**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Wednesday 22 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 THIRTY)

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

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

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
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# INDEX

THE CHAIRMAN: Good morning everybody.

JANE ANN BARTON, Re-called
Cross-examined by MR KARK, Continued

Q Dr Barton, we were going to the case of Mr Jeffrey Packman. Could you turn to Patient J's chronology, please. This gentleman I think was 68 years old when he died at your hospital. Yes?
A Yes.

Q I think we will all recollect with a certain vividness the circumstances of his admission to hospital, having had that period in his bathroom in his home on 6 August. Can we turn to page 8 of the chronology? We can see that on 16 August, so we are now some 10 days or so after his admission, he was obviously being considered for a bed at Dryad Ward at your hospital but he was still at the Queen Alexandra Hospital. He is seen by Dr Tandy. I will not go through her note. If we then go down to 18 August, we can see that he is reviewed by a registrar. There is a note that the wounds looked better and to "stop antibiotics from tomorrow. Continue as planned" and then the registrar has commented on another review by Dr Tandy. "P sores" – that is pressure sores, is it not?
A Yes.

Q "Pressure sores – extensive. Feeds himself. Not mobilising. Black stool overnight – nil today." We have examined already the possibilities in relation to that black stool. Certainly one possibility is that there was a gastro-intestinal bleed. Yes?
A Yes.

MR KARK: "No pain." Then a comment about the abdomen. "Check haemoglobin". "R/O bleed"? (Pause) I am glad it is not something I have simply forgotten. I think Dr Smith is giving me some assistance.

THE CHAIRMAN: He said "rule out".

MR KARK: Possibly. Can we go over the page, and if we go to 20 August, again there is a review by the registrar and we can see that there is no nausea and no epigastric pain. Would there necessarily be epigastric pain if he had a GI bleed?
A No.

Q It can be a relatively silent condition?
A Particularly if he was taking Clexane.

Q We will look at Clexane, obviously, but he was on Clexane at this time, I think?
A Yes.

Q Then towards the bottom we can see: "Following full reassessment of pressure sores, the wounds though malodorous don't appear to be as deep as first thought. Until necrotic tissue is removed, the wound appears to be a grade 3", which is a very high grade of sore – yes?
A Yes.

Q "All dressings changed. No complaints." Of we go to 23 August, this is the day of

his admission. He is recorded as being obese, which we know; he had arthritis in both of his knees; he was immobile; he had pressure sores. He was on a high protein diet, the purpose of which would have been what?
A To improve the chances of his tissues healing.

Q But his mental test score is noted to be very good and, despite his pressure sores, he does not appear to be in pain.
A Yes.

Q We heard something about this the other day. You would agree, no doubt, that the depth of a pressure sore does not necessarily indicate the severity of the pain that the patient actually feels?
A At any particular time, it may not be particularly painful.

Q "Better in himself." We know his legs were oedematous but apparently the word is illegible. "Chronic skin change. Ulcers dressed yesterday. Need review later this week." This was a review on Dryad Ward by Dr Ravindrane?
A It was.

Q I will not go back to looking at his clinical note but that is the sort of clinical note that I expect you wished you had made all along? It was a rather full and proper assessment, was it not?
A Very.

Q You would say, would you, that he had longer than you did?
A No. I would say that he wrote a better admission note than I sometimes did, although I tried usually to cover the problems and a plan for the patient being admitted.

Q Professor Ford's view of this patient was that the vast majority of rehabilitation wards would have tried to mobilise this patient. First of all, do you agree with that?
A Yes. Dryad was not, strictly speaking, a rehabilitation ward and, as you have already heard, we were limited in the facilities that we had. This chap was totally immobile and it was going to be very difficult with the physio and OTT cover that we had to get him back on his feet, even if we managed to heal the pressure sore.

Q I understand that but the whole purpose of giving this man a high protein diet and dressing his pressure sores was, hopefully, to get him up and out of bed?
A It was part of his general palliative care; it was to give him a chance.

Q And until this point, until his admission to your hospital, I think I am right in saying that all of his pain had to that point, over the 17 days that he had been at the QAH, been controlled by paracetamol?
A Yes.

Q They had not needed to go to stage 2 of the analgesic ladder, nor to stage 3?
A No.

Q Can we go over the page, please? He was prescribed, and this is Dr Ravindrane accepts I think his prescription, Doxazosin, frusemide, clexane and paracetamol. At that stage, there having been only one indication of a GI bleed, not wholly inappropriate to give

clexane but something which perhaps, on refection, might be better not to have been prescribed?
A It might have been appropriate, in view of the black stool on the acute ward, before he came down to consider whether it was appropriate to continue it.

Q And a blood sample was sent for analysis on 24 August to see what was happening with his haemoglobin?
B A And it had dropped to 12 grams.

Q I am not going to go back to the notes but we know that I think from page 212. How significant a drop is that?
A From 13.7, over that short period of time, it could have been significant.

Q It is something that needs to be watched?
C A It is something that needs to be watched and Dr Ravi I think indicated in the admission note "need review later this week". I would think he was probably referring to the blood count as well as the leg ulcers and the bottom ulcer.

Q The next day, on 25 August, the patient was passing fresh blood per rectum and then "Query clexane" and Dr Beasley quite rightly directed that Clexane should be stopped. Yes?
A Yes.
D

Q And you were going to review him in the morning. Passing fresh blood per rectum is indicative of what sort of GI bleed?
A At the rectum or the anus. He probably had a pile. I do not think it was the same that was causing the malena stool earlier on and later on in the case. It is much more likely to be a local cause, being fresh blood

E Q Because it would be a bleed in different parts of the bowel?
A In order to appear as fresh, it would have to be very close to the opening.

Q What are the causes of a GI bleed? What makes it happen?
A From the top end of the bowel to the bottom end of the bowel causes a blood vessel to break and blood to be lost into the bowel.

F Q And presumably that could happen in two areas of the bowel?
A It could happen anywhere in the 30 feet.

Q So not impossible that this unfortunate patient had a high GI bleed and a low GI bleed?
A I think it is very likely that he had two separate pathologies occurring.

G Q So the Clexane was stopped. Go over to page 13, please, when you reviewed him. There is a note by Sister Hamblin. "Fairly good morning. No further vomiting. Dr Ravi contacted re clexane. Advised to discontinue."

In fact, that had already been done. "Repeat haemoglobin today and tomorrow. Not for resuscitation."

H There is this query as to where that comes from. Yes?

A Yes.

Q "Unwell at lunchtime. Seen by Dr Barton this afternoon – await results of haemoglobin. Further deterioration – complaining of query indigestion, pain in throat, not radiating – vomited again. Verbal order from Dr Barton diamorphine 10 mg stat – given at 18.00 hours."

B I think you were asked previously by Mr Langdale what the significance of "stat" is. What does that mean?
A Immediately

Q So it is not a particular type of injection or a particular type of diamorphine. It just means give it now?
A Yes.

C

Q The reason for you doing that was because you were concerned about a possible myocardial infarction?
A I was.

Q Is it given because it relieves the pain of a myocardial infarction?
A Yes. It relieves the pain. It relieves the anxiety. It helps with the cardiac function. It
D is altogether an appropriate thing to do if you think someone is having a myocardial infarction.

Q The fact that he had, as we saw a little earlier, pain in his throat but not radiating, does pain in throat ---
A It can be from pain in the heart.

E Q This is not generalised pain. This is very specific pain, is it not, which you put down to a possible MI?
A I did.

