GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 13 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-THREE)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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THE CHAIRMAN: Good morning, everybody. I trust you all had a good week-end. I understand, Mr Kark, that the railways have presented us with a problem.

MR KARK: Yes. Unfortunately I have had a message from Professor Ford. His six o'clock train from Newcastle broke down. It had to be towed back to Newcastle. He is now on another train, but his estimated time of arrival at Euston is 11.15 and then he hopes to be here at 11.30. He is going to update me if he has any more delays or better information. Obviously many apologies for that.

He also wanted to apologise for not having come down last night but he had to cover for a colleague who is ill and so he could not do anything other than get the six o'clock train this morning. One has to say, up till now, that has not proved a problem but today, typically....

THE CHAIRMAN: It is always a risk, but we understand the circumstances. It is particularly unfortunate since it is he who has the timing problem in terms of his own evidence. I hope that that is not going to present too much of a problem but, as I indicated before, if the thumbscrews need to be applied, then they will be.

MR LANGDALE: Part of my very good week-end was spent reviewing really quite how much more I had for Professor Ford on the remaining witnesses. As I have indicated to my learned friend already in conversation this morning, I think I shall be able to move through them in terms of the issues I have to raise with Professor Ford fairly rapidly. Certainly had we started at 9.30, there would have been no questions but that I would have finished well within today. I am hoping that despite the late arrival – and I know it is not his fault – it will not throw the timetable out too much, and I would have thought there is still a reasonable prospect of completing his evidence by the end of tomorrow, which I seem to remember was the critical point.

THE CHAIRMAN: That is good news. I must say, it did appear to the Panel that a lot of the issues appear now to have crystallised and speed is picking up, which is useful. The time will not be wasted from the Panel's point of view. We are going to remain now and we will be reviewing the evidence which has already been given by Professor Ford, and doing any other reading that might assist us. It is not entirely wasted.

MR KARK: Looking forward just for a moment, hopefully we will finish Professor Ford by tomorrow evening. There is one further statement to read to you. I do not want to take up time doing that now because we are still waiting for information in relation to that, as to how much of that we have to read. The reading of the statement will take some three or four minutes. Then that will be the close of the GMC's case.

Can I just mention that there was an issue that you will recall about identifying a particular nurse. I think it is Nurse Collins whom we were looking at. We believe that that is being dealt with by the defence. The GMC are not proposing to call further evidence about it.

Once the GMC case has closed, there may have to be a period, as it were, of reflection as to whether there need to be any submissions made in relation to any of the heads of charge. Then, of course, we have to remember we have Dr Lord set up for a video link. My recollection is Thursday and Friday morning. Mr Jenkins tells me it is nine till one – thank you. It is really a matter for my learned friends and the Panel whether they wish to start

Dr Barton and interpose Dr Lord, or pause and wait for Dr Lord's evidence. Perhaps we'll see where we are on Wednesday but we will be very much in the hands of Mr Langdale.

MR LANGDALE: What Mr Kark has just said gives you the general possibilities, as it were, that we have been considering between ourselves. I think it is probably preferable if Dr Barton begins her evidence even if we have had a morning of Dr Lord or maybe Dr Barton starts her evidence on Wednesday, depending on what the issue is in regard to submissions. In any event, I would suggest that is preferable. It may be that if Dr Lord is dealing with matters on Friday morning through till one o'clock, it may be that if her evidence has not quite completed by then, we might be able to use the telephone because the Panel will have seen her and there is no problem about communication in that way – we have already done it once in the hearing. It may be we would run into Friday afternoon. I do not know – one has to bear in mind the time difference and the situation that Dr Lord would be in giving evidence, her time some time after midnight, I think. I cannot quite figure it out. May we leave that open? There is a possibility therefore that Dr Barton might not start her evidence until next Monday. There is, however, another defence witness whom we will need to try to interpose, who will not be available from Tuesday of next week onwards. It may be we will be seeking to interpose her evidence in the course of this week.

Neither Mr Kark nor I are concerned about the interposition of evidence from further defence witnesses while Dr Barton is either waiting to give evidence or is giving evidence in chief. The problem that might arise would be if it were in the middle of cross-examination, when we would be in a different situation, but I do not think that is going to arise.

THE CHAIRMAN: I agree. I think we keep it fluid and we cross bridges as and when we come to them, but it is always helpful to have a view over the top, as it were, as to what may be ahead of us, and we are grateful for that.

MR LANGDALE: May I also just add in terms of the long term view, defence evidence, whatever happens at the end of this week, it will certainly take up all of next week and we imagine the week after, very roughly speaking. I think that is what the Panel ought to have in mind.

THE CHAIRMAN: You are aware that the 23rd is a non-sitting day.

MR LANGDALE: Thank you. You have reminded me. We have been told.

THE CHAIRMAN: That is very helpful. Thank you very much indeed. As I say, the Panel will now read independently and we will resume as and when the Professor arrives.

MR JENKINS: May I just add something?

THE CHAIRMAN: Yes, Mr Jenkins.

MR JENKINS: I have made up a number of indexes. I have an index of the evidence that the Panel has heard already. It is just a chronology. It is done in three different ways. I have not shown it to Mr Kark. I will do that, and if he is content I will make sure you have that this morning. Also, the statements from Dr Barton that you have received, you have not had them for patients C, D or L – Page, Wilkie or Stevens – but for the others, there are a number of references to entries in the medical records and nursing records. I have not, I am afraid,

completed it but for those where I have been able to give you page references to cross-refer to paragraphs, I will make sure that you have those – again, once Mr Kark has seen it and if he is happy with those. It seems to me the Panel will be going through those statements, will see things that they have not seen before and will want to cross-refer to the medical records in each case. Again, if Mr Kark is content, I will hand in those that I have done, hopefully in the next ten minutes.

MR KARK: So far as the latter document is concerned, we are very happy for the Panel to have that. If corrections need to be made, we can make them. It is not going to be a contentious document. It simply correlates what Dr Barton is saying with patient notes, so we could not object to that.

THE CHAIRMAN: We are very grateful then. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everybody. Professor, welcome. We understand the problems that you have had. There is no need to go into them. We will go straight now to Mr Langdale.

GARY ASHLEY FORD
Cross-examined by MR LANGDALE, Continued

Q Straight off the train and into questions about patients again, I am afraid.
A That is fine.

Q I am turning to Patient D, please, Alice Wilkie. Again, unless I say to the contrary I will be using the chronology sheets every time, and I will refer you to things if I need to. This lady has advanced dementia and UTI problems, just by way of very broad summary. We can pick that up on page 2, for example, of the chronology on the 1 August 1998:

"81 yr old lady with advanced dementia."

There is a mention of UTI. Then perhaps we can move on to page 3 of the chronology. There is a section in the middle of that page dealing with the drugs and QAH on 1 August. I just want to make sure I have understood you correctly; that there is haloperidol being prescribed there and indeed administered. Did you indicate that in your view that was on the high side?
A I indicated the maximum dose would be a very high dose to give a frail, older person but the initial starting dose of 2.5 mg is reasonable. The maximum dose comes from the British National Formulary. That is where the prescriber has taken them from.

Q Yes, thank you. Page 4, then, please. On 4 August, still at QAH, reviewed by Dr Lord. Just to clear up one little point, one can see that she has said the overall prognosis is poor. That "+" sign, which we looked at when you gave your evidence in chief, looking at the note, it is clear it is an "and"?
A Yes.

Q It is not suggesting "Prognosis poor ++", so it is clearly an "and".

"... too dependent to return to Addenbrooke's..."

and so on. Then over the page, on page 5, the transfer to Daedalus. Dr Peters is the doctor who clerks her in, and the remarks – the referral letter – half way down that page ends with pointing out:

"Mentally she is dependent and needs feeding."

Then, over the page we carry on with some of the notes made at Gosport War Memorial Hospital. On page 6 we can see that the medical history is summarised as:

"... advanced dementia, urinary tract infection and dehydration."

It goes on to say:

"Patient has dementia – withdrawn + does not communicate."

I am missing out the next few words. Then:

"Appetite: Poor. Does have pain at times, unable to ascertain where."

A similar note just below that:

"Does have pain occasionally but cannot advise us where."

And you have already given your evidence about the difficulty with patients with dementia. It may well be they are in pain, but unable to communicate precisely where and so on. We can then see on page 7, on 10 August the review by Dr Lord when she is in Daedalus.

"... if no specialist medical or nursing problems D to a N/Home."

In fact, obviously that did not turn out to be the case.

"Very need, not expected to return to Addenbrooke"

is the CPN note on the same day. Then, over the page to page 8, 17 August:

"Deterioration recorded"

it says in the contact record.

"Condition generally deteriorated over the weekend. Beed"

that is the nurse, Philip Beed, from whom the Panel heard evidence:

"Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate & to use of syringe driver if Mrs Wilkie is in pain."

It is clear then, would you agree, that the deterioration was taking place without any administration of opiates at that stage?

A Yes, at that point she was not on opiates.

Q It is an example of precisely what can happen. That leads to a difficulty, does it not, in relation to opiates once they are administered in the patient who has been deteriorating, deciding quite what degree of deterioration is due to the opiates or not?
A Yes. I think particularly there is no additional description of what the deterioration constituted, so I agree with you.

Q Thank you. You yourself made the comment: "This is not a lady where an aggressive intervention was going to occur," and we then come on to question of the prescription which Dr Barton wrote out in case this lady was going to need the administration of subcutaneous analgesia - right?
A Yes.

Q Because we note that the first administration is in fact on the 20th, so I think it is three days later. Nothing wrong with the doctor writing that up by way of a safeguard for a situation which might arise?
A There is nothing wrong with writing up analgesia if it is required, but the prescription of a continuous infusion I am critical of, because it would be usual to prescribe as required single PRN doses of diamorphine, subcutaneously, if the patient was not swallowing or Oramorph if they are able to swallow, depending on what their status was. The problem, as I have discussed before, is that one cannot determine what this lady's opiate needs are. The majority of frail, older patients dying in continuing care need low doses of PRN analgesia. I looked at the paper you referred me to last week and indeed that point is made in that paper. It is not the prescription of analgesia which is being criticised here; it is the very high starting dose and wide range, as of before, for both diamorphine and midazolam.

Q Your same point as it were in terms, if you like, of the character of the prescription.
A Yes.

Q You indicated in relation to the situation on the 20 August, you said in your evidence that there was not any indication of pain in relation to the administration of the diamorphine and the midazolam. All right?
A It was not recorded in the days preceding the commencement of that. Obviously I note that there was a description she was in pain some days before.

Q Yes. The thing that I do not think has been drawn to your attention is that on the date in question when the diamorphine was administered, on that day, and before it was administered, the daughter of this particular patient – that is Marilyn Jackson – was in the hospital and her mother had indicated to her she was in pain. As a result of that she was so concerned about it that she summoned a nurse, who said, "We'll give her something," and it appears that after that, that is when the subcutaneous analgesia was administered, so there is an indication of pain and that was the response by the nursing staff.
A Yes. I may not have picked that up if it was recorded in the nursing notes, but clearly if the relative had expressed that, I would considerable appropriate give analgesia.

Q It is not your fault.
A No.

Q Because it was not in there. That was the evidence the Panel have heard and you just do not have the information about it. I am not complaining.

Q And I think the use of diamorphine again I would not criticise if the patient was not able to swallow. It is a matter that the dose and starting point I would be critical of.

Q Because you said yourself, one would want to see a record of the rationale.
A Yes. I accept that.

Q I am not going to go through that. We can see on the 21st on page 9 the entry by Dr Barton:

> "*Marked deterioration over last few days. SC analgesia commenced yesterday. Family aware and happy.*"

The nursing note following that:

> "Patient comfortable and pain free."

Then the administration is recorded in relation to the 21st of diamorphine and midazolam and she died that evening. You expressed the view that the drugs may have contributed to the deterioration but you cannot conclude that the effect of the drugs was, as it were, to play a part in death in the other sense?
A Yes.

Q She was going to die in the near future, I think were you words?
A Yes.

Q May I also just indicate to you the evidence that the Panel heard from that same witness, the daughter, Marilyn Jackson. She had indicated that she was in pain on the day when the subcutaneous analgesia was first administered and she was very sleepy. It appears she was very sleepy before the subcutaneous analgesia was administered. Again, that is consistent with the general deterioration, presumably. "In pain", I have already put to you, and she also said, "If I had known my mum was in a lot of pain" – and she probably was in her last few hours – "and someone had sat and explained the benefit of the syringe driver, maybe things would have been different." So it appears there is another indication from somebody that this lady was in significant pain towards the end of her life?
A Yes. I think the clear justification has not been recorded for the use of the sedative midazolam, and my criticism is not of the prescription of diamorphine if there was indication of pain, which there clearly was from the evidence presented to the Panel, it is the high starting dose, which was beyond what she required in terms of not seeing a response to more usual doses one would use in this age group.

Q Well, again we face the same difficulty, if a smaller dose had been applied and sometime later the pain was still there one could easily reach the level which was eventually administered.
A Yes, but I think the problem I have with that is clinical practice, you have very few patients who go to this level. I mean, after you had asked me the question last week, at the weekend I went and looked at all the diamorphine prescribing on three wards – continuing care ward, Walkergate Hospital rehabilitation ward and the stroke unit – and I looked at the

59 patients who had died in the previous eight months, and 19 had received opiates, which was about a third, which accorded with what my anecdotal impression was, and of those 19 only 4 had received doses more than 5 mg over a 24 hour period, and the highest dose was 20 mg over 24 hours, so this is a very high dose that you would not normally require to achieve pain control in terms of usual clinical practice.

Q So none of the patients you looked at in that sense, and I appreciate this is just looking at it from a particular point of view, and I am not going to attempt to go into any kind of detail for obvious reasons, so none of them were in the stage of Mr Pittock, who for several days required rather higher doses than any of those?
A Some of them were. Some of them had been on fentanyl patches for a long time, but most had required opiates just in the last day or two of life. I cannot conclude that this lady definitely would not have required 30 mg every 24 hours of diamorphine if it had been titrated up to that, but my view would be it would be very unusual for a patient like this to require that amount to achieve symptom control, and I think there still remains the issue of the midazolam and the lack of clear indication for that if she did not have terminal restlessness.

Q Very well. May I move on, please, to Patient E, Gladys Richards. This patient, we can see at the beginning of the chronology, was assessed on 4 February 1998, bearing in mind she was transferred to Daedalus Ward some months later, some six months later, and I am not going to go through all of the history, but I do want to pick up the first entry here, if I may:

"Assessed by Dr Banks."

The Panel heard evidence from Dr Banks.

"Severe dementia. Deteriorated since Christmas."

I am not going to read out all the rest of it, but he mentions at times being quite agitated and distressed during the day. This is the note where one has to add – and, sir, I think we gave the reference of page 110 in the nursing notes – Professor Ford, end stage illness, you may remember that expression we looked at; not surprising, there are considerable periods when she is asleep; obviously needs some help to relieve the distress she experiences when awake. Just this, please: end stage illness, when that is noted with regard to a patient suffering from severe dementia who is deteriorating, what does that encapsulate?
A I think to most geriatricians that would be describing someone who has severe dementia, and in the latter stages one sees increasing frailty, less activity, less food intake, often the patient develops further wasting and becomes more withdrawn, and one is anticipating they will die within a relatively short period of, say, weeks from usually bronchopneumonia or other complications.

Q Well, that gives us the general picture. I appreciate there may be variations patient to patient.
A Yes.

Q Then this lady unfortunately, as we can see on page 2, had a fall, but no apparent injuries, and then a rather more serious incident on top of the history we have just looked at; she is taken into the Royal Hospital Haslar after a fall where she fractured the right neck of her femur, and we can see the history that goes on for some period of time. Perhaps we can

move on, please, to page 4, because we now move into August of 1998, when she was reviewed by Dr Reid:

> "Confused, but pleasant and cooperative. 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 ..... transfer to GWMH."

Dr Reid's evidence was that he felt her prospects for remobilising were not good; perhaps understandable in the circumstances.

A I think anybody would agree with that.

Q Then over the page, please, page 5, the transfer to Daedalus, and this is the case where, on the referral, the top of the page, "Now fully weight bearing, walking with the aid of two nurses and a zimmer frame", appears to be rather over-optimistic, perhaps, in the circumstances, and we can see on the 11th, when she is admitted:

> "Not obviously in pain. Transfers with hoist."

We can move on, please, to the next page, still on Tuesday, 11 August, the assessment notes at the top:

> "No apparent understanding of her circumstances due to impaired mental condition".

Then there is the administration of Oramorph on that day. You say you could find no rationale in the notes for morphine at that point, co-codamol would have been appropriate, but you can understand, can you not, a doctor considering in these circumstances that Oramorph might be appropriate in relation to somebody who had had an operation of this kind and in that situation?

A Well, I think my view I expressed was only if one could not obtain adequate pain control with paracetamol and codeine, or other similar milder opiates, mainly because of the problems of confusion and drowsiness that the morphine might result in.

Q Because it would appear, because the Oramorph is not continued, the next administration is the following morning, before there is any further problem the Oramorph stops, and you can understand a doctor feeling that a lady in this state, having just been transferred after an operation of this kind, thinking that Oramorph might be appropriate to give her the best possible pain relief and a happier state of mind?

A Well, I still think it would be unusual if the patient was not on morphine when they were transferred from the unit to escalate the level of analgesia unless there had been a clear change in the patient. I do not think that would be usual practice in an elderly care rehabilitation ward setting. What one nearly always does on transfer is continue the medication that the patient is on at transfer and then review after a day or two how they are managing on that, and at that point, if she was not controlled with the analgesia she was receiving, you would escalate it there, but I do not think it would be practice – I know what you are saying, that here was a lady with severe dementia, towards the end of her life, are opiates reasonable? It still is not usual practice. One would look to give PRN analgesia, paracetamol and codeine, and only go to morphine if that was not working.

