GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 16 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-SIX)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody.

(Video link opened)

MR LANGDALE: Just before we start, Dr Barton has resumed her place here. It is clear to her and it is clear to us that we are entitled to take instructions from her about this evidence, or anything arising, but we are not otherwise communicating, just so the Panel knows.

THE CHAIRMAN: Thank you for telling us. That is very kind of you. (To the witness) Can you hear me?

THE WITNESS: Yes.

THE CHAIRMAN: Can you see me?

THE WITNESS: Yes, I can.

THE CHAIRMAN: You should have a piece of paper in front of you with an oath or affirmation on it.

THE WITNESS: I have.

THE CHAIRMAN: Would you please read that to us?

ALTHEA LORD, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

Q Hello, Dr Lord. I am going to stay seated if that is all right. I hope the Panel can see me as well. Can I just ask you what your present position is?
A I am currently working as a full time consultant geriatrician at Hutt Hospital in New Zealand.

Q That is Hutt – H-u-t-t?
A H-u-t-t. It is a small district general hospital which is just outside Wellington.

Q I understand. I think you were a consultant geriatrician in Portsmouth between 1992 and 2006?
A That is correct. Yes. I left at the end of August 2006.

Q We have heard your name many times in relation to patients at the Gosport War Memorial Hospital, and I think you used to see patients there?
A Yes, that is right.

Q Can you tell us what your job involved as a consultant geriatrician when you worked in the Portsmouth area?
A The job was quite mixed, so I had acute patients at Queen Alexandra Hospital, initially at St Mary's Hospital. There were acute wards which at one time were single consultant-led wards, but sometimes shared. I did outpatients alternate weeks at St Mary's

and Gosport, and then latterly only at Gosport War Memorial Hospital. Also I had rehabilitation beds initially again on Kingsclere Ward at St Mary's Hospital and long stay wards at Gosport. At one point I did St Christopher's Hospital at Fareham as well. As the work in Gosport increased, I ceased doing the rehabilitation at St Mary's Hospital and worked in Gosport War Memorial Hospital. That was a combination of what we call continuing care plus some stroke rehabilitation.

Q Right.
A And subsequently general rehabilitation. There was also a day hospital, and the day hospital in Gosport was the newest of the four day hospitals in Portsmouth. I initially worked at St Mary's and Gosport War Memorial Hospital, day hospitals, alternate weeks, but latterly it was only at the day hospital at Gosport War Memorial Hospital, which was Dolphin Day Hospital.

Q I think Dolphin was part of the complex of the Gosport War Memorial Hospital?
A It was.

Q It was on the same site?
A It was the new-build, yes.

Q We have heard that you used to do ward rounds on a Monday at the War Memorial Hospital and that on occasion Dr Barton would be there with you?
A Yes. That is correct, yes.

Q Can you tell us about the ward rounds? Which wards were you doing ward rounds on on a Monday?
A At the time, the last lot of ward rounds that I would have done with Dr Barton would have been on Daedalus Ward and Dryad Ward, but prior to that we also had beds on Redclyffe Annexe, which was annexe a little bit away from the main hospital complex.

Q We have heard ---
A The ward rounds usually consisted of --- Sorry?

Q No, go ahead.
A The ward rounds were usually on a Monday afternoon when we started stroke rehabilitation. It was on a Thursday afternoon as well, and we would have a multidisciplinary case conference, usually for about half an hour, 40 minutes, when the patients were discussed. Then we would do a ward round, when we would go together with the sister of the ward or the senior nurse, to see the patients and make decisions on their management and their prescription. Then usually, if there were relatives to be seen, I would see them at the end of the ward round.

Q Right. Can I ask you about how long a ward round would take if you were doing one on Daedalus Ward or Dryad Ward?
A Pretty much the whole... We would start at two o'clock, if I remember right, and by the time we had seen relatives it could be five o'clock, sometimes a bit after that, so pretty much the whole afternoon.

Q Did the time for a ward round change over time, over the years?

A Yes. Initially the wards were designed to be long stay wards, but as the continuing care ward patients were moved into the community, into the nursing homes, we were taking patients that were probably more slow stream general rehab and slow stream stroke rehab, and at the point when I left in 2006, even fast stream stroke rehabilitation patients in the Gosport and Fareham area were coming to Gosport War Memorial Hospital. So over the years – I was consultant from 1992 – the case mix changed, but it changed gradually.

B Q I want to concentrate ---
A Does that answer your question?

Q It does. I want to concentrate on the period that you knew Dr Barton between 1992 and her resignation in the year 2000.
A Yes.

C Q So you knew her and worked with her for eight years?
A Yes, I did.

Q When you were doing ward rounds with Dr Barton on a Monday, can you tell us how you would deal with each of the patients? How would they be introduced and what would the nature of the discussion be?
A Dr Barton would introduce the patients to me and would say this was a lady, and give D a brief history, the past history and the reason she was admitted, the reason she was transferred, and then would update me on the patient's condition. If there was anything relevant, then a senior nurse would add their comments to that as well. We would chat with the patients, examine them and then make a decision, a plan, for management, look at their medication and generally we were in agreement with the management plan.

Q Can I ask – did you have time to form a view about Dr Barton and her abilities and E skills as a doctor?
A Yes, I did. She was a good doctor.

Q What would you say about her level of commitment to patient care?
A She is a committed doctor and a good doctor. She is quite sensible, and she likes working with older people. She is a kind and caring doctor, and she was always ready to go that extra bit for her patients.

F

Q Were there any problems that you had with Dr Barton or disagreements about how patients should be managed?
A No major disagreements. I cannot remember there being any serious contentious issues.

Q I am going to put to you what you said in a statement made for the General Medical G Council. All right? You said that the ward rounds would normally take up one session. They would usually last between 2 and 5 p.m. Initially you used to finish the ward rounds on time. However, as the years went by the wards became busier and the ward rounds took a lot longer. Yes?
A They did.

Q You say:

H

"7. ... I would usually finish at around 6pm and complete other work as necessary. The days on which I was working at Gosport War Memorial Hospital were very long days. Sometimes I would not leave until 7 p.m."

Is that right?
A That is correct. Yes, that is correct.

B Q Are you saying there that the wards got busier during the time that Dr Barton was working with you at Gosport?
A The words did get busier in the period between 1992 and 2000. The work that I often returned to after I had finished on the wards would be dictated from the morning day hospital round, so that was done right at the end of the day.

Q I understand. Were the nature of the patients changing, by which I mean ---
C A Yes.

Q --- the sort of conditions that they had?
A The patients were getting more complex and from when I started as a consultant in 1992, quite a lot of patients were offered hospital continuing care for life, and those patients were relatively stable. You got to know them and got to know their families, but over the years there was a move to move the hospital continuing care into the community, into nursing
D homes, and at the same time there was, I suppose, a feeling to keep the beds as a resource you have. Coupled with that Haslar, which was the naval hospital and then became the service hospital, started doing trauma. With that there was an increased throughput of frail older people who lived in Gosport, whose families lived in Gosport, who needed aftercare after their surgery. There were only twenty general rehab beds in Portsmouth at St Mary's, and for some of those relatives it was difficult to travel. So we did take people for general slow stream rehabilitation from the – mostly – fractured hips and other fractures. That is how the
E case mix changed. I am sure this was before Dr Barton left us. We were also doing the slow stream stroke rehabilitation. People with strokes, a week after they had assessment on an acute ward, were moved closer to home for ongoing rehabilitation. So from this continuing care, which are people with probably sometimes complex needs, sometimes really big disabilities that they did not progress, we were then dealing with patients whose needs were changing, a different mix of patients. Looking back at geriatrics over the years, the care of older people, we were beginning to recognise and manage more conditions as I suppose we
F learn more about conditions and more about what can be done. So if I look ... Sorry.

Q That is all right.
A Shall I move on?

Q No. As the nature of the patients were changing, patients with more complex needs, perhaps patients who had undergone surgery recently, was there any change in the resources
G that were available at the War Memorial Hospital?
A No.

Q Were you given more nurses or more doctors?
A As far as I can recall, during the period that Dr Barton with us, I cannot comment on the nursing staff. I do not think we had any more nurses but I cannot remember that for certain. With the change in case mix, at the point that Dr Barton left us, she was still the only
H clinical assistant. Whether her sessional time got reviewed, again I cannot remember.

Q Can I come back to a ward round? When you were seeing patients, would you look at the prescription chart?
A I would.

Q We have seen that for some patients a syringe driver was used?
A Yes.

Q And we have seen that for some patients a syringe driver would be prescribed and not instituted straight away?
A Yes, that is correct.

Q Would you have been aware if that was happening with patients that you were caring for?
A Yes. The "as required" prescribing was in place for the syringe drivers, but also for other medication.

Q And in your view was that appropriate, for a syringe driver to be prescribed in advance of it being required for the patient?
A Yes. The reason the "as required" prescription, including the syringe drivers, are written up is so that if a patient was distressed, then continuous analgesia could be given and that was left, after discussion with the nurses, there was really scope then for the nurses to commence a syringe driver if the need arose. There was no resident medical cover out of hours and it was Dr Barton or her partners who provided that. So the aim of the syringe drivers being on the chart, as I recall, was to ensure that there was something to keep people comfortable if the regular medication and other "as required", the shorter acting medication, was insufficient.

Q As the consultant responsible for patients on the ward, did you have a view as to whether that was a safe way of proceeding?
A The "as required" prescriptions are something that we still do in practice today. With hindsight I think, having looked at the charts and the notes, leaving a syringe driver on the "as required" and having that discussion with the nurses, that they are now at a stage that this is going to be required, it was probably the dose range on the syringe drivers rather than the syringe drivers per say that the dose range probably could have been smaller. But I think to have left the syringe drivers as an option was reasonable practice, and that is something that I would do in my practice today as well.

Q We have seen anticipatory prescribing, a dose range written up for a syringe driver in advance of the patient requiring a syringe driver, where the dose range may be from 20 to 200 mg of diamorphine. Were you aware that that was a dose range that was on occasion written up?
A I had not quite registered that the dose range was that wide and I am not too sure why that was. I knew we were writing up – for me, the fact that it was written up in advance is sometimes necessary, but with hindsight maybe the 20 to 200 was probably too wide a dose range.

Q At the time, does it follow from your answers, you were aware that dose ranges were being written up in advance of a syringe driver being needed at all and you were content with that?

A Yes.

Q What was your understanding as to how the syringe driver would be started if it was felt necessary to move to a syringe driver? Would the nurses do it themselves?
A The understanding was that the nursing staff would discuss this with Dr Barton or one of her partners and have a discussion about the patient's condition, what the problems were, and then it would be a joint medical and nursing decision to commence the syringe driver.

Q From your experience of that process going on, were you aware of any problems?
A The problems probably were when Dr Barton was not on call for a weekend or out of hours. Sometimes getting the cover from her partners was difficult. Some of them did not feel comfortable with palliative care and some of them were very busy. But I am assuming that the nurses would have discussed it with the on call doctor in all instances.

Q If a decision was made to start a patient on a syringe driver which had earlier been written up by Dr Barton, were you aware of any difficulties with the nurses contacting Dr Barton for there then to be a decision to start the patient?
A I do not recall. If Dr Barton was on call, she was contactable and she also visited the wards fairly frequently: first thing in the morning, sometimes at midday, sometimes after she had finished surgery, as I recall. She was contactable. Sometimes some of the others were busy.

Q Can I ask about the nursing staff? You will have known Sister Gill Hamblin on Dryad Ward.
A I did.

Q What was your view of her as a nurse?
A She was an efficient ward sister, she worked hard, she was kind to the patients, she was exceptional with skin care, I worked well with her and there were certainly no tensions. She was a good nurse. She has left the hospital and I am not too sure if she is working right now.

Q We know she is not well, I am afraid. Can I take you to the other ward, Daedalus Ward? There was a Sister Joynes who was sister there for a number of years. How did you get on with her and what was your view of Sister Joynes?
A Sister Joynes was on the male ward before she was on Daedalus Ward and she was very much an old-school nursing sister, very professional, very good with patients and relatives, somewhat of a no-nonsense approach, but certainly good care of older people and I got on very well with her.

Q Then the ward manager at Daedalus Ward was Phillip Beed. How was he as a nurse?
A Phillip again was a good nurse. He did well and he has moved – we worked well on Daedalus – he probably had a different style of management, in that he encouraged the nurses to develop quite a lot of their skills and supported them. He has moved into the community and I believe he is enjoying his role. A good nurse again.

Q Just looking at both of those wards, Dryad Ward and Daedalus Ward, what would you say of the standard of nursing care that was provided for the patients?
A The nursing care was good, but again, as the wards got busier and we needed more rehab, we probably did not upskill the staff at the same rate. But the nursing care was good.

Q Upskill the staff. What do you mean by that?
A There was a need to move from care of the older person and good nursing to looking at rehabilitation issues. That probably took a bit longer with goal-setting in the multi-disciplinary work. There were therapists visiting the wards even at the time that Dr Barton was there, but the development of the multi-disciplinary rehabilitation took a bit longer.

Q Can I turn back to Dr Barton? If there were occasions when she needed to speak to you and you were not on site at the War Memorial Hospital, what would you say of Dr Barton's willingness to get hold of you?
A I was always contactable by phone and she could get me through the operators at Queen Alexandra Hospital. Most of the ward senior nurses knew what sessions I had in Gosport and when I would be there and if Dr Barton was worried, she would call and discus it, sometimes first thing in the morning, sometimes in the middle of the day.

Q Can I ask about her note keeping? We have seen notes by Dr Barton that are fairly brief, clinical notes.
A Yes. I think looking at the notes, the notes are brief and probably too brief.

Q Tell us, did you ever mention that to Dr Barton during the years that you worked with her?
A No, I did not. I do not recall doing so.

Q Why would that be?
A I am not too sure. It was probably against a background of being busy and at that time there was no formal supervision, where one sat down with a set of notes and went through them and looked at notes as we would do now when supervising other medical staff. Dr Barton was also already in post when I started. She was a competent GP, looking after our beds and we were working well. Looking back over the notes, I now realise that I probably should have been more critical about the notes.

Q You say that looking back. At the time did you feel there was any problem with the notes?
A I knew the notes were brief, but I did not pick up that they were actually lacking in a fair amount of clinical detail.

Q At the time, did you feel as if patients were being in any way let down?
A I do not think the patients were let down because Dr Barton was on the ward every day, certainly at least once or twice a day, sometimes three times a day. So I do not feel the patients were let down, but the records should have been there.

Q You talked about Dr Barton being busy. Is it your understanding that was the reason why the notes were brief?
A It was the busyness and the turnover on the ward and I think we were all busy at the time as well. It is not an excuse, but my understanding is that the wards got busier and, as a result, the note keeping suffered.

Q I am going to turn to certain patients with you now, if I may. I am going to start with a man called Leslie Pittock. Do you have any notes with you?
A Yes. Can I look at them?

Q Please do. It may be that the notes are put into different sections with a letter reflecting the patient. If that is so, this is Patient A, Leslie Pittock, and I am going to ask you to look, please, at a note that we have on page 68. I know you have looked at these notes recently, but I think you cannot recall this gentleman. Is that right?
A No, I cannot recall this gentleman at all.

B Q We have looked at this note on a number of occasions in the past and I am just going to invite you to identify as yours an entry for 4 December 1996, where you have written, "Frail 82 year old" and you write down a number of problems that he had.
A That is my handwriting and signed by me at the end of page 68.

Q If you look back one page, you should be able to see Dr Bayly, who was a registrar for Dr Banks, writing to you:

C

"Dear Dr Lord

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

D

That was the context in which you were invited to assess him.
A Yes.

Q Can you tell us what you thought this man's prognosis was from your note?
A From the note, I have said he was in a rest home and at that stage I did not feel that he could return to the rest home, where he would basically need to be independently mobile and manage with a little assistance with his personal care. He was completely dependent and the outlook for him was not good. I recommended additional nutrition supplements, bladder wash-outs and dressings for the ulcers that he had. I cannot recall this patient, but from the notes, the outlook was not very good.

E

Q If I can ask you to turn to page 188 in the same bundle, which is not very easy to read; there is another copy of the same letter on page 193 which is easier to read, but we do not have the right-hand side of the page. You will have to go to page 188 to see the words I am inviting you to agree. You say that overall, you feel that his prognosis is poor.
A Yes.

F

Q What does that mean?
A I am trying to give a prognosis and it means that I did not feel that we would be able to get him better to go back to a rest home to the level he was at. I cannot recall the details, but I did not feel that we were going to make sufficient gains in improving his function, given that the had had a depression, his nutrition was poor and his skin had ulcerated, probably from pressure, as well. So the outlook for him generally was not good.

G

Q In a man whose Barthel score was 0, and given the conditions you have written down in your note and in your letter, would you have anticipated that he would become less dependent as time went on?

H

A It would have been very unlikely.

Q Can I turn to another patient, please? I am going to take you, if I may, to a patient we know as Eva Page, Patient C. This is an elderly lady who you saw on Charles Ward I think at the Queen Alexandra Hospital on 25 February.
A Yes.

B Q Just look at your note. You say, "Confused", is it "with some agitation towards afternoon"?
A Probably "and". It could be "with". It is not clear on my copy.

Q It says:

"Says she is frightened – not sure why. Tends to scream at night.
C Not in pain.

Try..."

Is it tablets, or it could be "tds thioridazine"?
A "Try tds thioridazine".

D Q

"Son in Gosport therefore transferred to NHS C/C..."

Is that continuing care?
A Continuing care.

Q "At Gosport", and you have indicated when she could be moved?
E A Yes.

Q We see below an entry by Dr Barton that this patient, Mrs Page, had been transferred to Dryad Ward ---
A Yes.

Q --- continuing care. If you go over the page, do you see two more entries in your
F handwriting in the bottom half of the page?
A Yes.