Q We then see that his haemoglobin is now down to 7.7 from 12 a few days earlier, and that is a significant drop, is it not?
A It is a significant drop. I was not aware of that on 26 August.

F

Q I was just about to remind you. You told the Panel that you did not see this until two days later.
A Correct.

Q Part of the problem seems to be that the pathology lab were trying to get through to your switchboard but could not? Yes?
G A Yes.

Q You also said this, and I just want to confirm that this is your evidence, that you do not know why you did not get the information "but the result would not have altered my management of him. He had a GI bleed".
A If he had a GI bleed. My impression was, following the conversation between Sister Hamblin and Dr Ravi that he was not for resuscitation and that in my mind equated
H completely with not fit for transfer up to the acute unit. So whether he had or had not had

a myocardial infarction or whether he had or had not had a gastro intestinal bleed, which I did not know at that time, I would not have transferred him up to the acute unit because he was not well enough.

Q Let us pause there for a moment because we have heard a lot of evidence about what "not for resuscitation" means, have we not?
A Yes.

B

Q Whether it is not for 555 or not for 444, however you want to describe it.
A Yes.

Q What we heard that it means is that if a person has a heart attack you are not going to give them cardiopulmonary resuscitation?
A Yes.

C

Q You are not going to apply the paddles and all the rest of it, the reason being because the likelihood of them surviving is very low.
A Yes.

Q What it does not mean is that you do not continue to treat the patient?
A I did treat the patient. I gave him appropriate analgesia for his presumed myocardial
D infarction. I did not consider six people putting him on a trolley, transferring him into an ambulance, bumping him up the 10 miles to the accident and emergency department, a transfer then before anyone was able to even put up a drip and cross-match blood and consider giving him blood and any further endoscopy and treatment. It just was not practical; it was not possible for this man.

Q Is what follows from that this that if you had known on 26 August 1999 that this
E man's hemoglobin had gone down to 7.7 you would from that have strongly suspected a GI bleed, would you not?
A Yes.

Q So far as you were concerned, this man is on what we have called his terminal pathway?
A Yes. He seemed the following morning to have stopped bleeding. He seemed
F comfortable and stable and that bleed in itself was not a terminal event.

Q I understand that but I just want to understand your thinking ---
A But I would still not have considered him fit enough to transfer him to the acute unit.

Q In other words, even if you had known for certain that this was a GI bleed, so far as you were concerned, no curative treatment would have been offered to him?
G A Yes.

Q Would you have discussed that with the patient before you took that life-ending decision?
A I discussed it with his wife.

Q We will look at what you said to his wife. Were you giving his wife the option that
H he could go back to the Haslar for treatment?

A Not to Haslar, back to Queen Alexandra. I was not offering her a choice as much as making clear the stark realities of his situation and that he would not survive the transfer.

Q What Betty Packman told us was this. She got to see him at the QAH. He had been looking a lot better, she said. He improved quite a lot. He was making jokes. He never complained of being in pain. He was transferred to the GWMH for rest and rehabilitation. I visited him every day. On 26 August Dr Barton asked me to come to another room. She told me his organs were not working properly, he was going to die. I was shattered. I went back and he asked me what she had said. I did not tell him. Now, the patient was compos mentis. He had a good mental test score. Why, if you were making this life-ending decision for him, did you not discuss it with him?
A I cannot be sure at this remove of time what I did or did not say to Mr Packman.

Q Dr Barton, just think about that. You have never suggested in your statement, in the coroner's inquest, anywhere, have you, that you discussed this life-ending decision with Mr Packman?
A Well, if I said that I had and I had not, I would be telling a lie. I simply cannot remember how Mr Packman was dealt with by myself and the senior nursing staff after this event on 25 August.

Q If you had had such a conversation with Mr Packman and he had said, "It is all right, doctor, I am happy to die where I am", that is something I expect you might have recorded?
A Yes.

Q You would have recorded it, would you not? I know you did not have much time to make a note but that is a note you might have made?
A It is possible.

Q Would there be any reason for not saying to Mr Packman, "Mr Packman, we have got two choices here. I can give you pain relief and I can make sure that you are comfortable but you are going to die in the next week or so".
A He was not necessarily going to die. If he survived the myocardial infarction, which he had at that point for 24 hours, if he had no further gastrointestinal bleeding, even with haemoglobin of 7, he could have survived. He was not automatically on a terminal care pathway because of what had happened. It was because of what was possible that was going to happen.

Q But if the GI bleed continued, what then?
A If he had a further bleed, if he had further chest pain his chances were reduced.

Q I also have a note – I have not checked it and perhaps I will have to – that somewhere there is a nursing note at this time that he was bleeding into a towel.
A Sorry?

Q He was bleeding into a towel on the bed. I will check that. Obviously you do not have a recollection of that.
A No.

Q We will see if that is right. It is a note I have made on my chronology. It is for 26 August. Can we go over the page, please, to page 14? We then have your own clinical notes of that visit. You describe him as being,

> "Pale, clammy and unwell. Query MI. Treat stat diamorphine and Oramorph overnight. Alternative possibly GI bleed but no haematemisis",

B Meaning no vomiting blood.
A Yes, there was no blood in the vomit.

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

Q "Keep comfortable".
C A Yes.

Q "Happy for nursing staff to confirm death".
A Which, as you know, was a formality to ensure that should the worst happen, that a duty doctor did not have to be called in from outside to confirm death before the body was moved to the mortuary.

D Q I understand that you say that is a formality, but we heard from a number of nurses who said they would read those words, "keep comfortable" --
A As being palliative care.

Q Exactly. And for "palliative care" we can normally read "end of life care", can we not?
A Becoming end of life care, yes.
E
Q Professor Ford said about your comment,

> "Not well enough to transfer to acute unit",

"I cannot follow the logic of that", your logic being basically that, because he was so large, it would be difficult to get him back to the main hospital and he would not suffer the journey
F well.
A Absolutely.

Q Did you think at this stage, given what was happening with this patient – possible MI taking place, certainly the real possibility of a GI bleed and the possibility that you were making an end of life decision for this patient, the possibility of that – that you should take a consultant's advice?
G A I had, in the form of the telephone conversation between Dr Ravi and Sister Hamblin, what I considered was the locum consultant advice. The doctor who had admitted him to the ward, the doctor who had seen him 48 hours earlier and was aware of his general medical condition had said, "Not for resuscitation".

Q I am sorry, Dr Barton --
A Dr Ravi was well aware what we were able to do or not able to do at Gosport War
H Memorial. When he said, "Not for resuscitation", he was not referring to, "Do not jump on

his chest, give him CPR, give him oxygen". We could do that, just, but we could not do anything else. So if he had been even for CPR, he would have had to be transferred.

Q Dr Barton, "Not for resuscitation" does not mean, "Do not treat a GI bleed", does it?
A It is not for transfer up to the acute unit where resuscitation is possible.

Q That is not what, "Not for resuscitation" means.
A That is what it meant to me when I read that, when I heard that from the sister on the ward and when I looked back through this gentleman's medical notes.

Q Let us pause there for a moment. It follows from that that for any of these patients, if you have seen in their notes, "Not for 555" or "Not for resuscitation" or "Not for 444", if that patient becomes ill by reason of something other than their heart, that patient is never going to be fit for transfer back to the main hospital. Is that right?
A You cannot make a generalisation like that about a whole group of very ill patients. You can make that comment as regards this particular patient. He was too unwell for transfer. He was too unwell for CPR, for 555.