Q All right. Well, one can only say---

A That is why I can only express what is my experience of how we would work in most elderly care settings.

Q All right. Then moving on to the next day, we can see that Oramorph was administered the following morning at 6.15, and then, although Dr Barton prescribed further administrations, they are not administered, so the Oramorph is stopped, which obviously you would say was sensible if it did not appear to be being needed?
A Yes.

Q Then, as we have heard in other evidence, the following day this unfortunate lady has a fall of some sort in Gosport, and Dr Briggs is contacted. He advised an X-ray and analgesia, and there is no criticism of that obviously.
A No.

Q Over the page, as a result of that Oramorph is administered, and you are not critical of that, as I understand, in the circumstances?
A No.

Q We can see Dr Barton prescribes PRN in relation to that, that is in relation to haloperidol, perfectly sensible if that was needed?
A Yes, very much.

Q So there is no issue there.
A No.

Q Then the 14th, the next day, which is a Friday:

"Reviewed by Dr Barton.

Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to oramorph ..... Is this lady well enough for another surgical procedure? ..... Appears to have dislocated right hip. Referred for relocation."

Dr Barton, again not surprisingly, would you agree, considering asking herself the question, "Is this lady actually up to a further surgical intervention?" In fact, she did go back, but a perfectly legitimate consideration for a doctor to have?
A Yes, and absolutely the right action was taken in discussing that with the orthopaedic team.

Q Then carrying on with that, because she goes back to the Haslar in the circumstances, some Oramorph was administered, again there is no criticism about that, before she goes back, and then readmitted, as we can see on page 9. I am going to move on, if I may, please, to page 10, where we see the notes which refer to what drugs were administered at Haslar. You can note at the tope of page 10 in red "Drug charts (Haslar)". That shows that she was given 2 mg of midazolam, and that is intravenous.
A Yes.

Q So the effect of 2 mg of midazolam intravenously is what, if you can put it in a sentence or two?

A Well, when midazolam is usually used, it is used intravenously, and it has a different effect from giving it orally or by slow infusion, and it is used as a pre-medication or a sedative to assist in procedures, because the high concentration you get through administering intravenously means you get high uptake into the brain for a short period, and then that what we call redistributes out of the brain back into the blood, so it is very good at giving a short period of sedation and amnesia, and that is why it is used for inducing anaesthesia and for gastroscopy.

Q Yes.
A So what was unusual with this lady, what we are commenting on, is normally after giving 2 mg you would expect, with the redistribution, for her to wake up an hour or two later, and what they are describing is that she remained unresponsive, sedated, for a long time after this 2 mg dose.

Q That administration was obviously in connection with the surgical intervention that was taking place.
A Yes.

Q There is obviously no question of it being appropriate, and so on, but can you just by way of comparison assist us; that is the effect of 2 mg of midazolam injected, a bolus. 20 mg of midazolam over 24 hours; now, is it sensible to try and think of any comparison as to the actual effect on the patient, without making an over-precise calculation?
A Yes. I think the point is that after an hour or so the 2 mg midazolam would be distributed in a similar way in the body as if you gave 2 mg very gradually, so what it is saying is, the clue is that she is very sensitive, this lady, to midazolam.

Q Yes.
A Now, a lot of older, frail people are very sensitive, and it is why the starting dose used now is recommended to be 2.5 mg, and even back in the 90s the starting dose, as we have seen in the guidelines, was 10 mg, and that is because some older people are very sensitive. So 20 mg over 24 hours given by subcutaneous infusion, you cannot really compare the two, but the clue was there from the 2 mg that she would likely be very responsive to any infused midazolam.

Q If it is not a sensible comparison I will not pursue it with you, because the situations may be in effect rather different.
A It is very different. If the midazolam was indicated for having restlessness, you know, when she had adequate analgesia, the problem in my view is the high starting dose at 20mg and the failure to then adjust the dose if she did become very sedated. You could say that taking account of the response to the 2 mg, best practice would have been to reduce it even further, but I think actually they are two very different circumstances and I would not be overly critical in not necessarily incorporating that response when then prescribing midazolam. My criticism is of the very high starting dose.

Q Well, that is the point you make throughout really: this is too high for a start---
A Yes, but I would not criticise Dr Barton for not necessarily taking account on board that – I mean, I think one would have to be very au fait with everything that had happened, pick this up, and I think that would be quite difficult, and I do not think I do criticise.

Q I do not think you have sought to do so in your evidence so far. Then can we move on, please, to the 17th on page 10, still on the same page, "Transferred back to Daedalus", reviewed by Dr Barton, who says, last couple of lines:

"Only give oramorph if in severe pain."

Obviously no criticisms about that?
A No.

Q The doctor obviously being well aware of the situation there. Over the page to page 11, there is an administration of Oramorph when a nurse receives information that she is in pain. Again, no criticism there?
A No.

Q So that was Nurse Couchman, from whom the Panel heard evidence, and the Panel heard evidence about the circumstances of the administration of that Oramorph. As you yourself have said, it is very clear this patient was in pain. Then can we move on, please, to page 12, 18 August, Dr Barton:

"Still in great pain ..... I suggest [subcutaneous] diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

Then the nurse Philip Beed has a record of what had happened in relation to the discussion with the daughters, their agreement to the use of the syringe driver to control pain and to allow nursing care to be given. She was peaceful and sleeping.

"Reacted to pain when being moved – this was pain in both legs."

That is at 7 o'clock in the morning. We can see over the page the prescription that Dr Barton had written with regard to the diamorphine, midazolam and haloperidol. The following day, the 19th, we can look at the administration of the drugs on that day as well. So if one tries to look at the calculations on 18 and 19 August, particularly the starting point, it looks as though she had had in the previous 24 hours, including the dose of 10 mg administered twice in the early hours of the 18th, by the end of those administrations she had had a total of 45 mg Oramorph in that 24 hour period.
A Yes, that was my judgement.

Q That is exactly the figure you came to:
A Yes. You said you could not find a reason for going subcutaneously, but if there was a difficulty swallowing that might be a reason to switch to subcutaneous.
A Yes. It is just that that was not recorded in the notes that I could see.

Q No, of course. It is clear, is it not, that the Oramorph really was not enough?
A Yes.

Q Therefore, if you were following the calculation which appears to be the accepted calculation, then, in those days, at that time, halving the Oramorph takes it down to 22.5 mg, and then you allow for some uplift because of increased pain, 40 mg would not be an excessive figure in the circumstances, would it?

A No. In my report, as you know, I referred to a 50 per cent increase in dose as reasonable, which would equate to about 35 mg and my comment was that I would consider the dose infused was high but not unreasonably so and careful monitoring was required.

Q I do not think there is essentially any core issue between us. At that point in your evidence you deal with the 2 mg of midazolam intravenously at the hospital, Haslar, which I am not going to go over with you again. You have indicated at this point that the clinical situation has changed: a very gloomy picture unlikely to improve. Correct?
A Yes. There was no apparent new problem. It was in place. It was, in my view, unlikely – I am not an orthopaedic surgeon – that intervention would have been thought about in a patient like this.

Q Then I do not think there is anything else I need to ask you about your evidence in relation to that. You have indicated in terms of her death that the predominant cause of death in this case was dementia with the hip fracture. Again it is difficult to say what part the administration of opiates and the midazolam did or did not play – no doubt playing some part, inevitably, because of the state of the lady.
A Yes. She clearly required end of life palliative care, in my view, at this point. I am mainly, as you know, critical of the midazolam that was prescribed and administered.

Q I think I have covered with you those points with regard to that patient, so I am not going to ask you anything further on Patient E.

Move on, please, to Patient F, Ruby Lake. The chronology in the case of this patient starts in January 1998 and she is somebody who does not get to the Gosport Ward Memorial Hospital until August, so we can look at the history fairly rapidly, I think. Again this is somebody who had "background problems," as the way I am going to put it. On 24 February 1998 osteoarthritis, rheumatoid arthritis and gout, impaired renal function, and she seems to get a lot of joint pain. Just a very general picture on that first page. Over the page, we can see how this unfortunate lady had a fall. On 5 August, on page 2 she goes into the Royal Hospital Haslar with a fractured left neck of femur. She is 84. She had MI three years ago, no residual angina, and various other matters are set out there. On page 3, still in August, she was reviewed by the physiotherapist on 6 August. It says "Currently unwell" and there are various problems with regard to chest observations, and then we see "LVF" – left ventricular failure – on the bottom of page 3.
A Yes.

Q Over the page, she was commenced on analgesia to wean her off the patient controlled anaesthesia.
A Analgesia, I think that is.

Q Analgesia – I beg your pardon. Again, you have explained that, and I do not think I need to go into that any further. We can see the history going on. At the top of page 5, in relation to the heart history,

"Became breathless on movement from commode to bed. Given some oxygen."

This appears to be associated with the heart problem.

A Yes, it seems most likely. There is a question whether she had heart failure or infection, but it seemed there was an overall impression at the end that there was significant heart failure.

Q Thank you. Then there are the problems that she also had recorded on 8 August. Towards the bottom of the page:

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> "Unable to tolerate nursing on side ... Paracetamol given for pyrexia. Agitated at times ..."

Over the page again, to page 6, 9 and 10 August are dealt with there. On 10 August there was a review. Blood tests were conducted.

> *"Physio: Appears unwell today. ?MI ?chest infection."*

C

At the bottom of the page, again she is unwell: she is drowsy but denies pain. Chest infection is referred to and so on. "Much improved" in the afternoon. Again I think this is a case where you can see the ups and downs that happen -----

A Very much so.

Q -- quite commonly in this sort of history. This lady is an example of it. Over the page

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there are various problems. I am not going to read through those, but we can take note of them. I am going to move on, please, to page 8. On 12 August, at the bottom of the page, she has improved:

> "Has sat out today. Developing sacral bed sore. U+Es improving. Plan: Mobilise with physio to encourage oral fluids, stop augmentin, no IV fluids."

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Then can we move on to Dr Lord on page 9, 13 August.

> "Assess this lady re future management. Post-op recovery was slow with period of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work on her mobilisation. Previously lived in ground floor house. Physio has visited for past 6 weeks."

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Then Dr Lord's review itself at the top of page 10. I am not going to go through that because she covers the background position.

> "Ischaemic heart disease and LVF have been problems recently."

In the last few lines:

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> "Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMGH. Uncertain as to whether there will be a significant improvement."

One can see the doubts that no doubt were in Dr Lord's mind at the time. The physio records in relation to the same day,

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

There does not seem to have been any medical assessment about that. Is that something you would query?
A I am looking back at whether there was chest pain recorded earlier. There certainly was shortly afterwards.

Q We bear in mind, of course, that it does not tell us when the physio notes were made but they appear on the same day. Dr Lord is obviously reviewing her and saying ECGs show atrial fibrillation.

> "Ischaemic heart disease and LVF have been problems recently."

She does not suggest any further medical assessment, does she?
A No. That is her medical assessment. Physiotherapists often will not appropriately mobilise patients if they complain of chest pain or significant breathlessness which is atypical. What is not clear is whether the physiotherapy was documenting that chest pain which then leads to the subsequent nursing note talking about central chest pain. What may have occurred here is that the physiotherapist went to mobilise the patient and noticed they were complaining of chest pain, so he or she did not mobilise the patient and then referred that to the nurses. That is what I would read is happening here, but, yes, to answer your question, the chest pain needs an evaluation of course.

Q Dr Lord you would say has carried out a medical assessment.
A Yes, and does not mention chest pain at that time, so one would assume, although she documents ischaemic heart disease, that this lady was not complaining of chest pain at the time Dr Lord saw her and it may be that she developed chest pain when the physiotherapist was attempting to mobilise her.

Q What I am getting at is there is the medical assessment. I appreciate it is difficult to know quite when it occurred, but Dr Lord is just assessing the position and not suggesting that anything further needs to be done medically.
A In terms of further investigation at that point, no.

Q Thank you.
A I agree.

Q As you say, over the page, on page 11, "Unsettled night overnight. Continues to be very restless" and so on. The spray was given. You said that was to relieve angina, if I remember.
A Yes.

Q When reviewed by the physio the next day she is brighter and managing to walk a little but more. Again, part of the general up and down picture we have been talking about. Over the page, please, to page 12, on 15 August, the Saturday:

> "Left sided chest pain in the ribs ... since being manhandled. ECG – nil change, no effect with GTN."

Then:

> "Muscular-skeletal pain, consider PE or angina ... Analgesia codeine phosphate ... Consider spinal CT or VQ or pulmonary angiography."

A I think that should be "spiral" CT.

B Q Again, that is a review. Nobody is suggesting any intervention, or at least no intervention was carried out in relation to anybody doing anything. Is that fair?
A No, that is not quite the interpretation I would make.

Q Could you please make it clear. It is my mistake.
A I was not quite clear, in reading the notes, what the "mandhandled" referred to, whether it was the physiotherapist mobilising her or some other event which is not described. C Obviously because there was no acute change on her electrocardiogram and the nature of the pain, the working diagnosis was of musculo-skeletal pain, and the appropriate treatment is giving analgesia. What the assessing SHO, junior doctor, is obviously considering is that there is a possibility that this was another episode of angina or, more worryingly, a pulmonary embolus – which is an important, not uncommon complication of major surgery. The implication there is that if the situation changed and they became more likely, investigations should be undertaken with a view to treating those. I would not interpret that D to say that the medical view is for no intervention.

Q That is precisely what I was asking you to explain because I can very easily be misreading this in terms of the medical side. Going on to the following Monday, at page 13, 15 August was a Saturday, 17 August was a Monday. She is still in Haslar. Over the page to 18 August, the Tuesday, that is the day that she is transferred. Looking at that period of time between what the SHO had said on Saturday 15 August and another review on Monday 17 E August, nothing appears to have been done – and I am not suggesting anything should have been, but I am trying to get at the picture. There she is in hospital, somebody is raising these queries, what is done?
A I think at that point the plan was to observe her. Two things which happened prior to her transfer is that there was a spike of temperature at some point – which might suggest infection or indeed a pulmonary embolus – and she is more short of breath. But no interventions were taken or further assessments were taken in response to that, although she F is reviewed. She is seen on the ward, and clinically she looks well. Obviously with the benefit of hindsight, one can say this lady actually was quite unstable – and we will come on to that, no doubt.

Q I was going to ask you. The same difficulty, that this is a long time ago and looking at other people's notes, but it may be in fact that it would have been wiser to keep her in hospital.
G A I think there is no question about that, in retrospect – and it is easy to say with retrospect – that this lady was not stable and it would have been preferable not to have transferred her to Dryad Ward when she was transferred.

Q This is the case where you had had something of – and this is not a criticism – a change of view. Reviewing the matter, you said you had come to the conclusion that she was not really fit for transfer on reflection.

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A Yes. I am not sure I had commented on whether she was fit for transfer prior to that, but my view if I was asked – and I do not think my view has changed – and as I think most people would say with retrospect is that there were clues there that she was not very stable: the spike of temperature – we would normally keep people in 24/48 hours before transfer to a rehabilitation unit on a spike of temperature – and the breathlessness. Difficult judgments as to when to transfer people, in a context where there is often a lot of pressure on beds.

B Q Yes.
A One has to make fine judgments, but ideally one would have liked the medical team who were responsible for her at that point to have contacted Dr Lord or one of the other consultant geriatricians and say, "This has happened, are we still okay to transfer?"

Q All right. We can only deal with what actually happened.
A Of course.

C Q Having expressed that view, inevitably. Transferred to Dryad Ward: there is the transfer letter talking about the slow recovery exacerbated by bouts of angina and breathlessness and so on. On to page 15 of the chronology, still on Tuesday 18 August, the review by Dr Barton when the patient was admitted:

"continuing care. HPC: Fracture"

D and so on.

"PMH: Angina. CCF" – congestive cardiac failure. "Catheterised."

Then the plan is:

E "Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

You indicated she had had, in your view, "a very variable medical course" up to this point. I think that was the expression you used.
A I cannot remember. I would have to look at what I said in my report. Clearly she had a very fluctuating course prior to transfer.

F Q It is just the note I made of the phrase you used, but I think it comes to the same thing.
A Sorry. The same thing, yes.

Q On admission she may well have been suffering from recurrent chest pain, which may have been musculo-skeletal in nature.
A Or angina, or another problem, yes.

G Q It may have been musculo-skeletal.
A Yes.

Q Maybe angina. And a justification, in those circumstances, would you not agree, for prescribing Oramorph?
A No, I would not. I mean, if it is angina, the treatment is nitrates and then other approaches. You would use a beta-blocker very cautiously in this patient but there are other approaches where opiates are used for the treatment of pain due to acute myocardial

H

infarction. They are not used to treat pain from recurrent angina. For musculo-skeletal pain you would use moderate analgesics, possibly non-steroidal anti-inflammatory drugs, but it would be unusual to go to opiates for musculo-skeletal pain in the absence of a major fracture.

Q On the issue as to whether there is an element of relief of anxiety and distress we have already covered the views with regard to that. We can see on page 16 that Dr Barton writes up the anticipatory prescription for diamorphine, hyoscine and midazolam – just to take that on board as we move on. That is the end of 18 August. Over the page, on page 17, 19 August there is a record by a nurse with regard to the complaint of:

"chest pain, not radiating down arm."

That indicating that it was not a case of heart failure, is that right?
A Not so much heart failure. Heart failure itself does not give chest pain but angina can be associated with heart failure. But what is being written there is that the pain does not have some of the features which would suggest it was angina, and radiation down the arm is one of the features. It is not invariably present. It is also "not worse on exertion," so Nurse Hallman is expressing a reasonable description of the pain and suggesting it is not likely to be angina, although I do not think he or she is trying to be a diagnostician at that point.

Q No. But the clue there is, is it musculo-skeletal rather than angina? Would you agree? It may be impossible to say.
A I think it is very difficult to tell with this lady at this point the cause of a pain. It still could be cardiac in nature. She is not looking very well with this pain, but it equally could be musculo-skeletal, yes.

