the transdermal patch of fentanyl is increasing the concentration of fentanyl in this lady.

B Q Can we come back to the fentanyl and what happens thereafter? The potency of that fentanyl patch is going to reach its peak when?
A It is not going to be – we would say five half lives and, in someone like this, that is going to be at least 24 hours before you are going to see the maximum effect and possibly longer.

C Q So the patch is administered at eight o'clock, it would seem, in the morning of 2 March. On 2 March, Dr Barton appears to have written out a prescription – it is either the 2nd or the 3rd, but our chronology shows it is undated – for between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. If we look to 3 March on our chronology, we can see that the diamorphine and the midazolam at the rate of 20 mg each were administered from 10.50.
A Yes.

D Q At this time, first of all, is there any indication in the notes, unless something is pointed out to you later perhaps, that the fentanyl patch has been removed?
A I could not find any indication in the notes that the fentanyl patch had been removed.

Q So what you say I think about this, it follows from that assumption, is that the fentanyl patch is still there?
A On the information in the notes, that is the assumption I drew.

E Q Even if it had been removed, would the effect of the fentanyl continue for some time thereafter?
A It would. If we recollect, we looked at the British National Formulary yesterday which talked about 17 hours before the concentration would have halved.

F Q In that context – I am referring to your report at paragraph 6.13 – what do you say about the prescription first of all and also the administration of the diamorphine; prescription first, between 20-200 mgs of diamorphine?
A The first thing to say is that the notes record there is a deterioration but it is not very well described what the deterioration in Mrs Page was at this point. There is mention in the nursing notes of right-sided – no, neck and left side of body rigid, right side flaccid, a suggestion that she might have had a stroke.

G Q We will find that, if anybody wants to look at it, I am relying on the chronology at page 170 which is the note of the significant events.
A I could not find a clear indication that she was in pain and she deteriorated. There was also, because of the potency of the fentanyl, the possibility that the deterioration could itself be due to the opiates which would need to be considered. Equally, we have a description but we do not have a more detailed medical examination recorded, of weakness down the right-hand side, so she could have had a stroke, she possibly could have a cerebral

H

metastases which had suddenly got swelling around it. There are a number of possibilities for a deterioration.

Q If we look at the note, which I think we should because there is an amendment we ought to make to the chronology. If we look at the note on page 170, we can see at the bottom that there is a note:

> "Rapid deterioration in condition this morning. Neck and left side of body rigid, right side flaccid."

As you have indicated, that could be caused by a number of factors. Could fentanyl be a feature of that or not?
A You would not normally expect the fentanyl or opiate intoxication to produce focal neurological signs. We do not have a detailed examination. All we have is that description, but you would expect it to produce a depressed conscious level. It looks like this lady has a depressed conscious level, but there is no formal assessment of it, so again it is very difficult to assess from reviewing the notes.

Q Then the note reads, "syringe driver", and my reading of this is "commenced at". In our chronology we have "recommenced at", which would not make sense because there is no evidence that the patient had been on a syringe driver prior to this point. I am looking at page 10 of the chronology. You see it in the last line of the first entry:

> "Syringe driver recommenced at 10.50".

I think that should be "commenced". Could I suggest an amendment to that. This patient has fentanyl in her body. She is described as having a rapid deterioration, her neck and left side of body of rigid. What justification, in your view, is there for adding diamorphine and midazolam?
A Diamorphine is primarily to treat pain. We have no information presented that this lady is in pain. She could have been but it is not recorded in the notes. One would treat someone who has a stroke or weakness due to cerebral metastases with morphine, but that does not require opiates in itself. Similarly, midazolam is, in this context, for treatment of terminal restlessness, but we do not have any description that she is restless but, in particular, when she already has a lot of opiate that she has received, I cannot understand the rationale for starting in addition to that a diamorphine infusion.

Q Can we try and look at the rate of increase. It is difficult perhaps, it is harder than normal because we are dealing with a fentanyl patch. Let us take it at its lowest level, the fentanyl patch is the equivalent of 90 mgs of oral morphine?
A Over 24 hours.

Q To that is added a syringe driver of 20 mgs diamorphine and 20 mgs midazolam?
A I do not wish to over complicate it, but it is more complicated because the half life of fentanyl is longer, so it is the equivalent but it is taking longer to get up to the equivalent steady state. I am sorry to make this a bit complicated. She is not going to be at the full effect at 24 hours, and it is just slightly complicated, that is all. As you continue it, you are going to get increasing effects as the drug accumulates.

Q Is this combination of drugs going to have an effect on the respiratory and circulatory systems?
A Obviously, in broad terms, what she is now receiving from the combined prescription, we understand she still has the fentanyl patch on, she has 90 mgs over 24 hours from the fentanyl patch and 60 mgs equivalent of the diamorphine so she is having 150 mgs morphine equivalent over 24 hours at this point which is obviously a very high dose.

Q In your view is that consistent with *Good Medical Practice* or not?
A Only if there was a clear indication that she had pain and required further opiate treatment, but it is a very, very rapid escalation, the introduction of opiates in a patient who was opiate naïve until when she was she receiving oral morphine, a much lower dose of oral morphine, so it is a very large increase.

Q The patient's death was recorded the same evening at 21.30, The cause of death is given as carcinomatosis and carcinoma of the bronchus. Do you have any comment to make about the likely cause of death in this case?
A I think in this lady the underlying cancer was the cause of death and the drugs may have had a contributory factor, but you could say nothing more than that because she was so ill with advanced cancer.

MR KARK: That is all I am going to ask about this patient and we are moving on to Patient D. I have a new chronology to pass up.

MR LANGDALE: Perhaps the Panel would just note that there is not an account from Dr Barton with regard to this patient.

THE CHAIRMAN: What I am going to do is some quick mental arithmetic. The Panel will take time to match up the new chronology with the Patient D bundle. We do not need to give time for reading of a non existent statement, but it is now 11 o'clock and we do need to take a break for the Panel, if not, for others. I am going to say that you should all return at 11.40 am and the Panel will return at 11.20 am.

(The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back. Mr Kark, the Panel have taken the opportunity to work their way through the new chronology for Patient D and cross referred it to the Patient D bundle.

MR KARK: Can I also mention in relation to the last patient we were dealing with, Mrs Page, that Mrs Page's son is present in the room and he has very kindly provided us with some better copy medical notes. We have had those copied up and they are being renumbered at the moment. Once those are finished, we will provide them you, perhaps in the next break.

THE CHAIRMAN: Mr Langdale has seen those, has he?

MR KARK: He has not yet, no. I am sorry, they are still being copied.

MR LANGDALE: There is no problem, we can sort it.

MR KARK: Turning to Patient D, Alice Wilkie, again a very brief review in relation to her. She had been admitted at the very end of July to the QAH with an unresolved urinary tract infection. She is described as having as having dementia and she was catheterised due to incontinence of urine. We can see all of that from page 1. Page 2 of our chronology reveals that she is an 81-year old lady with advanced dementia. Could I take you to page 3. She is still on a catheter which is said to be draining:

"Needs plenty of encouragement with food and fluids."

Then we see that there is a QAH prescription by a Dr Wilson for a drug called haloperidol. Is that a variable dose prescription?
A Yes, from 2.5-10 mgs and would have been to control her behavioural disturbance and agitation.

Q We have looked at a number of prescriptions written by Dr Barton for variable doses and I want to compare those with this. This is for a range between 2.5-10 mgs and a maximum is stated. Is that in your view an acceptable way to write a variable dose or would you have criticism of that?
A No, I think it is useful to put in a maximum dose. It is often done with simple drugs like paracetamol, for example, "no more than 4 grams a day", so it is helpful to put in the maximum.

Q The range that has been specified, 2.5-10 mgs of haloperidol?
A It is reasonable; that is quite a large dose for an older person.

Q We can see that on 6 August, if we go to page 5 of our chronology, that the patient is transferred to Daedalus Ward. If you go back to 4 August:

"Reviewed by Dr Lord."

This is when she is still at the QAH:

"Usually quiet and withdrawn."

She is catheterised.

"CXR and ECG – NAD."

Is that "nothing abnormal detected"?
A Yes, the chest x-ray and ECG.

Q
"Plan: continue oral augmentin. SC [sub cut] fluids. Overall prognosis is poor +."

Does that mean very poor?
A I think, yes, I think one would interpret it as that.

Q "...too dependent to return to Addenbrookes. Transfer to Daedalus continuing care."

A That may simply mean and is too dependent to transfers because of poor prognosis.

Q "—› for 4-6/52 observation + then decide on placement. Keep bed at Addenbrookes."

B A Yes.

Q "DNR", do not resuscitate?
A Yes.

Q Then she is indeed transferred to Daedalus on 6 August. The very bottom entry on our chronology page 5 I think belongs at the top of the page:

C "Slept very well Sub/cut fluids continued. For Dryad Ward Gosport today. Assisted with washing and dressing. Catheter draining poor."

That is plainly a note made at the QAH and it may be important because at that time she was receiving subcutaneous fluids. Is that an indication that she is being hydrated, the bottom of the chronology on page 5?

D A Yes. She is obviously not drinking very well and is on subcutaneous fluids at that time.

Q She is clerked in and seen by Dr Peters. There is a referral letter. I am not going through that, the Panel have read it. If we turn to page 6 of our chronology, she is described as having dementia and being withdrawn. Her appetite is described as poor:

E "Does have pain at times, unable to ascertain where."

And there is another reference underneath that:

"Withdrawn – does not communicate well. Can be agitated at times. Does have pain occasionally but cannot advise us where."

F A Can I make a comment on that. In patients with advanced dementia who cannot communicate, it is actually quite difficult to tell whether they have pain. One of the aspects one would be interested in is what was it that the patient was exhibiting in terms of their behaviour that made the nursing staff think that the patient was in pain, because there are other causes of screaming and behavioural disturbance which are not secondary to pain, so it can be quite difficult to conclude that someone one is in pain.

G Q We can see that this patient still appears to have had, there is mention there, a urinary tract infection. I do not know if that had resolved by this stage. Would a urinary tract infection of itself cause pain?
A Not usually. It can do if it involves the kidney, but usually you get frequency and some burning but not usually severe pain.

Q We do see that the patient was catheterised?
H A Yes.

Q If the catheter was not working, as we have seen with other patients, can that cause a problem?
A It can be uncomfortable and patients with dementia can be aware of them and you can get secondary problems related to that.

Q If we turn to 10 August, I am deliberately not stopping on every entry because we know the Panel have read these, at the top of page 7, so we are still on the 6th, I have the nursing notes.

"Daughter was also there.
Alice has a Barthel of 1 at present. Alice did require haloperidol @ QAH for the 1st few days there. I will contact ward in 3-4 weeks time."

Then she is reviewed on 10 August by Dr Lord where she has a Barthel of 2 and she is said to be eating and drinking better:

"Confused and slow. Give up place at Addenbrookes."