Q I think you indicated in the first of those entries what the diagnosis was for that patient, cancer of the bronchus. Can you indicate what you have written after the question mark in the line below – is it cerebral?
A "? cerebral metastases".

G Q Can we go to the start of the note:

"Spitting out thioridazine."

Is that right?
A Yes.

H

Q "Quieter"?
A Yes.

Q And you have written:

"On prn SC diamorphine."

A Subcutaneous diamorphine.

Q Are you able to tell us the date of that note because it looks as though there has been some crossing out?
A That would be 2 March 1998.

Q That is the same day as Dr Barton's note immediately above it, I think?
A Yes, because the son was seen that same day.

Q You have written two entries on the same day, the second one after you have seen the son?
A Yes.

Q I am going to ask you about the "prn subcutaneous diamorphine". I am going to ask you to turn to page 278. Page 278 is obviously part of the prescription sheet for that patient. We see that subcutaneous diamorphine had been written up, but the date of administration is 3 March?
A Yes.

Q If I take you back to your note, are you able to tell us whether your note is correct to say that this lady is on subcutaneous diamorphine as at the 2nd?

A That is an error in my note because at that time she was not on diamorphine. On page 272, she had some intramuscular diamorphine that morning.

Q That is right?
A So in my note there is an error saying that she is quieter on prn subcutaneous diamorphine. I could not find any other prn diamorphine, so I must have referred to the dose that was given at 8 o'clock that morning. It was actually an iron dose and not a subcutaneous dose. That is an error in my note.

Q What we see further down in your note, again on 304, 305 I am sorry, is:

"Fentanyl patch started today."

You have just referred us to page 272, where we see fentanyl written up. We see that the fentanyl patch was administered on 2 March that day in the morning at 8 o'clock and have you signed the prescription for fentanyl?
A I have.

Q Tell us why you would have done that?
A I cannot recall exactly, but I think there was a cost implication with fentanyl. My recollection of this is that the pharmacist wished us to countersign the fentanyl. The reason

why I signed it – that is my recollection and I cannot think of any other reason why I would have countersigned the prescription, I cannot think of another reason – but I certainly remembered the pharmacist was conscious that fentanyl was quite costly and that was why I countersigned it. That is as far as I can recall the reason for that.

Q If you go back to page 278, we know that a prescription for prn subcutaneous diamorphine was written up at some point. Are you able to tell us whether you had seen what we have as page 278 when you wrote your note on 2 March?
A I cannot recall.

Q Do you think you might have seen it?
A I could have seen it.

Q That of course has a range of diamorphine written up of 20 up to 200 mgs. If you had seen that, would you have raised a concern about it with Dr Barton or would you have been content with it?
A If I had looked at a 20-200, I could have asked why the dose range was up to the 200, but I cannot recall – now at this stage I cannot recall whether I saw it and whether I did do anything about it.

Q If we go back to page 305, staying with your first note you have written:

"Agitated and calling out even when staff present."

We have read the next two lines. Is your last line for that entry:

"Ct [continue] fentanyl patches"?

A That is what it says.

Q "Ct" is continue?
A Continue.

Q Did you write a note having seen Mrs Page's son?
A Yes, I did.

Q Can you read it to us?
A

"Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue the present plan of management."

Then I have signed it.

Q Can I ask you about drowsiness and diamorphine. Clearly, you consider that diamorphine was appropriate as a drug to be given in those circumstances?
A Yes.

Q What would you say about continuing to give diamorphine even though a patient may be experiencing drowsiness?
A This lady – and I cannot recall the specifics – from the note we have had difficulty keeping her comfortable. Thioridazine, which is one of the typical phenothiazines, was not working, the other sedation was not working, she was very distressed. The diagnosis of the carcinoma of the bronchus, it was not confirmed but it was accepted that she would be managed as such. The concern was that in someone so agitated as to whether there was a cerebral metastases, as to whether could there have been some spread to her brain. She was not a lady who was ready for more investigation and that had been decided on the acute ward before she moved to Charles Ward. Even though someone is sometimes drowsy, if sedation is required unfortunately there is not the ideal sedative or pain relief that would not have side effects. With using morphine and the other drugs that we would use in palliative care, there is sedation and restricted depression with all of them. That is what I have been trying to explain in that note.

Q There is respiratory depression with all of them. What is your view about whether it was appropriate to agree to permit a degree of respiratory depression when you are treating a patient?
A It is always a balance and it is a balance with what I am trying to achieve. If you are trying to achieve pain control and achieve comfort and get rid of anxiety, sometimes you have to accept some of the side effects. It really depends on what the aim of the treatment plan is.

Q If doctors are there on a sporadic basis to review the patients, was that balance always easy to achieve?
A The close titration was difficult sometimes. During the week there was probably adequate cover and the nursing staff were really quite senior and used to handling syringe drivers. The balance between as to whether we were able to give better monitoring was probably not possible with the staffing levels we had.

Q The Panel here has heard that after Dr Barton resigned she was replaced with a doctor who was there full time, Monday to Friday 9-5, and that at later stages even more medical resources were put on to the wards. Is that right?
A Yes. There is still in place an associate specialist who has a postgraduate qualification from the College of Physicians so has the MRCP, and the people we have had in post since Dr Barton resigned have been of registrar grade or higher. The present post holder is an a non-career grade post. We also have three senior house officers. The out-of-ours cover is, I think, still unresolved, or was unresolved certainly was in 2006 because of rotas, but there is certainly more presence sense, there is also more consultant presence in Gosport.

Q I am going to take you to another patient. For us it is patient Alice Wilkie, pages 99A and 99B. This is a lady who had advanced dementia. We know from the history she had been on Mulberry Ward, which I think at an earlier time might have been described as a psychogeriatric ward. I think different names were being used or different descriptions were being used but that was its purpose. At the time you saw this lady, I think she had a bed at Addenbrooke's, which was a care home.
A Yes, it was.

Q Was that a psychogeriatric care home?

A Yes, it was. To return there, patients had to be independently mobile. They were in a supervised environment but, physically, they had to be reasonably good; just one of the larger care homes.

Q We have an assessment by you of this lady on 4 August 1998. Is that right?
A Yes.

B Q I do not need to take you through the detail of your note, we see a Barthel score on the third line. We see some investigations that you ordered and were writing the results down from, "NAD", for the chest X-ray and then you see "ACG" means nothing abnormal?
A No abnormalities detected.

Q You have written down a plan:

C "Continue oral Augmentin and subcutaneous fluids"?

A Yes.

Q
"Overall prognosis poor and too dependent to return to Addenbrooke's."

D Is that what you were telling me, that patients needed to be mobile to go to Addenbrooke's?
A Yes.

Q Can you help us with, "Overall prognosis poor", what were you meaning by that?
A That someone who was functionally dependent the Barthel score – there is an error in my note again – the Barthel score should be 1/20. A Barthel score of 20 is someone who is completely independent, able to do stairs and bath or shower on their own. So she scored 1
E out of 20 and was very dependent. In point 3 I have said:

"Overall prognosis poor and too dependent to return to Addenbrooke's."

But in 5, I have said:

"Keep bed at Addenbrooke's."

F

Because sometimes patients did recover unexpectedly, but overall my feeling was that the prognosis was poor.

Q The last line of your note you have written the letters "DNR". We probably know what that means, do not resuscitate.
A Yes.

G

Q Can you tell us why you would have made that decision and written it in that way?
A It is because this lady was very dependent, cognitively very impaired, physically frail – again, this is someone I cannot remember at all, I cannot remember what she looks like – and so cardiopulmonary resuscitation in that event is not likely to be successful. The resuscitation available is only basic CPR in Gosport anyway, so I made the decision that active resuscitation was not in her best interests.

H

Q The next entry we see is an entry by a GP, Dr Peters, that this lady had been transferred from Phillip Ward. He has written for from four to six weeks and refers to the Augmentin for a urinary tract infection. If we turn over the page, we see a further entry by you, I think, on 10 August?
A Yes.

Q Barthel now 2 out of 20?
A Yes.

Q "Eating and drinking better. Confused and slow." Is that what it says?
A Yes, it does.

Q "Give up place at Addenbrooke's". Is it "review..."?
A Yes.

Q "... in a month's time"?
A Yes. That is a review in one month, and if there is no specialist medical or nursing problems, discharge to a nursing home, so as opposed to going to a rest home. If she had remained stable, then we would look to discharge to a nursing home.

Q Can you tell us why you were saying that the place at Addenbrooke's should be given up?
A Because she would have to be mobile to return to Addenbrooke's, but her Barthel would have needed to be about 10 or 12, and in the week that we had her, there was no improvement. She was dependent, and also her cognition was not good. While it would have been nice for her to return to where she came from, at that stage it was not looking optimistic. It is always a balance as to whether you hold on to a rest home place because it would be nice for them to return there, or whether you give up that place because the progress has not been good.

Q The last line of that note is: "Stop fluoxetine." Fluoxetine, I think, is an anti-depressant?
A Yes.

Q Are you able to tell us ---
A It is very difficult...

Q Go ahead.
A I cannot recall the reason for that.

Q Can you tell us, if a patient was towards the end of their life would it sometimes be the case that anti-depressants would be stopped?
A It could be for a number of reasons. With cognitive impairment people can get quite apathetic and quite withdrawn, and it is difficult to know whether sometimes it is an underlying depression, or whether it is part of the cognitive decline. So anti-depressants are started, but sometimes there comes a point where you feel the person is not really improving, but I cannot recall the reason why I made that decision.

Q All right. I am going to move to another patient now. I should say, Dr Lord, that we would normally take a break after about one hour, but I am very conscious that you have had a full working day today and you may wish to continue.
A I would like to continue because I would not like to overrun to next week because next week is even busier than this week.

Q I understand. I will keep going unless I am stopped. I am going to take you to Patient F, please. She is a lady, Ruby Lake. For those who have the bundle open, I am going to take them to page 5515. This is an elderly lady who had leg ulcers in the past and had fallen and fractured her hip. If you have page 515, the bottom half of that page gives her age as 84, and it is a letter written in the medical records inviting you to assess Mrs Lake?
A Yes.

Q From the point of view of her future management. It says:

"[She] was admitted from A&E following a fall which resulted in [fracture] of the left neck of femur."

It details the operation she had undergone on 5 August 1998.

"Post-operative recovery was slow with periods of confusion and pulmonary oedema. She suffered vomiting and diarrhoea. Over the last two days however she has been alert and well and it is now our intention to work on her mobilisation."

You made an entry that we have at page 516, I think?
A Yes.

Q In which you says:

"Thank you. Frail 85 year old with..."

And you go on to deal with the operation she had undergone:

"[Left] cemented hemiarthroplasty of hip"

on 5 August?
A Yes.

Q We have heard before in the hearing but may not have made a note of what LBBB refers to?
A It is left bundle branch block and left ventricular failure. Left bundle branch block is a conduction defect in a heart, usually representing underlying ischaemic heart disease, although there are other causes for it.

Q And left ventricular failure is obviously another reference to her cardiac sufficiency?
A Heart failure, but predominantly of the left ventricle.

Q You have then written, is it "Sick sinus syndrome/AF" meaning atrial fibrillation?
A Yes, it is. It was either a sick sinus syndrome, which could be the heart being sometimes slow, sometimes rapid, and probably there were periods of atrial fibrillation where

the heart is very irregular. That again could be intermittent or it could be sustained. So there are significant irregularities with heart rhythm and conduction, coupled with some heart failure.

Q You then go on to suggest:

"Dehydrated but improving."

Then you refer to ulcers. Point number 7 is hypokalaemia. Just tell us what that is?
A That is a low potassium level. Potassium is one of the essential minerals and it is important for heart function, but also general muscle function. In this context, if potassium is low and someone is on digoxin there is the potential for digoxin toxicity.

Q The next entry is "Normochromic anaemia". Anaemia we probably all recognise. What is the "normochromic" aspect?
A It means that the cells have... "Normochromic" as it, the haemoglobin contained in the cells was quite normal, so they were not hypochromic, which means that they have very little haemoglobin in the cells, or microcytic, which means the cells are smaller. It probably should have read "normocytic, normochromic anaemia" – so normal sized cells with normal amounts of haemoglobin but there just was not enough.

Q You have then put "Vomiting and Diarrhoea ? [Query] Cause." You are questioning why that is occurring?
A Yes. At that stage it was not certain yet.

Q You have suggested potassium supplements?
A Yes.

Q That she be hydrated orally and that there should be tests done on her stools?
A Yes. "CNS" is "culture and sensitivity".

Q Yes. And you have written:

"It is difficult to know how much she'll improve but I'll take her to an NHS continuing care bed at Gosport War Memorial Hospital next week."

A Yes.

Q I do not know if you recall this patient at all?
A Not in any detail, but I have looked at the notes a few times in the last few years.

Q I am reminded, you have written a letter in respect of this patient and it is at pages 26 and 27. I do not think it adds anything to the note that we have just looked at.
A I am looking for page 26. (After a pause) Yes, I have found it.

Q The first two paragraphs of the letter, you set out the detail of the notes that we have just looked at?
A Yes.

Q You talk about stool cultures and, in the third paragraph you refer to the ulcers that she has, and you say:

"... overall she is frail and quite unwell at present."

A Yes.

B Q Clearly a number of medical concerns about her?
A Yes.

Q I am going to move on, if I may, to a patient whom I think you may recall, Arthur Cunningham. We have him as Patient G. We have a letter written by you in March 1998 at page 140.
A Yes.

C Q I do not think I need take you through it. It speaks for itself. On the second page of that letter, page 142, you talk about the dose of Levadopa for his Parkinson's disease that he was then on?
A Yes.

Q And it appears that you and the patient had a disagreement about what was the proper
D level?
A Yes.

Q How as he getting more than you thought was appropriate?
A There had been occasions, as I recall, where he would have a house call, usually at a week-end, and would be seen by a GP who did not know him and would say that his Parkinson's disease was quite severe. And so that is how he obtained a supply of doubles of
E stronger Sinemet than we prescribed. Although we checked medication at the day hospital, he on a few occasions had the stronger strength in his pocket. If it happens ---

Q Sorry?
A The Parkinson's --- Sorry?

Q How as he seeing doctors that he did not know?
F A If it is an out of hours house call, it could be someone from the deputising service, they would not necessarily have access to notes when they visited him.

Q I understand. So it was Mr Cunningham's decision to call an out of hours doctor?
A Yes.

Q I understand.
G A He was quite disabled. He had a war injury in addition to his Parkinson's.

Q We have another letter from you three months later on page 134.
A Yes.

Q Again, the content of the letter really speaks for itself but you do make a comment at the start of the second paragraph in relation to the amount of weight that he seems to have
H lost since you last saw him on the 10 March?

A Yes.

Q Are you able to tell us why that might have been?
A Further on in the letter I said there might have been a degree of depression.

Q Yes.
A Sometimes people with Parkinson's do lose weight quite rapidly for no reasons but you do not know that until some time has lapsed. At that point it was not certain. As I recall it, it was quite a striking difference in his appearance and that is why I put it in.

Q Can I just ask you? I am sure the Panel know, but you make reference at the beginning of the third paragraph to a "monkey pole"?
A That is the pole above the bed and ends up with a sling, and then a triangle, that actually helps people move in bed.

Q So it is to help him to ---
A It is a form of a bed lever but it is above the bed.

Q If we look over to the second page of that letter on page 136, we see on the third paragraph, you say you have reduced his Levadopa further. You had said at the top of the previous paragraph, you felt he was on too much of that medication?
A Yes.

Q And you say, towards the end, at the bottom of the page:

"We will need to ascertain as to whether Mr Cunningham is going to remain at Merlin Park..."

That was the home that he was in?
A Yes. That was the rest home.

Q And I think you saw him again, certainly in September 1998. We have a letter at page 458 of this bundle.
A Yes.

Q And we have a clinical note for the occasion when you saw him, starting at page 644.
A Yes.

Q Just dealing with the letter, if I may, at page 458, you indicate that he was reviewed in the Dolphin Day Hospital. You refer to a large necrotic sacral ulcer which was extremely offensive?
A Yes.

Q You talk about his Parkinson's disease. You say:

"... mentally he was less depressed but continues to be very frail."

A Yes.

Q And you say you have taken the liberty of admitting him to Dryad Ward with a view to more aggressive treatment of the sacral ulcer. What were the options for you at that stage given the ulcer that he had and his other conditions?

A The options were that he was returned to the nursing home where was and we asked them to deal with it. The fact that he had developed a pressure sore in a nursing home meant that he needed something that was more specialised and we must have had a bed on Dryad Ward available that day, because we did not admit people from the community direct to Gosport War Memorial Hospital. They usually came through our acute wards. So we must have had a bed vacant and it was either we sent him back to the nursing home he came from and asked them to deal with it, because that was the highest level of care he could have in the community, or we could have sent him to the emergency department at QA, where probably he would have waited a long time on a trolley to be seen and it would not have been an appropriate choice for him. So he was admitted direct to Dryad Ward from the day hospital on the same day.

Q By admitting him from the Dolphin Day Hospital, you are just taking him on to a bed within the same physical site at the War Memorial Hospital, are you not?
A It was in the same building, yes. On the same floor as well.

Q "DDH" in your note is obviously Dolphin Day Hospital. That is where you saw him.
A Dolphin Day Hospital.

Q "Very frail. Tablets found in mouth some hours after they are given." Is that what your note says?
A Yes. That is how it should read. It is badly written, but that is how it should read.

Q Would that be of concern?
A Yes. It meant that he had not swallowed them, had not been able to swallow them for whatever reason. It is important that medication for his Parkinson's and certainly his depression that the tablets are taken. So it indicated his frailty, it could have indicated a reluctance to have medication, it could have indicated a poor swallow, which can happen.

Q You then deal with the ulcer and you have drawn a diagram.
A Yes.

Q Just remind us where the lateral malleolus is?
A That would be the outer aspect of the left ankle.

Q "PD" means Parkinson's disease. "No worse", you said.
A Yes.