Q Therefore the situation might indeed justify the administration of the subcutaneous analgesia?
A At this point, one of the problems was that the morphine prescription did not clearly describe what it was for. We do give opiates with acute left ventricular failure, for example, but again one would normally give it intravenously or intramuscularly so there was not a clear description in the prescription of what the indication for opiates was. But I would not be critical at this point of giving an opiate. I do not think I am critical of giving an opiate for that particular pain in that circumstance but, again, we do not know if that is controlling her symptoms, what dose of opiate she is going to need if one chooses to switch, with good reason, to using a syringe driver.

Q We can see, just in relation to the conversion that by that time, I think she received 40 mg of Oramorph in the 24 hour period. That is the Oramorph 10 mg being given that morning, and taken the previous 24 hours – unless I have calculated it wrong, I think it is 40 which she received by way of total in that 24 hour period.
A That may mean I have not seen all the prescription charts extracted or the information.

Q That is what it may very well mean – I have been wrong.
A The doses I have were that this lady had received a 5 mg dose at 14.15 hours on the 18th, a 10 mg dose at 15.00 on the 19th, a 10 mg dose at 11.50 hours on the 19th. So I had her as receiving 25 mg in the preceding period.

Q Very well. Do not worry about it. It may well be I have that figure wrong. We can check on it. It does not mean that I have to pursue any particular point with you because it is simply a question of using the mathematics to see what the conversion would be to 20 diamorphine. We can move on in relation to 20 August, the Thursday. The deterioration overnight, general condition continues to deteriorate. "Very bubbly". What is that indicating?
A Usually secretions on the chest and in the mouth.

Q So again, associated in any way with her chest problems?
A Could be or, again, could be a problem of sedation of her respiratory function and swallowing from the sedatives and opiate she is receiving at this point.

Q All right. Again, it is one of those cases where the fact that she was rousable and distressed when moved, as is recorded in that same section, appears to indicate not over-sedated, would you agree? "Rousable and distressed when moved"?
A Yes. Of course, as we commented before, there is not a good assessment of conscious level, but if she was rousable and able to communicate when moved, I would agree that would imply she was not overly sedated but the notes, again, are very poor in this respect.

Q I appreciate that at numerous points, as with other case ---
A Yes.

Q --- it is difficult to say because there is not a detailed note. You have already indicated your criticism of the increase of the dosage that took place, looking at Friday the 21st. All right?
A Yes.

Q And you have indicated that in terms of the cause of her death, you cannot conclude that the doses were the cause of her death because of her other conditions?
A I think in my view they contributed to her decline, but she had had a very unstable course beforehand and was developing new problems and could well have deteriorated.

Q And if this is part of palliative care, in other words, that the subcutaneous analgesia is justified, inevitably there may well be a part played by the subcutaneous analgesia?
A Yes.

Q As part of her treatment?
A I think the problem is, I am critical that there was not a fuller assessment of her pain, with obtaining a cardiogram at that point and more details about her blood pressure and the rate of escalation of the doses was rapid and would be judged to be excessive in terms of guidelines and not clearly justified by the nursing records.

Q That is all I need to ask you about that patient, thank you – Patient F. Can we move on to Patient G, please. This is the case of Mr Cunningham. Admitted to Dryad Ward on 21 September. We can look very briefly at the history, I think, which starts in terms of the chronology in March 1998:

"Reviewed by Dr Lord...".

Towards the bottom of the entry there, five or six lines up from the bottom of it:

> "*Wonder if he could have had problems with intermittent left ventricular failure, but overall symptoms not too bad at present. Taking Leva-dopa for Parkinsons.*"

Then various items of medication are set out. Reviewed by Dr Lord on the 19th. Over the page on 19 June, Dolphin Day Hospital:

> "*Low in spirits .... Breathless occasionally. Oedema not a problem. Has had two falls since moving to Rest Home.*"

Various problems which we need not go through in detail.

> "*Transfers extremely hazardous...*"

and other matters mentioned. Towards the bottom of the page:

> "*Loss of independence and mobility. Possible visual hallucinations due to medication.*"

Over the page he is reviewed by a psychiatrist, Dr Scott-Brown at the Gosport War Memorial Hospital.

> "*Reviewed on behalf of Dr Banks...*".

Then again, another reference by Dr Lord. He is reviewed again at Gosport in July, on page 4 of the chronology. Various matters are set out. Reviewed by Dr Lord again, later on in July – page 5. 20 July at Dolphin Day Hospital, carrying on with a similar sort of picture. Then, on the sixth page of the chronology, 21 July, an informal admission to Mulberry.

> "Discharged to Thalassa Nursing Home..."

Various issues and problems referred to there and then we can move on, I think, probably to 21 September on page 8 of the chronology. That is a Monday, in case the days of the week matter, and they sometimes do here.

> "Reviewed by Dr Lord .... Admitted to Dryad.
> "*Reviewed in DDH today. Has large necrotic sacral ulcer, extremely offensive.*"

As you have already indicated, the central problem at this stage essentially is, "What are we going to do about this sacral ulcer"?

A Yes.

Q By way of nursing care and so on. Then over the page at page 9, still on this same day, Dr Lord is recording:

> "*.... Very frail. Tablets found in mouth – some hrs after they're given.*"

May I just ask you this: in terms of a problem for nursing care, is this something which happens from time to time with patients in this sort of condition, by way of a refusal of taking medication?

A Yes.

Q Or for what?
A For old patients and also patients with Parkinson's disease, they can have problems swallowing. So you do find nursing staff reporting patients having trouble swallowing tablets, or that they have not swallowed them. They are unaware of them and been unable to initiate, in effective, effective swallowing.

B

Q And on some occasions spitting tablets out?
A Yes.

Q Which may be part of a refusal to take medication or ---
A It may be, or that they are unable to.

C

Q Yes, all right. She refers in terms of the diagnosis to the sacral sore, the old back injury, depression, an element of dementia, diabetes mellitus – diet; catheter for retention. "*Plan*:" She sets out the stopping of various drugs. Dryad today and she says – we can perhaps take note in this first section on the top of page 9:

"... high protein diet, Oramorph PRN if pain."

D

There is Dr Lord suggesting if in pain, go straight in – my words – to Oramorph. Would you criticise that?
A She had underlined the PRN. If you have a very large ulcer, most people would say best practice is to go through the analgesic ladder and start with that.

Q That is what I was going to say to you. If we apply the principles you referred to earlier on, you would say, "I would have thought, go up the ladder" but in your evidence you said that you thought it was reasonable here to go to Oramorph. I am suggesting that when one looks at these things, it may well be reasonable to go to Oramorph in a number of situations which do not necessarily follow or recorded the analgesic ladder.

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A If he was in very severe pain, I think Dr Lord must have been struck by the severity of this pressure sore, but the recommendations would be to use the middle grade of the ladder first before going to opiates. She did emphasise the "PRN". She was being cautious is how I would interpret that PRN, is how I would interpret that PRN.

F

Q Absolutely, but I am just making that point.
A No, it is a fair point to make.

Q For obvious reasons.
A Yes.

G

Q Perhaps it highlights the fact, and we have seen it in other patients as well, that these sacral sores, bed sores and ulceration, can of themselves and often do produce a lot of problems with pain?
A Yes, there is no question about that. They can be very painful.

Q We can see at the end of her comment, she puts "Prognosis poor," which we have already covered?

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A And we have agreed.

Q And I do not need to go over that any more with you. Then over the page, page 10, reviewed by Dr Barton. The Panel will be hearing in due course that I think Dr Barton, Dr Lord having reviewed in the Dolphin Day Hospital, same building, actually came down with the patient, as it were, from Mulberry Ward to transfer to Dryad Ward.

> "*Make comfortable. Give adequate analgesia. Happy for nursing staff to confirm death.*"

And you have indicated obviously that this was a sick, frail man with many problems who could – could – die suddenly?
A Oh yes.

Q And, as you say, you would need to look at that particular note – I appreciate you were not there to see what Dr Barton did or did not do, but looking at the note, you said one obviously need to look at that in the context of him having already had a detailed assessment?
A Yes.

Q So no complaint.
A Yes.

Q I am sorry. I think there is a mistake on the chronology there, where it says "Mulberry Ward", it should, I think, be DDH but it does not matter. I do not think it is being suggested that the patient moved from Dolphin Day Hospital to Mulberry Ward then to Dryad?
A No.

Q And admitted from DDH. Perhaps we can just amend that: "Mulberry Ward" should be "DDH". Thank you. Would it be right to say – and I appreciate the precise point of time may be difficult to establish – but at this stage he was probably on balance entering a terminal stage? If it impossible to say, I will not press you on it.
A No. I think, going by Dr Lord's assessment, there is a common situation. You have somebody who is very frail. One can see they are highly likely to develop complications which may be fatal, but your approach is, even if there is only, you say, a ten or twenty per cent chance that you have this frail older patient, that they are going to leave hospital and get back to their nursing home, your approach is to bring him for rehabilitation. We are down to how we use words. I do not think at this point Dr Lord – we will have to ask her – was viewing him as being on a formal end of life care pathway, but there was clearly a view, which I think any geriatrician would recognise, that that might happen.

Q Yes.
A Within a short period, but the approach being taken was an active approach to try and heal his sacral ulcer.

Q Then we can see Oramorph was administered prior to the wound dressing. There is no criticism of that.
A No.

Q This is on page 10 still. Then we come on to the period of time in the evening where the syringe driver was commenced. We will just need to follow through the history in

relation to this. Over the page on page 11 there is a further nursing care plan about what the situation was. It is a little confusing. I appreciate we are trying to piece together things which happened some time ago and using these sometimes brief notes but it appears, looking on the record on page 11, that he is very agitated at 17.30, if we can pick up that time.
A Yes.

Q So 5.30 in the afternoon. Oramorph 10 mg is administered – assuming this is accurate – at 20.20 – twenty minutes past eight, and he is described as pulling off the dressing to the sacrum?
A Yes.

Q We will be hearing some evidence from a nurse about this occasion, but could we move on to page 13 for the moment just to follow the history through. On page 13 there is a record made on 22 September, so the day after, and this is a record made by a nurse who had been on duty the previous night, Hallman – do you see that name at the top of the entry?
A Yes, sorry. Yes, I do.

Q Just so you know what the picture is, that nurse has given evidence that that night she was on duty and this note which is made the following morning, when she is going off duty.
A Yes.

Q And she records a conversation with Mr Farthing, the relative, and she sets out an incident which she herself had not witnessed, but what she understood had happened with regard to him wiping sputum on a nurse, saying he had HIV and was going to give it to her, try to remove the catheter and so on and later syringe driver charged at 20.20. That is what she has recorded.

> "*Contains diamorphine 20 mg and midazolam 20 mg. Appears less agitated this evening.*"

This is in fact, I think, a later note, if I remember it correctly. That appears to be the history in relation to this. You indicated in relation to the prescriptions shown on page 12, which are dated the 21st --- All right?
A Yes.

Q You could not see a clear indication of why he needed to be written up for subcutaneous infusions?
A I could not see a clear indication for why it was started. He was on opiates.

Q Yes.
A He was swallowing the Oramorph at 20.20, as you described and so there was no evidence presented that he was not able to swallow and he had only had two doses of the oral morphine so, again, difficult to know what his opiate requirement would be.

Q All right.
A So if one is saying here is a man who is being given PRN oral morphine, is it reasonable, because, as we know, he had had some evidence that he might have difficulty swallowing, albeit with tablets rather than a solution, that he might need to move to a subcutaneous route, and again my response is it would be appropriate to give PRN doses

rather than a continuous infusion. That is my view of it. It is not inappropriate that there was some provision to be able to give a subcutaneous dose of diamorphine.

Q I follow. I think in relation to this patient he had been taken off antipsychotics. Would that influence what would be sensible to give by way of analgesia?
A Well, I think I comment in my report that it was appropriate the pain he was having with PRN opioids, if they had helped, but his agitation should have been treated with antipsychotic drugs, and I cannot recall what he had been taking in terms of antipsychotic drugs prior to admission---

Q To avoid delay, over the adjournment we will check and see if we can direct you to anything about antipsychotics. Just to follow through the history to get the picture as fully as we can---
A Sorry, just to answer that; certainly, if he is agitated and he has had antipsychotic drugs in the past and he is not on them now, your first approach would be to give antipsychotic drugs.

Q Yes, but the fact that he has come off the antipsychotics for some good reason, might that influence the dosage of diamorphine and midazolam you would think it sensible to apply?
A Well, this is a man who had agitation and behavioural problems before he had – a significant pressure sore is what the history is telling us, so I do not think diamorphine would be the appropriate agent to use. There is a difficulty that most of the antipsychotic drugs do worsen symptoms of Parkinson's, which is why one tries to cut back on antipsychotic drugs, and there is a fine balance to be struck there, which is difficult, so you would certainly want to control pain. You might consider using a sedative rather than an antipsychotic drug, but---

Q I was going to ask you, does midazolam then come into the picture?
A I do not think it is unreasonable if he is very agitated. Again, my criticism is the dose used and the failure to then review the response to it. Most people would introduce a small dose of an antipsychotic if somebody was acutely disturbed like this.

Q Just to follow through the history as we try and piece it together, back to page 10 of the chronology, there is a reference again at the bottom left hand section, and this is still Monday 21st:

> "Driver commenced at 23.10 containing diamorphine 20mg and midazolam 20mg. Slept soundly following. BS at 23.20".

A I am trying to recall what "BS" stands for.

Q I was hoping you were going to be able to say because I have forgotten. Blood sugar?
A I think it was blood sugar, and if he has diabetes that would make sense as to why they would refer to it.

Q Perhaps we can just notice the next thing:

> "2 glasses of milk taken when awake."

So it does not appear he was over-sedated and it appears that he could drink milk at that stage.
A At this point the driver has only just commenced. As we have talked about before, we have not got any of the accumulation and the final response one is going to see to the doses that are being administered.

Q Yes, we do not know what time he was awake, of course, it may be difficult to say, but some time during the night it would appear in any event.
A Yes.

Q That is as far as we can take it on that score. If we can just follow through the history, bearing in mind that he is on diamorphine of 20, midazolam of 20, as from that night---
A Yes.

Q ---if we can move on to page 14 of the chronology to 23 September, that is a Wednesday:

> "Reviewed by Dr Barton."

The nurse's note says:

> "[Seen by] Dr Barton. Has become chesty overnight. To have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to commencement of syringe driver. Informed that Cunningham on small dosage which he needed."

That is what the nurse has recorded. Then we look on, that same day, the evening:

> "23.00, syringe driver boosted with effect",

indicating that something had been allayed, or alleviated, yes, "with effect"?

> "Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chesty this morning. Catheter draining" et cetera.

So, again indication, not, as it were – I appreciate the expression "unconscious" may mean more than one thing – but not so over-sedated that---
A Well, I think that is difficult to interpret. I mean, obviously I would not agree that he is on a small dose – the comment made by the nurse. These are quite large doses, particularly midazolam. I mean, one can be both sedated and intermittently agitated. Certainly, he is not being presented as a man who is communicating or awake, but there is a record that he was agitated and that led to certainly the midazolam being increased very substantially, I have from 20 mg to 60 mg, and then the following day the diamorphine was increased.

Q Yes. It would appear terminally ill at that stage on the 23rd? If it is not possible to say, I will not---
A Well, again, we have got a problem here. He has deteriorated. He has had a period of behavioural disturbance where he is awake, he is tearing off his dressing, he is throwing things around, he is being aggressive to nurses. We now have a man without much

description, all we have got is he is agitated, but he is lying in bed and we do not know how alert he is, but it does not sound like he is very alert.

Q If we can move on to the 24th, over the page to page 15, the Thursday:

"Reviewed by Dr Barton.
Remains unwell. Son has visited again today and is aware of how unwell he is.
[subcutaneous] analgesia is controlling pain just."

Well, perfectly legitimate concern of the doctor to make sure that the pain was controlled properly, correct?
A Absolutely.

Q The CPN note:

"Physical decline, pressure sore's developed, admitted to Dryad Ward. He is terminally ill & not expected to live past w/e [weekend] according to sister on ward."

So really the picture here is that both the day and the night staff report pain on 24 and 25 September.
A It is unclear what they are observing in their response to pain. I mean, this is a man who was, as far as we can see, not complaining of major pain, he was obviously thought to have some discomfort when he was seen at the Dolphin Day Hospital, and then he has escalated within a very short period, 21 September, to a very high dose of diamorphine. So it is a very dramatic change, and at the same time he has also been escalated to a very high dose of midazolam, and I find it very difficult to know what signs the nurses were interpreting as to whether this man was in pain or not.

Q All right, but if he was in pain, let us say they are not completely wrong, this man is deteriorating, for whatever reason, background circumstances, he is clearly indicating he is in pain, and it does make sense, does it not, to increase the painkiller?
A If he is clearly indicating he is in pain, and we do not have a good record that I can confidently look at that and say this man clearly was in pain; all I am saying is it is a very high dose of diamorphine to have increased to within a short period for a man like this. I mean, one cannot say he was not; I was not there, and we do not know the exact details. All one can say is the notes do not provide a very clear justification and adjustment in the context that this is a very high dose for a patient like this. I mean, I think we have a general issue here that almost the commencement of the infusions marked the start of the end of life care pathway, and yet it is never very clearly described in the notes. One is trying to surmise what the thinking was of doctors and nursing staff around the use of it.

Q Can we just follow through the rest of it.
A Sorry.

Q No, no, absolutely, what you said saves me having to ask you another question. Page 16, just to follow through the picture. This is still on 24 September:

"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees."

Now, I appreciate it does not give you any detail, but there is an indication that there is a specific site apparently for pain, at least at some point.

> "Syringe driver renewed ..... with diamorphine 40mg, midazolam 80mg ..... Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware" and so on.