So "R/W" is?
A "Residential", I would assume the "R" stands for. Usually it is "residential home" we would say. I am afraid I cannot interpret the "W".

Q And "In 1/12" means in one month's time?
A Yes.

Q "... if no specialist medical or nursing problems ... to a N/Home."
A So Dr Lord was recommending she move to a higher level of care because of her increased dependency.

Q If we go then to about a week later, top of page 8, we can see a deterioration has been recorded.

"Condition generally deteriorated over the weekend. ... Daughter seen – aware that [I think it should be] mum's condition is worsening, agrees active treatment not appropriate & to use of syringe driver if Mrs Wilkie is in pain."

It appears that that day she was written up with diamorphine at a dose between 20-200 mg and midazolam 20 - 80 mg. At this stage do we regard this patient as opiate naïve or not?
A She is opiate naïve, unless my understanding of what she had received is incorrect.

Q If we look at what happened on 20 August, bottom of page 8 of the chronology, she started on a syringe driver at 13.50, diamorphine 30 mg and midazolam 20 mg?
A Yes.

Q And we can see that there is a note by Dr Barton, page 99B:

"Marked deterioration over last few days.
SC [subcutaneous] analgesia commenced yesterday.
Family aware and happy."

Perhaps we ought to look at that note which we have in our documents for this patient, page 99B.
A Yes.

Q The last entry prior to Dr Barton's entry on 21 August – unfortunately our hole punch has gone straight through the date, but I have written underneath it is 21 August 1998 and that is right on the chronology, and I see Mr Langdale nodding. The last entry is on 10 August, the one that we looked at from Dr Lord. Dr Barton writes, as we see:

"Marked deterioration over last few days."

Any indication that you have seen in these notes, apart from the two that we have referred to rather earlier, on pain?
A No. There is no record I could find on the medical notes or the nursing notes to indicate whether the patient was having pain at this point, or the nature of it, and what one would expect to see is an assessment of the patient to understand what the cause of the pain might be, to initiate appropriate treatment.

Q How would you expect that assessment to appear in the notes?
A By the record of a medical assessment which might be a combination recording nursing observations and observations of the doctors themselves. And then if there was pain, and you still were not sure of the source of the pain, I would be critical of going straight to opiates, to strong opiates. I think one could have tried mild opiates, paracetamol and codeine or non-steroidal anti-inflammatory drugs if she was able to swallow.

Q I am sorry – can you keep your voice up. It is a bit difficult to hear you even for me.
A I am sorry. I will start again. If, having assessed the patient, it still was not clear what the cause of their pain was or there was no treatable cause in terms of another intervention one could take, a reasonable approach would have been to start mid-way, or half way up the analgesic ladder.

Q Which would be what?
A Say with paracetamol and codeine, for example, if she was able to swallow at this point. Failing that, if the pain was thought to be very severe – and we do not have any assessments which give a clear indication in the notes of how this lady was – again I think a reasonable approach might have been to consider a one off oral dose or a small subcutaneous dose of morphine orally or morphine subcutaneously, but I think to start with such a high dose of a powerful opioid in an opioid naïve patient without a clearer justification is not good practice.

Q When you speak about a "low oral dose" as a start, what would you mean by a low oral dose?
A Five milligrams.

Q Five milligrams?
A For example, of morphine.

Q The equivalent of the dose that this patient was started on was 90 mg?
A 90 mg every 24 hours, yes, and that is a very high dose and in an opioid naïve, frail older patient one would expect there would be a high probability of adverse effects occurring.

Q And such adverse effects would be?
A Again, as we have discussed before the major important ones would be respiratory depression, depression of conscious level and that is why one would want to start cautiously with a small dose.

Q The lowest dose that we have seen Dr Barton prescribe for a syringe driver anywhere, I think, in these records is 20 mg. Is it possible to give less than 20 mg?
A Yes. You very definitely can give less than that, and it is often given.

Q Sorry? And it is ---
A It is given – 10 mg or even less.

Q If a syringe driver is necessary one could have started at a lower dose?
A Yes, but we go back to the point that the preferable way of starting opiates is by single doses first of all and you assess the patient's response rather than putting somebody straight on to an infusion, a continuous infusion.

Q Do we have to bear in mind, first of all, that all of these patients are elderly and we have looked at that previously. I am not going to go back through it. I think this lady is described as frail and elderly. Is that significant in relation to the starting dose?
A When we talk about how the elderly respond differently, we are talking about literature which has mostly studied relatively healthy older people. In general there is not much published scientific literature about the effect of frailty on drugs, but general clinical experience is that frail older people with comorbidities are even more sensitive to drugs where there is an aging effect.

Q This syringe driver is started, according to the records, on 20 August at ten to two in the afternoon. The diamorphine is coupled with midazolam. I am not going to ask you again to repeat your comments about that, but can we take it that they pertain to this case?
A They both potentially have profound depressant effects on conscious level and respiration and I think you would be surprised not to see such effects using this dose of diamorphine and midazolam in a patient like this.

Q And we can see that the next note that is made on 99B, on 21 August, after Dr Barton's note is:

"Pulse & Breathing absent.
No heart sounds
Pupils fixed
...
Family present."

And then the note, "For cremation" and that is at 6.30 that evening.
A Yes.

Q I just want to ask you a little, please, about the notes that we have here. The last note before Dr Barton's note on the 21st is 10 August, and then the next note is 21 August, which reveals that the subcutaneous analgesia is commenced. Do you have any comment to make on the quality of the note-making in this case?

A It is infrequent. Clearly one would not expect the extent of note entry in a patient in a continuing care or rehabilitation ward such as this, as one would see in a hospital unit where one would expect to see entries in the notes every day or two. An important issue is, there should be entries in the notes when there was a significant change in the patient's condition. I think the nursing notes referred to deterioration before the 21st so that should have prompted an assessment. Whether the nursing staff asked.... I just have to remind myself whether the nursing staff pointed out deterioration to Dr Barton or any other medical staff before that.

Q On 17 August there is a reference to "Condition generally deteriorated over the weekend"?

A Yes. This was not a lady where there was going to be an aggressive intervention policy pursued, but it still is important to medically assess if there is significant decline in a patient.

Q We have covered this and I do not want to spend long on it now, but before a decision is made to start a syringe driver with opiates in it with this lady, would you expect a note to be made as to why that is happening?

A I think absolutely. We care for many people, older people with dementia, who die from complications and become very frail. It is not common practice to use combined diamorphine and midazolam, or similar drugs, in infusion towards the end of their life, so one would want to see the rationale for that. It is not only a matter of it not being common practice; these are potent, powerful drugs and there should be a clear indication recorded in the notes as to why they were prescribed.

Q And are you able to say now whether these drugs appear to have, or may have contributed towards death or not?

A I think they contributed to deterioration but the note-keeping is not in sufficient detail. We do not have nursing observations of her respiratory rate or conscious level to be able to conclude the exact effect of the drugs. I think they may have but, again, this was an old frail lady with advanced dementia who was going to die in the near future, so I do not think once could say that drugs definitely contributed to death.

MR KARK: Thank you very much. That is all that I ask you about Alice Wilkie, and we are going to move on now to Gladys Richards.

We are moving through, if I can give the Panel some light. It is a long procedure but I am afraid it obviously has to be. It will take you a little while, I think, to read the chronology for Gladys Richards, although this is one of those patients who may well be in the front of your minds, as it were, and slightly out of the ordinary compared to the others but you will no doubt need 20-30 minutes. Can I pass up the new chronologies.

MR LANGDALE: There is, of course, a statement from Dr Barton for this patient.

THE CHAIRMAN: We will start on the basis that we will be looking for a 30-minute period but if that looks untenable we will let you know. Potentially we might bid for another ten minutes, but we will work on the basis at the moment that it will be thirty.

MR KARK: Thank you.

(The Panel adjourned for short time)

THE CHAIRMAN: Welcome back, everybody. The Panel have read the chronology for Patient E and have cross-referenced it to the Patient E bundle and, of course, we have read Dr Barton's statement in respect of that patient, so we are ready to proceed.

MR KARK: I am very grateful. Just before we do, can we do a bit of house-keeping in relation to what I think are definitely better copies in the Eva Page bundle, Patient C. Can I hand those out, please, to the Panel. I am sorry, I still have not given these to Mr Langdale, but I know that will not cause him any difficulty. These are replacement pages. Please take up bundle C – I am sorry, Professor Ford to interrupt your evidence – these are replacement pages for 272, 274, 276 and 278. They still, I am afraid, on 272 do not quite give us the full date.

THE CHAIRMAN: You have a bit more there.

MR KARK: It has a bit more there. I think generally they are certainly clearer copies.

THE CHAIRMAN: That is very helpful. We are most grateful for the addition. Thank you very much.

MR KARK: Once that task has been completed could we put away those notes for Mrs Page and take up bundle E for Mrs Richards and starting at least with our chronology, Professor Ford, we can see that on 4 February 1998 this patient was assessed by Dr Banks, I am going to ask the Panel on this occasion to turn up the letter at page 108. Mr Langdale has invited an addition to the chronology with which I entirely agree. The chronology reveals that Dr Banks found the patient had severe dementia. She had deteriorated since Christmas. She –

> "Does not seem over-sedated, but spends significant part of the day asleep. At times quite agitated and distressed during the day. Mobile and able to wander. Try regular haloperidol."

If we go to page 110, under the heading in bold "Impression" it says:

> "This is a lady with severe dementia with, I think N stage illness..."

We think it should be "end stage illness". I suspect this was a dictated letter.

THE CHAIRMAN: Yes. We have noted this on a previous occasion.

MR KARK: I am grateful.

> "... and as a result it is not surprising that she does spend considerable periods of the day asleep. She obviously needs some help to relieve the distress that she experiences when she is awake.

Management Suggestions

In the first instance, I think it is extremely important to try the regular Haloperidol"

Is that 5 mg?
A I think it is 0.5 mg.

Q It is 0.5 mg. Is that three times a day?
A Yes.

Q I think the suggestion is that one should just add a note in our chronology to remind the Panel of the comment about end stage illness. One can always go back to the original notes in the bundle to remind us of that. Then we see that there is a review on 2 March by Dr Banks.

"More settled. Conversation, although very minimal, is more coherent."

Then I am going to move on to 29 July 1998 at the bottom of page 2 of our chronology:

"Taken to A&E, Royal Hospital Haslar, after fall in nursing home, fracturing right neck of femur.
Fall onto right hip. Pain on movement of right leg. Quality of life has decreased markedly [since] last [six months]. For admission, operation, PRN analgesia."

Then at the top of page 3:

"Admitted from A&E, Royal Hospital Haslar. Undergoes operation – right hip hemi-arthroplasty."

There are notes in relation to the drugs that this lady was on. Could I just ask the Panel to note particularly page 243 of the drug charts? The operation takes place on 30 July and we can see that on 30 July she was on morphine for four days: 30 and 31 July, 1 August and 2 August. We can see that she is on regular haloperidol as suggested and she was also on co-codamol from 1 August and I think that continued to 7 August, according to this chart at page 243.
A Yes, that is correct.