Q Dr Barton, I am sorry. I understand that it may have been your professional, your clinical judgment that this patient was too unwell for transfer.
A It was.

Q What I am examining with you is how you interpreted, "Not for resuscitation". It does not mean, necessarily, "Do not send the patient back", does it?
A It means, in your clinical judgment, is this patient fit to even transfer back, and he was not.

Q That is what you think it means?
A I do.

Q I see. Let us move on to what you did for this patient. At that time you wrote out a prescription for him. First of all we can see diamorphine 10 mg intramuscularly, and that was given to him.
A Yes.

Q You prescribed Oramorph, 10 mg four-hourly, and also Oramorph, 10-20 mg four times a day, plus 20 mg at night. Now, the first of those Oramorph prescriptions, that means 60 mg a day, does it not?
A Yes, and he was given the first dose of that at night.

Q The second dose of Oramorph, the second prescription of Oramorph means up to 100 mg a day.
A Certainly.

Q What was the point of writing up those two prescriptions at the same time?
A I gave the nurses a range between 5 and 10 ml, between 10 and 20 mg to be given four times a day and 20 mg to be given at night to see him through the wee small hours.

Q Right, but what was the point of writing out two prescriptions for Oramorph?

A Because the second one was a larger dose than the first, you would not expect the nurses to use both. They would use the superseded larger dose rather than the smaller dose.

Q But the second dose is from 10 to 20 mg.
A Yes.

Q The first dose is for 10 mg.
B A Yes.

Q So the second dose subsumes the first, does it not?
A Yes, it is a larger range for nurses to choose.

Q I am just asking, was there any thinking behind writing up two prescriptions for Oramorph which in fact allow technically nurses to give this man 160 mg of morphine.
C A Because that is what I felt was an appropriate dose to give him at that point in time.

Q Professor Ford again said,

"This man was not destined to die. At least there should have been a discussion with the acute physician".

D You yourself did not pick up the phone to Dr Ravindrane, did you?
A I did not.

Q Let us look and see what happened to him. Page 15, please. On 27 August, there is no clinical note by you but Nurse Hamblin makes a note,

"Some marked improvement since yesterday. Seen by Dr Barton this am – to
E continue with Oramorph four-hourly – same given, tolerated well. Some discomfort this afternoon specially when dressings being done. Wife has visited this afternoon and is aware that condition could deteriorate again".
A Yes.

Q The Oramorph on this second day of his morphine medication is now being given to him at a rate of 60 mg a day.
F A Yes.

Q For what? Why was he being given 60 mg of Oramorph a day?
A Because he required relief from anxiety and distress, and presumably some pain, particularly when those hideous dressings were being changed and his legs were being dressed. He was comfortable on that medication.

G Q The only conceivable reference to pain is "some discomfort", is it not?
A Yes, but that is some discomfort on the medication. It probably would have been very uncomfortable for him without the medication.

Q You say that. Up to this stage again, there had been precious little reference to pain, had there not?
A Yes.
H

Q Except for the pain in his throat, which you had taken to be a sign of myocardial infarction.
A Yes.

Q In fact although these pressure sores were very deep and extremely unpleasant, offensive – however you want to describe them – there had been notes earlier that despite that he was not in pain from them.
A Yes.

Q Until the day before this man was opiate naïve, was he not?
A Yes.

Q Can we take it effectively that this man was now on a terminal pathway?
A I think that over the weekend he became terminal. I think he was still on a palliative care pathway which the nursing staff and I felt was quite appropriate and I think over the weekend he became terminal.

Q We can see that the weekend is 28 August.
A Yes.

Q And the 29 August when he carries on with that same dose of morphine.
A Yes.

Q Although in fact the nurses obviously had the ability to give more if they felt he needed it.
A Yes.

Q Then we come to 30 August, page 17. Sister Hamblin has made a note.

"This mane 30/9/099 complaining of left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. Very small amount of diet taken, mainly puddings".

So it is obvious that he is still able to take nourishment and certainly liquid.
A Yes.

Q "Recatheterised. When possible encourage fluids. Dressings renewed".

If we look at the prescription that was written up that day, and this was your prescription, was it?
A Yes.

Q You prescribed him, or you had prescribed him – we had better look at the drug chart at 174. Can you turn up, please, Patient J, pages 174 and 175? Your prescription, I think, appears on page 174. Is that right?
A Yes.

Q You wrote out a prescription for 40 to 200 mg.
A Yes.

Q Did you date that?
A It looks as if I dated it 26 August.

Q This is a daily review prescription, is it not?
A Yes.

Q When we were looking at this earlier --
B A I pinched one of their squares. I probably should not have dated it. I dated it the day I actually wrote the prescription, which was unusual.

Q Right, because when we looked at it earlier – I think it was in the Spurgin's case - you were saying that there was not a space for you.
A That is right, yes.

C Q So you appear to have written this out on 26 August. I think we may want to amend our chronology, page 14, and just make a note of that, because this prescription does not appear there. I am not suggesting that we redo the chronology, but it may just be worth popping in an asterisk on page 14.
A It is at the top of page 15, so presumably it still comes under 26 August.

Q Sorry. I think for the first time I am looking at an old version of chronology, but it is
D there, is it? It is under 26 August?
A Yes.

Q Let us come back to page 174. On 26 August you prescribed 40 – 200 mg of diamorphine and your usual prescription of midazolam.
A Yes.

E Q Why were you starting higher than normal on 26 August, please?
A Because he was 26 stone and I was minded that when I did, if I did need to start the syringe driver, 20 mg would not be an adequate dose.

Q But at that stage, on 26 August, there was no indication that you would need to start a syringe driver, was there?
A There was an indication to me that he might well deteriorate, but no, at that point
F there was no indication.

Q That is right.
A It was an anticipatory prescription.

Q But at that stage you were dealing with what you thought to be a myocardial infarction.
G A Yes.

Q Which you would not be dealing with by way of syringe driver, would you?
A Possibly.

Q What do you mean, "possibly"?
A Possibly if he had gone into congestive cardiac failure or if he had not recovered from
H the myocardial infarction the syringe driver would have been appropriate.

Q All sorts of things are possible.
A Yes, and that is why I wrote it up anticipatorily.

Q Can we go back please to page 17? On 30 August we have been through the note. Can you just help me with, "abdominal pain"? Is that something you would normally want to give diamorphine for?
B A Not as an isolated symptom on its own, but in this particular gentleman whose condition remains poor, and a known possibility – by now I had seen the full blood count. I knew that he had had at least one gastrointestinal bleed. I would have wanted to treat him with adequate opiate and something for the anxiety and terminal restlessness.

Q This is inevitably, once you have started the syringe driver, the end of his life, is it not?
C A He is not ending his life because of the syringe driver, but because of the underlying condition.

Q In general terms – I do not have his exact words – Professor Ford seems to think that it was inappropriate to use diamorphine to treat abdominal pain; would you agree with that as a generality?
A As a generality and Professor Ford was not standing at the bedside of this particular
D gentleman on that Monday afternoon. Up until this stage of course this gentleman had been on 60 mg of oral morphine daily; yes?
A Yes.

Q This was in effect, when you started this diamorphine, to double his dose.
A Yes.

E Q And you added to that "infusion 20 mg of midazolam".
A I did.

Q That was to do what to him?
A To deal with anxiety and the possibility of terminal restlessness.