Q You then go on to list a number of problems. The fourth one is depression and an element of dementia. Is that right?
A Yes. That is from previous assessments at the time. He spent some time with the psychiatric team as an inpatient and there were concerns that there was significant depression, but a degree of dementia as well.

Q You have written as point 5 "Diabetes mellitus - diet". Does that mean controlled by diet? He was not insulin dependent.

A Yes. No, he was not.

Q Point 6. Is it "Catheterised for retention"?
A Yes, it is. He had already been catheterised. I think that was some time ago.

Q If we go over the page to page 645, your note continues. You say, "Stop codanthramer + metronidazole + Amlodipine."
A Yes.

Q What types of medication are they?
A Co-danthramer is a laxative, which is predominantly a softener. The amlodipine is blood pressure and metronidazole is an antibiotic.

Q Are those all in tablet form?
A I need to look at the chart. Sometimes metronidazole can be used topically as well to the ulcers.

Q Page 757
A Yes. The metronidazole was being given orally. The reason that I do not usually use oral antibiotics unless someone really has a bad infection is that the tissue in the sacral ulcer is often dead and for antibiotics to penetrate that is extremely difficult. So that would have been why the metronidazole and amlodipine, because it was not really required for blood pressure control at that stage.

Q We have seen you cross through the amlodipline, the co-danthramer and the metronidazole and you have signed it each time.
A Yes. The magnesium hydroxide on that is also a softener. He had one laxative that was a stool softener.

Q Coming back to your note at page 645, the fact that tablets had been found in his mouth some hours after he had been given them, was that in your mind when you decided to stop some of those tablets, or not?
A Partly that, but also partly, were they really indicated? So a combination of reasons.

Q The next entry in your plan is "TCI". Is that "to come in"?
A To come in, yes.

Q "Dryad today. Aserbine for sacral ulcer." Tell us, how bad was that ulcer?
A That would be probably among the severest of the sacral ulcers, because there is a black scar on top. When that scar lifts, the ulcer would have been several centimetres in depth, because the tissue on top has died, but the tissue underneath that is degrading and that is why the ulcer is so offensive. The Aserbine was to try and lift the lid off it, if you like, and then allow the ulcer to heal from the bottom up, in the hope that it would.

Q At the bottom of your note, you have written, "Prognosis poor". What are you referring to there?
A Again, the outlook for him was not good. He had sustained a pressure sore in a nursing home, which really has qualified nurses and a high degree of nursing expertise. He had a long-term condition in the form of Parkinson's disease, which he had had for quite a while, and nutritionally he was not good. Mentally he had declined as well and the outlook

for him – at best, he would return to a nursing home, but to heal that ulcer, as I remember it, would have taken several months

Q What you say is that he should be nursed on site, given a high protein diet and "Oramorph prn if pain".
A Yes. So Oramorph if required for pain.

Q Oramorph. Is that a linctus, a syrup?
A That is a morphine elixir, morphine liquid.

Q It is not a tablet?
A No. It will be liquid and it will be short-acting.

Q Again, was it your view that it would be appropriate to go to that level of analgesia, given the condition you saw him in?
A Yes. From what I recall – and it was a long time ago – he was really quite distressed and I feel it was an appropriate decision.

Q We know that this man was subsequently put on a syringe driver with diamorphine and other medication. We have heard that a request was made by his stepson that the syringe driver be stopped at some point. What would your view have been if you had been asked? Is it appropriate to stop a syringe driver once a patient has been started?
A I did not see Mr Cunningham after he was admitted, so I do not know exactly. I do not have a picture of how distressed he was at that stage. In practice, in general, it would be really unusual for us to stop a syringe driver. Sometimes patients decline medication, but that could be for a reason of wanting to settle their affairs because they know they are terminal. Recently I have had occasion when someone has asked for morphine to be delayed until a relative came from overseas, because there were things they wanted to say and settle. It is always a balance, a balance as to whether you feel pain control is the most important thing or whether you feel that it is reasonable to withhold pain control to grant that request by the patient. By and large, once you make a decision to start a syringe driver, you really have worked through the other options and you have had the discussion that this person is at the end of their life and really needs this for symptom control. In my practice I cannot remember that we have actually stopped a syringe driver, but sometimes, as I said recently, we have not started strong medication. That was just a one-off.

Q You have told us that was for someone coming from abroad to see the patient.
A Yes. New Zealand is far away from most places!

Q I am going to take you to one more patient, if I may, and this is the last patient I want to ask you about. It is Patient L, Jean Stevens. The page I want to take you to, please, is 224. Again, I think you have had a chance to look at these notes recently, but you do not recall this patient.
A Not at all.

Q Page 224 is the request, I think of you:

"Please could you give your opinion as to the best path for rehabilitation of this 73 year old [female] who suffered a [right] CVE."

That is neck of femur?
A No, no. It probably was a stroke. It probably means cerebrovascular event.

Q "... leading to a dense [left] hemiparesis".
A Yes. Hemiparesis meaning the left side of the body was weak. So a stroke affecting the left side of the body, but it was dense, quite a dense weakness.

B Q It says:

"She is improving slowly and there is nothing more we can do for her on the acute medical side of things."

Was this an acute ward that you were being invited to see her on?
A Yes. The ward – that is a Haslar record I think – all the patients we saw at Haslar, C certainly then, the wards were all acute medical, surgical or acute orthopaedics.

Q I think if we go on to page 228, we have your clinical note. People may want to put a finger in there and also find page 734, which is your letter. In your note you say of this patient:

"Extremely unwell 73 year old with

D

1. Dense [right] hemiplagia due to [right] parietal infarction."

The parietal region is the side of the brain above the ear, I think.
A It is. Hemiplegia means that there was no movement at all. So I would use the word hemiplegia when there was complete paralysis and not just partial paralysis.

E Q "Ant MI". Is that an anterior myocardial infarction?
A It should be anterior myocardial infarct and left ventricular failure.

Q Atrial fibrillation we recognise. What would you say about the level of cardiac problem that this lady had?
A If I recall correctly, I think she was actually admitted with a myocardial infarct and then went on to develop a stroke.

F

Q You have written "Aspiration pneumonia". Aspiration means inhalation of stomach contents, leading to pneumonia?
A Yes. A poor swallow, probably associated mostly with the stroke and then inhalation of whatever the stomach contents into the lungs and pneumonia following that.

Q How serious a condition can that be in a patient of this sort of age and in this sort of G condition?
A I do not recall the patient, but certainly from my letter I was not keen to take her because I thought she was probably not going to survive even the short journey from Haslar to Gosport.

Q You say at point 5 in your note "Previous sigmoid colectomy". That is surgery on part of the bowel?
H A Yes. On the lower part of the large bowel.

Q You say in your note, "She is very chesty?"
A Yes. Chesty, flushed and tachyapnoeic. Tachyapnoeic meaning she is breathing rapidly.

Q Then:

> "I don't feel she is well enough to transfer to GWMH at this stage, and overall I feel is unlikely to survive."

Can you tell us, why do you think you were being asked to look at this lady at all?
A With a view to taking her over. This was 1999, so we were probably doing some after stroke rehabilitation at that stage. Again, with Haslar being busy with their emergency department, there was always pressure to move patients on to a facility that was slower stream. So I think we were being asked – it was unlikely this lady would have rehabilitated very quickly, but sometimes with strokes people do need a period of observation. I cannot recall the exact detail behind this.

Q She was coming from an acute medical ward and the request of you said, "We've done everything that we can."
A Yes, but sometimes that is not a good reason to move a patient. Sometimes people do need a bit longer. Transferring patients is not always in their best interest even though the distance is quite short. We have certainly had instances of patients who have been very poorly on arriving in Gosport. My opinion at that time was that she really was not well enough for the transfer.

Q That is certainly what you say in your letter at page 734.
A I have not been able to find 734, although I have read it. I have read the letter, I have not marked it.

Q Can I tell you what it says?
A Yes.

Q You detailed the concerns that you had from your note as to the medical problems. You go on to say that:

> "At present Mrs Stevens is extremely unwell."

You list the hemiplegia, the left ventricular failure and also an aspiration pneumonia. You say:

> "The speech and language therapist did not think her swallow was safe at all and at present she is on intravenous fluids. Overall I think Mrs Stevens is too unwell for transfer to Gosport War Memorial Hospital, but am willing to consider this if she is stable next week."

A Yes.

Q Overall her prognosis is poor, you have said?
A Yes.

Q Does it follow that you did not think she was stable at the time you saw her?
A Yes. From what I have written down, she certainly was not even stable enough to transfer, and the fact that I have commented that I certainly knew that she would not survive meant that the outlook for her was not good.

Q You say:

"I do not think it is appropriate for nasogastric or PEG feeding in her condition."

PEG, or PEG feeding, is that a line into the stomach?
A That is a line. The nasogastric means it is a fine tube down the nose into the stomach and PEG feeding would be direct feeding into the stomach through the abdominal wall. PEG tubes are better tolerated but they are more permanent and, given that the outlook for her was poor, at that stage I felt it was not appropriate to proceed to that.

Q We know that this lady was subsequently transferred to the War Memorial Hospital. Can I leave her and come back to the question of transfers. What you have said is that the process of transfer, even though it may be a small distance, may cause severe problems with patients?
A Yes. Some of the problems were that they were just too frail and moving them causes them to be quite distressed. I cannot remember whether this was during the time when Dr Barton was working with us and subsequently a few people with feeds in progress actually inhaled the feed while they were transferred, so we had to draft a policy that feeds will be discontinued on the morning of transfer. Sometimes blood pressure was low and they were just quite distressed.

Q Can I take you back to one of the patients we have looked at, Patient C. We were looking at Patient C at pages 304 and 305. I am going to ask you to look at a note at page 272. Looking at the entries on page 305, you made two on 2 March 1998?
A Yes.

Q Are you able to tell us whether that would have been a Monday when you did a ward round?
A Probably. I did not check this, some of the others I checked, but it was probably a Monday.

Q We will check it. If it was a Monday and you were doing a ward round, you told us you would have started the ward round at about 2 o'clock?
A Yes.

Q I am told it has been checked and it is a Monday. If we go back to page 272, we see that Mrs Page was given an intramuscular injection of diamorphine at 3 o'clock that afternoon. That is signed by Dr Barton on the prescription and given, I think, by a nurse with the initials SH, who we think would be Shirley Hallmann.
A Yes.

Q Would you have been aware of that if that was a ward round and you were going round the patients?

A Yes, I would have.

Q Is it a proper inference that you would have thought that appropriate treatment at that stage?
A Yes, it is because ---

Q Thank you. Do not let me stop you. If you want to say something else, please do.
A No.

MR JENKINS: Thank you, those are all the questions I wanted to ask.

THE CHAIRMAN: Thank you. We will take a short break at this point. It is important not only that we keep you as fresh as possible and I appreciate it has been a long day for you already, but the same applies also to all of us in this room. We are going to take a break for 15 minutes. Please feel free to get whatever refreshment you can and we will return in 15 minutes when Mr Kark will have some questions for you.

THE WITNESS: Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everybody and welcome back, Doctor. Have you been able to get some refreshment?

THE WITNESS: Yes, I have. I have had a drink and some chocolate.

THE CHAIRMAN: Thank you, we are fit to continue. Mr Kark, please.

Cross-examined by MR KARK

MR KARK: Dr Lord, I am standing up. I am probably in silhouette because I have a window behind me, but can you just about see me?

THE WITNESS: Not now, but you were quite clear.

MR KARK: As long as you can hear me, it may not matter too much.

THE WITNESS: I can hear you well.

MR KARK: Let me start by asking you about your work with Dr Barton. You told us you worked with her from 1992 until 2000 when she resigned?
A Yes.

Q You worked with her from for an eight-year period?
A Yes.

Q You built up a friendship with Dr Barton, is that right, as well as a professional relationship?
A Yes, I did.

Q Indeed, there came a time at the CHI inquiry when Dr Barton was giving evidence, that you acted as her friend, you were her supporter. Is that right?
A No, I do not recall that occasion, but I did go with her to an independent review somewhere. Yes, I did.

Q Let me make it quite clear I am not criticising you for one moment for doing that. You covered both of these wards at various times,but your actual clinical input on each was on alternate weeks. Was that right?
A Yes, at some stage we were covering for maternity leave and is when I think the alternate weeks came in. We had locums in the department and that did not work out very well, and I think it was over the cover for maternity leave that it went to alternate weeks, as far as I can recall.

Q It follows that you did not see the day-to-day running of the wards, nor even, in fact, the week to week running of each ward?
A No.

Q By the --
A The ward rounds ---

Q Sorry, there is this delay, I did not mean to interrupt you, did you want to add anything?
A No.

Q By the time you came to have any interaction with Dr Barton, she had in fact been a clinical assistant longer than you had been a consultant?
A Yes, that was so whenever I started.

Q When you were interviewed by the police, you also told them that Dr Barton and the nursing staff had, as you put it, a fair grasp of the situation and you could not think of an instance when you had been required to go down to the hospital on a day which was not one of your regular days?
A I had done so intermittently, but I cannot remember the exact details.

Q So far as Sister Hamblin was concerned, we have heard quite a bit about her. She was a very experienced and, can I suggest, a fairly formidable Sister in charge?
A Not sure about formidable. I did not find her formidable.

Q You did not. Did you on any occasion that you can remember challenge her administration of opiates to a patient?
A I do not recall.

Q Of the patients you have been asked about, and I am going to run through them – that is Lesley Pittock, our Patient A; Eva Page, Patient C; Alice Wilkie, Patient D; Arthur Cunningham, Patient G; and Jean Stevens, Patient L – you saw of those patients only Eva Page and Alice Wilkie once they had been transferred to the Gosport War Memorial Hospital. Is that right?
A Yes, that is right.

Q Is it fair to say, and again this is no criticism of you whatever, that it is very difficult for you to add anything to your notes because of the length of time that has passed?
A Yes, with most of them I cannot recall anything at all. Just with Mr Cunningham I can recall the overview of his care because I had seen him on a few occasions, but there is a lot of detail I cannot really put together.

Q Absolutely, and Mr Cunningham you were dealing with prior to his transfer?
A Yes, I certainly saw him at home, I think once in outpatients, then on a few occasions in the day hospital so we had contact over a period of time.

Q I want to try to understand your evidence about what you knew of the prescriptions. You have accepted that the dose ranges that you now know were prescribed, in other words the 20 to 200 mgs were too wide. Do you agree with that?
A Yes.

Q When you started, back in 1992, were those prescriptions already being written?
A I cannot recall.

Q At no stage did you challenge those inappropriate prescriptions, did you?
A No, I did not.

Q You told the police that you did not register that it was possibly an inappropriate use of morphine. Would that be right, that you did not register at the time that it was an inappropriate use of morphine?
A As regards the dose range, yes.

Q The reason why you now appreciate that those prescriptions were too wide is because you recognise that they could lead to harmful consequences?
A Yes.

Q Do you agree that they left too much to the discretion of nurses?
A Yes. We would expect the nurses to start at the lowest end and then have a discussion with the doctor on call, or the doctor who was covering, or Dr Barton about the dose increases, but there is no documentation of that.

Q Not only that, but we know, for instance at weekends when Dr Barton was off duty, one of the purposes of a variable dose was to allow the nurses to have a discretion to increase? You nodded, but we have to get your answer.
A Yes.

Q When you gave evidence to this Panel in relation to what the nurses could and could not do your first answer, which I noted down – the advanced prescription, the anticipatory prescribing – left scope for nurses to start a syringe driver as necessity arose. And then later you said that you were assuming that the nurses would discuss the initiation of the syringe driver. Can I just ask you, please, about that. To your knowledge, was the position that there were occasions when nurses activated syringe drivers on their own authority, obviously with an anticipatory prescription supporting it?
A Yes. With the prescription there, the nurses could start it, but by and large they would discuss it with the doctor on call.

Q Where does that information come from?
A Was the ----

Q Sorry. I did not mean to interrupt you.
A That is from what I --- Yes.

Q Where does that information ---
A That is what I --- That is what I recall. I would not be able to prove that.

Q So your understanding was that by and large the nurses would discuss the initiation of the syringe driver - yes?
A Yes, because that would indicate there was a change in the patient's condition ---

Q Exactly.
A --- that required a syringe driver.

Q And the syringe driver was the start for many patients, was it not, of a palliative care end of life route? Sorry, you are nodding but could you give your answer?
A Yes, it would.

Q You have told the Panel, quite rightly, that a variable dose is something which you still do and you said, I think, that a PRN prescription is something that you still use. Yes?
A Yes, I do.

Q Do you agree that where a PRN prescription is going to be written up that the prescription has to have a close range, a confinement, as to how much can be given?
A Yes.

Q And would you agree that there has to be, or ought to be, a clear notation as to the circumstances in which such a prescription could be given? Did you hear the question? Can you hear me?
A Yes, I can. You asked me as to whether there should be an indication ---

Q A clear note.
A --- about the circumstances?

Q Yes.
A Under which there should be an "as required" prescription?

Q Yes.
A Yes. Our charts with hindsight did not really have room for that as to the exact indication.

Q The danger of writing out a wide variable dose, without a clear note to the nurses as to how and when it can be used, is that a patient could be over-sedated. Do you agree?
A Yes, I do.

Q So far as note-keeping is concerned, you have agreed, I think, that Dr Barton's note-keeping was not satisfactory. It was too short?
A Yes.

Q You saw that, but you never picked her up on it?
A No, I did not.

Q Did you see the wide variation in dose ranges?
A I probably did, but it the significance of it did not register.

B Q So you noticed the lack of noticed, and you noticed the wide prescriptions, and you did nothing about either of those two problems. Is that right?
A Yes.

Q All right.
A Yes. Yes, that is right.

C Q So far as the notes are concerned, would you agree with this. In assessing where Dr Barton was only visiting the ward for, say, an hour a day – so an hour out of twenty-four – it was very important to have first of all a proper assessment of the patient's condition? Yes? You are nodding again, I am sorry.
A Yes, yes.