Then:

> "21.00: Nursed on alternate sides during night, is aware of being moved. Sounds 'chesty' this morning", and so on.

Then "Peaceful night's sleep" is recorded. We can see what happens over the page on Friday the 25th, when a doctor, Dr Brook, saw him. The note:

> "Remains very poorly. On syringe driver. For TLC",

is Dr Brook. It does not matter, but that is another medical person seeing him. That is Friday, the 25th. Over the page to Saturday, 26 September:

> "Condition appears to be deteriorating slowly" and so on.

The diamorphine then at 80, midazolam at 100, hyoscine 120 micrograms in 24 hours. By way of conclusion, you indicated he was at a high risk of getting bronchopneumonia anyway.

A Yes.

Q You thought it was difficult to conclude that the drugs did not play a part in his demise.

A Mainly because of the very high dose of midazolam he was being infused in the context of his diamorphine, but I am very critical of the midazolam, that that was progressively increased without documentation that he had terminal restlessness or marked agitation. This is a very high dose of midazolam that is being infused.

Q Had there been such a report that he remained agitated in any way, or restless in the sense that you are talking about, then the midazolam dosage might have been justified on the record?

A Well, I think it has gone beyond certainly the recommendations in the Wessex protocol, which would tend to 60 mg or 80 mg for 24 hours, but, yes, I think adjustment of the dose in response to symptoms is appropriate. I mean, what we have failed to see in any of these twelve cases is an adjustment downwards. It was only one way adjustment upwards, apart from the one occasion when Dr Reid reduced the dose in one patient.

Q So in those circumstances it would not necessarily be the adjustment as the amount of the adjustment that one would be looking at?

A Yes, and the failure to have recorded a clear justification. So, for example, the Liverpool care pathway did not exist then, but now if you run a protocol you have a four-hourly assessment of pain, agitation and other observations of the patient, and your treatment interventions are based on those four-hourly observations of nursing staff in patients at the end of life. Now, that is best practice, you would not expect to see that in all cases, but in many of these we just have a complete paucity of any description of the symptoms.

Q Yes, that is the problem one is faced with, you are faced with it, everybody is faced with it, and I am not criticising you as a result obviously. Just out of interest – last question before lunch – when did the Liverpool care pathway come in?
A Now, you have asked me a question I do not know, but it certainly was not being used in---

B Q No, no, I know it was not, I was just curious as to when.
A I think we started using it three or four years ago. I think it was being developed in the early 2000s, but I do not absolutely know.

MR LANGDALE: No-one is going to hold you to that. Sir, would that be a convenient moment? We are making fairly good progress, I think, on the patients.

C THE CHAIRMAN: Yes. Thank you very much, Mr Langdale. We will rise now and return at five past two, ladies and gentlemen. Thank you.

(Luncheon adjournment)

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

D MR LANGDALE: Professor Ford, if we could move on to Patient H, please, the patient with cirrhosis and so on, the liver problems that we have looked at more than once, and if we look at page 2 of the chronology, the fall fracturing the left humerus, and it is described on page 3, at the top, as a left greater tuberosity fracture. I think you have already indicated this in your evidence, it is a very painful fracture, that fracture, is it not?
A My understanding is it can be. Again, I am not an orthopaedic specialist.

E Q No surgical repair carried out, and, as we know, if we look at page 3, at the bottom, he received a single intravenous injection of morphine for analgesia and then paracetamol.
A Yes.

Q Over the page, on 23 September, page 4, in terms of the analgesia:

"Morphine is now [subcutaneous] injection and codeine phosphate has been added.
F Was administered this morning for pain."

He is complaining of pain and severe discomfort and given codeine. The bottom of the page, still the same date:

"Not helped by present pain relief so try morphine 2-5mg".

G We note intravenous.
A Yes.

Q Not subcutaneous in terms of that. Then page 5, he is still experiencing pain:

"Experiencing severe pain ..... Addressed with diamorphine."

H

One can see the history there with diamorphine being given with little effect, and then some more being given, and at the bottom of the page a further reference to diamorphine. Top of the page, page 6:

"Pain +++ from" the obvious cause.

We have got a situation where this pain goes on really, does it not, throughout the history of his time in that hospital? He is described as drowsy on page 6 on 25 September. He gets codeine phosphate and co-dydramol. That carries on. Can you just help us with one matter in relation to co-dydramol? If you look at page 7, this is not the only administration but it is administered as it is described on 26 September, just to take one date by way of an example, it is administered four times. Can you make any equation of that to something in Oramorph terms, or it is a meaningless---

A Well, I would not because we tend not to, as I think I said before, alter the starting dose of morphine in patients who have been on milder opiates. It does not affect the initial starting dose.

Q Right, but I am just trying to get a feel of what are we talking about; is it---

A Well, they are just much milder. I mean, I am not aware that people have generally tried to equate the moderate opioid to a dose of morphine, but probably ten-fold, I would have to look it up, but ten-fold less potent. There are much less strong drugs that---

Q Somebody has handed me note suggesting it is equivalent to 30 mg of Oramorph. Does that sound barking mad or possibly more or less right?

A That surprises me. I would have to look at that reference. I have not seen it in the *British National Formulary* or other---

Q It sounds as if I have been given a barking made note.

A I cannot see it is equivalent to 30 mg. I would be very surprised at the source of that.

Q Maybe I have been misinformed. Can we look back very quickly at file number 1, tab 4, just to see if this helps. If we go to the numbering inside the tab, to page 6, on the right-hand side of the two columns, what is in fact page 9 of the *Palliative Care Handbook.*

A Yes, I have it.

Q The opioid equivalent. That is the thing that is in my mind, where equivalents do seem to be at least worked out. To give us an idea, for example, eight coproxamol tablets would equate to 30 mg of morphine. Does that make sense?

A I am surprised at that. I would be interested to know on what basis that has been derived.

Q Would you just take a moment to look at the other codeine, dihydrocodeine. I will stick with those three.

A Yes, I said a potency of ten to one just now. I said approximately and that would fit with those figures there of 30 mg of morphine to 360 mg of codeine or 300 mg of dihydrocodeine.

Q And co-dydramol, if I am getting it right, is dihydrocodeine plus paracetamol.

A Yes, with paracetamol. It is a combination. I cannot exactly remember the amount of dihydrocodeine in co-dydramol.

Q Would you agree that a doctor considering whether to administer Oramorph would be entitled to consider the patients immediate previous history with regard to the administration of more moderate opiate type drugs, opioids?
A As it is indicating there, you certainly can do on the basis of this information, yes. I think most doctors do not, though, in terms of the starting does of opiates.

B Q In any event, if one had a mind to, if one had a mind to the *Palliative Care Handbook*, you might think it sensible.
A You could, but you would have to look at the exact amount being taken because these are larger doses of dihydrocodeine or codeine than you would typically take with the combination tablets which have quite low does of codeine or dihydrocodeine in.

C Q That is why I was asking about the co-dydramol, because it just says "administered four times".
A Yes, and that is quite a low dose. I would have to look it up, but I think it is about 8 mg or 10 mg each tablet.

Q We can check it in the drug chart if necessary. To carry on with this same patient, we can see the problems on page 8 that carry on with regard to his arm and other matters, sleepy and drowsy and so on. At page 9, 29 September, seen by Dr Birla:

D "Will be reviewing resuscitation status. Says medically there is little more to be done. May need nursing home placement."

Toward the bottom of that same entry:

"Not eating and drinking this pm."

E Then, at night:

"Settled well with analgesia."

Poor quality of life and poor prognosis is set out halfway down the page in terms of his history.
F A Yes.

Q Over the page, he remains when he is seen by Dr Ravindrane on 30 September. The state of the arm we can see, and appetite very poor.

"Complaining of pain in left arm, says the tablets are inadequate."

G Despite that, the medication does not seem to have been changed to increase the analgesia and at the same time it is noted towards the bottom of the page that he frequently refused that kind of analgesia. The pain carries on, on page 11, 1 October. The analgesia is spat out. Discomfort continues. Indeed, on 2 October we can see him refusing analgesia despite the pain. On page 12, 3 October 1998, discomfort continues on movement. I suppose one would say hardly surprising, if he is on just one paracetamol, one gram of paracetamol. We appreciate, of course, that the nursing staff are having the problem that he is certainly at times refusing medication.

H

A Yes.

Q Then the time comes when he is given some morphine: 2.5 administered. That is intramuscular. No problems there.
A No.

Q Then over the page, page 13, he is given some more morphine on 4 October, one presumes intramuscularly, and also paracetamol. He knocked his arm. That of course created further pain and morphine is administered the following day, 2.5 mg. Then 6 October, page 14 of the chronology, he is still in pain. Halfway down that entry:

> "Taking prescribed analgesia for pain in arm with only small effect."

It carries on; the picture remains pretty much the same. He improves a bit on one day or so. Over the page to page 16, on 8 October we heard from Dr Lusznat. One can see what the problems are that she has set out. Towards the bottom of that entry, we see "physically obese". This man had put on a great deal of weight, as I recall, when he was in hospital. This is fluid building up in the body. We will come to the figure later on, but I think it was something over 10 kilos of extra weight.
A Yes.

Q Obviously there is additional deterioration, if we look at the bottom of Dr Lusznat's note:

> "May have developed early dementia. Might be early Alzheimer's disease of vascular type dementia. Also depression."

And so on. Over the page, pain still not controlled. We can see towards the bottom of that entry on page 17:

> "Asked doctor to consider stronger analgesia, not prescribed codeine phosphate."

That does not seem to have been done to any significant degree. If we look at page 18, there is codeine phosphate 30 mg administered, if we just take that on board. Pain continues, discharge home, on 9 October on page 19, totally unrealistic. Codeine phosphate. Then paracetamol. PRN: co-dydramol. It goes on with him still staying in pain with the analgesia not apparently coping with it. If you look, please, at page 22 on 13 October, towards the bottom of the page, if we could just take that on board, 13 October,

> "Still in a lot of pain ... Legs very oedematous, at high risk of breakdown secondary to cardiac failure and low protein. Needs 24hr nursing care. Medication: Paracetamol 1g" –

plainly not enough to control the pain. Yes?
A Yes, he is clearly not being controlled on paracetamol and the occasional tablet of codeine that is being given.

Q Cardiac failure is obviously now an issue.
A Yes, or fluid retention to his alcohol-related liver disease. I think that could well be a factor.

Q I will come back to that in a moment. Would you look at page 23 for the transfer to Dryad, please. On 14 October, which was a Wednesday, he is transferred. Dr Barton reviews him.

"HPC: Fractured humerus left ...PMH: Alcohol problems, recurrent oedema, CCF" –

B she has noted –

"Needs help with ADL. Hoisting"

and so on.

"Plan: gentle mobilisation."

C

This is a man, obviously, who has been in pain for the last three weeks really.
A Yes.

Q Since his fall. Over the page on page 24, Oramorph was administered, it having been prescribed. We can see the prescription is recorded on page 25, where Dr Barton on that Wednesday, 14 October, had prescribed Oramorph PRN. In fact, 10 mg administered first of
D all, in the afternoon, and then 10 mg at night. You said it would be preferable to establish him on a regular moderate opioid analgesia but is it right that you would not really take much exception to the fact of that prescription of Oramorph at that stage?
A Yes. He had not had a proper trial of a good dose of regular moderate opioid with codeine or dihydracodeine, so given his liver disease and age one might have wanted to see if one could achieve control with that. You make obviously the point that he had had odd doses and had remained in pain, so one might well anticipate a need to move to morphine, but you
E could have tried that. I do not think I am overly critical. I was saying one has to be cautious in a man like this about the dose one uses because of his liver disease and so it is important to start with a low dose and monitor response in someone who is going to be more vulnerable to the adverse effects of morphine.

Q But we have seen the picture that paracetamol ----
A Yes. He needs better analgesia, it is quite clear from the notes.

F

Q All right. I will leave it at that. Just in relation to this particular painful fracture, pain can persist for a long time whatever you do, because nothing has been done to the fracture.
A Yes.

Q Is there also a problem with pain with regard to bleeding tracking down the arm?
A It is slightly out of my remit, but I would not have thought so at this stage. One of the
G problems was obviously that he had refused any fixation. One might have gone back and re-explored that with the orthopaedic surgeons, although he had indicated he was not willing to have intervention.

Q He was not having any of it, yes.
A But this would have been a difficult discussion to have had with a man who had cognitive impairment. But clearly there were problems getting ----

H

Q Yes.
A The hope was that this would heal and what normally happens is the pain reduces over time and then the analgesia required is reduced over time, but in some patients, if one does not get effective healing you get a continuing problem of chronic pain due to lack of the fracture healing and clearly you are in a difficult position then, when the preferred approach, which he had declined, was to fixate the fracture.

B Q Looking on page 24 at the other drugs prescribed by Dr Barton, towards the bottom of the left-hand section: frusemide and the others, in general all of those makes sense.
A Yes. I think the trazodone he had been on long-term as a sedative, and if he was stable on that that would be reasonable to continue, yes.

Q Over the page on page 25, at the top of the page, where it says:

C "Unclear. Drug charges indicate:

Hyocine: A doctor other than Dr Barton" –

that is in fact Dr Knapman, we know, and it was not administered. Then if we look at the general picture with regard to Dr Barton's prescription on Wednesday 14 – this is her anticipatory prescription – that would be reasonable, would it not, for a doctor who is
D concerned to ensure a regime of pain relief and medication, and it was still available with a patient like this whose condition could seriously deteriorate at any time?
A Again, my comment is as before, that it would be better to prescribe single PRN doses of diamorphine to allow the patient to receive analgesia but not the continuous infusion over 24 hours of diamorphine and midazolam when one has not stabilised this man and known what his requirements are. I was critical that if you are going to start, as was started this man, on a high dose of regular morphine, one has to recognise he was at potential risk of
E development encephalopathy or drowsiness and he needs close monitoring and dose adjustment if necessary.

Q If you are following the single dose route, which you are saying in your view would have been preferable ----
A Yes.

F Q A single dose of diamorphine.
A Yes.

Q Does not control the pain. Another dose at a higher level.
A Yes.

Q Then another dose at a higher level. The consequences to the patient are that he is
G getting – what? – two, three, four injections, if the pain is still not being controlled?
A One does not know. That was not done. But in most patients one would achieve control of the pain. In somebody who is already on opiates, let us be clear, the injection in his thigh or arm, his good arm, is going to be trivial in pain compared to the pain he is getting in his facture.

H

Q Yes.
A So I think this is not a strong argument in this sort of patient. The ability to observe response and adjust the dose of drug of morphine appropriately is much more important in terms of managing the patient.

Q If you are doing that and if it turns out that it does not control it, he is getting breakthrough pain every time, is he not?
A Yes, but you see we get back to the assumption that the syringe driver is a good way to initiate opiate infusion or maintain it in somebody who cannot swallow. The advantage of giving a single injection is you get an initial loading, high concentration, absorbed quite quickly. With a syringe driver you have to wait hours before you are getting much of it absorbed, so the idea that the syringe driver is a better way of providing analgesia out of hours when a doctor is not available is, in my view, flawed logic.

Q If you are administering the analgesia by subcutaneous infusion, you are aiming to achieve an avoidance of any kind of breakthrough pain, so that the dose can be adjusted if there is any problem. It is building up to take care of the situation. How does that create more of a problem for the patient?
A If you give a single subcutaneous injection, it is very similar to giving a single oral dose of morphine: you absorb it slightly more quickly in giving it subcutaneously intramuscularly. If you give an infusion, you are going to take longer to get to the same place. Also, there is the issue that is even more difficult to adjust the response to the infusion, because after you have given a single injection, a single oral dose, you know in an hour or two whether the patient has got adequate analgesia for that. With a syringe driver, you are not going to know that for much longer. Syringe drivers are good when you know the dose of opiate you need to establish and you are giving it over that 24-hour period. They are not good in the situation where you have somebody you are trying to get their pain control to begin with.

Q But at the same time you are criticising these doses as being too high. Is it not sensible to allow for the very problem you have just mentioned?
A Yes, I am sorry, I am not explaining myself very clearly, I do not think. We are agreed this man needs pain control, and he needs the opiate adjusting to give him enough to get his pain control. There was a high dose given initially – which one was not going to know if it was the right dose. You need to have a system to adjust that. The usual way to adjust that is to have a range of doses that nurses give – orally if the patient can swallow or subcutaneously – that you give up to four-hourly, and the nurses adjust the doses within that, and then you give the same dose every four to six hours to achieve stable pain control. I am saying it is more difficult once you start to switch to a continuous infusion when you have not established a stable opiate dose, and the dose that was prescribed by the opiate infusion was a very high dose, so you do not have any manoeuvrability in terms of the prescription to reduce it down to what might be a lower dose that the patient requires to achieve pain control without excessive adverse effects.

Q Very well. It would be important, would it not, in terms of considering what it was right to prescribe, to bear in mind the congestive cardiac failure?
A I think the major issue in this patient was the liver disease, in terms of bearing things in mind. If he was breathless from left ventricular failure, which was intractable and not controllable, that would be an indication for opiates, but we do not usually use that to control symptoms of left ventricular failure in patients with chronic fluid retention.

Q He had put on something like ten and a half kilos in weight during his time in QAH.
A Yes.

Q Cardiac failure, therefore, was a risk, was it not, of occurring any time?
A Yes. I think the main reason he was putting on fluid was his low albumen, related to his liver disease and poor nutrition. There may have been an element of cardiac failure there as well.

Q Might I just look with you, please, at page 26. We can see that in terms of the drug charts on Thursday 15 October, the total in terms of the Oramorph had ended up as 50 mg in total for the 24-hour period, three lots of 10 mg and 20 mg at night.
A Yes, that was what I observed.

Q We can take that as 50 mg in that 24 hour period. We can see also that his condition had deteriorated overnight and he was very chesty with difficulty swallowing medication. Yes?
A Yes.