Q Up until this point, as we have seen, he had been taking some food – he liked his
F puddings. Was there any reason not to continue with oral morphine?
A The report from my nursing staff that he was continuing to deteriorate, and in discussion with them, we would have decided that that was the point at which to start subcutaneous analgesia.

Q Since we have the file open can we look at page 64? You suggested, as I understood it, in passing that the initiation of this syringe driver may have been on the
G orders of a duty doctor.
A There is no mention in the nursing notes as to who sanctioned the syringe driver on that day. I had written it up the previous week. It was a Bank Holiday Monday; it is possible that I would have gone in to see the patient; it is possible that a duty doctor saw him.

Q If it was a duty doctor it is very surprising indeed, is it not, that he has made no clinical note?
H A Quite.

Q You agree with that, do you not?
A I do.

Q It is one thing for you who knows the staff well, you knew the patient, you knew the hospital.
A Yes.

B

Q But if a duty doctor walks in there and says, "Right, we are going to start this patient on his terminal pathway and put a syringe driver up it would be fairly astonishing if he or she did not make a clinical note.
A Absolutely.

Q And it looks in fact, does it not, as if this syringe driver was set up and started by
C Sister Hamblin.
A It is possible.

Q And she could have done that?
A In discussion with me at the time or in discussion subsequently, yes.

Q With or without discussion at the time with you.
D A Yes.

Q Her dose doubling up the morphine is on the basis of your prescription because your prescription only allowed for a doubling up, did it not?
A Yes.

Q And you anticipated, did you, many days earlier that that is exactly what he had
E required?
A I did.

Q Your prescient knowledge of that would be based on what?
A Knowledge of the patient, having seen him the previous week and long experience of starting doses of subcutaneous analgesia when needed, faced with a particular patient.

F Q Then at the bottom of page 17 we can see that he is said to be comfortable and having a peaceful night but he passes a large amount of black faeces and that is a clear indication, is it not, of a significant GI bleed?
A He has obviously had a further GI bleed.

Q But he passes a large amount of black faeces and that is a clear indication, is it not, of a significant GI bleed?
G A He has obviously had a further GI bleed.

Q That is a GI bleed that has gone untreated since it was first suspected?
A It has recurred since it first occurred the previous week, yes.

Q He is reviewed on 1 September, as we can see, by Dr Reid, on page 18:

H "Rather drowsy but comfortable."

Can we just look at this because his syringe driver is in fact increased by Sister Hamblin on the same day.
A At 19.19.

Q Dr Reid would have been seeing this patient when?
A That afternoon.
Q He describes him as:

"Rather drowsy but comfortable. Passing [something] stools Abdomen huge but quite soft."
A Melaena stools.

Q Meaning black with blood in them?
A Yes.

Q "Abdomen huge but quite soft, pressure sores over buttock and across posterior aspect of right/left thigh. Remains confused."

That is very likely to be the drugs taking effect, is it not?
A Yes.

Q This is the man who previously we have seen who had a high mental test score.

"For TLC. Wife aware of poor prognosis."

But underneath we see that the syringe driver is renewed by Sister Hamblin.
A As previous dose not controlling symptoms.

Q I was not going to stop. At quarter past seven in the evening:

"...with diamorphine 60 mg and midazolam 60 mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman has visited and is aware of the poor prognosis."

So in the afternoon he is described as comfortable. Sister Hamblin, on the basis of your prescription, increases the diamorphine from 40 to 60 and the midazolam goes up to 60. It looks as if it was tripled in a day, does it not?
A It does.

Q He was given 40 at 3.45 and then 60 at 7.15. That would have a profoundly sedating effect on him, would it not?
A Which presumably the reason was that she wished to control the confusion mentioned by Dr Reid on his ward round, which she would have felt was terminal restlessness.

Q This is his wife's description of this patient on the same day, on 1 September:

"He was unable to talk, he was unconscious."
A I am unable to comment about what Mrs Packman saw when she visited her husband.

Q And his daughter said this, after he got to your hospital:

"He was fine for the first three days. Then we got a phone call saying that he had had a heart attack. We went down. He told mum that he had had a bad case of indigestion. Two days later he was away with the fairies. He was drowsy; he could not feed self or drink self. It was quite shocking. After that he was comatose."

A That does not really fit with still taking puddings at the weekend, but there had obviously been a profound change in him during the time that his daughter was visiting.

Q Her timing obviously may well be out.
A It may well be out.

Q And as we can see, if we stay with page 19, on 2 September, the day of the next day, his diamorphine is increased once again, up to 90 mg and his midazolam is now up to 80 mg. Can we just remind ourselves that he had been started on morphine on 26 August.
A Yes.

Q We are now on 2 September and there is no question, is there, that the drugs by this stage would have caused a rapid deterioration?
A His condition caused the rapid deterioration; the drugs were administered to alleviate the symptoms of the rapid deterioration. They were not necessarily causing it; they may have been contributing to the drowsiness but they were relieving his symptoms. The constant balance in terminal care of a patient.

Q Despite the fact that he appears to have been comfortable when seen by Dr Reid on the afternoon of 1st it was felt necessary to increase his diamorphine and his midazolam not once but twice.
A Dr Reid was seeing a snapshot view of a gentleman he had not, as far as I know, previously met. The nursing staff were dealing with him and seeing to him 24/7 and were perfectly competent to make a decision with reference to me, if necessary, as to what dosage of drugs he should have.

Q There is no question, is there, that this patient ultimately died, at least in part, from a GI bleed?
A Certainly.

Q Why did you record his cause of death as an MI?
A Because I felt that he had on the previous Wednesday, Thursday had a myocardial infarction and that had led on to the problems that he had. I should have put gastrointestinal bleed perhaps as number two.

Q Sorry, when you say it went on to cause the problems that he had?
A He had a myocardial infarction.

Q Yes. It did not cause a GI bleed though, did it?
A No, I do not think so.

Q He died, as you have told us, of a GI bleed.
A He died as the... I do not know what he died of. He died as a result of a subsequent GI bleed, I imagine. It is difficult to say what actually happens in that terminal phase, what

the actual final cause of death was. But I felt that in his case the myocardial infarction was very significant.

Q Was there any concern in your mind when you wrote out that certificate that if you put down that he died of a GI bleed that somebody might inquire of you why he had not been treated for it?
A None at all.

B

Q Shall we move on to the next patient? That is Elsie Devine, Patient K.
I should just say that Mr Fitzgerald has looked to see if there is any support for my comment about bleeding into a towel and he cannot find it either. I am afraid I do not know where I got it from, so we should ignore it.

This lady on her transfer to you, which took place on 21 October 1999, had a – and
C I know what you are going to say about it but I am asking you to assist – good Barthel Score relative for her age and for the type of patients you normally received. She is Barthel 8.
A Yes, and I am going to say that that only reflects one aspect of her functioning.

Q I know you are.
A Her mental test score was not 20 out of 20.

D Q We understand that. And this was the lady who had been diagnosed with nephrotic syndrome. Can you just remind us again what that really means?
A She had an ongoing and progressive damage to her kidneys, which was eventually going to become terminal and had been decided by her consultants that it was not treatment.

Q I just want to ask you about this perhaps to clear it out of the way. She had been taking a drug called trimethoprim, had she not?
E A On two occasions.

Q I think you prescribed trimethoprim as well.
A I did. She had it I think once at the QA and I prescribed it. It is a urinary antibacterial for a presumed urinary tract infection.