Q And one which was noted?
D A Yes.

Q A clear plan of treatment and one that was noted?
A Yes.

Q And clear prescribing and careful instructions in relation to the prescribing?
A Yes.
E

Q I am going to turn, briefly I hope, to each of the patients whom you have spoken about. So far as Mr Leslie Pittock is concerned – and I am going to try and avoid going through the notes, but we can certainly look it up if we need to. I think you referred to page 68. You said, "I cannot remember this gentleman at all." Yes?
A No. What I said is correct.

F Q Yes. We are going to have to look at his notes. I am sorry. Can we go to page 68? On the 4 January, I think it should be, we can see your note.
A Yes.

Q And you make a suggestion as to his future care?
A Yes.

G Q

"High protein drinks
Bladder wash-out ..."

Is that twice a week?
A It is twice a week, yes.

H Q And then is it a form of dressing for his buttock ulcers?

A Yes. It is an iodine dressing.

Q And you say:

"I'd be happy to take him over to a long stay bed at GWMH."

Yes?

B A Yes. That is long stay, yes.

Q As a consultant you would not transfer a patient to the Gosport War Memorial Hospital unless you thought that the patient was stable enough for that transfer to take place. Is that fair?

A Yes.

C Q And when you wrote this note "High protein drinks and bladder wash-out twice a week" and then a note about his dressing, did you expect that somebody would pick up on those suggestions and hopefully act upon them?

A Yes. That was giving some direction to the care prior to transfer.

Q And the purpose of high protein drinks for this patient would have been what?

A Improve nutrition, with the hope of improving the ulcers and help healing. Nutrition

D is also important for a sense of well-being. All of this for someone who was quite dependent. The serum albumin was low; the protein level in the blood was low, so nutrition is an important part of well-being and healing.

Q And in order for him to heal, you would have expected those instructions to be followed ---

A Yes.

E

Q --- or at least to be taken into account?

A Yes.

Q You did not review this patient at the GWMH – is that right?

A I could not find any other entries. No. That was ---

F Q All right.

A --- the only time I saw him.

Q Let me turn, then, please again very briefly to Patient C, Eva Page. You were asked about drugs being used in a palliative care setting, and you spoke about having to weigh up the dangerous side effects of respiratory depression against balancing that up with a need to palliate the patient's pain. Is that right?

G A Yes.

Q And this was the patient, of course, or one of the patients – I am sorry – who was given a fentanyl patch. Yes? And there is no criticism of that.

A Yes.

Q You knew about that. You apparently countersigned the prescription because there is

H some funding issue. Is fentanyl something you still use in your practice today?

A Yes, very much so.

Q Now in those days, fortunately or perhaps unfortunately, the lowest dose of fentanyl patch was 25 mcg, was it not?
A Yes, it was.

Q That has now changed because there has been a recognition of the dangers that such a high dose can bring about. Yes? You can now get, I think, a 12.5 mcg?
A I think it is 12.5, yes.

Q And so when using a relatively large dosage such as that would you agree that considerable care has to be taken if you start adding any drugs to it?
A Yes. The way the fentanyl works is that it takes about 24 hours to build into the system. Then it remains relatively constant for approximately the next three days and then the patch needs to be changed.

Q In a patient who prior to the commencement of a fentanyl patch was opiate naïve, you would have to be extremely cautious about adding any further opiates to the drugs in that patient's system. Is that fair?
A Yes.

Q I am sorry, you are fading a little bit. Can you speak up?
A Yes. Certainly, you sometimes need to use opiates in the first 24 hours, but after that you have to be really careful about opiates thereafter.

Q In the first 24 hours the reason you might need to use opiates is if the patient is in pain and you need a bolus dose. Is that right?
A Yes.

Q Right.
A Yes, yes.

Q And you would not give a patient a bolus dose via a 24-hour syringe driver, would you?
A No.

Q You do not know, or did not know at the time, that a syringe driver was started while the fentanyl patch was still in place?
A I cannot remember that.

Q If you had known that, can we take it that that is something that you would have countenanced against?
A Yes, it would have been, and in my notes I had not been specific about taking the fentanyl patch off when the syringe driver was started.

Q But that is something you would expect Dr Barton to know in any event?
A And the senior nursing staff.

Q Can I turn, please, to Patient D, Alice Wilkie.
A Yes.

Q You may not need her notes, but by all means if it makes you more comfortable, please do turn them up. I think you referred to page 99a and b.
A Yes, I have them.

Q You saw this patient four days after her transfer to GWMH. Is that right?
A Yes.

B

Q You cannot remember her ---
A Yes, I do.

Q You cannot remember her at all?
A No.

C

Q And so far as stopping the fluoxetine is concerned, you told us that there may be a number of reasons for stopping it. It is not necessarily a recognition that the patient is at the end of their life?
A I cannot recall the reason I discontinued it.

Q I am going to ask you about a patient that you have not been asked about by Mr Jenkins, but about whom you were interviewed. That is Gladys Richards. Do you
D remember being interviewed about a lady called Gladys Richards by the police?
A I do.

Q You do?
A I do.

Q Because it was in relation to that case that I think the first police investigation was
E started and you were interviewed in relation to it. Yes?
A I was.

Q I should have checked. Do you have Patient E's notes with you or not?
A I do not have the notes, but I do have my statement. Excuse me a minute. (The witness went to check) I am sorry, I do have the notes.

F

Q You do have the notes? All right. Because you have not been asked about this, I think it would be unfair to ask you questions without you looking at something. Could I suggest you go to page 63, which I hope is a prescription. I am just going to get a note of mine as well, if you will forgive me. (After a pause) You can see that this patient was given midazolam on I think 18 August and at the same time as that this patient was on a syringe driver with diamorphine in it. Do you have a recollection of this being put to you Dr Lord?
A I cannot recall any detail about that, but I have read these statements very briefly and
G I certainly was questioned about the prescribing.

Q Do you recall saying:

> "I think it is highly very unusual for someone to require that amount of, someone who is up and walking wouldn't, wouldn't require this degree of sedation and the fact that some of this dose was administered and they have kept, the administration went on for a few days means that we have now gone into the palliative care situation."

H

That is just to remind you of what you said to the police. Do you agree that for an elderly, frail patient, as I suggest this lady was, to give her – I am just going to check – 40 mg of diamorphine together with 20 mg of midazolam would be a very large amount of opiates?
A It is a large amount of opiate, but it is very difficult to comment, because I did not see this lady at all.

B Q I understand. I am going to move on Patient F. I am not going to ask you to turn up the file. Ruby Lake. You saw her on 13 August – that was five days prior to transfer – and you did not see her once she was at the GWMH. Is that right?
A That is right.

Q I think you said, "I don't remember this patient in any detail" and you simply went through your assessment with Mr Jenkins. You cannot really add to your notes.
C A That is correct.

Q Can I then turn to Arthur Cunningham, Patient G? You yourself admitted this patient to GWMH. Is that right?
A I did.

Q The reason for doing so was because you felt that his care needs could not be met.
D A That is correct, yes.

Q The purpose of admitting him was for aggressive treatment of his sacral ulcer because he needed specialised nursing care. Correct?
A Correct.

Q Can we take it that with your knowledge of the nursing care on Dryad Ward, you felt
E that he could get that sort of treatment there?
A Yes. Dryad Ward, the nursing and nursing staff on Dryad Ward were very good with pressure sores and skin conditions. Also Arthur Cunningham had come from a nursing home with a pressure sore and we could have sent him back there, but I felt, as I said before, we probably did have a bed available as well. So it was to give him a chance to see if the pressure sore could be improved.

F Q We have looked at your note on 21 September at page 644 of the patient notes. You have commented that tablets had been found in his mouth and that has already been dealt with. If we go over to page 645, you end up by saying that his prognosis was poor, but you set out a plan for him:

"[To come into] Dryad today
Aserbine for sacral ulcer."

G

Then is it "nurse on site" or "nurse on side"?
A Side. So that he was turned on his side to keep pressure off the pressure sore.

Q Again we see "High protein diet"?
A Yes.

H Q And "Oramorph prn if pain". Yes?

A Yes.

Q Would you have examined the patient before you made this note?
A Yes, I would have. I would have examined him.

Q We can take it that certainly at that stage you did not think that the patient was then and there destined for a syringe driver with intravenous diamorphine that day.
A Not from that day's examination.

Q I have been corrected, quite properly. I said intravenous. You did not think that this patient was at the time of that assessment destined for a syringe driver with subcutaneous diamorphine being put into him?
A Not from my assessment in the day hospital that day. That probably would have been the morning.

Q The note that you have made is "Oramorph prn if pain". You at that time did not prescribe him Oramorph, did you?
A I cannot remember. I need to look at the chart. I think I might have written up – I did write Oramorph on page 754.

Q Can we just have a look at that? Is that your prescription on page 754?
A Yes. The Oramorph is my prescription.

Q Can we just look at what it is? This we know obviously is oral morphine. Can you just help us with the dose?
A It is 2.5 to 10 mg and the special direction is four-hourly. The route is oral and the date was 21 September 1998.

Q That is an as required prescription?
A Yes.

Q When you write out a prescription such as this, as required but four-hourly, are you expecting it to be given four-hourly, or are you saying it should not be given more frequently than four-hourly?
A It is not more frequently than four-hourly.

Q Although this patient's prognosis you have described as "poor", he was not at the time that you examined him for palliative end of life care, was he?
A The treatment that we were going to give him was not going to be curative. So it depends on how you define palliative care. Palliative care for some people really is over a long period of time, the care you give people to help them cope with death and keep them symptom-free. His treatment was palliative and he was towards the end of his life, having moved from rest home to nursing home, but from my notes, we thought we would have a go at trying to get the sacral ulcer better.

Q Because if you could get the sacral ulcer better, which you hoped to do with treatment on Dryad Ward, his quality of life would be considerably better, would it not?
A He would have been less uncomfortable, but probably would have still, if he survived and the ulcer had healed, he would probably still have had to go to a nursing home and he disliked being in residential care of any kind, from what I recall.

Q I understand that. He was not going to be able to go to his own home and look after himself, but if the sacral ulcer had been curable, as it were, or treatable, then there was the prospect that he would be able to return to a nursing home.
A Possibly.

Q You have been asked about the reaction to his stepson. He had requested that the syringe driver be stopped. First of all, you took no part in the decisions post transfer, did you?
A No.

Q You said that it would have been very unusual to stop a syringe driver once one had been started.
A Yes.

Q This patient was described by his stepson when he went to see him. He had been able to have a proper conversation with him some days earlier and he was described by his stepson as being "unconscious and unrousable". What the stepson wanted was to find out the patient's wishes. Would it be unreasonable in those circumstances not necessarily to stop, but to reduce the level of sedation?
A It is possible to reduce the level or possibly even stop the syringe driver if it was appropriate, but I did not really see him at the time and I did not see him when he got really distressed when the syringe driver was started.

Q Dr Lord, all of that so far as you and are concerned is perhaps speculation. What I am asking you is if a relative comes to you and says, "My stepfather is unconscious and unrousable and I want to find out if that is the state that he wishes to be in when he dies", it would be perfectly reasonable, would it not, to reduce the level of sedation so that he could at least speak?
A Yes, it would be reasonable to reduce it and monitor how he is.

Q And allow that sort of conversation to take place.
A That would be appropriate.

Q Finally, I am going to turn to Mrs Stevens, Patient L. You do not need to turn up any notes, but please feel free to do so if you wish. When you saw this patient, which was I think on 6 May 1999, you have described her as being "extremely unwell" and at that stage you did not want to transfer to the GWMH. Yes?
A That is correct.

Q I do not think you dealt with this patient thereafter, did you?
A No. I had no contact with her after that.

Q In fact, she was transferred 14 days later, after that date about which you have been asked, and you do not know what the state of her health was on transfer, do you?
A Not at all. I did not have any contact with her after that initial assessment.

MR KARK: Thank you very much, Dr Lord.

Re-examined by MR JENKINS

Q Can I come back to Sister Hamblin, Dr Lord? You were asked questions about her and you told us that she was very experienced. It was suggested she was formidable and you did not agree with that. If it were suggested that she was a sister with whom one would be reluctant to disagree, what would you say?
A I am sure we had our disagreements, but I do not recall there being any animosity or bad feeling or any particular issues.

Q What would you say about the level of co-operation amongst nursing staff on Dryad Ward so far as you were able to see?
A The atmosphere was always very good, very cordial. They seemed to work well. I did not have any problems.

Q You have told us that Sister Hamblin was particularly good with nursing people with skin problems or bed sores.
A She was. We had quite a lot of bad ulcers and really extensive pressure sores which took a long time, but healed very well and in some instances healed completely. I certainly recall someone on Redclyffe Annex that probably took the best part of a year, but healed completely.

Q Can I come to syringe drivers and the anticipatory prescribing that we have seen? What you told us is that you would expect the nurses to start at the lowest end, the bottom of the prescribed range. Yes?
A Yes.

Q Is that what happened in practice from your experience?
A They usually did start at the lowest end. However, having gone through some of the records, I find that they have probably gone for a little above the lowest end of the range that had been prescribed.

Q What you agreed when you were asked questions by Mr Kark was that it is important to have a proper assessment of the patient and for that to be noted in the records.
A Yes.

Q From your understanding of the position, were patients being properly assessed?
A I feel that patients were being properly assessed, but the documentation did not support that.

Q As far as the actual administration of medication was concerned, and particularly using the syringe drivers, what was your view as to whether that was being dealt with appropriately by nursing staff or not?
A Is that with hindsight or at the time?

Q At the time.
A At the time, they were being dealt with appropriately.

Q If you had felt that your patients were not being treated appropriately, would you have said something?

A I would have. I would have said something to the nursing staff and, if nothing was resolved, we would have gone to the nursing managers.

Q Did you ever need to speak to the nursing staff or Dr Barton to express concerns that you might have had about patient care?
A I did not have any occasion to do that.

B Q You were asked about Patient A, Mr Pittock. I am sorry I am going to ask you to draw up the records again. We have look at your note for 4 January 1996. This gentleman had bed sores and you raised the suggestion that he should be given a high protein diet?
A Yes.

Q If we turn, please, to page 226 towards the back of those records, do we have a nursing care plan?
C A Yes.

Q Would you expect nurses to draw up care plans of this type in respect of patients and the problems that were to be dealt with?
A Yes, I would.

Q Is that a nursing priority or a medical priority?
D A It is a nursing priority and at the time the nursing documentation and the medical documentation was separate. They were not integrated notes and this was part of the nursing documentation and would be the responsibility of the nursing staff.

Q Looking at page 226, what comment would you make about the awareness of the nursing staff that Mr Pittock's diet was not good and that he needed to be encouraged?
A It has been documented that the diet and fluid intake was poor and the desired
E outcome would be to make sure it was adequate. The nurse who documented this has written down:

"Soft pureed diet. Encourage fluids and to have clear drinks after food."

Q Was it apparent that the nursing staff were responding to concerns about Mr Pittock's diet or concerns about it?
F A The patient would also have, as I recall it, menu cards, in that the high protein options would be chosen for them or they would be assisted with that. I am getting a bit jumbled where I am in time, because at present we document the food supplements on the drug chart, but I think that is for New Zealand. We did not do that in the UK.

Q If we look at the pages preceding the one I have asked you to look at, we see a whole series of nursing care plans. Let us look at page 220 as an example.
G A Yes.

Q The problem identified is the superficial broken areas of skin on Mr Pittock's scrotum and a plan is drawn up to deal with that.
A Yes.

Q If you go on two pages to 222, a similar plan with regard to a sore on his sacral area
H and the left hip?

A Yes.

Q Are these examples of plans that one would expect nursing staff to draw up if there were problems with a patient?
A Yes, we would.

Q You were asked about Patient E, Gladys Richards. I do not ask you to draw up any notes. You were asked a comment on a particular dose that was administered and you said, "It is very difficult to comment because I did not see this lady at all". In commenting on a specific dose of medication, particularly analgesia and whether it was appropriate for a patient to be given that, would you need to see the patient?
A I would need to see the patient. I would also need to have a discussion with the people who saw them on a day-to-day basis in order to discuss how they had been the previous day, the previous night, what had been tried, what their intake was like, could they swallow tablets. It was a joint decision. But to comment as to whether it was appropriate for a particular patient without having seen someone, it is very difficult to comment.

Q Can I deal with Patient G, Mr Cunningham. Again, I think there are care plans and we have some at page 873-876. I do not think I need to ask you to read them, but is it apparent from 873, as an example, that the nursing staff drew up a care plan to deal with the sacral sore present on admission?
A Yes.

Q On the following page, we have the actions that have been recorded by nursing staff to follow that care plan?
A Yes.

Q Similarly with 875?
A Yes.

Q Also 876?
A Yes.

Q You were asked if this gentleman could be transferred to a nursing home and you said it was possible he could have gone to a nursing home if he had survived and the ulcer had healed, that was what you said. From your assessment of this gentleman, was there a possibility that he would not survive because of his condition?
A When someone is as frail as he was, anyone with a pressure sore, particularly with a pressure sore where the classification would be the most severe – it would be what we call a grade 4 pressure sore which is, of the grades, the top grade of pressure sore – the chance of surviving it, of it healing, was remote. The length of time it would take would be quite extensive, it would be some months. It would require someone not lying on the pressure sore, being able to lie on his side. From what I recall of his back injury, the reason he developed the pressure sore in the first place was probably because he was unable to lie on his side, with a combination of his, probably mostly, his back injury but also the Parkinson's he suffered from. Does that answer your question?

Q I think it does, but you told us this was the worst grade of pressure sore you can get?
A Yes.

Q You were asked about the stepson and it was suggested that the stepson's account was that Mr Cunningham was unrousable. If the records kept by nurses, and indeed the doctor, indicated that the patient was in pain, he was in pain when being attended to by the night staff and the day staff also noted that he was in pain – they thought especially in the knees – if the doctor's note commented that on what he was then receiving, the subcutaneous analgesia was controlling the pain just, would you have thought it appropriate to reduce the dose that the patient was receiving?