Q Again, would that be consistent with regard to congestive cardiac failure, particularly with regard to his being very chesty? We can see it over the page so we can follow it through. Dr Knapman says:

"O/E [on examination] bubbling."

I think it is part of the same picture, and it is recorded as being "Very bubbly chest this p.m." on the following day. Were these symptoms ---
A They could be but I do not think we had very clear evidence that it was definitely left ventricular failure. It could be. Ideally one would want to see a chest X-ray – more difficult to get in this setting – to show he had pulmonary oedema, but equally, given the time of it, one's main concern would be, in somebody who was vulnerable to the effects of opiates, he has had a dose of morphine that potentially you would not be surprised if it led to him becoming drowsy and then causes a respiratory depressant effect, so that could potentially also count for his deterioration. I am not saying he did not have cardiac failure. I am saying we do not have definitive evidence from a chest X-ray to be confident about the relative contributions of these various factors in this man.

Q One can see a doctor perfectly sensibly taking that into account and deciding what was the appropriate treatment?
A Yes. I was critical of Dr Knapman not considering that the opiates might be a factor here, and then just considering whether to adjust those downwards.

Q You have covered the next point I was coming onto.
A Sorry.

Q No, no. It is not your fault. It is all part of the same history. Dr Knapman you are critical of, but we can see there he is examining the situation and not indicating that in his view there was anything wrong or incorrect about the medication he was on at the time?
A Yes.

Q You say, "I criticise him for that"?
A I think it would have been best practice to consider that, the contribution of morphine given he had just started on that in someone who is vulnerable to the effects.

Q The diamorphine that is administered, if you look on page 28 on Friday 16th in the afternoon, that 20 of the diamorphine is broadly commensurate with the 50 mg of Oramorph he had in the previous 24 hours?
A It is.

Q And no midazolam at that stage, so any criticism there of that administration of diamorphine?
A If one is of the view at this stage that his deterioration is unrelated to the opiates and you are converting the opiates he was on to an equivalent subcutaneous diamorphine dose, that is the correct dose. But again there was an opportunity to consider whether the opiates he was receiving were the contributory factor to his decline and to cut back the dose.

Q Then we have another doctor, still on page 28, on the 17 October, Dr X, showing him as –

"Comfortable but rapid deterioration."

And that doctor's evidence was that it seemed he was very severely ill or close to death. "I have seen enough patients who have been dying to recognise that." So there is another doctor. Are you criticising that doctor's view as to the fact that ---
A By this time he has been deteriorating for some time and, of course, he is clearly ill at this point. There is no dispute about that. He has deteriorated. The notes document that. I am not criticising that assessment that he is very ill.

Q And if you look on page 29, midazolam on 17 October at 15.50 – any difficulty with that?
A No one appeared to have considered that this man's deterioration might have been due to opiate-induced encephalopathy or hepatic encephalopathy, or the effects of the opiates themselves, so the response to his deterioration has been to add another sedative in. Again, when I reviewed the notes, I could not find any clear rationale, if I remember correctly, for the prescription of midazolam in terms of symptoms of restlessness or agitation.

Q Had there been any such record, you would understand it?
A I would, although, there again, there was a failure to monitor carefully the effects of both the opiates that were infused and the midazolam, and to consider that they might have contributed to his initial and subsequent deterioration.

Q Then, on the 18th – the Sunday – the midazolam increased and also the hyoscine. I think you are critical of the hyoscine being increased which in fact, I think, was Dr X who decided to increase that?
A Not in my report that I provided. I do not think ---

Q Fine. If you are not critical then I need not trouble you.
A Hyoscine is really being used as a symptomatic response in most of these patients at the very end when they have problems with secretions, so I have not criticised that. I am critical of the midazolam increase again. These are large doses, it is important to emphasise,

in frail, older patients, the lack of documentation justifying the increase. One looks at this and it seems one cannot get a clear picture of the basis on which doses of diamorphine but particularly midazolam were increased when there was no recording of the patient's level of agitation or restlessness.

Q In terms of this patient's death, it may be that the opiates played a part. It may be they did not?

B A Because of the time and of his deterioration shortly after starting what is a high dose of morphine in somebody with liver disease, my view as they likely played a part in his deterioration and death. But, again, this – like all these patients, the majority of these patients – was of very frail, vulnerable man who could have developed heart failure or bronchopneumonia.

Q I think that is as far as I can take that issue with you in relation to Patient H. Can we

C just go back for one moment to Patient G. Do you remember, I was asking you about the antipsychotics being withdrawn. If we go back to Patient G's file, I just need to draw your attention because we checked on it over the adjournment. This is in the body of the file itself, if you would. Would you look, please, at page 324. It shows an entry – this is on 14 September.

A Yes, I have it.

D Q "Back to DDH after admission to Mulberry." That is at the top, just so you can pick up the drugs.

A Yes.

Q Mirtazapine ---

A Mirtazapine is ---

E Q Mirtazapine 30 mg; senna; triclofos? Is that right?

A Yes.

Q And risperidone?

A Which is an antipsychotic.

Q That is an antipsychotic. The mirtazapine is an anti-depressant?

F A An anti-depressant, yes.

Q Triclofos is a sedative, is it?

A That is a sedative, yes.

Q And you may remember I was asking about the effect of stopping those, and whether that might affect what was appropriate in terms of any opiate dose; as to whether those ---

G A You did, yes.

Q And those are the ones that apparently apply to that patient.

A My view would be they should not directly affect the need for opiate dose, but they do indicate the need to consider giving an antipsychotic drug and/or sedative if those symptoms re-emerge – agitation or restlessness whilst those drugs are being withdrawn.

H Q Can we also just take note in relation to that same page, coproxamol?

A Yes.

Q What is that dose – two ---?
A That is two tablets qds – four times a day is how I read that.

Q That is a maximum dose for coproxamol?
A It would be, yes. It is a combination of paracetamol and a mild opioid dose of dextroproproxyphene. Again, it is not used so much now.

Q But again, something a doctor considering what to prescribe in terms of any opiates could bear in mind, in terms of the previous prescribing history?
A They could do but, as I say, that is not how the majority of doctors approach when they initiate opiates.

Q We are back to the palliative care handbook point again.
A Right.

Q May I move on to Patient I, please, Enid Spurgin. This lady was admitted to Haslar following a fall on 19 March 1999, and the chronology shows the history thereafter. Page 2 shows that she received at one point some morphine and then suffered from hallucination, or hallucinations, and therefore "no further opiates" is the note made in the hospital.
A Just a comment. I think that note obviously does not mean "no further opiates" for life; it maybe means "no further opiates" in the immediate management.

Q Yes. I would have assumed that was the case. In fact we have the picture carrying on – I am moving on to page 4 – on 21 March that despite that note made about "nil further opiates" she did receive 5 mg morphine. All right?
A Yes.

Q So that does not seem to have caused any problem in fact?
A Yes, because the problem with her hallucinations may not have been just to the morphine at that point. She was immediately post-operative so there would have been a number of other factors which may have led to the hallucinations as well as the opiates.

Q Thank you. You have dealt with the next point I was coming to, thank you. You dealt with the position with regard to the possible bleed into the thigh, noted by Dr Woods. Then paracetamol really carries on thereafter. We have the history which I am not going to go into in any detail until we come to page 7. On page 7 one has the referral to Dr Lord and a review by Dr Reid: "92 year old lady…." in relation to the fracture.

> *"Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. ... consideration of a place at GWMH."*

Then Dr Reid:

> *"Fully orientated and able to give good account of herself. Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful. Would like to be reassured that all well from orthopaedic viewpoint. If all is well, happy for transfer to GWMH for further assessment....".*

Dr Reid gave evidence he had considerable doubts she would get back on her feet.
A Yes.

Q And we know this is the case where, in fact, I think there is no dispute about it and, indeed, the GMC side have called some evidence to make it clear that she was transferred before she was ready for it?
A Yes.

Q So we do not need to go over that issue. One can see the history of it at page 8 at the top. We can see Dr Reid recording the fact she is still in a lot of pain, and he agreed that this case was an example of the hospital tolerating a greater level of pain than on a continuing care ward. He himself had asked, could her analgesia be reviewed. The short answer is, if it was, it did not change. She stayed on paracetamol with the consequences we have seen.
A Yes.

Q Then on page 9 the admission to Dryad Ward. On 26 March the transfer letter, saying what the position was and Dr Reid's evidence – I think you may have been present for it – saying that that letter, the transfer letter, was quite at variance with what he had found two days before?
A Yes.

Q And he would be very surprised indeed if she was able to be weight bearing without a very significant support. On the top of page 20 we have the review by Dr Barton. We can see at the time of transfer what is noted in terms of pain relief in the note towards the bottom half of page 10. A little way through that note:

> "*However, transfer has been difficult here since admission. Complained of a lot of pain for which she is receiving Oramorph regularly now...*".

There is on problem – or is there a problem – about the prescription for Oramorph with this lady, with her history and the pain she was in?
A Again, in my report, I said she would not expect such severe pain this long after the surgery. Indeed, that of course was the issue that Dr Reid was really commenting on: "Is all well? Please check it." I think he was of the same view in the way he was requesting the orthopaedic team to review that. Again, I say it would have been preferable to go through giving a mild opioid because there is less risk of serious adverse effects with the paracetamol and only moving up to oral morphine if that did not achieve effective analgesia. I think the question then to ask was if this patient was requiring opioids two weeks after the surgery was why. What is the problem in this hip that it is so painful this long after surgery, when the patient should not be requiring opiates.

Q That does not appear to have been a question that occurred to the hospital which transferred her?
A Well, they did not have her on opiates then, of course, and they were saying she was mobilising.

Q But the pain. "Still in a lot of pain."
A Yes.

Q It does not seem to have occurred to them, if your thinking is right, and it may well be, to think, what is it that is causing this pain?
A I agree they should have done. I am not an orthopaedic specialist so I am reluctant to comment on the care on the orthopaedic ward. What I am commenting on is as a geriatrician who sees a patient coming for rehab after a fractured neck of femur. You would not expect a patient to be requiring opiates at that time point.

B Q The first issue is, what is causing the pain.
A Yes.

Q The opiates may be absolutely right for dealing with the pain?
A Oh, absolutely, yes, except that is exactly the point I am making; that it would prompt an examination of the hip and re-X-ray.

C Q As you know, when Dr Reid saw this patient at a later date – we will come onto it in a moment – in April he asked for an X-ray to be taken but appears not to have thought that an X-ray should have been taken before by anybody or that she should have been referred back. Would it be more sensible if we come onto it as we go through the history?
A No. I hear what you are saying. I think it depends what one believes of the previous account. If one believes the transfer letter, because she was transferred, that this lady was mobilising and was on paracetamol and therefore that was the true state of affairs, or the state
D of affairs that the doctors looking after her at that point were led to believe, one can see why an X-ray would not have been requested then. After transfer, there was obviously a change in function as suggested by the function on arrival at the ward at Gosport War Memorial Hospital compared to the reported. I am not accepting there is now some question being asked about how she was at the orthopaedic ward prior to transfer but, either way, when there was a deterioration that should have prompted a review.

E Q There is a 92 year old lady, having had a major operation which carries with it a number of risks in any event, in pain, in real pain; what is a doctor in Dr Barton's position supposed to do? She has got to treat the pain.
A Treat the pain and examine and determine the underlying cause of the pain, and it is two approaches.

Q Oramorph to treat the pain, I am suggesting to you, is a perfectly sensible course to
F take.
A I am suggesting that it would have been preferable to go through a moderate opioid first. That is all I am suggesting. I am not suggesting it was wrong to try and relieve the pain. If one chooses to go to a strong opioid and not through the middle rung, it is incumbent, of course, to ensure you monitor the patient for any adverse effects and adjust accordingly.

G Q I am putting that to you as Dr Reid said in his view it was perfectly sensible to prescribe the Oramorph and administer it.
A I am surprised he did not think the necessity for opioid analgesia at this stage did not require a review of the underlying cause, because, as I said, my experience and understanding is that you would not expect many patients, if any, typical patients, to be requiring opioid analgesia this long after surgery.

H

Q Then if we can move on, looking at page 13, which at the top of the page is dealing with 28 March, it was noted that she had been vomiting with the Oramorph.
A Yes.

Q Dr Barton advised to stop the Oramorph, and you say that is entirely appropriate.
A Entirely appropriate.

B Q She is on then co-dydramol. At the bottom of page 13:

"Please review pain relief this morning".

Co-dydramol on the 30th.
A Yes.

C Q Then on the 31st, administration of Oramorph, one administration, at 13.20, co-dydramol continues and then MST. Now, Dr Reid said there was nothing there that he would criticise. Do you agree?
A I do not think I was critical of this at this point in my report. I believe I said that co-dydramol had been tried and it obviously was not working, and MST was a reasonable approach.

D Q You do say if in acute pain, you said you would not use MST because it is slow release, but here it is appropriate since she had been on opiates is my shorthand note of what you said.
A Yes, I am not critical of that.

Q So MST runs through for a period of time, as we can see, moving on, and I am moving on pretty rapidly to get to 6 April on page 17.
E A Yes.

Q In relation to that review by Dr Barton, and her note of what had happened, you indicated that the treatment of the pain is appropriate, but the question was what was causing the pain.
A Yes.

F Q That is the same point. Then we can move on to where the consultant comes into the picture on---
A Can I just comment on that? I mean, you do expect, if a patient comes from an orthopaedic ward, that the hip will have been reviewed and the orthopaedic team was happy about it prior to transfer. So the issue is at what point should one begin to have concerns that things are not perhaps as they should be? I am not saying that it was necessarily the minute the patient arrived on the ward and was first seen by Dr Barton, but at some point somebody G had to start thinking, "Why is this hip still so painful?"

Q Then if we can move on to when Dr Reid did see her, on page 18, 7 April, he reviews the situation and we note that Dr Reid did not suggestion consultant with the orthopaedic team. We just register that fact.
A Yes, but when I heard his evidence I think he said it was not appropriate to contact the orthopaedic team until they had the result of the X-ray, was I think what he said, if I recollect H his testimony correctly.

Q I will remind you of it in summary.
A Yes.

Q A number of possibilities in terms of what the problem was: it might be dislocated; it might be deep-seated wound infection, or a superficial wound infection; and might be that the head of the femur had collapsed.
A Yes.

Q Of course, he does ask for an X-ray to be taken.
A He does, yes.

Q He did indeed say that he had to consider was she well enough to refer back to the orthopaedic team if the X-ray did show something. A perfectly proper consideration, is she going to be able to sustain this, survive this. He pointed out the risks even with anaesthetic, and so on, with regard to this lady, I do not think there is any dispute about that, and if it was a deep-seated wound infection a very poor outlook.
A Yes, and I think given this now becomes a complex area of orthopaedic management, you would expect that to be not necessarily an immediate transfer back, but a conversation between a member of the geriatrics team with a senior member of the orthopaedic team, and they would review the X-ray and there would generally be a discussion before any decision was made about the patient being potentially transferred back for any intervention.

Q Following through my own note, he indicated that there would not be much point in contacting the orthopaedic team immediately, because---
A No.

Q ---they would say "Take an X-ray".
A Exactly.

Q One can see that in fact, and I am not going to go into asking you about the reasons, but it appears that an X-ray may have been taken, an X-ray may not have been taken, so far as one can judge it, but in any event none was available, immediately available, and none was presented to Dr Reid when he next saw the patient a week later, which we will come on to.
A Yes. I think that X-ray should have been obtained within a reasonably short period, preferably the same day acknowledging the situation at Gosport War Memorial Hospital, maybe the next day, and that should have been reviewed by a member of Dr Reid's team.

Q Or Dr Reid?
A Well, it depends. One would expect usually the person responsible for the day to day care to review that, not necessarily the consultant who is requesting it, but there is a responsibility of *the* medical team as a whole to review that X-ray. I mean, that is the comment I would make.

Q Exactly. We have seen that in fact Dr Reid did not indicate that he wanted an X-ray taken immediately, and the normal procedure would have been for him to see the X-ray when he returned the following week.
A Okay, but I think the problem with that is if it was dislocated it would not be good practice to leave the patient waiting there another week. I accept he thought, from his testimony, that the likelihood of that was low---

Q Yes, he did.
A ---but that is why one would want, particularly a dislocation, because whereas the other causes, such as deep infection, necrosis of the head, you could argue could wait, and even that you can have a discussion about whether it would be reasonable to wait a week to institute, for example, antibiotic therapy, certainly if there was a dislocation you would not wish to wait that long.

Q Then if we can move on, please, to page 21, 11 April, she is in pain, Oramorph is given. This is all before any subcutaneous analgesia.
A Yes.

Q We note that she was very drowsy and irritable.
A Yes.

Q On the review by Dr Barton the same thing is recorded:

"unrousable at times ..... denies pain when left alone, but complaining when moved at all. Syringe driver possibly discussed with nephew" and so on.

The Oramorph continues, a single dose of Oramorph, and then the MST continues. Then over the page, Dr Reid on 12 April reviews the position:

"Now [very] drowsy".

Diamorphine had been established that morning, just to remind ourselves.
A Yes.

Q You can pick that up from the next page where the prescription is set out, 80 mg at 8 o'clock in the morning. Then Dr Reid concludes that the diamorphine should be reduced, and he thought 40 was appropriate. Do you remember that evidence?
A I do.

Q You are saying that that is a perfectly proper approach, or do you criticise that approach of Dr Reid?
A Well, I say first of all in my report that the initial dose of diamorphine that was commenced at 80 mg every 24 hours was definitely excessive with respect to the comparison to the oral morphine equivalent she had been receiving with the MST. So that is the first thing I say. She is then, after having this infusion for – he sees her in the afternoon, so she has been on this infusion for six hours, I think it would have been preferable to stop it and then re-start at an equivalent dose that she had been on, or only slightly higher, of the MST, and I lay out in my report that equivalent dose would have been between 20 and perhaps up to 35 mg of diamorphine. So I think she clearly needed some opiate analgesia, but the dose she had been given was excessive. So the right strategy was taken; I do not think it was reduced as much as it needed to be and should have been by Dr Reid.