Q So that would be to deal with the UTI. Can trimethoprim have the consequence in
F increasing creatinine levels?
A We discussed this at the Coroner's inquest ---

Q You did.
A ...and was felt that if there was it was mild and transient and uncommon.

Q In any event, once she was at your hospital she was no longer taking trimethoprim.
G A No.

Q So certainly your view would be that that would not be effecting her creatinine levels?
A Not when she arrived, no.
Q Can we go to page 4, first of all, just to have a look at her admission into the Queen Alexandra Hospital? She there had an episode of acute confusion. She was described as being "confused, aggressive and wandering". Her diagnosis was multi-infarct dementia and
H CRF.

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H CRF.

A Chronic renal failure.

Q Thank you. Then she is reviewed by Dr Taylor, who is the Clinical Assistant in old age psychiatry. Again, there are comments about her dementia. With patients who suffer from dementia, again can we take it that they have their good days and they have their bad?
A Yes. It is not a steep, vertical slope; they may have plateau days. But overall the general impression is a downward progression.

B

Q I understand that. Top of page 6, please. She is reviewed by Dr Jayawardena, consultant geriatrician and transfer is arranged to your hospital. She is described as suffering from:

"Moderate chronic renal failure. Admitted with a history of UTI."

C She is described as being:

"Quite alert. Can stand. Rather unsteady when walking."

She was, I think, 88 when she was with you.
A Yes.

D Q "Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation Programme. Will arrange transfer to GWMH."

And she was transferred to your hospital. In your view was that an appropriate transfer?
A Yes. This lady patently was going to need institutional care. There had been a lot of discussion with the family about where this would take place and whether they were going to have her back and she came to us as a holding operation while these things were sorted out
E within the family. So at that point she was medically stable and there was no problem about looking after her.

Q She needed a safe and secure environment; agreed?
A Yes.

Q She had had no pain whatever – not that is recorded, I do not think, in the notes.
F A No, no pain.

Q Do you disagree with that because we can look back through it.
A No, she may have had pain when she had her original urinary tract infection that took her into QA, but when she arrived on Dryad Ward she did not seem to be in any sort of pain.

Q And as far as I can see I do not think she had had any significant analgesia at any
G stage?
A No.

Q Then she comes to your care on 21 October.
A Yes.

Q And you have made a note that she transfers with one and you set out her previous
H medical history; you accept, I think that the myeloma is wrong.

A Was incorrect, yes.

Q "So far continent, needs some help with activities of daily living."

Not a particularly good mental test score, is it, nine out of 30?
A No.

B Q And that is a result of her dementia.
A Yes.

Q But her Barthel is 8 and we have both commented on that.

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

C Was that your genuine view?
A Yes.

Q "Needs minimal assistance with ADLs. Very pleasant lady. Appetite not good. Can be a little unsteady on feet. Both feet swollen. Seen by Dr Barton."

Then we come to your prescription and you have given her thyroxine for her hypothyroidism.
D A Yes.

Q Frusemide?
A A diuretic for her renal function, to reduce the oedema in her legs.

Q Temazepam to help her sleep at night, presumably?
A Yes.

E

Q And Oramorph. And your comment about the Oramorph, similarly with a patient we looked at yesterday evening was, "I felt she was entitled to this." Do you remember that?
A Should it become necessary for any reason in the future. It is written on the prn chart and I was not expecting it to be used unless it became necessary for any reason at all, and it never was administered.

F Q No, it is just your prescription that we are looking at though, and your basis for writing it. And your basis for writing it was that ---
A Should she need it at any time in the future; if she developed an acute illness or an acute problem the nursing staff had something available to give her for analgesia.

Q This was a patient who, as far as we are concerned, effectively had not had pain?
A Absolutely.

G

Q There was no reason to think that she was going to have pain at this stage of her admission, was there?
A None at all.

Q So you were writing out a prescription for the third category in the analgesic ladder because she might – even though there was no basis for it at all at that stage – one day have
H pain?

A Yes.

Q Let us move on. We can see that the next note that we have after your clinical note of 21 October is on 25th. She is seen by Dr Reid and she is getting herself about and she can dress herself. She is continent but she has got chronic renal failure. On Monday 1 November, the next note is by Dr Reid. He notes that she is "Physically independent but needs supervision of washing and dressing..... Continent. Quite confused and disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home."

Then over the page we can see that you prescribed Amiloride, is it?
A Yes, an additional diuretic to work in conjunction with the frusemide.

Q Then on 10 November we see that she is said to be "Confused during the night, wandering around ward. Refused night sedation". So this is the beginning of something of a problem presumably for her and also for the nursing staff?
A That is superimposed on a very gradual deterioration noted by Dr Reid at each of his ward rounds and the common things commonly occur. We assumed that she might have a urinary tract infection so that a mid-stream urine sample was sent off and she was started on Trimethoprim.

Q You also prescribed Thioridazine.
A I did.

Q Which is?
A A major tranquiliser.

Q I was going to say, a major tranquiliser. The purpose of that was what – to make her less agitated?
A Yes, make her less agitated, make her wander less, hopefully, and make it, I am afraid, easier for the nurses to look after her.

Q She stays on that major tranquiliser which is administered to her I think twice a day.
A Yes.

Q If we go to page 11, she is seen by Dr Reid. He is described as being very aggressive at times. "Ask Dr Lusznat to see". Dr Lusznat we remember was ---
A The psychogeriatrician.

Q Thank you. She has begun on occasion refusing her medication, as we can see. Can we go on now please to page 13 because she was actually reviewed by Dr Taylor. Is Dr Taylor also a psychogeriatrician?
A Yes.

Q "This lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward."

Mulberry Ward of course being effectively the geriatric psychiatric ward in the hospital?

A Yes.

Q And that would be a secure ward, would it?
A It would be more secure than our ward, yes.

Q "Mrs Devine is now at Dryad" having been transferred on 21 October. She is "aggressive, wandering, moving other people's clothes, refusing medication, poor appetite. Reviewed on ward. Happy, no complaints."

So there are periods for this lady where she is happy and contented and all right but obviously there are periods when she is confused and agitated?
A I fear that she was probably happy with no complaints because the fentanyl patch had been administered at 9.15 that morning and the level was beginning to build up and was making her feel more comfortable, slightly euphoric and happier than she had been when the referral was made to psychogeriatricians.

Q We have not yet got to the stage which takes place the next day I think when she is very aggressive?
A No. This is 24 hours before.

Q Exactly. You prescribed fentanyl – to deal with what?
A I felt that Elsie was entering the end-stage of her dementia superimposed on end stage of her renal failure and, as it turned out, there had been a marked deterioration in her creatinine. The result I think was not available until the next morning, but I felt that clinically she was going downhill quite quickly and I was minded to deal with her symptoms of restlessness, agitation, fear, anxiety in an appropriate way by using a transdermal opiate. I know it is licensed only for pain relief and I know also that in palliative care you often go outside the licence of a particular drug if you feel it is appropriate for that patient in front of you.

Q I think you also told the Panel that because it was a synthetic drug, you thought there was something about it ---
A Being appropriate for people with renal problems.

MR KARK: I am going to show you both the patient leaflet and also what we have been able to get from the manufacturers of Durogesic. I have given Mr Jenkins a copy of this yesterday. I will give you a copy and the defence another copy. (Copies distributed) I am afraid, as the Panel will see, one of the copies has sadly, particularly in the area that you need it most of course, been lopped off on the right-hand side.