A Everyone has to – you have to judge this on an individual basis and, using it hypothetically, it is possible to consider it. Whether it would have been appropriate with Mr Cunningham, in Mr Cunningham's case, I really cannot comment because I did not see him on the ward at that time.

MR JENKINS: I understand that entirely. Thank you very much, Dr Lord, that is all I ask you.

(Microphone adjusted for Panel questions)

THE CHAIRMAN: We have reached the point when it is open to members of the Panel to ask questions of you. I am going to look now to see if any of them do have questions. First I am going to introduce you to Mrs Pamela Mansell, a lay member of the Panel.

Questioned by THE PANEL

MRS MANSELL: You probably feel you have answered these questions, but for me some of your answers have made me want to ask other questions. If I look at Mr Cunningham, to Patient G.

A Your voice is coming and going. (Microphone adjusted)

Q Can you hear me now?

A Yes, I can.

Q Mr Cunningham. I read your initial assessment or I read your assessment for admission to Dryad Ward and, although you are saying at that point that the diagnosis for him was actually poor, simultaneously you were saying that the nursing home had to keep the bed open for the next three weeks. If you thought that there was absolutely no way that this pressure sore was going to be improved for several months, why would you be putting in to keep the nursing home open for the next three weeks? That seems a conflicting statement.

A Yes. The difficulty with giving up rest home or nursing home places is that they would be really hard to come by. Theoretically, even with a pressure sore, he could return to the nursing home and some people with pressure sores did return. It was just keeping that option open because that was the place that was, as far as we know, home for them. It was probably just being practical, I suppose, being pragmatic, to say that if it came to the point that it might have gone a bit better, we could have discussed ... Some of the nursing homes actually like to take people back as well, whether the pressure sore is getting better or not. The decision to keep the place open, I was just being mindful that if we were looking for a discharge from the ward for whatever reason, we had somewhere for him to go. It probably was not tied up with the prognosis for him. I was just being careful with having a destination for him to go.

Q As a lay person, when I read your plan here, it came through, for me it came through, that this was indicating possible treatment but also with a continuing care context. Are you saying that was different to that?
A Yes. The intention was always to treat him and, however poorly someone is and whatever palliation you use in the form of pain control, I was of the opinion that we had to have an attempt to heal the pressure sore. So, while we are saying the outlook is not good, let us give him some treatment because sometimes what we predict is not what happens, sometimes people look very poorly, but given time and we have all had that, people do get better. I could see why it probably sounds very ambiguous that I was saying that, "He was not good, let us do this", but then his outcome is not good so – I am probably not explaining this very well. It is probably recognising that he was towards the end of his life but was there something we could do because if this got better, maybe we could improve the other problems, so it was to give him that chance.

Q Let me take you to another point because what you actually talk about is the high protein diet. If I actually have a look at Dr Barton's assessment, which is at page 647 which I think is on the same day as you made your assessment – is it the same day as you made your assessment?
A Can you give me a minute, I have not turned it up. (Short pause)

Q We have no mention in that about the high protein diet. We do have the phraseology that we have come to understand is linked to palliative care end of life care. That is about make comfortable, give...

> "...Give adequate analgesia and I am having happy for the nursing staff to confirm death".

When we look at the nursing notes which Mr Jenkins took you to, we saw a lot of emphasis on the pressure sores and trying to improve those, but I do not think there was the same emphasis on the high protein diet and actually seeing this man as getting him prepared as continuing care to try and improve his condition other than improvement of the sore. Am I interpreting it incorrectly or is that how you might see this? I suppose the question is, would you see how Dr Barton has written up this person and the care plan for this person as being consistent with your own? I am questioning that there are differences, but what would be the consistency?
A My interpretation would be that Dr Barton and the nursing staff took into account what I had written. They would have included the actions there because they did use the English they might have used anyway, the nursing staff could have made that decision anyway, but I ---

Q Might this assessment here indicate that on the ward they are actually seeing this patient in a poorer condition than you have actually seen him.
A That was the same day.

Q That is right. So I am just questioning whether it looks to you like a worse prognosis than you have actually given? This looks much more like the end of life assessment.
A The nursing staff certainly ----

Q No. I am looking particularly at Dr Barton's initial assessment.

A With that assessment, I would have anticipated that she took into account what I had said anyway, and then putting this down in addition. That would be my reading of that.

Q So you did not actually get to review this person on the ward, did you?
A No, I did not.

Q So this person probably dies more quickly than you had expected him to die?
A Yes. That is correct.

Q So what review did you actually do to satisfy yourself that the treatment and the plan was appropriate for him? How he was being cared for on the ward.
A I did not do any review after he had passed away.

Q It did not actually raise any concerns for you?
A No, it did not.

Q But I understood that you wanted to be satisfied that the care, et cetera, on the ward was of a very high standard, and the treatment that they were giving, an analgesic control by the medical staff, was up to standard?
A Yes.

Q So in what way could you have satisfied yourself?
A I certainly heard that he had passed away but I did not look at the notes, Dr Barton's notes or the nursing staff's.

Q When you were being asked by Mr Jenkins about the quality of the care was that based sometimes on assumptions?
A Yes, it would have been what I observed on the wards.

Q Rather than any detailed assessment of how patients were being treated?
A We did not do any critical review or audits in those years, I do not think. I do not recall.

MRS MANSELL: Thank you very much, Dr Lord.

THE CHAIRMAN: Thank you, Mrs Mansell. Mr William Payne is a lay member of the Panel.

MR PAYNE: Good day to you. Good day. Can you hear me well? Can you hear me?
A I can hear you well. Yes, I can, thank you.

Q I would like to ask you a question with regard to the amount of time Dr Barton spent at the hospital. You said that you worked with her for eight years. Was it eight years that you worked with her?
A Yes. Yes.

Q We were told that Dr Barton had a contract for around 14-20 hours. Would you say that she over-fulfilled that contract? Would she be there longer than 14 hours per week?
A More than two hours a day, and she often did pop in at the weekend. There certainly could have been occasions when she did more than 14.

Q I am trying to ---
A But I ---

Q Go on. Carry on, please.
A I would not have been on the ward every time she visited the ward, but from what I knew of the time she did visit, and I am not aware of the details of her contract either, she probably could have done more than 14 hours on some weeks.

Q But she certainly attended every day through the week, Monday to Friday, every day?
A Yes. Yes. Except when she was on leave.

Q The reason I am asking those questions is with regard to the anticipatory prescribing. If she is going to be there every day, is there a necessity to prescribe in such a way that she did, using a syringe driver – that type of prescribing for pain control?
A My understanding was that although she was there during the week-days, she was not always there at the week-ends, and there would be some nights when her partners – the partners in her practice – would be on call. So my understanding was, it was to cover those times that some of the anticipatory prescribing did occur.

Q But some of these patients were prescribed on days like Monday and Tuesday, anticipatory prescriptions. The week-end is a long way away. That is what I am saying.
A Yes.

Q And she is going to be there every day, and ward rounds with yourself, that is all afternoon. I am just wondering why there was a necessity to use that type of prescribing?
A She would not have been on call out of hours every day. During the week, there would have been some days when her partners would be on call as well.

Q Yes, she mentioned that. That is another question that I have. You said – I think you said anyway – that her partners were reluctant to prescribe a syringe driver. Did you say that?
A Some of them were not comfortable with palliative care or prescribing opiates at all.

Q Do you know why that was?
A No.

Q Can you just give me a second, please? (After a pause) If a nurse on the ward when the doctor was not there felt that she needed to get a different dosage of any type of drug, could a doctor have been contacted and given verbal permission for that drug to be administered?
A The usual procedure with a verbal order would be that you repeat it to two nurses.

Q Right?
A So sometimes we give a verbal order, but you would repeat it to one nurse, and then you repeat it to a second nurse. That was protection of the nursing staff.

MR PAYNE: I think you answered my question. Thank you very much indeed.

THE CHAIRMAN: Thank you, Mr Payne. Dr Smith, do you have any questions?

DR SMITH: Yes, please.

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

DR SMITH: Hello, Dr Lord. I am going to confine my questions to Mr Cunningham as well. I think you still have the file in front of you in case we need to use it?
A Yes, I do.

Q First this, just in general terms about sacral sores. Of course, you said this was is horrendous and probably the worst one you had seen, but help me with this. Does the fact that a sacral sore is very large and looks horrendous – does that mean that it will be painful? Is there a correlation between the size and depth of a sore and its pain?
A Not consistently. Everyone is different, and sometimes the sores are painful when they start off. Sometimes it is painful when the scars lift off and they are healing. Sometimes it is painful when they are inflamed. Sometimes pressure sores are not painful at all, so it is very variable.

Q Thank you for that. In your note in the day hospital you said that he should have Oramorph if in pain, but you have not made a note that he was in pain. Do you agree with that?
A No.

Q You have not?
A Yes, yes, I do.

Q You agree with that?
A I have not.

Q Then to Mr Jenkins you said that he was really quite distressed and I am wondering if that was an assumption or recollection?
A It is a vague recollection. Mr Cunningham, the last few times we had seen him, was always quite distressed. He was distressed with being in residential care. It is a vague recollection. It is not a very clear picture

Q And so you associate the word "distress" with different things?
A Yes.

Q It might not be pain. It might ---
A It might not be.

Q --- be unhappiness about his lot, as it were. Okay.
A Yes.

Q On Dryad Ward there is a team and you are at the top of that team, and Dr Barton is working for you. Is that correct? Is it right to say "for you"?
A I do not know. Probably.

Q In medical hierarchical terms would that be right?
A I would carry the consultant responsibility for the patients. So, yes.

Q Under your direction?
A Employed by... Under my direction. Yes.

Q And obviously with you.
A Yes, certainly.

B Q And then there is a team of nurses, day nurses and night nurses, and they have a hierarchy. You have described, I think, quite graphically at one point how starting a syringe driver with diamorphine and midazolam at that time in your experience, in your knowledge, signals the start of an end of life pathway. Was I right to make that ---
A Thank you;

Q You went on to say that it is not stopped, the driver is not stopped. It carries on, and
C the ---
A Not usually.

Q Not usually? And my assumption to that would be, until the patient died. Would that be correct?
A Yes.

D Q So am I right in this, then? That a decision to start such a syringe driver is in fact a decision to enter an end of life pathway?
A Yes.

Q Who makes that decision, that this patient – your patient – is now entering an end of life pathway?
A It should be a joint decision with the patient, with the staff looking after him and
E wherever possible with the relatives as well.

Q You never saw him again once he left the day ward? The day unit.
A I did not.

Q So you were not involved in a decision to put him on a syringe driver, a decision that may be parallel to an end of life pathway. Is that correct?
F A No, I was not.

Q You were not involved in your patient's change in status?
A No. I do not recall the involvement.

Q Does that concern you?
A Dr Barton and the nurses were competent, and the nursing decision that night, if
G I recall it right, was that night the syringe driver was to be commenced. Sometimes they do need to make the decision. I cannot remember if I was contacted about it while Mr Cunningham was alive. I really do not recall.

Q You have drawn attention to the fact that a line of treatment was started after what I suggest was an acute event. It would be reasonable to call it an acute event. You brought that subject up. Is that your understanding? Something happened in the night?
H

A Yes. He was clearly very distressed at night and we did not know that there had been distress at night as actively before.

Q He was distressed. By all means refer to the notes, but do you recollect what that distress consisted of?
A No. I did not see him at all, and this is from the nursing notes.

B Q My understanding was that there was an episode of acute aggressing that he threw things around and made some threats to the nurses. Does that ring a bell to you?
A Yes, yes. It does.

Q We have heard from our expert witness that such episodes of aggression or acute confusion do occur in elderly patients. They are almost to be expected from time to time when they are in distress. Is that something you would agree with too?
C A Yes. Yes, I would.

Q So we have a man who, in your mind, because you write it down had prospects. Would you agree with that? He had prospects for some recovery?
A There was a chance. At that stage I was willing to give him that chance.

Q And you were quite ---
D A That is what I felt at the time.

Q You were quite precise in laying out a plan for his prospects?
A Yes.

Q And you sent him to a ward where you were confident that they had a particular skill in treating bed sore. You were quite happy with that?
E A Yes.

Q And he has an acute episode, and then he goes on an end of life pathway, a terminal pathway. Can you help me, because I would quite like to hear how you would reconcile what happened to the man with prospects. He was your patient. How do you reconcile what happened?
A The way I would need to reconcile that would be to have a more detailed conversation
F with the nursing staff who were on duty overnight and what is not clear from the notes is that there was agitation. What is not written is as to whether there was any pain, any other distress.

Q No. We do not know.
A From the notes.

G Q We do not know because there is nothing written to say that. That is true.
A Yes. Without knowing that detail, I cannot really comment on that.

Q Finally, you have tackled the same question that was put in a slightly different way, but I would still like to ask it again. What is it that makes you feel that the syringe driver might not have had its dose reduced, if not stopped, to see how Mr Cunningham might have been, if not to allow his stepson's request, to see if Mr Cunningham could tell us what his
H wishes were?

A I am sorry. I lost the beginning of your question.

Q I am sorry. That was too long a question, I think.
A Yes.

Q In this train of thought ---
A It is about reducing ---

B

Q Yes. In this train of thought, in the context of an acute event, how do you say, why do you say, that the dose might not have been reduced or the driver not stopped to reassess Mr Cunningham? Let us put it that way.

A When I replied I think to Mr Kark, I said it is something that could possibly have been considered and we do occasionally consider that.

C

Q Let me crystallise it this way. If you had been asked, because his stepson had requested it and the nurses brought that request to you, what might you have said?
A We would have discussed it. It might have meant reviewing the patient to see what happened or suggesting a lower dose. There could have been any number of options. An alternative option, if we felt there really had been pain and distress, would have been to talk to his family and explain and see if they still wished to have it reduced. It is very difficult
D because it is all hypothetical. I know the request was made, but I do not really – from the notes, I cannot make out whether there was any definite pain which would have been significant for me to make that decision. Sometimes you might have needed to have reduced it, say, for a couple of hours and then seen if that really caused any distress. It is possible to consider it.

Q It is an option?
E A It is an option, but without knowing a lot more detail of how Mr Cunningham was that night or the next day, it is difficult to comment.

DR SMITH: Thank you.

THE CHAIRMAN: Dr Lord, we have now reached the stage when I will ask the barristers concerned whether they have any questions for you which arise out of questions that were
F asked by members of the Panel. Mr Kark?

MR KARK: I have no questions.

THE CHAIRMAN: Mr Jenkins?

<u>Further re-examined by MR JENKINS</u>

G

Q I have three questions and they are all about Mr Cunningham. You told us you certainly heard that Mr Cunningham had passed away.
A I did.

Q What was your reaction when you heard that?

H

A I cannot recall an exact reaction. Some sadness, because I had known him for some years and, when you have known people for some years, there is always a little bit of sadness. But I cannot recall whether there was any other reaction.

Q You were asked about pain and I would like to ask you to look at two pages in the records: pages 865 and 866. This is an assessment sheet, it is completed by nursing staff and we see on the second page of it that it is dated 22 September 1998, in other words, the day after Mr Cunningham's admission to the ward, and it is completed by a nurse we heard from called Freda Shaw. If you go back to the first page, we see that when she has completed the document, she has ticked at the bottom two boxes, one to indicate that yes, he was in pain, or that there was pain, and yes, it was being controlled. Yes?
A Yes.

Q I think if we go back to the prescription sheets for this patient, page 754, we know that Freda Shaw has signed the document and dated it the 22nd. We do not know when she has filled in the other bits of it and filled in when Mr Cunningham was in pain and when it was controlled, but we know that as a result of your prescription of Oramorph, Mr Cunningham was administered Oramorph on a couple of occasions on 21 September.
A Yes.

Q Can I ask you about the dose range? Why did you choose a wide range: 2.5 to 10? It is a factor of four, is it not?
A 10 is not that large a dose if someone is really distressed and in pain. That was the dose range. 2.5 was sometimes enough for patients, but often not. It could be enough. It was just so that there was scope for the nursing staff to increase the dose if they felt it was appropriate.

Q I think if we go on to page 758, we can see the date when the syringe driver was started.
A Yes.

Q It was at night, 11.10 at night on the 21st, the day after he was admitted.
A Yes.

Q Again, I am not going to take you through the nursing records or the other medical records, but if the records suggest that Mr Cunningham was uncomfortable when he was being administered to, both at night and in the daytime, over the succeeding days, the 23rd and 24th – and again, Dr Barton's entry is that the analgesia seemed to be controlling his pain just on the 24th – would you think it proper care for the patient to reduce the pain relief that he was then on?
A As I said before, it is possible to consider it, but you really need to judge everyone on an individual basis. It is really impossible to generalise on that.

MR JENKINS: I am grateful. Thank you. That is all I ask.

THE CHAIRMAN: Doctor, that really does bring you to the end of your testimony. Thank you very much indeed for joining us by video link today. It is enormously helpful to Panels when we are able to receive live evidence, even if it comes by way of video link. We recognise that we have put you out quite considerably to accommodate us with the difference in time and we really are very grateful to you. Thank you very much.

THE WITNESS: May I just ask a question?

THE CHAIRMAN: You may ask. I do not guarantee to be able to answer it.

THE WITNESS: Do I have to come back tomorrow or am I done now?

THE CHAIRMAN: Your testimony is at an end. You are free to go.

THE WITNESS: May I make a comment?

THE CHAIRMAN: You may.

THE WITNESS: It is looking through these notes, it is something that I have got used to hearing in New Zealand – and I am not trying to say that anything is better – but I really feel that we need – and certainly when I left Portsmouth, we did not have what are called integrated notes, where every specialist, every different discipline writes in them. Having looked through these notes recently and when I have looked through the current notes that I am using, it is very valuable to even have a therapist or a social worker enter, "Patient not seen. Extremely unwell with temperature". That gives you a better reflection of the patient and I really feel that notes should be integrated. That is just a suggestion.