Q Any criticism of him continuing with midazolam, because he does not ask for any alteration in the dose of midazolam?

A Well, I was critical of it being started, and in the context of somebody who is over-sedated and very drowsy it should have been stopped, unless there was a clear indication for it to begin with.

Q He indicated that she was terminally ill at that stage and he would not consider referral back to Queen Alexandra Hospital. Her prognosis was "awful" is the word he used.
A The difficulty we have got here is I think it is very difficult to assess this patient because their situation has been changed quite markedly by the drugs that have just been commenced that morning, and so we are back to what I have said before, that it is very difficult to assess how the patient is because it is in a sense masked or contributed to by what Dr Reid himself has acknowledged was a too higher dose of diamorphine.

Q What was the marked change?
A She had become very drowsy.

Q She had been drowsy before, had she not?
A On the MST, and she had had a substantial increase in dose and had become much more drowsy. So one could say the deterioration looks most likely to be due to the marked increased in the diamorphine dose she has had with the commencement of midazolam.

Q Forgive me, she had been very drowsy before any subcutaneous analgesia. What is the marked change?
A Well, clearly Dr Reid had thought there was a marked change, or else he would not have reduced the dose.

Q No. He thinks she is on too much, but this marked change which you say was brought about by the administration of diamorphine, it is just making---
A Sorry, you said to me that Dr Reid said there was a marked change, she was deteriorating and now dying, so that is the marked change I thought you were referring to. Sorry if I have---

Q It is not your fault, it may well be mine, but I do not think I said anything to you about Dr Reid saying a marked change. What I put to you was that he had said she was terminally ill, he would not consider a referral back to Queen Alexandra Hospital, her prognosis was awful.
A Okay.

Q Just so you can be clear what point I am trying to make, you said there was a marked change which was clearly due to the subcutaneous analgesia on that day, and I am putting to you that there is no sign of a marked change; she had been very drowsy, for example, the day before.
A I was taking the marked change you were referring to that Dr Reid had described as an indication that she had deteriorated substantially, certainly since he had last seen her.

Q That is what your understanding---
A But to answer your question, again we are back to the notes do not record very clearly the exact conscious level and status of this lady across these few days.

Q Well, we will be repeating the same points if I continue with any other aspect of that. In terms of drowsiness, can I just ask you this---

A Sorry, can I just say if she was drowsy, it is very difficult to understand why the midazolam infusion was commenced. I mean, what would be the rationale for commencing the midazolam infusion if she was drowsy? It is a sedative. So there was no point in giving a sedative to a patient who was already drowsy.

Q Well, you have the position, for example, showing that "Enid denied pain when left along, but complaining when moved at all" on the 11th.
A Yes. In fact, I quote that in my report. So that is an indication to give analgesia, but there is no indication from that to give a sedative, diazepam, at the dose that was given.

Q May I just ask you one other thing about a cause of drowsiness. Would the septicaemia from her infected hip, if that was the case, cause drowsiness? It might well?
A You would expect it to in a patient like this.

Q Thank you. You will remember that Dr Reid concluded, although it cannot be definitive because no X-ray was seen by him, that the deep-seated wound infection in his view was the most likely cause of this problem?
A We seem to always be trying to conclude that the drugs which we know cause drowsiness are not the cause of the patient's drowsiness that we are looking at. I would say about that there was no clear evidence presented in the notes that she was septicaemic in terms of having an elevated temperature or having a low blood pressure. It is fully acknowledged she may have had chronic sepsis in that hip joint, and there are a lot of factors pointing to that, as were discussed.

Q Professor Ford, please do not misunderstand me. I am not suggesting for a moment that diamorphine and midazolam will not have that effect of causing drowsiness. It is a question of whether the opiates were causing the marked change in the sense that we are talking about here.
A I understand what you are saying. There has not been a marked change in the issue of infection in the hip. This has been a concern since very shortly after surgery with a continuing pain. You were asking me if she was septicaemic and had systemic infection would that make her drowsy, and my response would be it definitely would. What I am saying is there was not clear evidence presented in the notes that this lady was septicaemic as opposed to had a chronic infection of her hip. I am not saying she could not have been septicaemic, I am saying I could not draw any conclusion from the notes about that.

Q Fair enough. May I just ask you about one other thing to do with this patient, please. In terms of midazolam, Dr Reid, though not an expert, thought that if midazolam was playing a part in bringing about this patient's death, and we are talking about something other than double effect, it would take effect in about two or three hours, you would expect to see--
A I believe he is incorrect in that, because the midazolam would take much longer to accumulate than two or three hours when it is being infused.

Q It would take longer in your view?
A Yes, it would take at least a day or two before you have maximum effect.

Q As he said, he indicated that that is the time limit he thought would apply for it to be starting to take its real effect?
A Again, I reiterate, this is a high dose to give a frail, older lady.

Q That is all on Patient I, thank you very much. (To the Chairman) Sir, there are a couple of documents to go in. Might they go in now, if you are thinking of taking a break, just before we do?

THE CHAIRMAN: Yes to both.

MR LANGDALE: Mr Jenkins has got them.

B

MR JENKINS: Sir, before you and the Panel close the file, can I distribute these three pages. (Same handed) You should have been handed earlier on today three documents. I hope they were vaguely helpful if you could understand what they were.

THE CHAIRMAN: Up to a point.

C MR JENKINS: I understand. Can I just take you through them.

THE CHAIRMAN: Yes.

MR JENKINS: There should be a one page document which is an alphabetical list of witnesses that you have heard from.

D THE CHAIRMAN: Are we talking about what we were given earlier today?

MR JENKINS: Yes. You should have been given seven pages. The first is a one page document which is an alphabetic list of witnesses and what day you heard them.

THE CHAIRMAN: This is the document that is unheaded but begins "June Bailey" and ends "Dr X, Day 11."

E

MR JENKINS: That is right. The intention with that document is that if the Panel think "When was So-and-so called?" this should tell you which transcript to go to. In addition to that, there was a three-page document, copied on two sides of paper, which is an expanded version of the same thing, so that if the Panel want to know "Where do we find our questions of Dr Reid?" let us say, they should be able to find the page number very quickly.

F THE CHAIRMAN: Yes, we understood that, and in the light of that, we wondered why we had been given the first document, since everything within the first document is included in the second.

MR JENKINS: That is because it is quicker sometimes just to look at the one page.

THE CHAIRMAN: Do you have particular views as to where we might lodge these various

G documents?

MR JENKINS: No, I do not.

THE CHAIRMAN: An unfortunate invitation!

MR JENKINS: File management is always a matter for the Panel.

H

THE CHAIRMAN: It is a matter of whether we should give them an exhibit number.

MR JENKINS: You can. You may want to put them at the start of bundle 1, the generic bundle, with the other documents – as a plan, as it were.

THE CHAIRMAN: We will discuss that, Mr Jenkins.

B MR JENKINS: The third document, again, should be on three sides of paper. You have an incomplete schedule of references for Dr Barton's statements. You have seen statement for Patients A and B.

THE CHAIRMAN: That is page 1 of 5.

C MR JENKINS: That is right. Page 2 of 5 you do not have, because that relates to Patients C and D and you have not seen the statements. Page 3 of 5 should have Gladys Richards and Ruby Lake. You will note there are some amendments in there. For example, Gladys Richards, paragraph 12, I have put in italics "*demented lady*". That is what is written in the note, not what is typed up in the transcribed note. What I have said in paragraph 22 is the entry in the typed statement: "IV morphine at Royal Haslar Hospital." That is what it says, but that does not reflect what the notes say. She did not get intravenous morphine at the Haslar.

D

I have corrected some typos as well.

When you get to the third side of paper, you should have Mr Cunningham, Mr Wilson and Mrs Spurgin, If you look at the Spurgin entries, you will see a number of numbers in brackets. Paragraph 11 is the first, paragraph 18 has a couple more, and paragraph 30 has a fourth one. The numbers in brackets are put there because those are pages that I understood E you did not have. I have those and I am going ask for those to be distributed.

THE CHAIRMAN: That is page 4 of 5. Will there be a page 5 of 5?

MR JENKINS: There will, but I have perhaps given you enough to cope with at the moment. I will produce that over the next day or so, if I may.

F I have given you a false reference, apologies. At paragraph 11, it should say "37" not "23". It is Enid Spurgin, Patient I. Pages 38 and 55 are page numbers you have. In paragraph 30, I was suggesting that page 9 was a document you did not have. In fact you already have it in the bundle of material.

That is intended to be helpful. I hope it is. You are just about to be given pages 37, 38 and 55 which I am inviting you to insert in bundle I, the medical records of Patient I. (Documents G distributed)

THE CHAIRMAN: Very well. We will resume, please, at 25 to four, in twenty minutes time.

(The Panel adjourned for a short time)

H MR LANGDALE: Professor Ford, would you go to Patient J, please?

A Mr Langdale, would you mind if I made a comment about Patient I?

Q Of course not. May I make it clear that if at any time, having thought about anything, you want to add a comment, please do.
A I find it quite difficult to retain all the details of these 12 cases. You asked me why I thought Patient I had deteriorated after the diamorphine infusion and I wanted to indicate to you why I held that view. On page 27 of the clinical notes, an entry from Dr Reid says – and the transcript is not entirely complete in the chronology –

> "Now very drowsy (since diamorphine infusion established). Reduced to 40 mg/24 hours."

It was that entry that I took that there had been deterioration and that Dr Reid appeared to consider it was possibly related to the diamorphine and I certainly did, so it was just to explain my earlier statement.

Q Thank you for pointing that out. As I say, if anything else ever occurs like that, please ask to take the time to look it up and we will check. It does not cause me to ask any further question.

Patient J, Mr Packman. A very large gentleman, trapped in the bathroom and so on. We have been through this comparatively recently. Would you look on page 2 of the chronology, the bottom left-hand box, which is dealing with the opinion of the doctor, Dr Dowse.

> "In view of premorbid state and multiple medical problems, not for CPR in event of arrest."

I do not ask you to explain "not for CPR" but "In view of premorbid state". What is he really saying there?
A In view of how he was prior to the current admission and I think the issues are about his limited mobility. Obviously he had had a recent dramatic decline in his mobility. He had a number of problems with chronic leg ulcers and limited mobility because of his obesity.

Q We see the further notes that are recorded. Page 4, please, 8 August, halfway down the left-hand side. It talks about speaking with his wife, who had problems of her own.

> "Mick [Mr Backman] will probably need rehab/long term care"

is the comment made. Page 5, at the top of that page,

> "Spoke with wife. Informed of what Dr Reid had said. Looking to go to GWMH."

Then seeking to transfer him to Dryad on 15 August, page 7, but there was no bed available. A description really of the condition on 15 August with regard to his size and the nursing problems that created, leaking of serous fluid, the sloughing and so on, necrotic areas. A nurse described this patient's sacral sore as being "horrendous." There is no dispute about that.
A Yes.

Q It was obviously a real problem and very painful. On page 8, the entry we have already looked at with you in chief, 18 August, when he is reviewed by Dr Tandy, and there is a mention of "Black stool overnight" which you indicated could be an episode of melaena.
A Yes. I think in retrospect, it clearly was.

Q The picture becomes more convincing.
A In retrospect, yes.

Q We can move on, please, to page 10, where he is admitted to Dryad and reviewed by Dr Ravindrane – the registrar, as it were, immediately under Dr Reid, so part of Dr Reid's team. He clerks this patient in. We can see the description there. Dr Reid commented, just to remind ourselves, that he would disagree fundamentally with any suggestion that this patient had been sent to Dryad because there was a potential for mobilisation, as he had no such prospect. Does that appear to be a reasonable opinion?
A I am surprised he is so negative in that. I think this was a man who had been mobile, albeit to a limited extent. He was living at home. There is a statement recorded in the chronology that he had seen the dietician and indicated he wished to lose weight. There is no disputing how difficult it was going to manage to mobilise this man, with both his pressure sore and obesity, but I think the vast majority of rehabilitation teams would have made efforts to attempt to mobilise him, recognising it could take a very long time. But if that is Dr Reid's opinion, that is his opinion.

Q Yes.
A Of course.

Q Then at page 11 on 24 August temazepam prescribed by Dr Barton – just noting that in passing. Moving on to 25 August at the top of page 12, this is the passing fresh blood per rectum, and Dr Beasley saying, in effect, stop the clexane.
A Yes.

Q Totally sensible. And to be reviewed by Dr Barton the following morning. Then we can move on, I think, over the page to 26 August, where Dr Ravi, as he is described in the second box down on the left, was consulted. This is on the telephone.
A Yes.

Q Dr Barton's review we will look at in a moment, but Dr Ravi, when he was contacted about clexane, advised to discontinue.

"Repeat Hb today and tomorrow. Not for resuscitation."

The reading of that is that that is Dr Ravi saying that on the telephone. He said he could not remember saying so and was not able to say whether that was him. Just take it, if you would, that that would be what had happened ----
A I would take it that Nurse Hamblin would have reasonably asked Dr Ravindrane, to whom she was speaking, given that that had been his resuscitation status, "Is he still not for resuscitation?" That is the conversation as I would have imagined it.

Q If I may say so, that makes total sense. Dr Ravindrane would have known that he had been on clexane at the hospital prior to getting to GWMH and would have known that the view there was not for resuscitation.

A Yes. Certainly if he had not been for resuscitation at the main hospital site, given the resuscitation facilities and team available at the Gosport War Memorial Hospital, it would be somewhat illogical to change that resuscitation status decision at Gosport War Memorial Hospital.

Q That contact between Dr Ravindrane and GWMH would have been an opportunity for him to have said, "If there's a problem with regard to that bleed, maybe he should be referred back."

A I think it is implicit in the statement to check the haemoglobin, because there would be no purpose unless one was going to take action and the action would have required transfer back, because if I recollect there was a statement by someone that blood transfusions were not given at Gosport War Memorial Hospital.

Q That is right, yes.

A And I would not expect them to be. We stopped administering blood transfusions at Walkergate Hospital in the early 1990s.

Q All right. Dr Barton's review, if we can move on to that, please, on the following page. We bear in mind that the haemoglobin results come in, and we remember the drop with regard to the haemoglobin. Her review. It says, "Called to see male" but that is "Called to see **pale** ..."

A Yes.

Q So it reads:

"Called to see pale, clammy, unwell. Suggest ?MI treat stat diamorph ..." –

That is an initial injection of diamorphine there, as it were – yes?

A Yes.

Q "and Oramorph overnight. Alternative possibility GI bleed but no haematemisis."

Which means what, please?

A "Haematemisis" means vomiting blood.

Q "Not well enough to transfer to acute unit."

Obviously you did not see this patient – no criticism of you at all. That is obviously the view formed by the doctor, seeing the patient at the bedside, as it were. Correct?

A That is the view written down there, yes.

Q And we proceed on the basis the view formed.

A Yes.

Q "Keep comfortable ..." and so on. Without seeing the patient yourself, it is very difficult to give any sensible criticism of that view, is it not? That is not a criticism of you, but that is the fact of the matter.

A I would disagree with that. I think I was asked to review the notes and I think it is reasonable to pass a view on what was appropriate medical management in the light of the information recorded in the notes, and that is what I did in my report.

Q When the doctor seeing the patient, experienced doctor, forms that view, there is no basis, is there, for you disagreeing with that?
A Well, I cannot accept that. I think I am looking at this as a geriatrician and a general physician who manages these types of patients. My view is this was a man where the working diagnoses – which I think were reasonable – were that he had had a myocardial infarct or a GI bleed. I do not think it is unreasonable for an expert who is brought in to comment on a case to comment on what the appropriate management of that would be on the basis of the information recorded in the notes.

Q Professor Ford, I fully accept what it is you are brought in to do and what it is you are entitled to express by way of your opinion, but when you are faced with this and a doctor forming that view, without having seen the patient and being able to form a proper judgment you really are not in a position to disagree with that, are you? How can you be?
A I do not think that decision should have been made by the clinical assistant without discussion with the on-call acute physician or the on-call geriatrician. As I state in my report, I find this statement "not well enough to transfer to acute unit" difficult to understand. He is clearly very unwell and in my view that argued even more strongly for the case to transfer him to an acute unit for treatment, unless it had been decided with the patient that he did not wish for additional intervention to reduce his likelihood of future death or disability. So that is how I look at this. Had there been a statement, "The patient did not wish further intervention such as blood transfusion" et cetera, et cetera, that would be a different matter; but that was not recorded in the notes.

Q So if Dr Reid had expressed the view recorded, "I agree, not well enough to transfer to an acute unit," you would say, "I am in a position to disagree with that"?
A Personally, on the basis of the information I would disagree with that decision, whoever made it. As I said in my earlier evidence, this is a man who is in his late sixties. He has gross obesity. He is cognitively intact. I cannot see, unless he has expressed a wish that he does not require treatment, if he had a GI haemorrhage why one would not consider transferring him back for at least blood transfusion if he required it.

Q In relation to his age, do you remember you made the point that he was - you put it very tactfully – just into the older age group at 67. Although his chronological age compared to a number of these patients was comparatively young, his comorbidities were such – is this right – that his physiological age was much older and may well have meant that active interventional therapy would have been futile?
A He is certainly biologically older than the average 67-year old. I think we can all agree with that, but I think a really important issue is that he is cognitively intact. He could have been engaged with decision-making, and he was living at home. One was not talking about particularly aggressive treatments for him if he had either a myocardial infarction which the evidence would suggest he probably did not, or an acute GI bleed. I think the vast majority of acute physicians, if called about a patient like this, would not have problems with admitting a patient like this back to the acute hospital site to at least have a blood transfusion, particularly if his haemoglobin result had been discussed with them, and to be considered for endoscopy. I indicated that I thought it was most unlikely he would have been a candidate for surgical intervention to treat his GI bleed, but that is my experience as an acute physician

and as a geriatrician. Unless he had given clear advance indication that he did not wish for further treatment or unless there was a clear indication that his quality of life was so poor and it was inappropriate to do this with the patient, I cannot see it was in his best interest to not at least discuss further interventions that he might have had.