Q Can you just help us, please, Professor Ford, about co-codamol? It is a tablet, is it?
A Correct. It is a tablet, a combination of paracetamol and codeine.

Q Are you able to tell us in what form it comes?
A I think if you see next to the co-codamol it says "eff", which I would take to stand for effervescent. So you can take it either as a tablet or there are tablets that dissolve in water, which are easier to take if people are having trouble swallowing tablets.

Q What dosage is co-codamol?
A Each tablet contains 500 mg of paracetamol and I am pretty sure it is 8 mg of codeine. So it is a small dose.

Q Paracetamol we know about. What about codeine?
A Is a mild opiate.

Q It is a mild opiate. Your report details with this entry on 30 July and I am afraid I foolishly had not identified where it is in the notes, but I think there is a note which may also be relevant by Surgeon Commander Malcolm Pott dated 30 July. I suspect this is in the clinical notes, but I will have a look in a moment, stating:

> "After discussion with the patient's daughters, in the event of this patient having a cardiac arrest, she is not for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished."

We will find that if we go to the bottom of page 174, which is a horrible copy, and slightly clearer at the top of page 175. We can certainly read the words at the top of page 175 "cardiopulmonary resuscitation" I think it is, and:

> "However she is to be kept pain free, hydrated and nourished."

I think you pick that up in your report.
A Yes.

Q We have dealt with this. The fact that a patient is not for resuscitation in the event of a cardiac arrest is no reflection upon the rest of her medical care.
A No. That is a very specific decision about a very specific clinical event that might happen.

Q Then if we go back to the chronology at page 3, she is reviewed on a ward round after her operation and she is described as being "up and eating". Then at page 4 of the chronology, on 3 August 1998:

> "All well on ward round. Sitting out. Has nursing home place but family not happy for her to return."

We heard something about that.

> "To GWMH."

Then:

> "Reviewed by Dr Reid.
> Confused, but pleasant and co-operative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH."

A Yes.

Q She was reviewed by a house officer on 8 August:

> "Quite distressed first thing, but settled after haloperidol. Little breakfast taken, but ate well at lunchtime."

A

So we have an indication there that she is taking food and drink orally. On 10 August:

> "Referred to GWMH.
> Now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. Continent. When becomes fidgety and agitated means she wants toilet. Occasionally incontinent at night. Occasionally says recognisable words. Wound healed, clean and dry. Pressure areas all intact."

B

Then the following day she is transferred to Daedalus Ward. Can we then look at Dr Barton's clinical note?

> "[On examination] frail demented lady. Not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL [activities of daily living]. Barthel 2. Happy for nursing staff to confirm death."

C

Just pausing there for a moment, we have seen that phrase elsewhere in the notes and we commented on it in relation to the last patient. Is it appropriate in these circumstances to make that sort of notation in your view?

A I do not think the nursing staff confirming death is necessarily inappropriate in a patient with advanced dementia. I think what is lacking in this note is a summary of what the plan with this lady is.

D

Q What would you expect to see?

A A reiteration of the previous plan to improve mobility with a view to discharging back to the nursing home.

E

Q If that plan had for any reason changed or if the patient's condition had deteriorated between the two hospitals, would you expect any note to be made of that?

A Yes. Clearly this lady was making quite good progress. Given her dementia and having had a hip replacement, she had achieved some mobility, albeit needing a lot of assistance with walking with a zimmer frame and the assistance of two nurses. So if there is any major change in that, which there appears to have been, but it would depend on when Dr Barton had assessed the patient, whether they had had a full nursing and physiotherapy assessment at the time Dr Barton wrote that note. They would not have seen the physiotherapist, I would not have thought, at that point. The "transfer with hoist" may be the initial nursing plan as to how they were going to manage the patient until a physiotherapy assessment. Obviously I am speculating in this respect.

F

Q We had better not do that. Can we look at the drugs which were written up upon admission? We have those on page 6 of our chronology. Oramorph was prescribed prn – and I am going to stick to the milligrams, because it makes it simpler – between 5 and 10 mg. The higher of that dose was administered twice on the day of admission, it would appear, at 1415 and 1145. Diamorphine was written up, between 20 and 200 mg; hyoscine was written up; midazolam was written up, between 20 and 80 mg, and haloperidol was continued, because she had been on haloperidol before. Is that right?

A Yes, she had. She had been taking haloperidol regularly at the previous hospital.

G

H

Q And lactulose, which we are not going to be concerned about for the moment. Can we deal with the Oramorph first? You have dealt with this in your report at various points. In fact, I think in your police report you dealt with it at paragraphs 219, 220 and 221. Focusing first on the Oramorph for this patient, do you have any commendation or criticism of first of all the prescription and secondly the administration of that drug?
A On the information available in the medical and nursing notes, there is no rationale presented for prescribing morphine at this point. This lady was mobilising a few days before at the Royal Hospital Haslar and taking regular co-codamol. So that would be the appropriate analgesic to continue, unless there had been a major change in her situation. In fact, I am not sure whether we know she was still taking co-codamol after 7 August, between the 7th and the 11th, but even if she had stopped it or was still taking it, the appropriate prescription for analgesia would be to continue the co-codamol in my view. That could have been written up either as a prn or a regular prescription. Either would be reasonable and appropriate, I think. But to move to prescribing morphine, when obviously there is the potential for significant adverse effects, without a clear description of there being a change in the pain severity or lack of control on other painkillers, means the prescription has no justification.

Q If there had been a significant change in the patient's condition, quite apart from making a note about it, which you have discussed, what else would you expect the doctor to do about it?
A I would expect a description of the change in the patient's function and then an examination of the patient to determine again why they were in more severe pain.

Q It follows from that, as I think you have revealed before, and it is in the Wessex protocol as well, you need to identify what the source of the pain is.
A Yes. I think it would be very expected that for any patient of any age being prescribed morphine, there would be a clear indication recorded in the notes for that.

Q Let us look at the rest of the prescription that was written up on the same day but not administered. I am not going to ask in relation to every patient for your comments about the wide range of drugs, unless your view for any particular patient is different. If you think it is justified, then you will no doubt reveal that. Prescribing diamorphine for this patient on the day of her admission, starting at 20 mg with a variable dose going up to 200, with midazolam. What view, if any, do you have about that?
A I cannot find any information in the medical and nursing notes that would provide any justification for that prescription. This is a lady who, having had a major change in her level of function, against a background of slow deterioration, is now improving from a major surgical procedure. She has been referred for further rehabilitation in an attempt to improve her mobility, with a recognition that that may not be possible, to get her back to her previous level of functioning. So there is no information which would justify why this patient would potentially need nursing staff to commence infusions of diamorphine and midazolam. The notes do not say at this point that this patient is deteriorating and has symptoms which require those drugs.

Q If at this stage the nurses had taken it upon themselves to decide, because, for instanace, the patient was screaming and they had not appreciated that she might need the lavatory, if the nurses had taken it upon themselves in fact to act upon this prescription and administer it, would that potentially have had any adverse effect upon the patient?

A Again, the doses, without going through them, are high starting doses in what is at this point essentially an opiate naïve patient. She has not yet received any of the oral morphine and there is a high risk of serious adverse events again.

Q You said opiate naïve. What about the codeine?
A That is a very mild opiate. We tend not to – it does not induce significant tolerance, so you are essentially dealing with a patient who is opiate naïve.

Q Can we continue with the chronology, please? At the top of page 7, we see:

> "Reviewed by nursing team.
> Requires assistance to settle and sleep at night. Nursing action: Night sedation if required. Observe for pain. 23:30: Haloperidol given as woke from sleep very agitated. Did not seem to be in pain."

Then the next day, we can see that Oramorph was administered at 0615. Then it was prescribed I think at a different rate, 5 mg four times daily and 10 mg nocte. That prescription again was not administered, but do you see any justification for such a prescription?
A What the notes are telling us is that this lady is agitated and dementia is the likely underlying main cause of that. There is no record that she is in pain. In fact, to the contrary: we have an entry which says she does not seem to be in pain. So opiates are not an appropriate treatment for agitation and confusion in patients who are pain-free.

Q The last time that Oramorph seems to have been given is the 10 mg administered at 0615 on 12 August. Then the following day, at 1.30 p.m., the patient appears to have been found on the floor and she is hoisted into a safer chair. It is plain from that that she has been able, with assistance no doubt, to remove herself from the bed and into a chair. By 1330 on 13 August, would you expect the Oramorph to be having any effect, the Oramorph given the day before in the morning?
A I am just checking exactly when she had the last dose. She had a dose at 6.15, more than 24 hours ago. So, no.

Q We can see that although – and I am just going back to the drug chart – Oramorph had been written up, there are a number of crosses against where the time when the prescription would normally have been given. So we take it that those prescriptions were not given. In any event, the unfortunate patient was found on the floor, no injury was apparent, but she had pain in her right hip and Dr Reid advised an x-ray and analgesia for that pain.
A Yes.

Q Was that an appropriate course to take?
A I think someone should have come and examined her. An x-ray is the right thing to do, to examine the leg if it is shorter, to see if there is evidence, clinical evidence, of a dislocation or other problem.

Q We can see that Oramorph was administered at ten to nine that evening and the following day she was reviewed by Dr Barton. We can see this note:

> "Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to Oramorph."

How should we read those words, how should we interpret that annotation, "very sensitive to Oramorph"?
A I think that relates to a comment from when she had received morphine at the previous hospital, if I remember correctly. I think I mentioned that in my report, unless it related to her observations of her response to the morphine she had received on the ward.

B Q The patient was in fact x-rayed and the notes reveal that she had indeed dislocated her hip. No doubt that would be a very painful occurrence for her?
A Yes.

Q She is taken back to the Haslar?
A Can I say at this point, clearly she is in a lot of pain and it is appropriate for her to have more powerful analgesia.

C

Q She is taken back to the Haslar and the dislocation is reduced. She then remains at the Haslar until 17 August. I want you to see page 286 to pages 291 of the drug charts at the Haslar. If we turn to page 291, we can see that Oramorph is written up but not given?
A Yes.

Q That is on 14 August. Is that haloperidol?
D A Yes.

Q It is given on 16 August and then co-codamol and that appears to have been given on 15 August. If you go back to page 286, I think the Panel have the file of the original prescription sheets. Could we retain it while we are going through this exercise so that Mr Fitzgerald can dig out any relevant prescriptions. I am going to see if we can find the sheet which is our page 286. We are going to have to make some enquiries because this file
E contains the GWMH prescription sheets and not the Haslar prescription sheets. We will look at that and see if we can identify when that was given. We know that the patient was transferred back to Daedalus Ward on 17 August when she was reviewed again and we have a note from Dr Barton on page 31. There is a note that she remained unresponsive for some hours. That means after the surgery presumably?
A Yes, I would assume that was after the sedation which was given to replace the hip – sorry, to correct the dislocation not replace.