THE CHAIRMAN: Are you going to give this an exhibit number?

MR KARK: I was going to suggest, if this is convenient and appropriate, to put it at the back of our BNF section where we are looking at all the other drugs. I do not know if that would be sensible.

THE CHAIRMAN: Mr Langdale, you have not objection? Very well. We will place these at the back of the BNF tab in volume 1.

MR KARK: It is tab 3 in panel bundle 1 and this will be pages 54 onwards. I am not going

to put it away just for the moment. In due course that is where it will go. Dr Barton, I will give you a moment to look at this and then I am going to ask you to help us about various aspects of it because we have looked at fentanyl but we have not really seen much about it so far. The first three pages, as I understand it, are the leaflet that comes with the ---
A The patient leaflet, yes.

Q The patient leaflet. Can we just go through this together before coming back to ask you to look at Elsie Devine. If we look under the column on the left hand side, we can see the heading

> "What is the name of this product and its ingredients?
> The name of the produce is Durogesic."

That is the same as fentanyl.

> "1. The Durogesic 25 patch contains 2.5 mg of fentanyl and gives a dose of 25 micrograms of fentanyl every hour."

If we look under the next heading "What is Durogesic" we see the last words of the first paragraph: "Each patch lasts for three days." The next heading is

> "What kind of medicine is the Durogesic patch?
>
> Durogesic patches contain fentanyl. Fentanyl is one of a group of strong painkillers called opiods, which must be used only under a doctor's instruction."
>
> "What do Durogesic patches do?
> Durogesic patches help relieve very bad and long-lasting pain. They do this by slowly letting the painkiller, fentanyl, pass from the patch, through the skin and into the body."

On the right-hand side; "Who cannot use Durogesic patches?" At the second bullet point:

> "Durogesic patches are only suitable for long-lasting pain and are not suitable for pain which lasts only for a short period."

Pausing there, the reason for that is because the patch is meant to be on for three days.
A The patch takes 24 hours to build up to its steady state level of activity and lasts for three days. It would not be appropriate to give it for somebody who was having a mild cardiac infarction. It will not give you an acute level of pain relief or anxiety or distress relief.

Q Rather like a syringe driver, it is not there for instant pain relief, is it?
A It is much slower to reach its steady state than the syringe driver.

Q "What shall I know before using Durogesic patches?

> If any of the following apply to you then please tell your doctor before using....
>
> - problems with your lungs or breathing

- problems with your heart, liver or kidneys
- headaches or head injury

If you are very ill, very thin or elderly, you may be more sensitive to the effects of Durogesic patches."

So far as that is concerned, the thin and the elderly you would have been well aware of?
A Yes.

Q I want you to understand this in context. Professor Ford was not overly critical of the use of the fentanyl but it is what happened thereafter and the addition of other drugs, you will remember, that he was most particularly concerned about.
A Yes.

Q We can see, just following on in that section:

"Like some other strong painkillers, Durogesic patches may make some people unusually drowsy and breathe more slowly or weakly than expected."

Then it tells the patient what to do if that happens to them, one of which is to take the patch off immediately. Can you go half-way down the page; "Can I take other medicines if I am using Durogesic patches?" At the second paragraph:

"There are some medicines that we know can affect the way Durogesic patches work. These medicines include some other painkillers, sleeping pills" et cetera "Your doctor will know which medicines are safe to take with Durogesic."

You would have to be very, very careful at prescribing opiates of a type if a patient had a Durogesic patch on, would you not?
A You would not be looking for prescribing them at the same time for any length of time.

Q That, you would agree, would be a very bad practice?
A It would be inappropriate to run them both. What we had to do the following day was to take the patch off and then institute the syringe driver in the same way that we had done in a previous patient and allow the level of the Durogesic to diminish as the level of the syringe driver increased.

Q But again you would be aware – and we will see this I think as we go on through the leaflet – that even once you have taken the patch off, the effects of it are going to continue because the drug is still going through the skin?
A And diminish through that next 24 hours. I was aware of that.

Q We will look at it in a moment to see how long it takes to diminish. We do not need to look at the next page, unless anybody is keen to do so. Can we go to the last page of the patient leaflet:

"Occasionally Durogesic patches can also cause the following:

- sickness or feeling sick

- drowsiness
- hallucinations
- skin rashes
- dizziness
- confusion
- feeling 'high' or unusually care-free
- difficulty going to the toilet".

B

All of this you would have been aware of?
A Yes.

Q Can we go to what I have marked as 57? It is the one with close type and three columns. If we look at the left-hand column, we can see, two-thirds of the way down, "Durogesic" is the heading. It describes how the system works, releasing fentanyl into the
C systemic circulation over a period of 72 hours. Then under "Uses",

"Durogesic is indicated in the management of chronic intractable pain due to cancer."

Although it is rather technical, could we look three lines underneath that?

"Durogesic provides continuous systemic delivery of fentanyl over the 72 hour
D administration period. After the first Durogesic application, serum fentanyl concentrations..."

Does that effectively mean fentanyl in the blood?
A Yes.

Q Just to keep it simple.

E

"..serum fentanyl concentrations increase gradually, generally leveling off between 12 and 24 hours and remaining relatively constant for the remainder of the 72-hour application period."

Yes?
A Yes.

F

Q Please go a few lines on to the middle column and the first paragraph:

"After Durogesic is removed, serum fentanyl concentrations decline gradually, falling approximately 50% in 17"

– and that is the median hours, the range being between 13 and 22 hours. Let us pause there
G for a moment. On average it takes 17 hours to lose half its strength. Is that a reasonable way of putting that?
A Yes.

Q "Continued absorption of fentanyl from the skin accounts for a slower disappearance of the drug from the serum than is seen after an iv infusion. Fentanyl is metabolised primarily in the liver."

H

A That was why it was appropriate for a lady with problems with her renal function.

Q We will look at that in a moment but I understand that that is what you say. You see a little table, and we have looked at this before; I am not going to take any time over that. It is the same table that appears, I think, in the BNF. Underneath that do you see this?

"For both strong opioid-naïve and opioid-tolerant patients, the initial evaluation of the analgesic effect of Durogesic should not be made before the system has been working for 24 hours due to the gradual increase in serum fentanyl concentrations up to this time."

Yes?
A Yes.

Q At the bottom of the page, please, same column:

"*Disconsolation of Durogesic:* If discontinuation of Durogesic is necessary, any replacement with other opioids should be gradual, starting at a low dose and increasing slowly. This is because fentanyl levels fall gradually after Durogesic is removed; it may take 17 hours or more for the fentanyl serum concentration to decrease by 505. As a general rule, the discontinuation of opioid analgesia should be gradual."

Then it deals with elderly patients, which this patient undoubtedly was.

"Data from intravenous studies with fentanyl suggest that elderly patients may have reduced clearance, a prolonged half-life and they may be more sensitive to the drug than younger patients."

Can we just pause? A prolonged half-life means that it is going to take longer in that range that we have looked at earlier?
A This is a study done using the drug intravenously. It does go on to say that pharmacokinetics did not differ significantly from young patients though serum concentrations tended to be higher. I do not think you can extrapolate across what happens when you give the drug intravenously to using it transdermally.

Q That is a legitimate point and I accept that. Can we move on to see what it says next:

"Elderly, cachectic" and it should be "debilitated patients should be observed carefully for signs of fentanyl toxicity and the dose reduced as necessary."

That would apply, would it not, to the patch equally?
A Yes.