Q I will just remind you of another passage from Dr Reid's evidence, or rather this was my note of it. With regard to the prescriptions – and we are looking at page 15 – he indicated that it was difficult to say what was the propriety of those without having seen the patient. The patient was clearly very unwell on the 26th. We can agree on that?
A We can.

Q In his view – this is Dr Reid's view – to give diamorphine was appropriate. Given his problems, his prognosis was extremely poor. Would you agree with that?
A We know he has had a major gastro-intestinal haemorrhage with the information we have. He is a high risk candidate.

Q Can I interrupt you?
A Please do.

Q The finding is, "Possibility GI bleed" at that stage.
A Yes.

Q Sorry – carry on.
A And I was going on to say, if he has had a myocardial infarction and an ECG was, again, not obtained, which I would be critical of, again he would be at high risk of having death from the myocardial infarction given his obesity and other problems. We can agree he has a high risk of death, but the situation is not hopeless. This is not somebody who is definitely going to die if they have an acute myocardial infarction or an acute GI haemorrhage. Even if we felt the prospect – this would certainly be my practice – that he had an 80 per cent risk of dying from either event, and I do not think it would be as high as that with treatment, one would transfer back from the twenty per cent, and the possibility of a good outcome with active treatment unless the patient did not wish, or had previously indicated he would not wish such treatment. Just because he may have a poor outcome does not impact on offering what we are talking about, a relatively limited treatment in terms of aggressiveness such as blood transfusion or monitoring on a coronary care unit.

Q His prognosis was "extremely poor" were the words used by Dr Reid.
A Well, it is extremely poor without treatment, as obviously we have seen. I do not think the situation for this man was completely hopeless. In my view, I do not think he was destined to die. I am commenting as a general physician. If one is going to pursue this line, I think one would have to ask a gastroenterologist how they would view his risk, and a cardiologist if he had a myocardial infarct. I think at the least there should have been a discussion with the acute physician at that point.

Q May I move on to the Oramorph first of all. Is Oramorph appropriate in these circumstances?
A I think the difficulty here is the decision has now been made he is for end of life care. I have indicated that was not appropriate. Therefore I would not think the morphine was appropriate, but if one accepts he is on end of life care, if he has pain, certainly an initial dose, if one thinks he is distressed with a myocardial infarct, then an opiate is appropriate.

Q We can see that the history on 27 August. The nursing note says:

"Some marked improvement since yesterday. Seen by Dr Barton this am – to continue with Oramorph 4 hourly – same given, tolerated well. Some discomfort this afternoon, especially when dressings being done."

B Then the remaining history over the next few days – Oramorph, poorly but comfortable, very poorly, condition remains poor and so on. If you look on 30 August, please, on page 17, on the left hand side there is a note by Sister Hamblin:

"... left abdominal pain. Condition remains poor. ... No further complaints of abdominal pain."

C Also:

"Syringe driver commenced at 14.45."

Then:

"Very small amount diet taken, mainly puddings."

D So he is taking something. All right? Just register that fact. Then, over the page, please, to page 18.

"Appeared to have comfortable and peaceful night. This morning has passed a large amount of black faeces."

E Then can we move on to the review. That is the day after that by Dr Reid.

"Rather drowsy, but comfortable. Passing melaena stools. Abd [abdomen] huge, but quite soft. Pressure sores over buttock .... Remains confused. For TLC – stop frusemide + doxazosin. Wife aware of poor prognosis."

At that stage, bearing in mind the situation there,, any criticism of that?

F A I think the difficulty here is, there is a course of management being taken. He has been put on end of life care. Four days later, not surprisingly, he is no better. We know his haemoglobin, when it was last checked, was 7. It has almost certainly dropped even lower at this point. The patient will look extremely ill and unwell, and he is on that pathway. It has been decided. Of course, at that point he could have been referred back. There could still have been attempts at resuscitation but of course the outlook now is even bleaker because we have had four days of no active treatment for his underlying GI haemorrhage. Sometimes

G one finds oneself in a position managing patients where you have got to a position you think you should not have got to with them, but you have to take a decision at that point. I do not know what I would have done if I had come across a patient at this point. He is clearly very sick. You would have to decide do you take heroic measures. If you come in and look at this afresh, this is a man with a massive GI bleed. At this point do you transfer him back? Your chances are certainly far less for a good outcome than they were four days ago.

H Q We have heard the evidence of Dr Reid about that, and you have already told us.

A I am giving you my view on what I see presented in the notes.

Q Exactly. That is all I think I need to ask about Patient J. Can we move on, please, to Patient K, Elsie Devine. This is the lady with the renal problem, nephrotic syndrome and so on. The lady also where we have to take note of creatinine levels and so on. I am just trying to move on to a page where it makes it sensible to start – perhaps page 3 of the chronology. Date, 20 July 1999. There she is reviewed by the SHO to Dr Stevens.

B

> "*Remains well on current treatment with no new problems. Creatinine slowly worsening – 192 on test sample. Albumin low. Symptomatic treatment only.*"

The significance of that, please: "Symptomatic treatment only"?
A In that context?

C Q Yes.
A Where they are looking at a renal function, I would think it means, if her renal function deteriorates, she would not be for dialysis or other intervention. That is how I read it.

Q Within the context ---
A Yes.

D Q --- of that problem?
A Yes.

Q Thank you. Page 4, on 9 October 1999:

> "Admitted to Queen Alexandra Hospital with episode of acute confusion.
>
> *Confused, aggressive and wandering. Diagnosis: Multi-infarct dementia, CRF.*"

E "Multi-infarct dementia"? Is that the same thing as vascular ----?
A Yes. There are three main types of dementia. Alzheimer's is the commonest and vascular dementia is the second commonest.

F Q We carry on with that picture and then we can move on, please, to 21 October on page 6 of the chronology. Dr Barton's review here. You indicated, I think, if my note is correct, in relation to the MMSE 9/30, you said, "Quite low, in keeping with severe dementia"?
A Yes.

Q So that figures in terms of that?
A Yes.

G Q Dr Barton says:

> "Get to know. Assess rehab potential. Probably for rest home in due course."

That is the assessment?
A I agree with that, yes.

H

Q We do not have any problem with the drugs prescribed, which we see on page 7 except, I think, the Oramorph. The thyroxine and so on, no difficulty. Oramorph being prescribed for ---
A You were asking me about the morphine prescription.

Q Yes, please.
A I could not see any indication for this patient, who is not recorded to be in pain, and we would not write a patient with dementia and behavioural disturbance up for PRN morphine.

Q The Panel in due course will hear Dr Barton's evidence. That is your view?
A Yes.

Q I shall not raise any other issues with you because we have already dealt with those one way or another. Can we move on, please, to page 8, where the review by Dr Reid can be seen on 25 October. In any event, Dr Reid did not query the prescribing of Oramorph?
A No, he did not.

Q And in his evidence, he indicated what his view was and his view fortified by his review of her on 1 November on the same page, where we can see:

> "Quite confused and disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home."

The situation continued. There is no criticism by you about the subsequent administration of the various drugs, including the drug that was later discontinued. Can we move on to page 11. 15 November:

> "Seen by Dr Reid. Request for review by Dr Lusznat.
> *Very aggressive at times. Very restless. ...*"

At the bottom of the page:

> "Referral to Dr Lusznat by Dr Barton."

We need not do anything other than notice that as part of the history, and I want to go on, please, to page 13, on 18 November 1999, when there was a review by Dr Taylor. Again, deterioration, more restless and aggressive. Refusing medication, Not eating well. Towards the bottom of that same entry:

> "*Aggressive, wandering, moving other people's clothes...*"

and so on.

> "*... poor appt* [appetite]."

On this day we have to bear in mind there is a difference, according to that note, in relation to the behaviour in the early part of the day and the behaviour later on.

> "*Reviewed on ward. Happy, no complaints. Waiting for her daughter.*"

It appears by this time the fentanyl was having some effect, would you agree? Because the fentanyl is administered at 9.15 that morning.
A I would agree her behavioural disturbances vary and I would agree at this point she has a fentanyl patch. I am not sure I would agree that that establishes that the fentanyl has improved her behaviour.

B Q Is it not a bit of a clue that that is what has improved things and made her happier?
A As I indicated in my report, opiates are not a treatment for behavioural disturbance in dementia. It is a treatment for pain in people with or without dementia.

Q Is that not a clear indication that in fact this lady was happier, better, in a better frame of mind as a result of the administration of fentanyl?
A But she has had variable aggression, is my reading, throughout her stay. This is not a C dramatic change.

Q No. It may not be dramatic, but it is a bit unfair, is it not, to say, "Well, in my view, that has nothing to do with the fentanyl," is it?
A I did not say it had nothing to do with it. I said one cannot conclude that the fentanyl is the reason why her behaviour has improved. I said something slightly different.

D Q All right. I accept the criticism of my phraseology, but in fact it would be perfectly reasonable to conclude that it was the fentanyl, would it not?
A It may have but, again, as I indicate in my report, it is not a standard treatment. If it is, you still have the issue of having to monitor a patient like this very carefully because it is a very large opiate dose. It is 90 mg of morphine equivalent over 24 hours, and there is a high risk of significant adverse effects.

E Q We have heard the evidence from Dr Reid about the propriety of using fentanyl, which I think I have already put to you in the past, and I will not repeat. Over the page to page 14, on 19 November:

> "Review by Dr Barton.
> *Marked deterioration overnight. Confused, aggressive. Creatinine at 360. Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs SC subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death.*"

F A Can I comment on that?

Q Please do.
A Because I think this is the problem, if one hypothesises that the pensioner was G improving her behaviour, she is now on it a bit longer and she is confused and agitated again, so that is why I think it is very difficult to conclude that the fentanyl improved her behaviour.

Q Yes, indeed. It may be one or the other. It may be both. "Marked deterioration over the last 24 hours" is the description given in the nursing note there, the "Significant events" section, "extremely aggressive", and this is the incident in the morning which the Panel has heard about when there was considerable difficulty in dealing with her, "taken 2 staff to H special" and so on. Chlorpromazine – no problem with that you have told us?

A No. Sorry, can I just make another comment---

Q Yes, please do.
A --- on an earlier comment by the nursing records:

"Needs [subcutaneous] analgesia with midazolam."

B I think again that raises concerns that the nurses did not understand the role of midazolam, because of course it is not an analgesic, it is a sedative for restlessness.

Q Yes. What was actually administered was diamorphine and midazolam, as we can see over the page on page 15.
A Yes.

C Q Dr Reid indicated he would have been more cautious in his use of diamorphine and midazolam, but in his view they were within a reasonable range. You say that they were not appropriate.
A No, they are not appropriate standing alone, the diamorphine infusion, it is too high a dose and it is not appropriate when you are adding it in to the continued effect of fentanyl, which will be circulating for a considerable amount of time. We discussed that in my earlier statement.

D Q Can you just help in the particular circumstances of this case: the fentanyl commenced on the 18th, and again I am not trying to ask you to do some impossible calculation, but administered at 9.15, if we go back to page 13, if you see in the bottom left, fentanyl administered at 9.15 on the morning of the 18th.
A Yes.

E Q Then moving on to the 19th, when you are talking about the administration of the diamorphine and midazolam at half-past 9 in the morning, assume the fentanyl patch is removed, what---
A Yes. So the lady has had the fentanyl patch on for 24 hours, so she will have absorbed 90 mg morphine equivalent, but the issue, to go back to our discussions beforehand, because fentanyl has a much longer half-life, so it persists much, much longer than morphine, and the *British National Formulary* of 1998, whichever one we are referring to around that
F time, states it may be 17 hours or more for it to disappear, so---

Q Can you help with what therefore we are talking about in this case, twelve hours later?
A So whereas before, if you are giving regular doses of oral morphine, after four hours the morphine is going down and you are replacing that with the subcutaneous diamorphine, here you have got a position when the fentanyl is persisting much, much longer with its effect and you are adding in the diamorphine, so that in that period, the first 24/48 hours, you are
G exposing the patient to much more overall opiates when you replace a fentanyl patch with a subcutaneous infusion of diamorphine than when you replace regular oral morphine or MST with a subcutaneous infusion of diamorphine. So you have to bear that in mind when you are looking at the treatment and the response of the patient. So when I say that the dose of 40 mg over 24 hours of diamorphine was excessive, it is even more excessive in the context of the fentanyl, which is still having an effect.

H Q What I am trying to get at, and it may be impossible to get a precise---

A Is what is the equivalent---

Q What sort of amount---
A Well, I think conservatively you would have to add on at least 20 or 30mg---

Q All right, something of that order.
A ---of morphine equivalent. I mean, because it is changing hour by hour, so you cannot give a simple answer to the effects.

Q Well, I think that is as far as one can take it exploring that issue. Thank you for that. It gives us an idea of the sort of thing we are talking about. Then on 21 November the diamorphine at 40 and the midazolam at 40 continues, and the family are aware of the position, and so on. I do not think there is anything else I need to ask you about that case. Thank you. Then Patient L: this lady admitted to Royal Hospital Haslar, and the second page of the chronology:

"after experiencing chest pain and collapsing at home. CT brain scan conducted."

She had had a fall, chest pain and so on, "MI x 2 – AF", atrial fibrillation, and so on, all those other things recorded. You indicate that there were signs therefore of a stroke, is that right?
A Yes, she has a severe stroke.

Q The consequences one can see being recorded. "Analgesia" on page 3 "needs reviewing", some given with fair effect. This lady was on a nasogastric tube for quite some time, and I am going to come back to that when we are at Gosport, if I may.
A Yes.

Q She is transferred to the coronary care unit, and we can see the history, and obviously there were significant problems in relation to this case, is that right?
A Yes. I mean, she has had a stroke and there is a question about whether she has had prior to this a myocardial infarct, and she has had a clot form in the heart and that go to the brain to produce the stroke.

Q Then on to page 7, 5 May, when she is referred to Dr Lord, and the comment on referral, at the bottom of that box on the left hand side:

"Nothing more we can for her on acute medical side."

Over the page, she is "Treated with oxygen and diamorphine for respiratory failure".
A Which is rather in contrast to the previous comment, one might say.

Q I was going to ask you, but that is what occurred, right, and "small doses of diamorphine to keep comfortable", is what is said in that same box on the left hand side at the top, at Haslar. Is that something you are critical of?
A It would not be generally my approach for patients who are in respiratory failure due to aspiration pneumonia, we would not give opiates, so that is my comment on it. It was done, but it would not be my practice, and it certainly would not be the practice of the vast majority of stroke physicians who look after these patients.

Q It seems to be what was---

A It was what was done, yes.

Q We cannot go into it---
A I mean, it may be there was a thinking she has had a myocardial infarct and there may be elements of left ventricular failure, if one is trying to find a reason to justify it.

Q Yes. On the left hand side:

"Aware of poor prognosis. Remains for 444. Condition remains very poor."

Then over the page on page 9, 6 May:

"Discussed with consultant. Not for resuscitation."

Reviewed by Dr Lord, and she sets out the situation, four lines into the body of that:

"Extremely unwell."

A little bit further down:

"Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH. Overall prognosis poor."

We do not need to go into that again. Then she suggests, at the bottom of the page:

"[Lower the] Total [or bring down] Total fluids to 1½l/day".

Is that what that means?
A Yes, because she thought she was fluid overloaded.

Q "Salbutamol [nebulisers] if wheezy ..... Diamorphine if distressed".

So there is another indication of a consultant in this case thinking that diamorphine was appropriate to cope with distress.
A Yes, I note that. It would not be my practice, but clearly that is being confirmed there, yes.

Q Then over the page, at the top:

"Remains poorly .....[Intravenous] diamorphine given as px."

Sorry, it has gone out of head as to what that means, "px" – as prescribed. Further deterioration on 7 May, some improvement on 10 May, and then---
A Sorry, I read that as no further deterioration, but that maybe that is---

Q I beg your pardon.
A I am not saying that is what it is, I am just saying---

Q I think you are quite right, it does appear to indeed improve three days later. Then on page 11, a review by Dr Tandy:

"Appeared to improve over weekend. Barthel is zero."

She gives a further description as to the position:

"she developed further central chest pain. Don't think stable enough to transfer to GWMH at present."

B

So this is the second occasion where the view was not right for transfer at this stage.
A I think this is not uncommon. We see stroke patients who are in need of rehabilitation at this stage, but they are very sick and they are not appropriate for transfer to a rehabilitation ward.

Q Thank you, and I think it follows that it may be, it can arise in such cases, where C somebody sees what may be a window of opportunity, but it turns out after transfer not to have been a window of opportunity. It is very, very difficult to decide.
A Yes. I mean, people have looked at this in terms of stroke patients, and if you have an off site rehabilitation unit there is a necessary transfer back of around 15 per cent of patients who turn out not to be stable enough to stay on the rehabilitation unit. So this is a well recognised problem in stroke patients.

D Q Because I am going to suggest that that may in fact have been the case here, where she was---
A Yes, absolutely.

Q I do not think you disagree?
A No, I do not disagree with that.

E Q Bottom of page 11 on the left:

"Pain settled. Further escalation in treatment appropriate."

Then still before she gets to Gosport War Memorial, on page 12, on 12 May, bottom left hand side:

F

"Reviewed on ward round.
Feeding well through [nasogastric] tube. [Complaining of] chest pain, relieved by GTN .....
Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why [patient] would be allowed to die naturally, rather than be resuscitated or put on ITU, if she had a further MI or respiratory failure/arrest."

G On to page 13, 13 and 14 May, she is reviewed by an orthopaedic specialist; no intervention needed. Bottom left hand side:

"Very uncomfortable this evening. Diamorphine [given subcutaneously] to assist settling".