F Q

> "Now appears peaceful continue. Plan: Continue haloperidol. Only give Oramorph if in severe pain. See daughter again."

That annotation "Only give Oramorph if in severe pain", would you have any criticism of that?
G A No, I think that is a very appropriate comment and the expectation would be that now the hip has been relocated, it should not be as painful but it clearly might be sore for some days afterwards and there might be a need for analgesia.

Q At some stage, certainly that day, the patient does appear to be distressed.
A Yes.

H

Q Something has obviously occurred with that patient and it may be to do somehow with her transfer?
A Yes. There was a lot of discussion in the notes and some statements about the way she was transferred back to the ward when she came back from the Royal Hospital Haslar.

Q We heard from one of her daughters about finding her mother in a very uncomfortable position in the bed and having to obtain assistance to put her legs straight?
A Yes.

Q From here on in, there are notes that this patient was in pain?
A Yes, that seems very clear, she was in severe pain.

MR KARK: I am very grateful. We have found that note in relation to the drugs and it may be worth briefly going back to it. It is the Haslar drug charts which are 286 to 291. If we turn to the 14 August – I am sorry I cannot find the document we were looking at before with the midazolam. It is page 286. Can I invite you to add on page 286 that the date for that midazolam is 14 August 1998. Professor Ford, just going back to the 14th momentarily, the patient having suffered a dislocation, she is taken back to the Haslar on the 14th, she is given midazolam and it looks like 2 mg.
A Yes, I would agree, I believe it is 2 mg.

Q Is that an appropriate dose?
A It is slightly out of my area of expertise because that is an anaesthetic pre-med, so I would not really like to comment, but it seems to me to be a sort of induction sedation dose that is used.

Q Coming back to the GWMH, page 12 of our chronology:

> "Reviewed by Dr Barton.
> Still in great pain. Nursing a problem. I suggest [sub/cut] diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

We can see from page 13 that on that day Oramorph is administered 10 mg twice, said to be in the early hours. Do you have page 13 of the chronology?
A Yes.

Q Then Dr Barton prescribes diamorphine, 40-200 mg, 40 mg is administered at 11.45 together with midazolam of 20 mg?
A Yes.

Q That midazolam appears to be being administered on the basis of Dr Barton's original prescription?
A Yes.

Q Because there is no fresh prescription for the midazolam?
A Yes.

Q What do you say at this stage about the diamorphine being administered at this point and then with the addition of midazolam?

A Mrs Richards had been receiving oral morphine at this point and I think over the previous 24 hours had received, I have recorded, 45 mg in a series of 5 mg and 10 mg doses. In the notes I could not find a clear reason why there was a need to switch to the subcutaneous route. It seems the patient was still in pain, so one could have increased the dose that was being given orally, but if there was difficulty swallowing or difficulty getting the patient to take it, it would be not unreasonable to switch to a subcutaneous dose. The dose that was prescribed is high in terms of equivalent terms. If we take the 45 mg of morphine, that equates to 15 mg of diamorphine. If one uses the half conversion, which has been used rightly or wrongly by some doctors, that would be 23 mg. If you wanted to increase a further 50 per cent, say, the usual guidelines, that would take you up to about 35 mg, so the 40 mg that is given is high but it is not completely unreasonable. It is high, but I would not be overly critical of that so long as the patient was being monitored.

Q What about the addition of the midazolam to that?
A That is not clearly indicated. The haloperidol is appropriate because she has been receiving that for a long time and if she cannot swallow the haloperidol, it is appropriate to continue giving her that because of her agitation. One has not at this point seen a response to the diamorphine and if she is comfortable with the haloperidol, would that control her symptoms?
A Given we know she is very sensitive to a single 2 mg dose she has had, the 20 mg – which is as we have said before a high dose to start with in an older person – would be, again, very likely to produce adverse effects when it is started at the same time as a significant increase in the opiates.

Q It is the combination again?
A It is the combination, but even without the opiates, that dose of midazolam on the basis of her prolonged sedation after the 2 mg, might be expected to produce profound depression of conscious level.

Q Are you saying effectively that the note, which I think Dr Barton has recognised in her clinical note, in relation to the patient's reaction after the operation is a flag?
A Yes, if that is what was being referred to, if this happened in another hospital, but it was an important piece of information if it was in your mind as a prescriber.

MR KARK: I am going to continue. I am aware of the time, but I would prefer, if the Panel can bear it, to finish this patient. (The Panel concurred) (To the witness) Can we continue with the drug administration. On 19 August the same drugs are administered then together with hyoscine, and hyoscine will be the result of secretions potentially produced by the other drugs?
A Yes. I would perhaps give some context. I think at this point the clinical situation of this lady has changed quite dramatically. The hip is a problem again. It is not dislocated and there is nothing obviously remediable, and in a lady with severe dementia this paints a very gloomy picture for the future and she is unlikely to improve and is likely to have a deteriorating course from here on.

Q In terms of the cause of this patient's pain, would you expect any assessment, or has sufficient assessment been done, to try to find out what has gone wrong?
A You would expect an examination of the hip. I am trying to look back at what was written in the notes at that point about whether there was any shortening or any other obvious problem in the hip. An x-ray was performed, that was appropriate. You could say that since

the hip seems a problem, best practice might be to discuss yet again with the orthopaedic team was there anything to be done, but I would not be critical of that particularly because there would be limited interventions that could be done here I think.

Q The clinical notes you will find at page 31, and we can see that there is an entry on 17 August. It looks like the 12th, but it is the 17 August, "Readmission to Daedalus". That is the note we looked at earlier. After that, 18 August:

> "Still in great pain. Nursing a problem. I suggest sub/cut diamorphine/haloperidol/midazolam. Will see daughters today."

That I think is the only note about that that we have from Dr Barton?
A I think ideally one would want to see a record of observation of the hip and whether movement of the hip, particularly rotation, gave rise to pain. All the indication is that the pain is from her hip from what we have heard, but there is no detailed examination recorded. The x-ray was done, which was the most important thing in terms of identifying a problem that was likely to be potentially correctable.

Q Then the drugs hereafter continue, on 21 August she is described by Dr Barton as being:

> "Much more peaceful. Needs hyoscine for rattly chest."

"Much more peaceful" indicating that she does not seem any longer to be in pain, but we do not know whether she is conscious or not?
A We do not have any formal observations of conscious level by the nursing staff at this time.

Q On the same day we see:

> "Condition very poor."

And in the same line:

> "Pronounced dead at 21.20."

This patient's death certificate revealed that she died of bronchopneumonia. We will see this cause of death given again and again. Can you give the Panel a little assistance about that?
A I think the predominant cause of death here was dementia and the hip fracture, I think that is what has led to the deterioration of problems. Bronchopneumonia is a common preterminal/terminal event in any mobile patient and also if you have drugs which suppress respiratory function, that will also often show signs of bronchopneumonia.

Q So the diamorphine and midazolam can themselves lead to the inability to ---
A Yes, because they depress respiration and you get less clearance of chest secretions.

MR KARK: Sir, I think that is all that I want to ask about this patient, and I would welcome the opportunity of just reviewing the notes very briefly. Perhaps we could then treat that as the end of dealing with Mrs Richards and we could move on to reading the chronology for Patient F. I think you already have them.

THE CHAIRMAN: No.

MR KARK: We have to hand that one out. We will hand out the notes for Patient F. We will make sure, Professor Ford, you get a copy before we break. (Document distributed)

Perhaps we can break there for the moment.

THE CHAIRMAN: Yes. We shall break now for lunch and the Panel will then go straight into the reading of these documents for Patient F. If when we come back you do have anything else on Patient E, we will deal with that first.

I think we shall come back, then, please at 2.50.

(Luncheon adjournment)

THE CHAIRMAN: I see that not absolutely everybody is back in the room. However we shall start but I have to make an immediate confession to you. The Panel have not used all of the time that they intended for the purpose expressed because another matter has come up, which is of general time-tabling. It concerns as much as anything, as I understand it, the administration of the overall GMC operation here.

The Panel have been told of the circumstances and we have given a preliminary view. I understand that the Panel Secretary at the end of the day will discuss what we have just been told further with the parties. This undoubtedly will have some effect on the way in which we all look at where we are going in terms of timescale. At any event we were going to begin with our return this afternoon by asking you if you were able to assist the Panel with a little crystal ball-gazing in terms of how the next few days are going to pan out.

As it had been left, we have all known that, for administration reasons, tomorrow would not be available to us as a sitting day because the room is required although the Panel have been able to make arrangements to do independent reading elsewhere.

There was then the issue of the following day. We had been told that Professor Ford would not be available and we were asked for an update on that and then, of course, as to canvassing his availability for next week. It was an update on that that we first sought from you.

MR KARK: When I last spoke to Professor Ford – and I have not spoken to him about this for a day or two – so far as Thursday is concerned, that is an inextricable engagement. He is, I believe, speaking at a conference and it is his event, as it were, and he has not been able to extricate himself from it. He will no doubt explain in a moment to you. I have not sought to disturb that because I gather it really is one of those professional commitments that he is unable to escape from.

We therefore have Friday. I certainly hope that I would finish examination in chief on Friday morning. We are going slowly – and that is no fault, I hope, of anybody's – there is material to get through and the Panel have to acquaint themselves with the material before you hear the evidence from Professor Ford. That is actually making his evidence much shorter than it might otherwise be. He is not referring to letters and notes that are in the chronology that he might otherwise have to refer to.

Professor Ford is available on Monday. He was meant to be starting, I believe, his family holiday on the Tuesday but he is understanding as far as anybody in those circumstances can be that he is likely to have to be here Tuesday. Beyond that we have not really got.

THE CHAIRMAN: I think we probably need now to spend a couple of minutes looking at that, starting with observations from Mr Langdale and his team, because you seem to be suggesting that if you were to finish your examination in chief during the course of Friday, that would not give a great deal of time for the rest of the process. Do you, Mr Langdale, have any sense of the sort of time that you would be wishing to have? It is difficult in advance.

MR LANGDALE: This is the question one always dreads and I am as bad as anybody at the Bar can possibly be in estimating how long I am going to take to do anything, but I can say this in the presence of Professor Ford: a certain amount of time has been taken by Professor Ford in explaining what I am going to call basics with regard to what is in the books and general matters with regards to analgesia, patient care, opiates and so on. It is not going to be a case of my taking issue with him as to what those precepts are. I will have to ask him some questions about the general approach in the context of this case. I hope that will not take too long. I find it impossible to say now quite how long that part of it will take.

With the individual patients, obviously one speeds up a great deal in terms of the Panel not having to read material. The issues have become narrowed down and the actual issues which have to be explored with Professor Ford on the individual patients are not that wide ranging because a lot of his criticism is directed in certain aspects which, though no patient is identical, repeat themselves in the context of patients. I doubt if it is going to take as much time as it otherwise would. I will have to draw his attention to certain other aspects and so on.