Q Then,

"Contra-indications, warnings, etc."

"Durogesic is a sustained-release preparation indicated for the treatment of chronic intractable cancer pain and is contraindicated in acute pain because of the lack of

opportunity for dosage titration in the short term and the resultant possibility of significant respiratory depression."

Then we can see "Respiratory depression". If at any time you find me filling in part of the word on the right-hand side and you disagree with my interpretation, then I am sure you will let us know.

B "As with all potent opioids some patients may experience significant respiratory depression with Durogesic; patients must be observed for these effects. Respiratory depression may persist beyond the removal of the Durogesic system."

So that is the long-lasting effect of fentanyl, is it not?
A Yes, the following 24 hours.

C Q If you look below, you will see that there is specific comment about those with hepatic disease and renal disease. We are dealing with renal disease, are we?
A Yes.

Q Let us look at that:

D "Less than 10 per cent of fentanyl is excreted unchanged by the kidney and, unlike morphine, there are no known active metabolites eliminated by the kidney. Data obtained with intravenous fentanyl patients with renal failure suggest that the volume distribution of fentanyl may be changed by dialysis".

A Again that is not appropriate in this administration.

E Q "That may affect serum concentrations. If patients with renal impairment receive Durogesic, they should be observed carefully for signs of fentanyl toxicity and the dose reduced if necessary".

A Absolutely.

Q Does that provide any support, as it were, to your contention of this being a sympathetic drug?
F A It says that less than 10 per cent of fentanyl is excreted unchanged by the kidney, and it does not produce active metabolites. So it was an appropriate drug to use in that lady in those particular circumstances.

Q Can we look, please, at drug interactions, and this is the last passage I will ask you about. It is at the top of the next page, left hand column,

G "Drug interactions, the concomitant use" –

meaning at the same time.
A Yes.

Q "of other CNS depressants, including opioides may produce additive depressant effects, hypo ventilation",

H

meaning lowered breathing.
A Yes.

Q "hypo tension", meaning lowered blood pressure.
A Yes.

Q "and profound sedation or coma may occur. Therefore the use of any of these drugs concomitantly with Durogesic requires special care and observation".

A Yes.

Q Finally, "Side effects", two paragraphs down,

"The most serious adverse reaction as with all potent opioids is hypo ventilation. Other opioid-related adverse reactions include nausea, vomiting, constipation, hypertension, somnolence, confusion, hallucinations, euphoria, pruritus".

What is that?
A Itch.

Q Thank you, and "urinary retention". That is all that I want to ask you about that document. I was proposing to go on with this patient, unless doctor you need a rest at any stage. I am entirely in your hands again.
A I am fine.

Q I am just aware that we have been going longer with this patient than normal. So she is given a fentanyl patch at 9.15 on the morning of 18 November. That night we see that there is a marked deterioration overnight, yes?
A Yes.

Q She is described as being confused and aggressive. Her creatinine is now up to 360.
A Yes.

Q The fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs subcutaneous analgesia with midazolam".

Now this is your clinical note, is it not?
A Yes.

Q "Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death".

This lady, I expect you would say, is now on her terminal pathway.
A I would.

Q We know that she was in fact because she died two days later. She is described as "extremely aggressive", and we heard that vivid account of this patient holding on to the rails at the side of the ward. Is that something you witnessed yourself?
A Yes.

Q It is. Were you called to that incident?
A I arrived on the ward to find this incident going on at 7.30 that morning.

Q So what happened to this lady from hereon in, you would have been very well aware of.
A Yes.

B

Q You would have been well aware of the fact that this lady was already on fentanyl.
A Yes.

Q She was refusing help from staff and at 8.30 you authorised the use of chlorpromazine.
A I did.

C

Q That should have had an immediate calming effect.
A It is a major tranquiliser, hopefully to sedate her and allow them to get her into bed.

Q Is it the sort of thing that is used in mental hospitals?
A Yes.

D

Q It is a shot in the arm or the buttock, presumably, which quietens the patient right down.
A Yes.

Q So that is given to her at 8.30. Fifty-five minutes later a syringe driver is commenced.
A Yes.

E

Q You would have known how important it was to have removed the fentanyl patch prior to that starting.
A It needs to be removed approximately at the same time so you can start the process of the fentanyl level lowering as the syringe driver level, as Professor Ford said, does not immediately kick in but the level begins to build up. So you want to achieve a seamless cross-over of the two agents to keep the patient comfortable.

F

Q Dr Barton, as we have just seen in the leaflet, it takes an average – not for an old person but an average – of 17 hours for that fentanyl to reduce to half its potency.
A Yes.

Q So with an elderly frail person who would be particularly susceptible to the effect of opiates, you need to be particularly careful, do you not?
A Yes.

G

Q Otherwise the danger is that you are going to over-sedate them and possibly kill them.
A She needed sedation badly at that stage. I was not minded to allow her to rev up again and cause herself damage later on in the day with a recurrence of the behaviour that I had seen at 7.30 in the morning. I had to provide adequate sedation for her.

Q I understand your reasoning, but the danger that I have just put to you is that, with this lady who was very elderly -- she had fentanyl in her system -- there is a considerable danger,

H

is there not, with her particularly, when you use opiates that if you do not get the dose right you are going to over sedate her and kill her?
A There is a danger of over-sedation, yes.

Q How long does the chlorpromazine last?
A Four hours.

B Q Four hours, before it begins to reduce or is gone completely?
A No, I would think if it was given intramuscularly that it was down to its second or third half-life by lunch time.

Q With a syringe driver, we have spoken a lot about syringe drivers, but the drugs from a syringe driver start immediately, do they not?
A At a very low dose.

C

Q At a very low dose.
A And build up.

Q The drug that you had decided to administer to this patient, at its lowest – we can see at page 15 – was 40 mg of diamorphine. Yes?
A Yes, which was pretty much by my reckoning, an exact cross-over from the dose of
D the fentanyl patch.

Q With the fentanyl patch at its full strength.
A Which it was.

Q Which it was.
A Which it was.

E

Q At the time that you start the syringe driver you are well aware that the fentanyl patch is at full strength, are you not?
A Yes.

Q She has been given chlorpromazine, which is a major tranquiliser.
A And she is acutely aggressive, anxious and frightened, so I have to give something
F with the diamorphine in the syringe driver to control that anxiety and aggression and fear, and that was the midazolam.

Q At the time you started the syringe driver, Dr Barton, she was none of those. She was in bed, was she not?
A Because she had had 50 mg of chlorpromazine and I was not going to give her any further chlorpromazine.

G

Q I understand that, but at the time you started the syringe driver she has now got fentanyl in her system. Yes?
A Yes.

Q She has now got chlorpromazine in her system, which is going to last four hours or so, and you set up a syringe driver with 40 mg of diamorphine in an elderly patient, and 40 mg of
H midazolam.

A Yes.

Q Professor Ford described this as "extremely excessive".
A I do not agree. I felt that the dosages were appropriate for the clinical condition that I was faced with that morning in that particular patient.

Q He said of your use of midazolam,

B

"This demonstrates a misunderstanding of the use of midazolam".

You do not agree with that.
A I do not agree with that.

Q He said,

C

"The fentanyl would be persisting in its effect and you are exposing the patient to much greater effects. Conservatively you are adding 20 to 30 mg of diamorphine".

This would have had a profoundly sedating effect upon this patient, would it not?
A If you agreed with his calculations, yes.