That is on to the same point we have discussed already. Over the page, on the 15th it says:

H

"Diamorphine ..... [given subcutaneously] with good effect."

On the 16th, on page 14:

"Settled and slept very well without diamorphine. Feed continues as per regime."

Reviewed by SHO the following day. Paracetamol given, we can see at the top of page 15. Then liaising with GWMH on 18 May. They are happy to take her with the above results, in other words the situation as it appeared to be at that time. I do not think I need trouble you with the next lot of notes. Can we move on to page 17, when the transfer to Daedalus Ward actually took place. The transfer record sets out the position. On transfer the patient was receiving aspirin, enalapril, digoxin, isosorbide, mononitrate and subcutaneous diamorphine. So that is continuing---

A Yes.

Q ---for the same reasons as the hospital gave.

"For rehab at Gosport".

She is admitted. The nursing referral sets out the position. We can go over the page, I think, without missing out anything important, to page 18, to the review by Dr Barton. So this is still on 20 May and she sets out the position. I just want to ask about the significance of aspiration pneumonia. So is it right that in any event she had chronic lung disease, chronic obstructive pulmonary disease?

A She did have. The aspiration pneumonia we would consider probably somewhat separate from that, in that it is a problem that occurs in stroke patients because of their swallowing difficulties and dependency. So in patients with severe stroke, a fair proportion develop, as the name says, aspiration, they have an ineffective swallow and they get infection on the chest. Now, that occurs in patients both with or without chronic obstructive pulmonary disease, but clearly grand lung disease makes the problem worse, because you start off with poorer respiratory function.

Q May I just ask you a further aspect about this question of aspiration pneumonia? I think it probably follows from what you have just told us, but if you have had an episode of aspiration pneumonia, the chances of having a second or subsequent episodes are high?

A Increased. A lot depends on your swallowing function, and I cannot remember if this lady had a formal assessment of her swallowing undertaken.

Q I am going to come on to another aspect of that which I think the records show. It is an increased risk?

A It is an increased risk undoubtedly.

Q It is not going to be a surprise if it happens, in other words?

A Yes.

Q Would it be also the case that that risk would be increased if a nasogastric tube had been pulled out by the patient?

A If it is half pulled out and you end up with feed going into the top of the pharynx, yes, it can, but in general it is thought nasogastric tubes have a neutral effect on aspiration pneumonia in stroke.

Q I rather think in this case that had happened, what you have just described.
A I think at one point she did have a misplaced tube, but I am not sure if any feed had been administered through it.

Q If you go back to page 6, we can just pick this up in case it is of significance, page 6, top left hand box, towards the end of that entry:

> "[Chest X-ray]: No NG tube seen but NG tube in! On RO NG tube this was found to be in nasal cavity, therefore feed has been placed directly down nasopharynx therefore can't exclude aspiration."

Is that---
A Yes. So I think in this case it is very clear that her pneumonia, a precipitator, or at least a major contribution, was the misplacement of the nasogastric tube.

Q We can see, in relation to the---
A She did have a swallow assessment, I see on the next page.

Q Yes, but in relation to the situation with regard to the history at Gosport, pursuing the same point for the moment, would you move on to page 19, which is still dealing with entries relating to 20 May.
A Yes.

Q I need to ask everybody, please, you included obviously, Professor Ford, to look at a particular page in the records, medical records, in the file, page 1334. On that page the handwriting is reasonably clear. At the bottom left hand corner can you pick up the date 20 May.
A Yes.

Q "NG tube repassed c/A"---
A I think that is "O/A", on assessment.

Q Sorry. "[On assessment] this a.m. as Jean pulled it out." Then can you make out the rest?
A "Bolus fed this pm" I think it says "55mls/hr due to"---

Q "[patient]"---
A Yes, which does not seem quite right, "pulling out NG tube".

Q ---"pulling out NG tube. Also due to recent history of aspiration pneumonia for referral to dietician".

So it looks as if that problem had occurred on that day as well?
A No, I do not read it that she had had feed down the tube as before. I mean, there was a very specific description before that the tube was found not to be in the stomach and feed had been commenced. It is usual not to commence feed until you are sure where the tube is placed. I think what had happened here, a common problem with nasogastric tubes, is that the patient had pulled it out, because they are uncomfortable, and this happens, and I think what this is saying is that they had replaced the tube and they have given her some bolus feed

down the tube. That is how I interpret that. I think they are not saying there had been a clear instance of feed being given to the wrong place---

Q I see what you mean.
A ---is how I interpret it.

Q You are quite right, the note does not say, but there is obviously a problem with this tube.
A Yes.

Q In the sense we were just talking about. That was something obviously anybody would have to have an eye to, this risk in relation to aspiration pneumonia.
A Yes. It is quite difficult to manage nasogastric tubes in a unit such as a ward at Gosport War Memorial Hospital. Again, we do not transfer patients with nasogastric tubes to this environment because of they problem. They are pulled out, they are difficult to replace, you need to get X-rays, so managing a patient with a nasogastric tube in this environment is difficult. I am not saying it was wrong to transfer the patient but I am just explaining these patients who often were transferred in the 1990s are difficult to manage because of the issue of having to check the placements and you do not have medical staff on site all the time.

Q Looked at the picture as presented on the day of her admission, 20 May, would it be sensible to view it in this way, that really this patient's chances of successful rehabilitation were very small indeed?
A I think we have to go into more detailed definition of what we mean by successful rehabilitation and what we mean by very small. I am sorry to be pedantic.

Q Do not hesitate, just explain what you say.
A She is currently stable but she is an older lady with a severe stroke. I think I have said in my previous statement she is not very elderly, she is in her seventies. We would expect to be able to manage complications now with modern stroke care in an acute rehabilitation unit. The patient is more likely to survive than to die – let me put it that way. They will leave hospital but they will be left with severe disability. As I indicated in my earlier statement, this is not a lady who is going to be living independently. The options are either a nursing home or a considerable support package to manage this lady in her own home, with the help of her relatives and also formal carers going in – and that would be after a period of two to three months in hospital, anticipating slight improvement. But there is a high possibility of further aspiration pneumonia, pulmonary emboli, or in this lady additional cardiac problems that she has maybe had. The approach in these patients is you start a rehabilitation programme when they are stable, although you are anticipating there may be medical complications, but you still give the same intensity of rehabilitation that the patient can tolerate and that you can provide – and I recognise there was a limited therapy input from what I have heard from the statements at this unit. Again the situation is not hopeless but the outlook is poor. This lady is going to be left with long-term disability and in this context now we would have a range of discussions about the appropriate level of care. Some families might indicate that the patient would have expressed a wish not to receive treatment for active problems if they developed another pneumonia and one might withhold antibiotics. There is a range of approaches which would depend very much on what one thought the patient's view was and what they had to look forward to. Again, the discussions we have now are much more explicit and open with families and relatives than they were in the 1990s

and so decisions were often made "in best interests" so one has to not apply the standards we apply in practice now to what we did back in the 1990s.

Q Of course. Thank you for that general picture. If we can look at the remaining history here, on page 19, still on 20 May, we can see:

> "Pain: Not controlled. Complains of abdominal pain due to history of bowel problems. Oramorph given."

We can see that she is given 5 mg, as is shown halfway down that page. Dr Barton had prescribed 5-10 mg PRN. Your view is that you would not use opiates in this situation.
A No, and I think it I worth explaining why, because opiates are not good in terms of patients engaging and effectively recovering rehabilitation. There are studies which have shown they impair people's ability to recover, so we do not favour them. I am critical of the use of morphine because this problem of abdominal pain, as far as I could read from the notes, was not a new problem. It was a chronic problem that had been investigated, as I indicate in my earlier evidence, by at least one or two other specialists, and opiates have not been deemed to be an appropriate strategy to manage it. In general that is the case with chronic pain: one would not use opiates.

Q As we have seen, in fact opiates were used.
A Yes.

Q In the hospital before she got to Gosport.
A But not for abdominal pain is my understanding. It was an ill-defined distress.

Q It appears not.
A For breathing problems.

Q It appears to be to settle her.
A Yes.

Q Or various other descriptions. That is all I need to deal with in terms of the Oramorph. The prescription with regard to diamorphine and midazolam written anticipatorily, you have indicated that in terms of the administration of diamorphine and midazolam on 21 May, on page 21 of this same document, at 20 minutes past seven in the evening – and we can just look at the history on that day in the bottom left-hand section:

"11.30L: To have GTN spay PRN. Now on regular (4 hourly) Oramorph."

Philip Beed, the charge nurse, at six o'clock in the evening:

> "Uncomfortable throughout afternoon despite 4hrly Oramorph. Husband seen and care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life."

Then the syringe driver commenced at 7.45 that evening.

Perhaps we could just do the calculation again. She had had, in terms of Oramorph, I think 35 mg in the preceding 24 hours. Is that right? That is the note I have, but you had better check it.
A Yes, that is correct. In my corrected report I thought she had had three doses of 5 mg and three doses of 10 mg, so it was 35 mg.

Q If it is 35 mg, divided by two we have 17-18 mg ----
A 12-18 mg, I had, yes.

Q Call it 18 mg for the sake of the calculation. Without increasing the strength of the analgesia, diamorphine 20 mg is 2 mg above.
A Yes.

Q But it is more or less a straight swap.
A I said that if you were looking to continue opiates – and of course my view was that they were not appropriate, but if you were doing a straight conversion – that was an appropriate dose to start with.

Q It looks as if the nurse did what he said he would do.
A Yes, in terms of the diamorphine.

Q Yes. The diamorphine and midazolam.
A Well, I am critical of the midazolam.

Q I appreciate that every time we look at this you say you have to take into account the midazolam. That is the drug in a number of these cases that you particularly focus on in terms of saying it is inappropriate.
A Yes.

Q Then another doctor comes into the picture on 22 May, page 22. This is Dr Beasley. He is not suggesting there should be any change to the administration of the drugs. If we look down on that same page, at the bottom left-hand side,

"08.00: Condition has deteriorated. Very bubbly. 10.20: Still very bubbly."

Dr Beasley was contacted and there was a verbal order to increase hyoscine to 1600 micrograms. Again, is that indicative of aspiration pneumonitis?
A I think you just cannot tell at this stage. I mean, I was critical of the discussion of her being uncomfortable. There was no description of what the pain or the problem was that was being treated here and in the context we are at now, where she is deteriorating for reasons that are not clear and she has secretions, the prescription of hyoscine is reasonable.

Q In this case, it may well be, in fact, that the recurrent aspiration pneumonitis essentially played a principal part in her death.
A Well, we are making an assumption that she had recurring pneumonitis and there is no evidence presented in the clinical notes to support that that was the cause of a deterioration or pain at this point. There is no information which allows us to determine what the cause of her deterioration and this description of pain was at this point.

Q Would very bubbly be consistent with aspiration pneumonitis?

A I think the difficulty is that once patients are deteriorating and particularly if they are less alert, you often get this as a pre-terminal problem, a problem impairing secretions.

Q It may be a pre-terminal problem of the kind.
A Yes. Also, of course, you do get a problem with secretions in people with active chest infection.

B Q I think we have covered those topics as far as we can. Just in case you think that is absolutely the end of my questioning, I have two more matters. They are both very short, but we have got through the bulk of the papers. Just to go back, if I may, to patient Elsie Lavender, Patient B. This is not, as it were, challenging your evidence or seeking further explanation but I wonder if I can ask you to consider a particular point. Elsie Lavender, Patient B, the lady who fell at her home address and went down a flight of stairs.
A Yes, I remember.

C Q You will remember the lady in terms of the immediate problem in particular presenting itself at Gosport, the pain in the chest and arm.
A Yes.

Q We have been through that history. This is to do with the diagnosis or possibility of brain stem stroke. I want to try to get something clear with you as to where we are on this.
D Would you look in the file, looking at the medical records, page 242. We have the letter from Dr Tandy, writing to Surgeon Commander Taylor at the Haslar, talking about the patient having a fall, unable to stand, a bit battered and complaining of pain across her shoulders and down her arm.
A I am missing this page.

Q Your bundle has not been adjusted. Perhaps you could turn it up at page 935. You
E have the same document there.
A Yes, I have it now.

Q On the second page of that letter, page 936, it says,

> "I think the most likely problem here is a brain stem stroke leading to her fall."

F I want to try to get this clear. At the end of that paragraph she says,

> "I do not think her brain stem stroke would show up particularly well on a CT and we're now 11 days post-ictus."

A Yes.

G Q There are two things. The brain stem stroke may well have been the thing which caused the fall.
A I think it is unlikely, because I do not think the symptoms she had are typical for a brain stem stroke.

Q What I am trying to get at is that the symptoms that she had in relation to the pain, shoulders, chest and so on, may well be the result of the fall.

H

A Yes, at this point I entirely agree. I can understand why that was being thought and that is not unreasonable.

Q The fall may have involved some kind of cervical fracture.
A Yes. To be clear, she has had a fall. Everyone is pretty confident she has fallen all the way down the stairs. She could have fallen because of her poor vision, she could have slipped. She does not necessarily have had to have had any new medical event to account for having had a fall, or she could have had a new event like a faint, or a seizure, or a stroke for that matter. That is another thing that is possible. My view was that the clinical signs that she had after she was examined over the next week or so were not typical for a brain stem stroke. But I can understand why it was thought she might have had a stroke, because she has got diabetes, she has atrial fibrillation, she is elderly, she is at high risk to have a stroke. That was not an unreasonable working diagnosis. When she is first seen with all this bruising – and I think she is described as being fairly battered at one point – it is quite hard to assess whether there is true weakness because the joints are so painful. Patients are difficult to examine and so the picture is often difficult to assess. Clearly, as we have indicated, there was thought about whether she could have injured her neck.

Q Yes.
A Even at that point.

Q Yes.
A So, yes, the fall is what would have produced the neck injury, the cervical spine injury, if she had it.

Q Yes.
A Which I think is likely but we do not know because we do not have the X-rays and we have not had an MRI scan.

Q It is just a question that one has to divorce symptoms exhibiting themselves which may be the product of the fall.
A Yes.

Q From what it was that may have cause the fall.
A And I think the point is that two or three weeks later you would not expect this continuing pain, and, more importantly, you would not expect from having some force and bruising that the lady could not use her hands to feed herself. That indicated she had true neurological weakness, which must have been due to either a cord injury or a stroke – and I have indicated that the pattern was much more typical for cord injury.

Q The note in terms of her admission is:

"Fell down the stairs. Large pool of blood at top of stairs. ?hit head at top of stairs and fell down the stairs."

A These patients are difficult to assess. I have seen many stroke patients as a stroke physician. I had a case of a man who fell off a ladder. Initially we thought he had had a stroke, but we thought we had better look at his neck. Sorting out whether people have had a stroke or a cord injury in this setting in the early days is not always straightforward. Dr Tandy is quite right about the CT scan. It would, in my view, have been unhelpful, so one

would have had to decide whether one wanted to get an MRI scan – and you have discussed the issue of the cervical spine X-ray and whether that was obtained and whether it showed anything.

Q Thank you for that. The second and I really do hope last point is this. When I was putting to you the situation with regard to Dr Barton and her workload, and you were saying that you still would have thought there would be time to do this, that and the other, as to the degree of excess pressure and excess workload, would you regard it as a matter of some significance that, when Dr Barton left, a Monday to Friday all day medical presence was thought appropriate to replace her? It is a rather significant increase to cover the same amount of patients and the same situation. Might that perhaps not be an indication that, indeed, the workload on Dr Barton was excessive?
A It could be. Determining what is the right level of medical support and nursing support into units is always a vexed issue. One always has to argue quite strongly for additional resources for these services. The other issue to consider is that the workload and the nature of work were continuing to increase. I think one has to take account of that. I looked at it from comparison to the support we had in our own service, but I think one would need to look at what was then required to provide a proper service afterwards. As I said, there is no doubt the workload was changing and was increasing. That would mean at some point there would have to have been increase in input. As I said to you, a lot depended on the input from the consultants so I do not think I can be definitive in my comments about this. All I could do was describe a comparable set-up and the input we had. But yes, to answer your questions; clearly the amount of support that was required afterwards, if it was the same level of workload, is a factor that would support the contention that Dr Barton had an excessive workload.

MR LANGDALE: Thank you. That is all I need to ask.

THE CHAIRMAN: Thank you very much, Mr Langdale. Mr Kark, I am not going to ask you to start today.

We shall break now, and start again at 9.30 tomorrow morning, please, ladies and gentlemen.

MR KARK: Can I just convey that Professor Ford did indicate earlier today that he certainly would be content to start at nine.

THE CHAIRMAN: Unfortunately we will be testing the video at nine o'clock.

MR KARK: I was going to say, in any event I do not think for my part that that will be necessary. I will be about thirty minutes, or I hope less.

THE CHAIRMAN: I think we are making good time, and there is a pre-existing appointment for the video link to be tested at nine as a consequence of poor results in this morning's test before we started.

MR LANGDALE: Without detaining Professor Ford at all, it is simply an administrative matter in terms of Friday. I wonder whether the Panel would consider rising on Friday afternoon no later than three o'clock. The reason for that is that Dr Barton has to have some further attention to her leg which is best done on that Friday afternoon. If, of course, we are at the stage of evidence where the evidence does not require her to be present, then there is no

difficulty. It may be that we will have reached a stage where she is giving evidence or about to give evidence. I wonder if the Panel would have that in mind because that is what I shall be asking to happen on that Friday.

THE CHAIRMAN: Should we be at a stage on Friday when the doctor is giving or is about to give evidence, then of course that must take priority and we would in those circumstances rise at three.

MR LANGDALE: I am grateful.

THE CHAIRMAN: Nine thirty tomorrow, then, please, ladies and gentlemen.

(The Panel adjourned until Tuesday 14 July 2009 at 9.30 a.m.)