THE CHAIRMAN: Thank you very much for that suggestion, doctor. You are free to go. Thank you very much indeed.

(The witness withdrew)

THE CHAIRMAN: I think we will adjourn now for luncheon and return at 1.55.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Dr Barton, although we have had a witness interposed, I do not think we need to swear you again. You are on oath and you remain on oath. Mr Langdale?

JANE ANN BARTON, Recalled
Examined by MR LANGDALE, Continued

Q Dr Barton, when we adjourned your evidence yesterday, we were dealing with Patient B, Elsie Lavender, and I was asking you questions in relation to the chronology. Do you have that in front of you?
A Yes.

Q In relation to the chronology for Patient B, we had reached page 11 at the point when we stopped. At the top of page 11 – this is relating to the date 26 February 1996 – we had reached the point where we were about to look at the drugs that you prescribed on that date. First of all, there is the MST, which you have already covered. 10 mg was administered at 0600, then discontinued and then 20 mg twice a day commenced at 2200. So she is now, as it were, on 40 mg a day of MST. Then the prescription by you relating to diamorphine, 80 to 160, midazolam 40 to 80, hyoscine 400 to 600 mcg. None of those were administered on that

day. I need you to deal with this question. There is this lady with the continuing pain, as we already discussed yesterday, the analgesia being prescribed at that time and indeed administered was MST. Why write up an anticipatory prescription in her case? Are the reasons the same as in other instances you have mentioned?

A I anticipated that should her condition continue to deteriorate, there would come a time when she would be no longer able to take oral analgesia or her condition would merit other than just pain relief and I would want to administer it subcutaneously. She was now not opiate naïve, so I would not be starting at 20 mg of diamorphine; I would go in at a higher dose.

Q Why 80 as opposed to 20?

A Why 80 rather than 40? Because I anticipated that I might well need a higher dose of diamorphine when the time came to use it. Because of the nature and severity of her pain, which was not typical of cancer pain or pain that we have seen in some of these other cases following recent surgery or anything like that; it was a very atypical sort of pain.

Q If you were, as it were, doing the half calculation on 40 mg of oral morphine, MST, divide that by two, you get 20.

A Assuming her condition was stable and she did not require an increase.

Q You allowed for an increase to allow for the fact that if subcutaneous analgesia has to be started, it is going to be pain not being controlled by MST.

A Yes.

Q What I want you to deal with is, why not put the lowest dose in the range as 60? Why choose 80? I wonder if you could help with that.

A Because I anticipated, with the nature of the pain that she was suffering, that she was going to need a higher dose of diamorphine. Standing there at the bedside, looking at this lady, I felt with my clinical experience and that of my nurses that it was going to be necessary.

Q If subcutaneous became ---

A If we came to subcutaneous analgesia.

Q And midazolam. Why 40 to 80?

A Similarly, a slightly higher dose for the same reason: to control her symptoms. There was a lot of restlessness and agitation with the pain already when she was being seen to even on the 25th, 26th, 27th.

Q I am not going to trouble you with hyoscine. I will just ask you to deal with a point that was raised by a member of the Panel with Dr Lord. If it is the case that this is not, as it were, a long weekend or anything of that kind, you are going to be coming into the hospital normally speaking the following morning. Why write up an anticipatory prescription at that stage?

A You need a range, a small range, to cover the time at which the syringe driver is going to be changed and the assessment of the patient is going to be made. Depending on when it went up, it might have been 24 hours later before I came into the hospital or some time after I left the hospital. So I needed that amount of flexibility in the system to cover that 24 hours.

Q If we can go back to something we have already touched upon in your evidence, but I would like you to deal with it specifically in this context. If you did not write up an anticipatory prescription and, say, two days later she, in the view of the nursing staff, required subcutaneous analgesia and you are not there and you are not due in in the next hour or so, what would be the practical disadvantage of your not having already written up the prescription?

A This patient would have to wait in pain. An hour might be acceptable to members of the public, but it could be anything up to 24 hours and I was not prepared to allow my patients to suffer pain and distress for that length of time while they waited for me to come and sign the prescription.

Q How might it happen that there might be a delay of 24 hours from the time that the patient was sustaining pain at a level requiring subcutaneous analgesia?

A Just after nine o'clock, I had left the hospital on a morning. I was doing other things, I was not due back until the following morning. It could be very nearly 24 hours before they got me back on the ward again.

Q Supposing it happened on a Friday evening. What is the problem about getting out an on call doctor?

A Because the experience and safety of the on call doctors could vary enormously. You could get one of your partners or a local GP who understood the situation and was familiar with prescribing syringe drivers and happy to do so. You could get someone else who was not.

Q The consequence in such a case is that the patient would wait over the weekend in effect.

A Yes.

Q Moving on, on that same page of the chronology we can see the administration of the MST on the 27th, that is the following day, at 40. There are other matters relating to the nursing care and you can see:

> "Analgesia administered. Fairly effective. Able to help when dressing this [morning]."

We bear in mind that on 29 February – I think this is something we added to this in handwriting – you were contacted with regard to blood sugar levels and you prescribed Actrapid.

Q What was the purpose of that?

A This was to bring a very raised blood sugar down which would have had the advantage of making you feel more comfortable and reducing the risk of her going into a diabetic coma.

Q On 1 March, still the problem with pain. In fact she refused medication that evening and then she was persuaded to take the MST, it seems. The following day.

> "Slight pain, took medication well."

Two days later, which I think is 4 March, which I think is a Monday:

> "Patient claiming of pain and having extra analgesia PRN. MST dose increased to 30mg twice a day."

So she is now on 60mg?
A Yes.

Q Although you may not be able to specifically recall this patient, that would be a Monday morning visit by you?
A Yes.

Q As you are able to write the prescription to indicate the increase, would you have examined her on that day?
A I would. I would have noted the marked deterioration in her overall condition. She was now definitely going downhill.

Q The physio sees her that day and recommended three turns of the head to the right, five neck retractions every two hours. She needed reminding. The analgesia had been increased as we have seen. Over the page on page 13, in relation to the drug charts, they show what it was you had prescribed by way of the increase. On the 5th, which is the Tuesday, the following day, you reviewed her and wrote:

> "Has deteriorated over the last few days. In some pain therefore start subcutaneous analgesia. Let family know."

What is not recorded on the chronology, and I think we may have hand written in, you also wrote:

> "Not eating or drinking."

In relation to the administration of subcutaneous analgesia, your prescription was 80-160 diamorphine; 40-80 midazolam. Did you have in your mind a risk that those doses of diamorphine and midazolam might over sedate or produce respiratory depression in this lady?
A I did.

Q How do you approach the exercise, what is the judgment you make about it?
A The judgment is that I wanted to give her adequate pain relief and relief of her symptoms of what were now becoming terminal restlessness, so I was minded to give her adequate analgesia and sedation to control those and I was accepting that she might well be over sedated.

Q Why not, in those circumstances, if I can ask you this, lower the dose to, hopefully, achieve pain control and agitation control without over sedation or respiratory depression?
A And run the risk of putting her through another 24 hours of discomfort like the weekend and then the Monday she had already had. She needed an adequate level of pain relief and relief of restlessness.

Q That was your judgment?
A That was my judgment.

Q "Let family know", what does that signify?
A That signifies that the discussion we had with Mr Lavender at the end of the previous week, to the effect that we were going to need to use subcutaneous analgesia, had now arrived and the syringe driver was going to be put up and that she was dying.

Q We can see the entry below that, which is from the significant events notations:

"Patient's pain uncontrolled."

So she had had a very poor night obviously:

"Syringe driver commenced at 09.30. Son contacted by telephone, situation explained."

There is a similar note which we need not bother with on the nursing care plan. Over the page, page 14, we can see what the prescription was. Here it was diamorphine 100mg, so it had gone up, midazolam 40mg and hyoscine we need not trouble with. Professor Ford raised this issue in relation to this situation, suggesting that it should have been checked why she was deteriorating, "It would be difficult to tell if it was affected by the opiates", in other words the MST. What do you say to that, as to what the practicalities were of you checking with regard to the deterioration or any other steps you might have taken?
A We did check for the obvious things like dipping her urine and a full examination of the lady to see if there was any obvious cause for this sudden deterioration such as an infection. The likeliest reason, logically, for her deterioration was an extension of whatever was happening following her possible brain stem stroke or following her crush fracture of the vertebrae or whatever it is postulated was happening. Whatever was going on, it was getting worse and none of those would have been treatable in any way, shape or form.

Q The following day she is reviewed by you and it rather looks as if it might have been a morning visit?
A The syringe driver was then renewed.

Q Further deterioration and it says, "SC analgesia commenced", but it had been on the 5th:

"Comfortable and peaceful. Happy for nursing staff to confirm death."

On that day, you also indicated, it would seem that you indicated, that medication other than through the syringe driver should be discontinued. Over the page:

"Pain well controlled. Syringe driver renewed at 9.45."

That day there was a further administration of the same subcutaneous analgesia for the reason you have already indicated. It was working, "pain well controlled". Was this lady in a coma by this stage, are you able to say, or what was her general state?
A I am not able to say anything other than she was peaceful and comfortable.

Q Would that be an expression you might use which would cover a patient being, in effect, unconscious or in a coma or unrousable; different people have used different expressions?
A Or closely approaching death. I do not think there is any way of distinguishing between those different terminologies describing the same event.

Q I expect you have already answered this, from what you have told us, but why not, if she was very much, I am going to use the expression, "out of it" reduce the diamorphine and the midazolam to keep her, if possible, more alert. What would be the point of doing that?
A More alert to feel more pain.

Q That is what you consider?
A That is exactly what I would have felt.

Q She died at 9.28 on Wednesday 6th. That is all I need to ask about Patient B. Patient C, the lady with the suspected carcinoma. We have been through the history already in some detail. Admitted to QAH following a collapse. A general deterioration and if we look at page 2 of the chronology, there is a record at page 299 in the notes. I am not going to turn it up but we did look at it earlier. On page 299 there are entries at the hospital for 12 and 13 February, which is why I am referring to it at the top of the page of the chronology, for palliative care and the son agreeing that she was not for invasive treatment. We move on through the month of February, still at the Queen Alexandra under Dr Lord. She was transferred to Charles Ward and we have heard about that. Over the page at page 4 of the chronology, she was reviewed by Dr Lord on 25 February. We have dealt with that evidence very recently, and on 27 February she is transferred to Dryad. Diagnosis in the transfer form is set out and in the bottom of the left-hand column on page 4 we can see the notes you made in relation to reviewing this patient on 27 February.

> "Transferred to Dryad continuing care. Diagnosis of Ca bronchus made on CXR on admission 6 February. Generally unwell, off legs, not eating. Catheterised. Needs help with eating and drinking. Bhartel O.
> Plan: Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death."

There is no dispute that she was plainly very ill when she came into Gosport. Professor Ford makes no criticism of your notes there and many people in those circumstances, he indicated, would use opiates even if she was not showing pain. Professor Ford indicated that in his view there was a view that opiates could be prescribed for the relief of anxiety and agitation in cancer patients, in effect, is what it appeared to be. As far as you are concerned and in terms of the symptoms exhibited by a patient, would there be any difference in your mind at that time in the 1990s as to what was appropriate to a patient who was suffering from cancer but was exhibiting exactly the same symptoms as a patient who was medically unstable, unwell but not with cancer. Would you be saying to yourself, "I can legitimately use opiates because this patient has a carcinoma of some kind, but I cannot in another patient who is exhibiting exactly the same symptoms"?
A I always felt at that time that it seemed very unfair that if you had a diagnosis of cancer, then it was legitimate to give you opiates to relieve anxiety, distress, fear of dying, aguish, all of these things, but because your illness was equally terminal but caused by heart failure or a severe stroke or something else medical, you were denied opiates, they were not appropriate to use simply because you did not have cancer. I never understood that concept.

Q Then we can move on over the page to page 5 of the chronology where the significant events section of the nursing notes, care notes, sets out the situation. I am not going to read all that out. Past medical history is given on the nursing care plan, a spell summary. The drug charts. You prescribed Oramorph, there is no criticism of that, 2.5-5 ml (5-10 mg); thioridazine and the other things that you prescribed are digoxin, frusemide and so on. The next entry on the chronology, page 6 in our record, shows the next day 28 February:

> "Very distressed, calling for help and saying she is afraid. Thioridazine given with no relief. Patient remains distressed. Oramorph 2.5mg given with no relief. Doctor notified. S/B doctor for regular thioridazine and regular heminevrin [at night]."

It looks as though it was a Dr Lang, it does not perhaps matter very much, but not you. What would be the rationale for the doctor taking the action that he did at that stage, regular thioridazine and heminevrin?

A Because as an out-of-hours on-call doctor he was presented with a patient whom he did not know who was presenting with symptoms of distress and agitation and difficulty getting off to sleep. He very properly prescribed a major tranquiliser and a sedative for the night time.

Q Nursing care plan for the 28th:

> "Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Urinary catheter...
> Encourage fluid intake."

And so on. The drug charts for that day showing 5 mgs of Oramorph, thioridazine, heminevrin, as we have already seen in relation to the picture. On page 7 of the chronology, the 1 March, we can see what the drug charts show. Two doses of thioridazine and the heminevrin continues:

> "Slept well but calling+."

Presumably calling a lot.

> "Shouting from approximately 05.30. Spat out all medication."

That is over the weekend because the next date shown on chronology, 2 March, is in fact a Monday so you come in on the Monday, see her and record in the notes:

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

It looks as though you knew Dr Lord would be coming in to do a ward round that afternoon. Can we take it, if you look over at page 8, that when Dr Lord reviewed her, it looks as though it was a Monday afternoon ward round, you would have spoken to her specifically about this patient?

A Yes.

Q You would have indicated what your thinking was?

A Yes.

Q And deal with the question with regard to the necessity or requirement for opiates. If we look on page 9 of the chronology, we can see that on the morning of that Monday, Monday the 2nd, you had prescribed in terms of diamorphine 5 mgs which was administered at 8 o'clock in the morning and also at 3 o'clock in the afternoon. Is that right?
A That is correct.

Q On the 2nd?
A That is correct.

Q And whose decision was it to start the fentanyl ?
A Mine.

Q Because we can see your prescription and the patch administered at eight o'clock in the morning. Would you explain, please, what it was you were doing and why, because we have a fentanyl patch being placed on the patient at eight, so it is starting to provide diamorphine, and diamorphine being given as a single injection of 5 mg at eight o'clock and then again at three o'clock in the afternoon. Professor Ford does not criticise the administration of the diamorphine, and thinks the decision to use fentanyl is reasonable. Would you explain what is in your mind in terms of that process?
A I knew that the fentanyl would take up to 24 hours to build up to its maximum effect in a patient, so that I knew that I would need to give a small loading dose of diamorphine to provide her with immediate relief from her symptoms which would last for approximately four hours, and I could then give a second one at about three o'clock in the afternoon to aid her with this process as the level of fentanyl built up in the body and she began to get relief from her symptoms.

Q Can I use this instance to deal with another point. I appreciate this is fentanyl.
A Yes.

Q Why not, when you thought it right for subcutaneous analgesia to be provided, diamorphine – let us take it by itself – why did you not in those cases provide a single injection by way of a loading process in those instances because of the time that it would take for the subcutaneous diamorphine to start taking effect?
A There did not seem to be the same degree of time lag before you got an effect from the subcutaneous analgesia in the syringe driver as we saw with the fentanyl. The fentanyl was definitely much slower to kick in. This subcutaneous syringe driver seemed to start to work more quickly. I know from Professor Ford's evidence he felt that it took 17 hours or more. Clinically it appeared to be effective much more quickly. I very rarely had to use a loading dose of diamorphine at the start of the infusion.

Q Can I just ask this. It may be an unnecessary question, but if you had thought it necessary ---
A I would have done it.

Q --- to provide diamorphine by way of a loading dose by way of injection ---
A Yes.

Q --- I presume you would have done so?

A Yes.

Q So that is really based on your clinical experience as to what appeared to be the effect on the patients you were treating.
A Yes.

Q So Dr Lord comes in on the Monday afternoon, and it is clear from her evidence, and nobody is suggesting to the contrary, she did not in any way disagree with what it was you had instituted by way of analgesia?
A Yes.

Q Her note continues, having recorded what she had diagnosed and so on:

"Continue fentanyl patches.
Later: Son seen. Concerned about deterioration today. Explained about agitation and that drowsiness probably due in part to diamorphine. Accepts his mother is dying. Agrees to continue present of ..."

I think it is "management" rather than "medication". Dr Lord has confirmed what it meant and so on. In relation to the drowsiness where Dr Lord, it appears, was saying to the son, "The drowsiness is probably due in part to diamorphine." Is that something you would have appreciated at the time yourself?
A I think I would have been well aware that having given 5 mg diamorphine intramuscularly that she might well be drowsy for a couple of hours after that.

Q And the son, it seems, looks as if it probably was some time in the afternoon---
A He visited ---

Q ---- because there was a second administration of diamorphine at three o'clock that afternoon.
A Yes.

Q Although nobody can give precise times, does that appear to fit the chronology on this day?
A Dr Lord would have asked to see him at the end of her ward round, which would have been approximately between four and five, as we heard from her.

Q Then in relation to the significant events documentation, the picture is set out again. We need not go through it all because it is covered by what has taken place before. I would like us to move on to page 9, where we can see the prescription and, indeed, the administration of the drugs we have just been talking about. As Professor Ford indicated, she was inevitably dying at this stage and in relation to end of life care, you can take some risk or risks that you might not otherwise take with regard to the effects. That was his view – the adverse effects of these drugs. On that same day you had written up an anticipatory prescription on 2 March for diamorphine, midazolam and hyoscine. Why did you need to do that, bearing in mind this patient on the morning of the 2nd was receiving fentanyl and during the day was to receive two intravenous injections of diamorphine? Why write up an anticipatory prescription? First of all, why an anticipatory prescription at all before we come on to doses?