I would have thought, and this can be no more than a guess, I am bound to take the equivalent of a day, and I think it would be wiser to think I might be as long as a day and a half. I hope that is being over-pessimistic, but I cannot really say. It remains a bit of a guess. I shall do my best, of course, to keep matters within the confines of my own duty, and endeavour to keep matters as brief as I can.

THE CHAIRMAN: Taking that on board, and recognising there is then the matter of re-examination from Mr Kark, inevitably a substantial period of time with questions from the Panel and then counsel's own questions arising out of those of the Panel.

It would appear at best to be tough but do-able by the end of Tuesday.

MR LANGDALE: I was just going to say, that would be my best guess.

THE CHAIRMAN: If it is tough but do-able we need to have in place a Plan B or a longstop in case it remains tough but no do-able.

MR KARK: The Plan B, I am afraid, has to be to ask Professor Ford to give us another day. That is the reality.

THE CHAIRMAN: Or possible day.

PROFESSOR FORD: I already planned to revise my plans, to be available for all of Tuesday. I have changed my holiday plans accordingly. I would be very reluctant to have to come back later in the week because that is the remainder of the time I am spending with my family. I am, however, then on holiday for a further week but at home. If needs must I could come on the Monday or another day that week, although obviously I would prefer not to, but I recognise that may be necessary.

THE CHAIRMAN: The following week we would be, presumably, into the defence case so we would not be able to then revert to the GMC case. We have to finish the GMC case before we can go on.

PROFESSOR FORD: I could ask whether I could make myself available on the Wednesday. It is really not something I would like to do.

THE CHAIRMAN: I think if we can at this stage agree on that. I think it is clear that none of us would wish to put you in a position where we would need to be asking you to come back on the Wednesday. There are some things we can all do to try to assist with the days, in terms of the times at which we sit. But within all of that there is an overriding obligation to the doctor to make sure that the Panel remains sharp and receptive. A Panel that is hearing evidence when it is so tired that it is not able to take it on board properly is not doing the doctor any favours at all.

MR LANGDALE: I fully appreciate that point. Thank you for mentioning it. I think in terms of the cross-examination of individual patients, it is not going to be such tough going from anybody's point of view because we have all been through it, at least in chief, with Professor Ford and it is not as if I need to review each aspect of the patient history, or anything of that kind. I would hope that the concentration problem may not be – who knows – as bad as might otherwise appear.

THE CHAIRMAN: What I am going to say then, Mr Kark, is this. We are going to get on now. The fact that we have not had all the time that we would have wished on this patient is regrettable but it is by no means the end of the world. We can make that up.

We do have the advantage of two days coming up when the Panel can do a certain amount of pre-preparation. One of the things that we can undertake to do is to ensure that for Friday, Monday and the rest of the time in which we may be receiving evidence in chief, that we will not require therefore any further time for pre-reading because we will have done it.

MR KARK: That would make a very significant difference. I would ask the Panel also to consider whether we might sit earlier on Friday. I suggest that with reluctance, but the reality is that a half hour here and a half hour there does really make a difference.

THE CHAIRMAN: They do indeed. All I have to do is remember that I must also balance the need to keep a Panel sharp and fresh.

MR KARK: Of course.

THE CHAIRMAN: In principle, I do not see a problem with that. We might as well say now, then, that on Friday, Professor, we will start half an hour earlier and we will see what other savings might be made, if that is convenient to you.

PROFESSOR FORD: It is. I am on call for the stroke service in Newcastle on Thursday evening, so I cannot stay here, but if I get the six o'clock train which arrives in at nine o'clock for a 9.30 start – assuming there are no travel delays – that will be fine for me.

MR KARK: We were looking at a nine o'clock start, but you were here at 9.15. You cannot make it for nine o'clock?

PROFESSOR FORD: I cannot release myself. I cannot leave that early in the morning to get here before that. I am sorry.

MR KARK: Fair enough.

THE CHAIRMAN: We will start at the normal time, but we will be looking to get a half hour here and there in the remainder of the time to make it less likely that we do have to put the thumbscrews on you for the Wednesday. If we possibly can, I think we are all agreed, we are going to be aiming for the end of Tuesday but nobody can commit themselves at this stage.

MR KARK: I am grateful for all that. Let us move on. (To the witness) We are now going to turn to Ruby Lake, Patient F. Do you have the chronology in front of you?
A Yes, I do.

Q This lady, as we can see from page 2 of our chronology, was admitted to the Royal Haslar on 5 August of 1998. She had had a fall which fractured the left neck of her femur. She underwent surgery. Prior to that it is revealed that she was walking 100 yards and then had to stop because of arthritis. She had lived alone, but she was mobile, independent and self-caring. The plan was, as we see at the top of page 3, after the operation:

> "For X-ray and bloods tomorrow morning and then to mobilise when comfortable."

She is reviewed by a physiotherapist on the 6th and further reviewed on the 7th. Then on 8 August, at the bottom of page 5, we see a nursing note:

> "All care given. ... Remains very breathless. ... Sacrum broken in sacral crease. ... Sat out for half an hour. Mobility poor. Unable to tolerate nursing on side. Poor fluid intake. Paracetamol given for pyrexia."

So she had a slight fever of some sort. Does that mean a raised temperature?
A Yes. Yes, pyrexia does mean that.

Q

> "Agitated at time."

Then it says "Cyclizine given". I do not think we have come across Cyclizine?
A It is an anti-emetic.

MR LANGDALE: I am sorry to interrupt but can we just take note in the history. I am not objecting to the speed at which this is being done. Can we take note of the entry on 6 August, the bottom part of that with regard to "LVF". It is page 3, 6 August, just that little last thing.

MR KARK: I am sorry.

"Fluid overload – LVF"

Is that left ventricle failure?
A Left ventricular failure, yes.

Q And then –

"Infection."

A Yes.

Q What is the correlation between fluid overload and LVF, if any?
A When you have heart failure, you develop pulmonary oedema, fluid on the lungs. The different diagnosis that the doctors are thinking of there is either the patient has a chest infection or that they have pulmonary oedema due to heart failure.

Q And "Stop ivi". Is that intravenous fluid?
A Yes. They are thinking that the intravenous fluid the patient has been given post-operatively may have precipitated the fluid on the lungs in the context of impaired heart function.

Q Moving on then, bottom of page 5, we have dealt with. On 9 August she walked around the bed but her mobility is described as poor. She walked round the bed with a zimmer frame and assistance. She sat out for an hour. She was unable to tolerate nursing on side, always rolling onto her back. On 10 August, physio revealed:

"*Appears unwell today. ?MI*"

Myocardial infarction?
A Yes, that would be what "MI" stands for.

Q And "?chest infection", so those are the differential diagnoses?
A Yes.

Q "*R/V* [review] *mane.*" Then, underneath that:

"*Patient unwell. Vomiting/diarrhoea, drowsy, denies pain, orientated. Apyrexial.*"

So the temperature has gone?
A Has come down to normal, yes.

Q "*Chest clear.*" Underneath that:

"*14.30: Much improved, alert, bright and orientated.*

CXR ..."

Is that a chest X-ray?
A Yes.

Q
"*... chest infection. On augmentin.*"

A Yes. An antibiotic.

Q Does that necessarily reveal that that was, in fact, the cause of her chest problems, or may there still have been an infarction?
A Their conclusion is that was what they thought at this time the diagnosis was; that there had been a chest infection. It is not absolutely certain that she seems to have got better on the antibiotics, so the temperature has come down. That would be a reasonable

Q At the bottom of that page of the chronology, could I just suggest adding one note which comes from page 511, which you have picked up, I think, in your report, Professor Ford. It comes from 10 August 1998, so the day that we are looking at, and there is a Surgeon Captain Farquharson-Roberts?
A Yes.

Q He states:

"For all necessary treatments and resuscitation..."

A Yes.

Q And then there is a word that, I am afraid, I cannot read. Or "... and resuscitate...", and then there is a word. This is in the middle of page 68 of the notes.
A Yes. I could not read that word either.

Q Whereas with some patients, as we have seen, there is the notation "Not for 555" or "Not for resuscitation" certainly at that stage of the patient's treatment on 10 August she seems to be noted "For resuscitation"?
A Yes.

THE CHAIRMAN: Could you repeat that?

MR KARK: It is quite difficult to read. It is "511" right in the middle of a page. It has a large "68" – it is right in the middle of the page, 10 August 1998, and I think you can see:

"For all necessary treatment and resuscitate [something]."

Can we go on to the top of the chronology, the top of page 7. This lady is obviously having problems with diarrhoea and her skin appears to be having problems.

"Ate small amount of ice cream. Ulcers need redressing – both legs."

She had an unsettled night and she was incontinent of faeces, and her sacral area remained red. That would be uncomfortable for her, no doubt?
A Yes, it would.

Q Or painful. On 11 August she is seen by a physiotherapist. She remarks that she remains unwell.

B "L base remains quiet."

A That would most likely be referring to the left base of the lung. The physiotherapist probably listened with a stethoscope herself and would be possibly indicating there was still residual infection.

Q Then over the page of the chronology, I am just trying to stick with the chronology for
C the moment, she feels nauseous and she has abdominal pain.

"Later: Much improved, apyrexial, good urine output.
Chest: Good expansion R = L."

Would that be the lungs as well?
A Yes, that would be the lungs.

D

Q
"Plan: Switch to oral augmentin...".

Augmentin is used for what?
A It is an antibiotic commonly used to treat chest infections.

E Q
"... encourage fluids" and then "Ensure."

Ensure is ---?
A Is a dietary supplement to help maintain nutrition.

Q Then urine output is down and the plan is to stop IV fluids. Later, we see she is given
F a full wash, her bottom and sacral area is very red and breaking down in the cleft. She is described at 1930 as:

"Remains very sleepy. To encourage oral fluids. Urine output satisfactory."

Then on the 12th she is described as "much improved", she has sat out, but she is developing sacral bed sores. Over the page – and again, I am not referring to every part of every entry –
G on 13 August she is seen by Dr Lord and at the end of that, which seems to be her conclusions, she is still dehydrated. Hypokalaemic is?
A Low potassium in the blood.

Q And normachromic?
A It is a certain type of anaemia, often seen in chronic disease, rather than iron deficiency anaemias or other vitamin deficiency anaemias.

H

Q Then:

"Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at the present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement."

MR LANGDALE: Might we just know what she said about ECGs and ischemic heart disease in that section?

MR KARK: Certainly.

"Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease and LVF have been problems recently."

A Atrial fibrillation is irregular heart beat. That puts patients at risk of having a stroke.

Q We can see that the physio notes underneath that:

"Unable to mobilise at present due to chest pain."

So that does not seem entirely to have resolved itself.

A No, it does not. She was still really quite medically unstable at this stage.

Q The following entry at the top of page 11, we can see she has had an unsettled night, she is still complaining of central chest pain and she is given a GTN spray. A GTN spray would be given to relieve any heart ...

A To relieve angina. It is a nitrate.

Q Then:

"Comfortable afternoon. Oral fluids taken. No [complaining of] chest pain. For transfer to GWMH next week."

Then on 14 August she is described by the physio as:

"Brighter today. Sitting out. Walked short distance with frame ... To gradually [increase] distance ..."

Over the page to page 12, she is reviewed and again it is recorded that unfortunately she has chest pain in her ribs through to her back since being manhandled. The ECG reveals nil change and no effect with GTN. What does that indicate to you, if anything?

A The doctor assessing her would be looking to see if there was evidence of any acute myocardial ischaemia, whether she was having a heart attack, or a prolonged period of angina at rest. The ECG was normal, there was no relief with GTN, which would be a sign often that it was a cardiac pain, so her differential diagnosis has become muscular-skeletal pain or alternatively pulmonary embolus, which is a clot to the lung; she has been dependent, so she is at risk of that, and he or she is still considering angina.

Q The patient is given codeine phosphate. Then at 0700:

"Some pain due to arthritis in left shoulder overnight. Had paracetamol to good effect."

We can all see what follows after that. Then I am going to take you through 17 August. She is described as sitting out in a chair. Then at 2015:

B "... Seemed confused this afternoon, reluctant to move herself from bed. ... paracetamol given."

Then on 18 August:

"Reviewed by SHO at Royal Hospital Haslar.
Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well. [To]
C GWMH today."

Again, "spike temp"?
A That means the temperature was elevated the previous afternoon on the 17th, which relates to that recorded temperature of 38.8°.

Q Now 37.3°?
D A Which is normal.

Q At two o'clock in the morning, there is a note that she has increased shortness of breath and oxygen therapy is recommended. She is then transferred, it appears, to Dryad Ward. We can see the transfer letter. I am not going to go through that, but can you have a look at the clinical note made by Dr Barton?

E "Reviewed by Dr Barton
Transfer to Dryad Ward continuing care."

Her history reveals she has had a fracture of the left neck of femur on 5 August 1998, she has had angina and CCF. What is CCF?
A Is congested cardiac failure, again, indicating heart failure.

F Q Then:

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

Are you able to comment, having looked at that whole background, on the state of this patient at this point of transfer?
G A Yes. In my report I commented that it was reasonable to transfer this patient when they were medically stable for rehabilitation and that was the plan, but she had had a really very medically unstable course and had multiple medical problems. I think certainly in retrospect one can say she was not really fit and stable to be transferred. So in retrospect, one would have perhaps said it would have been better for her not to be transferred. Dr Barton's note also suggests there has been quite a change in her mobility, in that the notes say she was mobilising well the previous day. So again, there is a difference in mobility recorded. The
H "happy for nursing staff to confirm death", again, this is a lady with multiple medical

problems who could die. I do not think there is a problem with that in itself. I think the issue is whether that is interpreted or seen to indicate an approach to treatment of any active problems that develop. This was a lady who has had infection treated, she has been assessed for angina, they were going to investigate if she had a pulmonary embolus and I cannot comment whether that statement is an indication that there has been a change in approach to this patient in terms of investigation and active treatment of any other problems.

B Q I wanted to ask you about that. You deal with the quality of the medical assessment by Dr Barton at paragraph 8 of your report.
A I comment there, I think particularly in a patient like this, where there has been a change in function, they are no longer mobile and they have been quite medically unstable, that it would be good practice to have baseline observations and an examination of, for example, the chest and heart. It would be helpful to have a baseline as to what the patient's condition was at the time of transfer and arrival at Dryad Ward.

C Q What are the fundamentals of a baseline observation assessment? What are you looking for in the notes, if you are looking to know where you are starting from?
A One is the patient's level of function, and that is described. We have a description of the mobility. The second is some basic observations which are usually done by nursing staff, which would be pulse, blood pressure, temperature and often oxygen saturation. I think in this patient, who has had an elevated temperature, who has had problems with their heart,
D those I think are assessments that should have been undertaken. As I say, I would normally expect those to be done by nursing staff on admission. Then I think an examination of the patient's chest, respiratory rate and listening to the heart would be a reasonable baseline set of physical examinations.

Q Who would you expect to perform such an examination?
A I would expect the assessing doctor, who in this case was Dr Barton.

E Q If we go over the page momentarily – we will have to come back to where we were – we can see that Dr Barton has prescribed Oramorph, between 5 and 10 mg prn, and temazepam. I am going to ignore the rest for the moment. Do we also see underneath temazepam that bumetanide is prescribed?
A Bumetanide, which is a diuretic drug.

F Q And allopurinol?
A Allopurinol is a drug to treat gout and lower uric acid levels in the blood.

Q How are those taken?
A Orally usually. I think they were prescribed orally. Allopurinol only comes as an oral preparation. Bumetanide comes as tablets or an injection.

G Q So all of those drugs, the Oramorph, the temazepam, the digoxin, Slow K, bumetanide and allopurinol, all of those would be orally administered?
A Yes, they are.

Q Can we deal, before we move on to the box below, with Oramorph? You deal with this at paragraph 9 of your report.

H

A Yes. I could not find in the notes a clear indication or rationale for prescribing Oramorph. This lady had not been on regular analgesia, if I am correct, and there is not a description of what the Oramorph is for.

Q In terms of the analgesic ladder, you have described Oramorph as being the third level. Where should Dr Barton have started, in your view?
A It depends what is being treated. If it is pain from the sacral sore, paracetamol and codeine would be reasonable drugs to start with.

Q What about the chest pain?
A I think this is more complicated. For any patient with ischaemic heart disease, it is often standard, because they often take nitrates themselves, to write up GTN to take if the patient gets angina type pain. This patient was a bit more unstable than that. There were concerns whether she was having a myocardial infarct at one stage and you would not write up prn morphine for a patient who you were concerned might have severe coronary pain due to a myocardial infarction or acute coronary syndrome. That would not be good practice, the reason being that the patient needs an assessment as to the cause of the pain.

Q Can we move on, please? First of all, that Oramorph that was written up was in fact administered, 5 mg was given at 2.15 in the afternoon. Does what you say about the prescription apply with equal force, as it were, to the administration of it?
A I thought the administration was not appropriate. It was given for anxiety and distress in the absence of any pain. That would not be an appropriate use of morphine.

Q Can we have a look at the basis of that? If we go to page 15 of the chronology, we can see that she settled and slept well from 10.00 p.m. until midnight. Then:

> "Woke very distress and anxious, says she needs someone with her. Oramorph 10mg given 00.145 with little effect. Very anxious during the night. Confused at times."

If that were the basis for giving this lady Oramorph, what do you say about it?
A I think it can be criticised. The patient is anxious, they have come to a new environment, they have been quite unwell, they are saying they want someone to sit with them. The first response would be for a nurse to sit with the patient. Nurses would not necessarily be able to sit with her all night, but you would expect, unless there were major staffing problems or other problems on that unit, a nurse to be able to sit with the patient for 20 or 30 minutes. If they were no better at the end of that, I think it would be perfectly reasonable to give either a hypnotic, temazepam, which I think she was written up for, or an antipsychotic drug such as thioridazine or haloperidol, but not morphine.

Q This appears to have been given at quarter past midnight, so I think we can take it that it has to be a nurse deciding to give that.
A Yes.

Q Does that reveal anything about the nurse's understanding of how these drugs were meant to be used?
A I think it did raise to me concerns that the nurses had interpreted that prescription of morphine to be used to treat anxiety or agitation in older people, in the absence of pain. I think most nurses would look at morphine being used to treat pain. So I thought that was potentially a confusion or maybe that was the general understanding of nurses, that morphine

was to be used for either pain or anxiety and I think that would not be an appropriate use in the majority of patients.

Q Can we look on to the prescription that was written at the same time at the bottom of page 16? At the same time as Oramorph was written up, Dr Barton has also prescribed her a variable dose of between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. Can you just help us, please? I appreciate you have dealt with this on a number of occasions, but with this particular patient, is she to be regarded as opiate naïve?

A Yes. When that was written up, she had not received – well, it depends on the exact timing of that, but assuming this was written up on the day of admission, she was opiate naïve and there was not a clear indication recorded as to why she might require diamorphine and midazolam as a continuous infusion.

Q I do not want to waste time by asking you again about what that increase in dose would be. I think we have your evidence about that and your comments about the wide dose range applied to this patient and this prescription.

A Yes, they do. The comments I have made before for other patients apply.

Q Can we go, please, to the top of page 17 of the chronology? We there see a note made by Nurse Hallman:

> "[Complaining of] chest pain, not radiating down arm – no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver."

We are going to have to chop this up, I am afraid. First of all, "complaining of chest pain, not radiating down arm", is that an indication of whether this patient was in heart failure?

A Well, it would not be heart failure. The concern is that this lady has had chest pain before and there have been concerns that that might be due to a pulmonary embolus, that it might be due to coronary ischaemia. She is looking unwell. She looks too unwell for this to be likely to be muscular skeletal pain and you would expect a medical assessment. Obviously contact was made with whoever was the on-call doctor at that time.

Q Does any assessment appear to in fact have been done?

A I did not find a record of any assessment in the medical records.

Q We can see that at this stage the diamorphine which had been written up – I say "at this stage"; essentially in the afternoon at 4.00 p.m. – and the midazolam which had been written up were both started at 20 mg over a 24-hour period.

A Yes.

Q What do you say about the appropriateness or otherwise of that administration of the drug?

A I would consider it inappropriate. There has not been a diagnosis made. There were a number of assessments which needed to be done, as were done on previous occasions on this lady: an ECG, a heart recording, was obtained, you would want to know the oxygen saturations, the respiratory rate, listen to the chest, possibly get a chest x-ray, think about whether she was having a pulmonary embolus, all of which would have very different treatments. What has happened is that there has been a symptomatic response, in that the

patient's chest pain is being treated now with a continuous infusion of diamorphine, which I would say is excessive both in dose and also in the decision to use diamorphine in the absence of a more detailed assessment, a working diagnosis, and there is no clear indication for midazolam, which has been started again at a high dose.

Q We can see that the next entry is 20 August at 12.15:

B "Condition appears to have deteriorated overnight. Driver recharged at 10.10. Family informed of condition."

Then there is a note:

"Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when
C moved. Syringe driver recharged at 07.35 ..."

A patient being distressed in these circumstances can be the result of what; are you able to assist us?
A It could be the result of a number of problems. She may still be in chest pain, she may be confused, she may be hypoxic.

D Q What would be causing her hypoxia?
A She could have a chest infection or pulmonary oedema, or her respiratory rate could be being depressed by the midazolam and diamorphine. There are a large number of possibilities and in the absence of any more detailed nursing or medical assessments it is difficult to know what was the definite cause of deterioration at this point.

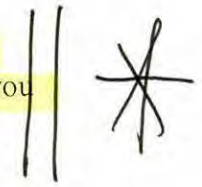
Q By this stage, would the syringe driver which had been started at 4 o'clock the
E afternoon before, be having any significant effect on her respiratory rate?
A I would expect it to with that dose and, her being essentially opiate naïve, she would not have developed tolerance. It is a reasonably large dose and the midazolam dose is a large dose.