A There were two reasons for writing up the subcutaneous infusion. One was to cover the situation if her pain relief was not adequate on the fentanyl patch.

Q So if the fentanyl was not doing the job, it was to cover that.
A 24 hours, when I came in the next morning, I would be able to make an assessment of whether the fentanyl was doing the business. The other reason was, she was no longer now able to take her thioridazine. She might well need an anxiolytic and a terminal restless drug in the form of midazolam, and the only way that I could administer that drug would be subcutaneously. There was no other way of doing it. At that point, therefore, I would have to make the decision to change over from the fentanyl patch to the subcutaneous infusion.

Q Perhaps I can ask you about that just by way of procedure. If that was to happen, if you were there when it happened; in other words, the patient being taken off the fentanyl and subcutaneous analgesia starting, would it be the case that you would see to it that the fentanyl patch was removed?
A Immediately.

Q In terms of your understanding of the way the nursing staff operated, assume you were not there and the decision was taken to commence subcutaneous analgesia, what did you understand would normally happen with the nurses?
A The patch would be removed and a notation to that effect made against the prescription on the drug chart. You would not want to have the fentanyl patch still applied and be running the subcutaneous infusion.

Q It appears in this case, and I think maybe in another, that although the fentanyl patch may have been removed, nobody recorded it?
A Yes.

Q They neither recorded that it was still there, nor that it had been removed?
A Yes.

Q In this case that is the position save for the fact, I suppose, that on the 3 March, at the bottom of the drug charts do not show fentanyl being administered in any way?
A It would not show that it was still being administered, except that it had been written up for three days, but it does not show that it was actually physically removed from the patient – but that would have been the procedure.

Q Thank you.
A Bearing mind there was still some fentanyl in the body, as the fentanyl level gently reduced, then the syringe driver level would be gradually building up.

Q Then can we move on to that, because I wanted to ask you about your perception as to what would be going on with the analgesia, when a patient has been on fentanyl and they have been on a fentanyl patch for, let us saying, 24 hours?
A Yes.

Q And the switch is then made from fentanyl to subcutaneous analgesia in the form of diamorphine and midazolam, in this particular case they started at 10.50 in the morning on the 3rd. What was your understanding as to what was going on with the fentanyl, which is

still there in the patient, patch removed, subcutaneous analgesia starts to be administered. What is the picture there?
A Fentanyl, in my understanding, in those days would have been out of the system by another 24 hours, so that the level was gradually reducing in the body through the 3rd. At the same time, the 20 mg of diamorphine was gradually increase in level in the body so there would be a cross-over moment when the analgesia would be equal.

B Q Can we look at that, stick by step. You take the fentanyl patch off?
A But there is still some.

Q The fentanyl has reached its peak, and your understanding was that whatever fentanyl was still there in the body would have gone after 24 hours?
A Yes.

C Q Therefore the actual amount of analgesia that the patient is receiving would be declining throughout what would have been the second day of the fentanyl patch administration?
A Yes.

Q At any particular rate? At a steady rate or what are we going get?
A I assumed at a steady rate, other factors being equal.

D Q Then the subcutaneous analgesia is administered with the fentanyl patch off, and obviously it builds up in the way that it normally does and so there would, as you say, be a cross-over point?
A Yes.

Q Was there a risk in your mind, because the diamorphine that is being administered is
E at 20 mg and the midazolam is at 20? Was there any risk in your mind that with the administration of those drugs and the fentanyl still being there, a risk of over-sedation or, indeed, respiratory depression because of the declining effects of fentanyl?
A There would always been a risk. I was prepared to accept that risk in order to give her adequate analgesia and to add in the midazolam. I thought that that risk was acceptable in this particular patient.

F Q On the 3rd, in the normal course of events you would have visited the hospital, because that is a Tuesday, 3 March?
A Yes.

Q No record by you of anything to do with this patient. Would you explain why, because on that day ---
A I would institute a marked changed in her medication.

G Q Why no note?
A Because I should have, and I was time constrained and I did not. I saw to the patient rather than making a note in her notes.

Q But it follows from what you have just said that obviously you were there that morning?
H A I saw her.

Q You would have seen her, and it would have been your decision ---
A Yes.

Q --- to say, "Start the subcutaneous analgesia."
A Yes.

B Q So it is not a case of the nursing staff taking a view and having to contact you. So, as you say, you should have recorded the reasons for that, or something to do in your view which you did not, but that was our rationale -=--
A Yes.

Q --- on the day?
A Yes.

C Q Then over the page, onto the last page of the chronology, significant events. The documentation shows the note by Sister Hamblin.

> "Rapid deterioration in condition this morning. Neck and left side of body rigid – right side flaccid. Syringe driver recommenced at 10.50."

D In relation to that, just to get the picture in term of the timing, it looks as though Sister Hamblin, when she came on duty that morning, recorded the fact on information presumably, and either she saw herself, or somebody indicated, "... deterioration in condition." What is the significance to you of the neck and left side of the body being rigid, and so on?
A I imagine she had had some sort of cerebral event, possibly had bled into a cerebral metastasis, or had had a stroke.

E Q Assuming that is information that was available to you that morning when you did the visit, your regular visit, would that have had any bearing on your decision that the subcutaneous analgesia should be administered, or did it play no part?
A It played no part.

Q I am not going to ask you anything more about that. This lady died at 9.30 that evening. Patient D, please, Alice Wilkie. This lady was in her early eighties at the time we F are considering. She goes into Queen Alexandra in July 1998 with an unresolved urinary tract infection. She was a demented lady, as we can see and, over the page, page 2, from the records, she in fact suffered from dementia. On 1 August the clinical notes records at the hospital advanced dementia. Over the page, at page 3:

> "[She] needs plenty of encouragement with food and fluids."

G Haloperidol and Augmentin prescribed and administered. Can we move on to page 4? This is 4 August 1998. Reviewed by Dr Lord. We have heard the evidence from Dr Lord about this this morning and we have seen what she had to say about the situation, as she described it in her evidence. She was very dependent, cognitively impaired, very frail and therefore active resuscitation would not be in her best interest. We will move on to page 5, when she is transferred to Daedalus Ward. The doctor who clerked her in – not you; we have heard evidence about that. We can see that the referral letter, half way down that page, point out

H

UTI, pyrexia, dehydration, dementia and so on. For four to six weeks observation "Then decide on placement." For antibiotics, Waterlow 16, Barthel 2.

"Mentally she is dependent and needs feeding."

The fluid intake at QAH had been supplemented with s/cut fluids. She slept very well.

B "For Dryad Ward Gosport today."

The notes go on at the hospital. Then over the page, on to page 6, she having been clerked in by that other doctor, notes from the nursing staff at Gosport, Nurse Joice:

"Transferred from ... QAH for 4-6 weeks assessment and observation + then decide on placement. Medical history ...".

C

Then at the bottom of page 6 on the left, Nurse Joice is recorded:

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

In relation to patients with advanced dementia, or indeed perhaps earlier dementia, can it be D quite difficult to tell what pain they have?
A Very difficult for them to tell us, or even for them to understand themselves what they are suffering, but they are undoubtedly suffering.

Q So you may get a patient who is screaming out or shouting out or calling out as a result of something other than pain. It may be that it is pain?
A They are giving you lots of non-verbal clues, but they do not understand them and you E have difficulty in understanding them.

Q Would you say there is any advantage in terms of either nursing experience or experience of a doctor acting as clinical assistant in seeing patients over years with these sorts of conditions? Is there any advantage or assistance that you are given just by that experience, in terms of trying to make a judgment as to whether the signs which might indicate pain or in fact pain, or is it still very much open to question, however many years' experience you F have?
A I think if you have had a lot of experience in dealing with demented patients, you perhaps are more alert to these non-verbal signs and to the clues they are trying to give you. You have to be careful obviously not to miss something obvious like a urinary tract infection. If you have ruled out all those sorts of physical causes, you are then left with the problem, is this mental anguish? Is this physical pain? From the point of view of treatment, does it matter? Are you not going to try and help the patient whatever you think the cause of the pain G is?

Q Then on page 7 of the chronology, "Visited on Daedalus Ward". This is the CPN notes. "Daughter was also there." The person recording the notes says she will contact the ward in three to four weeks' time. Then she was reviewed by Dr Lord on 10 August. Again, we have heard from her about that:

H "If no specialist or nursing problems D to a [Nursing] Home."

In effect, Dr Lord said that was if she remained stable. She stopped the fluoxetine, the antidepressant, but she is unable to recall now why she stopped it. There may be more than one reason which might have applied. Then the CPN notes for 12 August, two days after Dr Lord has seen the patient:

"... physically unchanged. Very needy, not expected to return to Addenbrooke."

We have here a phase, starting on 6 August, which is shown on the fifth page of the chronology, where she had been clerked into Daedalus Ward – I cannot offhand tell you what day of the week that was – Dr Lord sees her on 10 August – that might well be a Monday, if it was a Monday ward round by Dr Lord. Then we get an entry for 12 August and we get an entry for 17 August, but nothing by you. When we look at page 8, we can see that although it is undated, it looks as though you have written up an anticipatory prescription on perhaps 17 August, or it might I suppose be the 18th. Why is there no record by you of anything for what is a period of over a week, 11 days, it would seem, before we see you writing out a prescription? How do we view the picture there?

A If a doctor who cannot be named clerked the patient in that day, it suggests to me that I may have been not there for a few days. When I came back, we were faced with a situation on the ward that we had mayhem occurring.

Q Would you explain what you mean by that? We are now in August 1998. What was the problem?

A We had a patient on the ward whose family were causing us considerable problems, both with the nursing and the medical staff.

Q That patient being?

A Gladys Richards. It became increasingly difficult to settle to any sort of clinical routine which would involve the making even of scanty notes in the patient's medical records.

Q I wonder if you could just help us with this? Would it be the case, or might it be the case, that for a period of say a week you might be visiting the ward in your normal way in the morning and not making any record about a patient who had been reviewed by Dr Lord at one point?

A Yes. And who we thought at that point was relatively dependent but stable.

Q Can we take it that so far as one can judge it, on 10 August, when she was reviewed by Dr Lord, you were not present? The afternoon of a Monday perhaps.

A It is perfectly possible that I was not present on a ward round.

Q So it may be that you were not on the ward at all during those days; it may be that you were. Is that how we look at it?

A Yes.

Q Then on 17 August, in terms of the records there are, on page 8 of the chronology, it says "Deterioration recorded". This says "Contact record".

"Condition generally deteriorated over the weekend.
Beed:"

That is Phillip Beed –

> "Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate …"

That is, the daughter –

> " … and to use of syringe driver if Mrs Wilkie is in pain."

The daughter is a lady called Marilyn Jackson from whom the Panel heard evidence pretty near the beginning of this hearing. Judging by Phillip Beed's note, is that consistent with the syringe driver having been written up on the 17th?
A It is.

Q So although it is undated, it is difficult to see how he could have referred to the use of a syringe driver unless he knew that that was something which might arise.
A Yes.

Q Therefore you had prescribed it. If that is the 17th that you had written out the prescription, the anticipatory prescription, the same question, because it is a different patient. I am going to ask you why did you write up an anticipatory prescription on the 17th, as opposed to writing it up any earlier? What was it about the 17th which made you think that that situation might arise?
A I would have been alerted by Phillip and by Phillip's report on what the daughter had said that Mrs Wilkie's condition was now deteriorating. She was not as well as she had been, she was not eating and drinking as she had been. She might well soon reach the point where she was unable to take oral medication and we needed to focus more on some terminal care for her.

Q I would like you to deal with this. Had this patient been on any form of opiates prior to 17 August?
A None at all.

Q Why then prescribe, albeit anticipatorily, these strong opiates on the ladder, the highest level? Why not prescribe something like a middle range opiate?
A A middle range opiate is not going to address the problem of terminal restlessness, agitation, distress. Co-codamol or co-proxamol would not have been appropriate, even if she had been able or willing to take them.

Q Would you say this was the position or not? If this lady had not exhibited any pain, her condition has deteriorated generally over the weekend, but she does not exhibit any pain, would there be any necessity for first of all subcutaneous analgesia?
A There would not be any necessity for subcutaneous opiate analgesia. There would have been a possibility, had she become very restless and agitated at the end, that they might have wanted to use some midazolam in a subcutaneous form.

Q Can we pause there just so we can take stock? If no pain had been exhibited or observed in this lady, but terminal restlessness/agitation had exhibited itself, it would have

been appropriate, or might have been appropriate, to administer subcutaneously just midazolam?
A It might have been.

Q Do we think of it in this way? If there is no pain exhibited, do not administer diamorphine.
A Think very carefully on clinical examination whether an opiate is necessary.

Q If you wrote her up for that prescription on that day, albeit anticipatorily, it seems to follow that you must have been there and seen her that day on the 17th.
A Yes.

Q Would you have spoken to Phillip Beed about this patient in the ordinary course of events?
A Yes.

Q Why not prescribe Oramorph in terms of pain initially for this lady?
A Again, because she was reaching the terminal stage. Oramorph would only help with pain and distress, but not terminal restlessness, agitation and pain. It would not be appropriate by itself orally.

Q Three days later, 20 August, diamorphine is administered from 1350 and midazolam at the same time.
A Yes.

Q What has been happening over that three-day period: the rest of the 17th, 18th and 19th?
A She has been quietly deteriorating, quietly dying.

Q Would you help us as to why there appears to be no note made either by you or the nursing staff as to what was going on over that period?
A Because, to my eternal regret, our concentration was all focused on the other situation and I did not make a record. I would have seen her when I went round the ward, but I did not make a record of what was going on. She was quiet, she was not causing any trouble, she was reasonably comfortable, although she was going downhill, she did not get any analgesia or anxiolytic until literally at the end of her life.

Q When you would have been on the ward doing your normal morning visit, would you have noted the fact, when you discussed the patient with the nurse or just said, "Is everything all right" or whatever it was, would you have noted one way or the other whether there were nursing records of what was happening to the patient on those days?
A No. As Dr Lord pointed out this morning, the nursing records were in a separate part, so they were not immediately available. I relied on verbal reports from the handover night staff to day staff in the morning, not the written records.

Q You have made reference for the second time to the problems that were existing at that stage. I would like you to indicate in a little bit more detail what they were. What were the problems in relation to Gladys Richards? Not the patient herself, but was this something to do with relatives?
A Yes.

Q What was the difficulty?
A Sitting just inside the patient's single room with a notebook each, recording who was going past, what was going on, what the nursing staff were doing, stopping and questioning nursing staff who were on other duties on the ward, totally disrupting the routine of the ward. Phillip Beed found it very disruptive and I think he lost his normal rhythm of running the ward daily. The normal handover to me was not as good and as full and as appropriate as it could have been on those days.

Q Was that something that the nursing staff spoke to you about?
A There was nothing we could do about it.

Q Forgive me. Was that something the nursing staff spoke to you about?
A They spoke to me and I was aware of it happening when I went in each morning.

Q I will come on to you in a moment. The nursing staff spoke to you about it.
A Yes.

Q You yourself witnessed it.
A Yes.

Q On those occasions that you visited on your morning visits – and we are concerned with Daedalus Ward – I will come on to the patient in a moment when we look at the history with regard to Gladys Richards – in general terms did you speak to the relatives or did you not speak to them or what? What is the general picture if you saw them?
A I would say good morning to them, but I did not feel that it was appropriate that they should disrupt my business round and my attending to and caring for the other patients on the ward.

Q Did you ever say anything to them about the effect that this appeared to be having?
A No.

Q Why not?
A I am a coward. I felt really that it was a nursing management problem. I felt that the management should have come on to the ward and helped Phillip Beed deal with the problem. I felt that I, as the visiting clinical assistant, was purely responsible for the medical care of the patients in the ward, not what was going on.

Q We will come on to the history with regard to that particular patient soon. Dealing with the situation with regard to Alice Wilkie and Marilyn Jackson, she told the hearing that on 20 August, when she was visiting at some point in the early afternoon or round about lunchtime, she indicated – and this is before she is ever on any opiates – she could see that her mother was deteriorating, was less mobile and so on, and she had called in at the hospital and spoken to Phillip Beed before this, who had said she was not well at all and she said, "I could see she was going to die in there." She confirmed that she did not want her mother to suffer. She says that she was never told anything about the kind of drugs that were being administered, but I am not going to trouble about that difference in evidence, because the Panel heard from Phillip Beed about what had been said about that. She does say (the daughter, Marilyn Jackson) that on the 20th her mother indicated to her that she was in pain. That indication was such that she went out of the room to summon a nurse and it appears the person she got hold of or the person who arrived was Phillip Beed and he said – this is her

account of it – something along the lines of, "We'll give her something." It appears that shortly after that, or some point after that, the diamorphine and the midazolam was administered, if Marilyn Jackson's account is right. What you had prescribed in relation to diamorphine three days before was 20 to 200 and midazolam 20 to 80. If it is right that it is Phillip Beed administering the diamorphine, he has not kept to the minimum dose. Are you able to say anything about that?

A I imagine that he would have contacted me before he put that syringe driver up at 13.50 that afternoon and said, "I have the situation, I wish to start at 30mg of diamorphine and 20mg of midazolam", and I would have agreed.

Q Why agree to 30mg when all that happened, if this is right, is that the patient has indicated she is in pain, why not say to Philip Beed, if we he had got in touch with you, "Start at 20mg". What would make anyone decide not to go to that dose?

A Because he felt 30mg would be more appropriate.

Q If that is what occurred, that he contacted you and said that was his view, would you have agreed with it or disagreed with it?

A I would have been happy to agree with that. His was the most recent clinical judgment at 13.50 that day, although I had seen her first thing in the morning and written up 20mg.

Q This is a patient in relation to whom you had already had formed the view that she might well reach that stage in any event?