Q Can we look at what happens thereafter. Over the page we are still on 20 August, the driver is recharged it seems at 09.15 and then the rate of the diamorphine is doubled to 40 mg
F and the midazolam is also doubled. That appears to be over, effectively, a 12-hour period. Looking at it globally, if we looked at 21 September, at 07.35 the diamorphine is put up to 60 mg and the midazolam is up to 60 mg, so over a 24-hour period, if you look at it from 9.15 on the 20th to 7.35 on the 1st, it appears to be a tripling of the dose.
A Yes, it is.

Q How should we be looking at these increases. We know that you have told the Panel
G that you can increase at increments.
A One would want to see clear rationale for these large increases. The increases are greater than those which are recommended in the Wessex protocols and other guidelines, which would be a 50 per cent increase. One would generally increase one drug at a time to treat a specific symptom, but the escalation of doses over that period in an older patient like this would be expected to cause very marked sedation.

H

Q The patient dies at 6.25 that evening. In your view, would the administration of the syringe driver potentially have a significant effect on that event?
A I was of the view that the doses administered over the period would very likely contribute to her death, yes, but again, because she had a lot of other medical problems, you cannot conclude that the drugs were the cause of her death.



Q I understand.
A I think the issue is, at this point, clearly she was being treated as somebody at the end of life. If there were clear justification to palliate symptoms and that was the agreed management plan, that might be acceptable and appropriate, but that information was not available in the notes to justify the escalation of the diamorphine and midazolam.

Q On 18 August, three days earlier than this, she is described as:

"Well, comfortable and happy and mobilising well."

If there was this sort of significant change in her health, would you expect a clear note to be made about it?
A Yes. This lady had been very actively treated right up to the day of transfer and was being assessed. If there was a deterioration, you would expect there to be a medical assessment and if there was a chest infection for that to be treated, if there was a pulmonary embolus for that to be treated. That, to me, would be appropriate unless you are accepting that it was entirely appropriate that she was being quite medically unstable and at the point of transfer to Dryad Ward there is a complete change in approach to management and that that was appropriate, but that is not clearly laid out in either Dr Lord's letter or justified in any other correspondence. There is a comment "gentle rehabilitation", so even on that initial admission to Dryad Ward, that was the plan which was reasonable and appropriate.

Q Going back to that note at page 78, which is the clinical record made by Dr Barton, the last note she makes is:

"Get to know. Gentle rehabilitation. I am happy for nursing staff to notify death."

The next note records Mrs Lake's death. If there were any reassessments, would you expect them to be noted?
A If there was a reassessment I would expect it to be entered in the notes. With a lady like this I think you would have to consider it relates to what I described yesterday, that sometimes patients are transferred over when in retrospect they should not have been. She was very medically unstable and I would expect there to have been at least a discussion as to whether it was appropriate to transfer her back for further care because it was going to be very difficult in this setting if the agreed plan was still for active treatment.

MR KARK: That is all I ask about Mrs Lake. Again, perhaps that would be a convenient moment to pause for some reading.

THE CHAIRMAN: Yes, indeed. The new chronology for Patient G is just about to find its way to us.

MR KARK: I think we were going to suggest we hand out all the chronologies now to make sure we do not forget to do that at the end of the day.

THE CHAIRMAN: That is probably very wise, then we definitely have them for the next patients.

MR KARK: I will just ask for that to be done. (Copies distributed)

THE CHAIRMAN: Miss K, the Panel already have the new chronology for. There is a replacement Patient A.

MR KARK: We are trying to remember now what we have added, but I know it was something crucial.

MR LANGDALE: 9 January.

MR KARK: I think L has been transmitted, but it is being produced at the moment.

THE CHAIRMAN: I understand it is with the print room and we hope to have it by the end of today. As far as Patient G is concerned, we have now received both updated chronology and we note that within the file of Dr Barton's statements there is a statement in respect of G.

MR KARK: About 20 minutes/half an hour?

THE CHAIRMAN: I think we will take a short break and combine that with some reading efforts. It is coming up to ten to four. If we say quarter past four, that will give everybody a chance for a quick break and give the Panel a chance to dip their toe into the paper.

MR KARK: Thank you.

(The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back everybody.

MR KARK: The chronology in relation to Mr Cunningham is fairly extensive. I expect you have been reading it again over the last few minutes. I am not going to spend any time going through all the early entries. The Panel have read them all and they reflect this patient's state on of health. There is reference to him suffering from Parkinson's and being a difficult man to manage; him losing weight. He was reviewed on occasions by Dr Lord. In July he found himself on Mulberry Ward, which we heard was the elderly psychiatric ward, or the ward for the elderly. Reviewed in September, and this was the first reference to infection, to sores being diagnosed, his weight being mentioned. This is page 7 of the chronology. His weight is recorded as 68.6 kg:

> "Not eating too badly, sleeping reasonably."

On 21 September he is reviewed again by Dr Lord at the Dolphin Day Hospital in respect of a sacral ulcer and he is admitted to Dryad Ward.

Can we look at page 8 of the chronology first. We can see that on 21 September when he is reviewed, he is shown to have a large necrotic sacral ulcer:

"Extremely offensive. Some grazing of the skin around the necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance."

Pausing there, this gentleman is being seen at the Dolphin Day Hospital?
A Yes.

Q It is being suggested he be admitted to Dryad Ward for treatment?
A Yes.

Q What sort of treatment can be applied to this sacral ulcer?
A Essentially it is nursing care which is at a level which you cannot achieve in patients in the community. Admitting to a rehabilitation unit allows you to do more intensive nursing care, more regular dressings with staff that may be more experienced and would be more available than would be the case if he stayed in the community. Getting large pressure sores to heal in patients who are in the community is very difficult, so admitting them is an appropriate practice that is done.

Q If there is a necrotic area, with a reddened area with a black centre, would that indicate debridement?
A You would often consider debridement and various ways to do that.

Q Is it aserbine?
A Yes, I am not particularly familiar with that. It is a type of dressing to clean ulcers, I believe.

Q If we go to the top of page 9, the patient is described as:

"Very frail. Tablets found in mouth some hours after they are given. Offensive large necrotic sacral ulcer."

I will not go through the rest of that. Can we look at the diagnosis first.

"Sacral sore.
PD."

A Parkinson's disease:

Q
"Old back injury. Depression and element of dementia. Diabetes mellitus - diet."

In other words it is diet controlled diabetes.

"Catheter for retention",

so he is suffering from urinary retention?
A Yes.

Q "Plan: Stop codanthramer"?

A Which is a laxative, and metronidazole which is an antibiotic which he was probably on because of the inflammation and offensive nature of the pressure sore.

Q "Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet."

A Yes, because if you improve nutrition, one of the problems with achieving tissue healing is if you have poor nutrition you do not get good tissue healing, so, again, admission and ensuring patients take a good diet with high protein to help ulcer healing.

Q "Oramorph PRN if pain. Nursing home to keep bed open for next 3/52 at least. Patient informed of admission."

So that is admission to the hospital:

"Inform nursing home, Dr Banks + social worker. Prognosis poor."

What is this gentleman's biggest problem, as it were?
A He obviously has lots of problem, but the main problem at the moment is the sacral sore. If that is not improved, he is likely to get infection and become more unwell and frail from the sacral sore itself.

Q The suggestion of PRN Oramorph, is that a reasonable suggestion at that stage?
A Yes, one would expect this to be painful. I cannot see what other medication he was on at this point, but if he has not responded to codeine or paracetamol, it would be an appropriate analgesic, yes.

Q Because he was not at that stage actually in hospital, he was visiting a day hospital, I do not think we know what pain killers he had previously been on.
A I think you should go up the analgesic ladder with someone like this, but if it is very severe some people would consider starting Oramorph. The other rationale for that might have been, I think it is mentioned, some of the concerns about swallowing tablets, so slightly easier to swallow syrup, but that in itself is not a strong indication to go to Oramorph.

Q At the bottom of page 9:

"Seen by Dr Lord. Pressure sore looks worse although NH [nursing home] felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to keep bed for 2/3 weeks at least. Plan of care for ward written in med [medical] notes by Dr Lord."

MR LANGDALE: I am sorry. It is my fault, maybe I missed it, did you mention "Prognosis poor".

MR KARK: Yes.

MR LANGDALE: I am sorry, my mistake.

MR KARK: That is the plan for this gentleman, to treat his sores and he is being admitted to Dryad for that purpose.
A Hopefully, with the intent that after two or three weeks this sore will have improved enough that he can be discharged back to the nursing home.

Q He is reviewed the same day by Dr Barton and we have her note at page 647. This is the one where we have the note at 644 which is pre-transfer on 21 September and then the note from Dr Barton on page 647 at the time of transfer. We apparently have a photograph which we cannot see, but it is in the notes if anybody wants to look at it. 21 September Dr Barton writes:

> "Transfer to Dryad Ward
> Make comfortable
> Give adequate analgesia
> I am happy for nursing staff to confirm death."

In terms of assessment and plan, how do you regard that note.
A I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated. I do not think anyone would have any particular problems with any of that. There is a clear instruction about the type of approach to analgesia from Dr Lord. They are happy for the nursing staff to confirm death we have discussed before. In itself, this is a sick, frail man with many problems and he could die suddenly. That is not the issue. It is whether that has connotations around other aspects of his management.

Q I was going to ask you about that note and also the note "make comfortable". We have heard, as you appreciate having read the transcripts, quite a lot of evidence about that being a euphemism for a particular route.
A It can be a euphemism, but it can be exactly what it says. I would not like to speculate about what the specific meaning. I would acknowledge that it can be interpreted in different ways.

Q It is a question of how the nursing staff would interpret the note?
A Yes.

Q Back to the chronology, please. We will find the drug charts, or the chronology dealing with the drug charts, at page 12. On the day of his admission, Dr Lord has prescribed a PRN dose of Oramorph which we looked at earlier from 2.5 up to 10 mg of Oramorph.
A Yes.

Q And you commented on that already. Dr Barton then prescribes 20-200 mg of diamorphine. We are dealing with the prescriptions first before we actually deal with their deployment, and 20-80 mg of midazolam and hyoscine. In terms of this patient, at this stage of his life, how do you regard those prescriptions?
A I will not go through; the prescriptions are too wide and hazardous for that, but, yet again, I do not see a clear indication as to why he needs to be written up for continuous infusions. In previous discussions of this I indicated the benefits in somebody who might have difficulty swallowing, and there were some suggestions that he might well have

difficulty swallowing, of having an alternate route which could be for PRN. Oramorph itself is subcutaneous or could be written as separate subcutaneous diamorphine. That would be appropriate, but not to put a high starting dose of diamorphine and midazolam when one has not established his response to morphine to begin with.

Q I am sorry. I just wanted to ensure I had not misheard you. Did you say that Oramorph could be given subcutaneously?
A Sorry. Oramorph cannot. Morphine can be. Sorry. Thank you for correcting me on that. Morphine can be given subcutaneously but diamorphine is generally used, so what I am saying is, it would be appropriate and good practice if one was concerned about his ability to swallow to have alternate PRN opiates to give which would say, "Administer if unable to take Oramorph".

Q Before we come back to the actual administration of those drugs, I think we need to go to page 13, which reveals a note from the evening before so the day that that prescription is written out, we then see this note, which is made the following day:

> *"Mr Farthing has telephoned, Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when Arthur tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. Also tried to remove catheter and episiotomy the bag and removed sacral dressing throwing it across the room, finally he took off his covers and exposed himself."*

That in any setting, I suppose, is challenging – what is nowadays described as challenging behaviour?
A Yes. One does come across older people who are confused and agitated, or can occasionally be difficult, of course. The history suggests there were difficulties with his behaviour in other settings.

Q Then, if we now go back to page 12 of the chronology, do we see that night, at ten minutes past eleven, the diamorphine and the midazolam which Dr Barton had prescribed, is started? Sorry – you are nodding?
A Yes. I do apologise.

Q That is all right, but it has to go on the transcript. Unless Dr Barton was attending the hospital that time it appears that that was or may have been a nurse-led decision?
A Yes. It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?
A He is taking Oramorph, so he is getting morphine to control the pain, so there is no need to change that unless he is refusing to take medication, which this note does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness, so it would be quite reasonable if one was going to use pharmacological measures to control his behaviour – one does not always have to resort to that – to look at a dose of haloperidol or thioridazine. One would start with an antipsychotic as a rule for these sorts of symptoms. One might consider a benzodiazepine but for this sort of agitation and behavioural difficulty most geriatricians would not choose a short-acting benzodiazepine but you would not choose

to give midazolam or some continuous infusion when that is recommended for use with the management of terminal restlessness.

Q This was a patient who, it appears, was able to swallow his Oramorph, at least because we know that was being administered. Is there any other indication as to whether this gentleman needed a syringe driver as opposed to any other form of delivery?
A I am trying to find it. There is a record that he swallowed a drink of milk, if I have it correctly.

Q There is. I think he took two glasses of milk. It is page 10, the bottom of page 10.

> "Driver commenced at 23.10 containing diamorphine 20 mg and midazolam 20 mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this [morning]."

Can we look at how this administration went on. First, if the nurses had started diamorphine and midazolam inappropriately and the doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving, recognising that because you started a continuous infusion it is going to be some time before the maximum effects of that infusion will occur. It might be up to 24 hours. That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent.

Q If we go on in our chronology please ---
A Sorry, can I just add a comment to that?

Q Yes.
A Partly that is because behavioural disturbances often are intermittent and people have behavioural problems and agitation for a short period. You treat that and then you withdraw the drugs. The trials which have looked at behavioural disturbances in patients with dementia and psychotropics show, for example, a very high response rate in the placebo group, the group in a trial who do not receive any active treatment, about 40 per cent, and 60 per cent with treatment. That is a broad generalisation. You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care. This again does not seem to be explicitly articulated. It does not seem to be the reason it was started by the nursing staff. It seems to follow his behavioural problems and it is trying to palliate those symptoms, but it is not clear that there was an intent that he was for terminal care.

Q We can see on page 13 that the driver continues. Over to page 14, at the top, it continues on the 22nd and is administered at twenty past eight in the evening, or re-started at twenty past eight in the evening. Then, on the morning of 23 September, he is reviewed by Dr Barton. This comes from the significant events in the nursing plan. There is no note, I do not think, made on the 23rd of any review by Dr Barton, but we have one on the 24th at page

645 of the file notes. Can we just look at the bottom of page 14 before we go to that. In relation to 23 September:

> *"Became a little agitated at 23.00, syringe driver boosted with effect. Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chesty this morning. Catheter draining, urine very concentrated."*

B I do not think we have food or fluid charts for this patient?
A No, no.

Q The only entry we have is the two glasses of milk that we have looked at?
A At this point my interpretation of the notes was that he was not receiving any hydration or nutrition.

C Q And the comment "syringe driver boosted with effect": can you just help us with this. The syringe driver can be boosted, I think, with a button on the side?
A I interpret this to mean the infusion rate was increased. That is my interpretation.

Q Let us have a look at the top of page 15. We can see that in the morning of 23 September, at 9.25, the 20 mg dose of diamorphine is continued and then re-administered but at the same dose at 8 p.m. The midazolam appears to start at 20 mg and then there
D appears to be a three-fold increase?
A Yes. And I think that is what the term "boosted" means, so it is a threefold increase in the infusion rate of midazolam. That is a very high dose for this man and a very, very large increase.

Q It may be obvious but what effect is that going to have in terms of sedation?
A This dose would be definitely expected to produce very marked sedation in a man of
E this age.

Q We heard evidence from Mr Stewart-Farthing – Day 6/8 – that on the 23rd, the day that this boost took place; he found him (he called him Brian) unconscious and unrousable. He says he went berserk, got very angry and he demanded to see the people responsible in the hospital, and he had a row with Sister Hamblin. He asked for the syringe driver to be removed so that he could speak to Brian. Now, obviously one does not have to follow,
F I suppose – you have indicated yesterday – the wishes of relatives.
A Yes. And that is in the best interests of the patient. One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be. Good quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand.
G These are the potential problems with using sedation therapy. It is not just the risk of respiratory depression. It is that you are rendered less conscious which, by definition, is what sedation therapy does.

Q If he is described as unconscious and unrousable on 23 September, first of all is that a state that the patient should be in?
A It would be a state that he would be in if he had a clear indication and his symptoms
H were uncontrollable through any other means except by going to that level of sedation; but

this was a very large dose, a very large increase, and there was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point, and see what happened. He was variable in his agitation and, of course, we had the problem that it possibly was the diamorphine and its metabolites that might be worsening his agitation. It is a very difficult situation. The good palliation at the end of life, you try and adjust and optimise drug therapy, so you minimise side effects. You keep a patient's symptoms in control, but you keep them as alert as possible. The aim is not to render patients unconscious through high doses of sedation therapy.

Q Even if you do not feel that the nursing staff, or the doctor does not feel it appropriate to remove the syringe driver completely the dose could be reduced?
A Yes. If you have somebody who is over-sedated, or has excessive amounts, and that is your judgment, of opiates or sedatives, it is best to initially stop for a few hours and then see what happens to the patient, and then re-start the infusion at a lower rate. That is best practice if someone is clearly overly treated. It is reasonable if they are not in an immediately life-threatening situation to reduce the infusion.

Q If we have a look at Dr Barton's note on 24 September – it is page 645 if anybody wants to turn it up but it is revealed in our chronology at page 15:

> *"Remains unwell. Son has visited again today and is aware of how unwell he is: sc analgesia is controlled pain just. Happy for nursing staff to confirm death."*

And over the page, at the top of page 16, Sister Hamblin:

> *"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 50 mg, midazolam 80 mg and hyoscine 800 microgram. ... Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition."*

Can we just look at the drug charts set out at the bottom of page 16 of the chronology:

> "Diamorphine: 40 mg/24 hrs administered at 10.55"

This is all on 24 September. Then, on the same day:

> "... increased to 60 mg/24 administered...".

A Yes.

Q So within a 24 hour period, unless I am misreading it, just looking back at page 15, on the 23rd he had been on 20 mg diamorphine and by the end of the 24th he was on 60 mg of diamorphine?
A Yes.

Q The midazolam, he had been on 20 mg on the 23rd, and we have already looked at that – there was that threefold increase.
A Can I comment? I find it difficult to know how the nurses could assess the pain was in his knees at this point. He had a very marked depressed conscious level so I find that comment slightly surprising. I would have thought it would be difficult for them to gain an

idea where his pain was. I can only assume when he was being moved he was making noises which led nursing staff to believe he was in pain.

Q Can we carry on, please, we see at the bottom of page 16 that the syringe driver continues. Over the page, now on 25 September, we can see that the driver is recharged with 60 mg of diamorphine and 80 mg of midazolam. At the bottom of the page, Dr Barton has re-prescribed the diamorphine, this time with a higher starting dose, of 40 – 200 mg. Midazolam is prescribed again, as is hyoscine. The diamorphine continues to be given at 60 and the midazolam at 80. Over the page, at page 18, we are on to the 26th, the note is:

> "*Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. ... Driver recharged ...*"

and, again, it has gone up to 80 mg of diamorphine and 100 mg of midazolam. If we go back to the notes at page 647, we can see that there is a note on 25 September by, I think, Dr Brook?

A Yes.

Q

> "Remains very poorly on syringe driver
> For TLC."

By this stage, what sort of condition is the patient going to be in?

A He is dying. With those doses of midazolam in particular and diamorphine, he is bound to be deeply unconscious. It is a very high dose of a potent sedative drug.

Q This patient, I think we all understand, is not being hydrated.

A Yes. At this point, the decision has clearly been made that he is dying; he is not for hydration or nutrition. He is moved into this at that early period. Once he has a depression of his consciousness level, it would seem he is on at that point an end of life pathway.

Q So from the point on 21 September, after his agitation, he is put on the syringe driver and it is increased either with diamorphine or midazolam on I think a daily basis. By this stage on 26 September, in your view is he going to be saying anything, is he going to be rousable?

A No, he is not. I just think it is an unusual approach to managing the problem. I think most geriatricians faced with this type of problem would have carried on with intermittent prn morphine at this stage and would have given a prn variable dose of an antipsychotic, such as haloperidol or thioridazine would have been used, and one would have observed the response. One would not have started an infusion at this point.

Q We can see that the patient died at 11.15 p.m. on 26 September. In your view, would these drugs have had any significant effect on that event?

A I actually think it would be difficult to conclude that the drugs did not play some part in his death through causing deep sedation and respiratory depression, but equally the literature is unclear about people who are clearly having palliative care – this is often cancer patients – as to whether sedation therapy significantly shortens life. But in this patient, who was not initially in that setting, I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he

was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death.

Q At the time that he was transferred on 21 September, he was supposedly destined by Dr Lord for a high protein diet.
A Yes.

Q Does any of that plan in fact appear to have been put into action once he had got to the GWMH?
A No. The plan appears to have been changed by the behavioural problems and the institution of the diamorphine and midazolam infusions at that point. When he was admitted, Dr Barton's note still indicates there was a plan to try and improve this man's function and his pressure sore.

MR KARK: That is all that I ask about this patient. I suspect that would be a convenient moment to break.

THE CHAIRMAN: Yes, particularly as there will be a need for certainly the Panel and I guess yourselves to be organising those papers which you need to take out of the room tonight, since it will not be available to us tomorrow. Thank you. We will resume on Friday at 9.30.

(The Panel adjourned until 9.30 a.m. on Friday 10 July 2009)