A We had decided that.

Q On page 9 we can see what happens the following day in terms of the records. There is the entry made by you in the clinical notes:

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

No details are given as to what the marked deterioration was, but how would you describe it, particularly with regard to the last couple of days before this entry?

A Her whole demeanour would have changed. She would have become more withdrawn, quieter, not taking food or fluids, not wanting to move. The whole general picture of when I saw her that morning as compared with previous mornings on the ward, so it was just an overall general picture.

Q She had been deteriorating since the 17th, it would seem. Did it occur to you that the deterioration you observed on the 21st, or the state she was in on 21 August, might have something to do with the diamorphine and midazolam?

A Not at all, because the deterioration was already well underway and was proceeding, or I was hoping that the subcutaneous infusion would make the deterioration more comfortable for her.

Q We can see a note by Nurse Joice at 12.55 on the 21st:

> "Condition deteriorating during the morning. Daughters and granddaughters visited and stayed. Patient comfortable and pain free."

We can that she remained on that dosage of diamorphine and midazolam during the day and she died at half past six that afternoon or early evening?
A Yes.

Q In relation to Marilyn Jackson, there is one thing I need to ask about. She indicated that your name was never mentioned and she had never met you, but at another point in her evidence she said you had walked onto the ward, ignored her and her two daughters, and had said, "It will not be long now", and walked back out. Is that something, a picture, that you recognise or not?
A It was not an appropriate or caring thing to say to a patient in front of relatives, and I would be mortified if anybody had thought I had said that to a patient in front of relatives. It was not my custom to go into a room and make comments like that.

Q Do you remember whether you had any contact with her or the daughters?
A I cannot.

MR LANGDALE: That is all I was going to ask about that particular patient. Perhaps this would be a sensible time to break. May I mention one thing? There is a matter where Mr Kark and I do not agree about a witness who is going to be called, or may not be called if my learned friend is right. It is a witness who will have to be called, her availability being only Monday, it would have to be on Monday. It is not a long witness, but it does mean that the Panel and your Legal Assessor will have to hear some argument about whether this witness is going to be called or not.

It is difficult to know how long these things take. I do not think it will take an enormous amount of time, the issue is quite a narrow one. It may be sensible for the Panel to consider, once we have had the break, whether it would be better to hear the legal argument at about quarter to four and then the Panel will be able to decide whether they need to take any great length of time, having considered whatever advice is needed. It will give you some leeway if it turned out to be a knotty problem, which I do not think it will, so that if you needed further time you can consider it tomorrow morning.

THE CHAIRMAN: Why do we not take the break now, and on our return we can hear the issue and we can take it from there.

MR LANGDALE: With respect, that seems entirely sensible.

THE CHAIRMAN: We will rise now and return at half past three.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: I am dealing with this point which concerns a nurse trainer called Betty Woodland. She is a witness that we hope to call on Monday. She has worked as the Royal College nursing representative and has given support to a number of the nurses who have given evidence before you and also at the inquest that took place in March and April this year.

THE CHAIRMAN: Was that the lady that was sitting at the back throughout a large number?

MR JENKINS: That is absolutely right. She was sitting at the back as a supporter of nurses who have been called to give evidence. We were entirely content for that to happen. Although we had a statement from Betty Woodland, we were not anticipating calling her as a witness. She has given us further information after the witness Shirley Hallmann gave evidence, evidence about various matters but including the proposition that she, Shirley Hallmann, discussed her concerns about the use of diamorphine with Betty Woodland. Betty Woodland has something to say on that issue as to what was said to her, if anything, by Shirley Hallmann about that.

We would like to call Betty Woodland to deal with that issue essentially, although she is able as a witness to give evidence about various other matters. She can talk about any concerns in 1991 because she was there at the time and the importance of them and how they were dealt with. She can deal with Dr Barton as a doctor about her skills and her character.

Had it just been those issues, we would not have sought to call her but, because matters have been raised by Shirley Hallmann which are significant and may be important for the Panel, we would like to call Betty Woodland on this issue. She does not deal with any of the twelve clinical cases with which the Panel are concerned, so her hearing evidence from other nurses is not going to affect any evidence she might give to you. In any event, she was present for, I think, nearly all the evidence at the inquest which covered a number of the patients and most of the patients that you are considering.

Sir, you will know as a lawyer that anyone who is going to give evidence at an inquest is entitled to sit in at all stages, so Betty Woodland was perfectly entitled to sit in and listen to every word of evidence whether or not she was to be a witness there or here. I would hope that the fact that she has heard some evidence and has sat in during some of this hearing would mean that her evidence is not affected in any way. She is relevant, we would say, certainly on the question of Shirley Hallmann, any concerns that Shirley Hallmann had and whether she, Shirley Hallmann, raised concerns to others and whether Shirley Hallmann raised concerns about the use of syringe drivers and diamorphine at a time when she was making that complaint. I think you had the document, you recall Shirley Hallmann being cross-examined about it, she made a written complaint to Sister Hamblin, and to a lesser extent Dr Barton, about the way which she was treated as a nurse.

In broad terms we would like to call her. She has heard some evidence and it would not be usual for a witness to be called who has heard some evidence in a hearing. I hope that would make no difference at all. It should not affect the nature of the evidence that she is going to give. She was here for some of the day that Shirley Hallmann gave evidence, but our understanding is that she was not here when Shirley Hallmann was asked about her letter of complaint. Even if she was, I do not think it would affect her evidence one way or another. We have clearly gone back to Betty Woodland to out what her recollection is of discussions she had with Shirley Hallmann.

The rules that govern that evidence at this hearing are obviously the 1988 rules. I think we have looked at them already in this hearing. It is rule 50 with which deals with evidence and you will know that the Panel can receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them.

There a proviso, a caveat, to that, and it is that:

"Where any fact or matter is tendered as evidence which would not be admissible as such if the proceedings were criminal proceedings in England, the Committee shall not receive it unless, after consultation with the legal assessor, they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable."

B I do not address you whether it is or would be admissible in the UK, the real test is whether its admission is desirable and we suggest it is. It is an important matter which goes to the extent of the credibility of Shirley Hallmann. She is the nurse and the only one who has suggested that she had concerns about the use of syringe drivers and diamorphine during the time with which you are concerned.

C We know the history of 1991 and you have heard a number of witnesses saying whether those concerns were still live in the mid-1990s and thereafter. Shirley Hallmann is the only one who talks about the period with which you are concerned and this is evidence which she undermines. Therefore, we say it is important and for that reason it is desirable that you should hear what Betty Woodland has to say it. That is the application and the basis upon which it is made.

D THE CHAIRMAN: Thank you, Mr Jenkins. Before we hear from Mr Kark, I wonder if we should allow the doctor to return to her customary seat on the defence bench. It seems unfair to keep her isolated. (Witness left witness stand)

E MR KARK: Before I respond, I want to be clear about the ambit of the evidence that is being sought by the witness because my learned friend has raised essentially three areas: the first is general evidence about Dr Barton's skill and character, which is plainly material that the defence would have been be aware this witness could speak about when she was sitting in the public gallery; secondly, what she, Betty Woodland knew of the issues in 1991 when, as we know, they were raised; and, thirdly, the Hallmann grievance, as perhaps I could call it, in 2000. Is it being proposed that she should be called to give evidence about all three of those issues, two of them or just one of them?

F MR JENKINS: If she is to be called, I will deal with all the issues that she has raised. I think it would be fair to her, but the decision to call her is based upon one of those. I should add, I know Betty Woodland can say a little more about Shirley Hallmann and other concerns that have been expressed either by her or about her.

G MR KARK: I do not follow the logic of "it would be fair to her". What you are concerned with is whether you ought to receive this evidence in the case of Dr Barton. First, about Betty Woodland. As I understand it, she has been representing the nurses, not only the nurses who have been called to give evidence before you, but the very large number of nurses who have previously been interviewed by the various parties, the police at various inquiries and the GMC. We know that she sat during the coroner's inquest and you are all aware that she was sitting at the back of the room – I think she was the lady who sat with Mr Barton – throughout the evidence of the nurses, perhaps missing out Shirley Hallmann in the afternoon, I am not sure. I accept that from my learned friends if they say so. The application that is being made is in fact under rule 50(5) which reads:

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> "Without leave of the Committee no person shall be called as a witness by either party in proceedings before the Professional Conduct Committee unless he has been excluded from the proceedings until he is called to give evidence."

The rule is automatically engaged. Whether we object to the evidence or not, it is an issue you have to consider.

B The first matter I would respectfully suggest that you ought to consider is how important is the evidence that the defence are seeking to lead. Within that, you will have to consider what is the ambit of the evidence because you would be entitled to admit part of the evidence and not other parts. If you feel part of the evidence is important for you to hear but the other parts are less than important or potentially contaminated, you would be entitled to say, "We will hear A and B but not C", or however you want to put it. You need to look at the danger of contamination which affects its weight, and you need to look, in my submission, at the C specific issue which has given rise to the reason why the defence say they now want to call Betty Woodland when they did not before. That, as I understand it, is essentially simply in relation to the 2000 grievance that Nurse Hallmann had.

You may take the view, although it is a matter for you, that when trying to see the woods through the trees in this case, that is a relatively minor issue, if not a very minor issue. It is a complaint made in 2000. You have D1 in your bundles. Nurse Hallmann spoke about that. D So far as Betty Woodland is concerned, what she actually said about it when she was cross-examined by Mr Langdale on Day 13/at page 81, was:

> "...this was a very general letter that Betty Woodland, my Union representative, helped me to write because I went to her with my concerns and she advised me to make a grievance, which I did, and she sat down with me and helped me to compose this letter."

E She said:

> "This was a very informal letter to put the grievance in."

She said on page 82 of Day 13:

F

> "...two people knew about what was going one. One was Barbara Robinson, the hospital manager, and when I went down and saw Betty Woodland about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them."

G That is it. You will have to consider whether, in all the circumstances, it is necessary for you to hear further evidence about that, weighing up the fact that the witness has had the advantage of listening to all the nurses in the case. I am not going to spend any more time on it. It is right that it should be flagged up for your attention. It is entirely a matter for you whether this evidence is so important that you should give leave to call it in spite of the breach of the rules.

H THE CHAIRMAN: Thank you. We will hear from the Legal Assessor.

THE LEGAL ASSESSOR: I advise as follows. Although, of course, the Panel technically has look at rule 50(5) first of all, it might be helpful for the Panel to look at that last when it has come to some conclusions about the desirability of hearing the evidence.

I already advised as to rule 50(5) on Day 1 of the hearing on page 4 but then, as the Panel will recall, we were looking at it from a different angle. The Panel was looking at if from the question of whether somebody who was a witness should be allowed to sit in. Now the Panel is looking at whether somebody who has sat in should be permitted to be a witness.

I gave some advice, but it is not totally applicable to the present situation because of the changed facts. I would advise the Panel that a sensible test for them to apply and consider would be whether they are satisfied that their duty of making due inquiry into the case makes the reception of the witness desirable. The Panel can properly bear in mind that the witness has already heard some evidence in any event and the issues of cross-examination might be dealt with properly in cross-examination. I would suggest that the Panel applies that test later on.

So far as the other matter is concerned, as I understand the position, there are, perhaps, four areas as to which the defence are seeking to call Betty Woodland: first, as to general character and the skills of Dr Barton. Secondly, as to what she knew of the 1991 issue, if I may call it that.

Thirdly, a conversation dealing with Betty Woodland, and that appears, I think, in transcript Day 13, pages 65 and 81. I would invite the Panel to look at those in due course.

Fourthly, as I understand it, Mr Jenkins had also wished to call Betty Woodland to deal with some other peripheral issues concerning Nurse Hallmann. I am not quite certain what they are, whether they would amount in some way to a challenge to her credibility, or a challenge to her skills as a nurse – I know not. However, if one looks at page 85 of the transcript on Day 13, as I understand it, the third area in which Mr Jenkins would wish to call Betty Woodland is this. I will just find page 81, in fact.

MR JENKINS: The pagination often differs between the hard copy and the computer version.

THE LEGAL ASSESSOR: I think I am at page 82. I hope I am. The passage I have is this. Mrs Hallmann was asked:

> "Q ... What I am asking you to clarify is, why not put in one extra sentence, 'I am also being harassed...', or whatever the right word was ... if that was really part of your complaint?"

I hope the Panel has found that reference. The reply was:

> "A It was and two people knew about what was going one. One was Barbara Robinson, the hospital manager, and when I went down and saw Betty Woodland about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it

was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them."

If one concentrates on that last sentence, one could perhaps say it is ambiguous as to what was said by Betty Woodland about the syringe drivers, but it is unambiguous that Nurse Hallmann is saying that she had expressed to Betty Woodland her concern about the syringe drivers. She is quite clear about that.

As I understand it, that area of the evidence which I have just read out is one important matter – perhaps the main matter – upon which Mr Jenkins would like to call Betty Woodland to give evidence. Mr Jenkins has described it as an issue of Mrs Hallmann's credibility or credit but that, of course, is a matter for the Panel to consider.

There is some guidance in *Archbold* which says at paragraph 8-146:

> "Generally evidence is not admissible to contradict answers given on cross-examination as to credit – i.e. the answer cannot be impeached by the other party calling witnesses to contradict a witness on collateral matters: ... One test was formulated by Pollock C.B. ... 'If the answer of a witness is a matter which you would be allowed on your own part to prove in evidence – if it had such a connection with the issues, that you would be allowed to give it in evidence – then it is a matter on which you may contradict him.' The question whether evidence is relevant to an issue in the case or truly collateral being one for the judge, the Court of Appeal will only interfere where his decision was plainly wrong."

So generally, evidence is not admissible to contradict answers given on cross-examination as to credit.

The position here, of course, is this: the Panel may think that if Nurse Hallmann is to be asked about that specific conversation with Betty Woodland I have referred to, yes, in a sense it does go to Nurse Hallmann's credit, but it is also as to a specific issue in the case, namely the use of syringe drivers at that time, and the view that people had as to the use of those syringe drivers.

My advice to the Panel is this. The Panel has to consider whether the evidence called by Mr Jenkins, or proposed to be called by Mr Jenkins, from Betty Woodland is collateral, whether it is relevant to an important issue in the case or whether it is clearly irrelevant and going purely as to a matter of credit.

Clearly the evidence about character and skill is something which, I think it is conceded, is something which could be called in any event, subject to the issue of Betty Woodland having already sat in in the case. Certainly the 1991 issues have been raised in the case at some length by both parties.

So far as the conversation with Betty Woodland is concerned about the syringe drivers, and expressing concern as to them, as I said it is a matter for the Panel, but the Panel may think that that does go to an issue in the case. Perhaps I may illustrate the situation. If the defence were wishing to call evidence about the behaviour of a GMC witness in completely different circumstances, if they wanted to allege that she behaved in a disreputable way socially, or something like that, the Panel I am sure would have no difficulties in concluding that that was

a purely collateral matter. But here the issues raised are issues which the Panel may think, at least potentially, go to the heart of the case.

As far as the other matter, the last matter referred to by Mr Jenkins, is concerned the Panel may not be clear as to what that in fact involves, other issues surrounding Nurse Hallmann. The Panel might take the view that if the defence were seeking to call Betty Woodland to give evidence about Nurse Hallmann's behaviour on other occasions or her general reputation, or something like that, the Panel might well take the view that it is a collateral matter that purely goes to the credit of Nurse Hallmann and does not deal with the real issues in the case.

May I try to bring matters together? What I advise is that the Panel consider whether these four areas which have been raised by Mr Jenkins are collateral areas, or whether they are areas which properly go to real issues in the case. If the Panel is of the view that they do, then that will assist the Panel in coming to a conclusion under Rule 50(5). If, of course, the Panel decide that the evidence which Mr Jenkins seeks to call is collateral and does not really relate to any issues in the case, then the Panel may come to another conclusion under Rule 50(5).

That is the advice that I give to the Panel. I do not know, Mr Chairman, you might like the parties to comment if they would like to do so.

THE CHAIRMAN: Yes, it is my invariable practice to ask if there are comments on the advice.

MR JENKINS: Sir, I have no comments on the advice but can I help on the facts. As to the fourth issue, I have been vague, and deliberately so. Can I be a little less so. Betty Woodland was asked to adjudicate on a complaint made by Shirley Hallmann about another member of staff in a different setting at Jubilee House. Betty Woodland did investigate the complaint and ----

MR KARK: I am sure my learned friend is not about to reveal ---

MR JENKINS: I am not going to let the cat out of the bag, but I am going to point to the bag. Betty Woodland was asked to adjudicate and consider whether there was a sound basis.

THE CHAIRMAN: We have seen the bag. It is in sight. Thank you.

MR JENKINS: I am going to leave it there.

THE CHAIRMAN: Thank you.

MR JENKINS: That, I hope, is a little more detail on the fourth matter.

THE CHAIRMAN: Yes. I think what I would like to do is to ask strangers to withdraw and I want to have a preliminary discussion with members of the Panel. It may be that we will ask you to come back swiftly, or it may be that we will not do so. Either way, you will hear something from us within a few minutes, but there is a preliminary issue in there I need to discuss.

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. Mr Kark and Mr Jenkins, the Panel have disposed of the preliminary issue that I was concerned about, and need say no more about that. It goes no further.

We have considered how we are going to proceed. We are going to be taking some time in terms of some of the transcripts that are going to be required. As a consequence, we will not be in a position to give you a determination, which will be written, until tomorrow morning. I would hope that it will not be long into the day, but I would say not before ten o'clock. If we are ready at ten, that will be great; if not, it will be as soon thereafter as we possibly can.

We will formally go back into camera and tomorrow morning the Panel will deliver its determination. Thank you.

STRANGERS, ON DIRECTION FROM THE CHAIR, WITHDREW, AND THE PANEL CONTINUED TO DELIBERATE IN CAMERA

(Parties were released until Friday 17 July 2009 at 10.00 a.m.)