D Q Well, let us take your calculations for a moment. The fentanyl patch at the time the syringe driver started, you had not in fact organised or directed or ensured that the patch was removed, had you?
A Nursing staff understood that once they had got everything else sorted out and organised, they would then remove the patch from this lady, and that was done at 12.30.

Q Sorry, everything else "sorted out and organised"?
E A After they had got her into bed and got her washed, and got her comfortable because she had been in her nightwear hanging onto the bars in the corridor of the ward. It was not their first priority to remove the patch. It was the first priority to get her into bed, get her comfortable and get the syringe driver set up.

Q It should have been their first priority, should it not?
A That is a nursing procedure.

F

Q No, Dr Barton. You authorised this syringe driver, did you not?
A Yes, and I authorised that the patch be taken off.

Q Why did you not direct or ensure that it was taken off immediately or do it yourself?
A Because I was going to do a ward round on the rest of the ward and the other ward and go and do a morning surgery. I was not in the habit of handling fentanyl patches.

G

Q You were not in the habit of handling fentanyl patches.
A No.

Q I see. Let us look at this lady's condition at about 10.30. The syringe driver is up and running, beginning to put 40 mg of midazolam and 40 mg of diamorphine into her. She is still under the effect of the chlorpromazine, is she not?
H A Yes.

Q And the fentanyl patch is at its peak.
A Yes.

Q Are you concerned in any way about that now, with the benefit of hindsight?
A No, I am delighted that she is now comfortable and they have been able to get her into bed and nurse her properly.

B

Q You see nothing wrong with that situation?
A Nothing at all.

Q When you saw her daughter on 19 November that afternoon.
A Evening.

C Q I beg your pardon. Freda Shaw saw her on the afternoon of 19 November and simply said to her,

> "'She will not know you, love. She has been sedated to be comfortable'. Mum squeezed my hand, otherwise she gave no reaction. She did not open her eyes. I met Dr Barton around 5 o'clock. She did not introduce herself. She said, 'Follow me'. She said, 'You know your mother has multiple myloma', and she said that she was in
D shock".

She said that she did not know. She said there was no discussion about the syringe driver or fentanyl that day. That is a pretty unsatisfactory state of affairs if that is right, is it not?
A If that is correct. That interview, it does not sound as if, having come back from having finished a duty surgery in the evening, that I would have neglected to mention the treatment that her mother was having and the concerns we were having about her general
E condition.

Q You unfortunately made no note about it.
A I made no note about the conversation, no.

Q On the Sunday, on 21st, the patient is still on her diamorphine and the midazolam and she dies at 8.30 in the evening. Yes?
F A Yes.

Q In your view her cause of death was chronic renal failure.
A It was.

Q Would you accept that with that amount of opiates in her body, a significant cause of death may have been opiate sedation?
G A I still consider that the cause of her death was chronic renal failure.

MR KARK: Sir, we are about to move on to the last patient. Would that be a convenient moment?

THE CHAIRMAN: Thank you very much indeed, Mr Kark. We will come back just before 11.30 please, ladies and gentlemen.

H

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Mr Kark, before you commence, a little bit of timetabling. May I please formally inform the parties that this Panel will rise early on Tuesday 28 July? A Panel member is required elsewhere and efforts were made to minimise the disruption and that is the result of it. It will be a 3 o'clock rise, so we will lose two hours. If it looks, Mr Langdale, as if in any way that is going to cause difficulties then we will look at ways in which we can sit earlier – shorter lunches or whatever.

MR LANGDALE: I am sure we will be able to work round it, sir.

MR KARK: Dr Barton, we are moving on to the last patient, Mrs Jean Stevens and I am going to take you back to 30 April, which we find at the bottom of page 5 of the chronology and over the page. This patient had, just to remind ourselves, she had collapsed at home. She had had chest pain and I think the diagnosis was that she had had a probable right infarction in her brain.

A Yes.

Q So she had had a stroke.

A A major right-sided stroke.

Q Then we can see that on 30 April she is described, at the top of page 6, as "bubbly". Suction with no effect. She has no gag reflex and the nasogastric tube is down, query, aspiration. Patient very distressed. Then they x-ray her and they found that although the nasogastric tube is in, it cannot be seen on the x-ray and it appears that it has been somehow misplaced and so she has been receiving her liquid supplements, I suppose it is, straight into the lungs.

A Yes.

Q Which would have done her no good. Professor Ford commented that it is certainly possible that her pneumonia would have been caused by that. That having been rectified, if we go over to page 7 we can see on 5 May she is described as taking food, or beginning to take food orally,

> "To start foods as directed by speech therapist. She has got some residual weakness and sensory inattention but improving. Referral to Dr Lord: could you give your opinion as to the best path for rehabilitation for this 73-year old female? She is improving slowly. Nothing more we can do for her on the acute medical side".

Over the page, again, there is a reference to aspiration, pneumonia, in respiratory failure, "Poorly ++. In distress". She was given small doses of diamorphine that day.. At the bottom of that entry on page 8, we can see, "remains for 444", but over the page, at the top , on 6 May, we can see,

> "Discussed with consultant. Not for resuscitation".

A Yes.

Q Then we can find a review by Dr Lord. She is described as being,

"Extremely unwell. Very dense left hemiplegia, left ventricular failure and aspiration pneumonia. Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH. Overall prognosis poor. If Mrs Stevens survives and is stable next week, happy to take her to slow stream stroke care bed at GWMH towards end of next week".

You would trust Dr Lord, would you not, to make that assessment? If she views that she is fit for transfer, then you would be happy to accept her.
A Yes.

Q On occasions she is given over the next days intravenous diamorphine in small quantities, I think. Then can we go to the top of page 11, which reflects 10 May:

"Reviewed by Dr Tandy. Appeared to improve over weekend. Barthel is zero. She has dense flaccid hemiparesis."

Can you help us with what that is?
A She had complete weakness down the left side of her body, arm and leg.

Q That is the result of her stroke?
A Of the major stroke.

Q "Can only obey simple commands. Tolerating nasogastric feeds so far (this morning). She developed further central chest pain. Don't think stable enough to transfer to GWMH."

So she is still unwell?
A Yes.

Q Then can we go to the bottom of page 12 – and I am not going through all of these, but if you think that any are particularly relevant I have no doubt you or Mr Langdale will comment.

"12 May 1999. Reviewed on ward round. Feeding well through nasogastric tube. Complaining of chest pain which is relieved by GTN. Obs stable. Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why patient would be allowed to die naturally, rather than be resuscitated or put in ITU, if she had a further MI or respiratory failure/arrest."

So that is not saying not for treatment; it is saying that if she has a respiratory failure or another heart attack she is not going to be ---
A Ventilated or given any heroic measures, yes.

Q Over the page, page 13, she was given on 14 May diamorphine, 5 mg at night to assist her to settle. Your comment was, "This coincides with my view of the use of diamorphine"; yes?
A Yes.

Q Can we go on now to the bottom of page 15, when things appear to have got a little better. She is reviewed on a ward round. Liaison between Royal Hospital Haslar and GWMH.

"Patient sitting in chair. Observations are stable."

She has had blood test results.

B

"Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating nasogastric feeding well. Seems to have recovered from aspiration pneumonitis. Slow improvement in orientation, speech and strength. Still faecally incontinent and requires a catheter in situ."

So she is not well but she is well enough, it would appear, for transfer.

C A Yes.

Q Over the page, please, 19 May reviewed by physiotherapist. She has a cough again. Then on 20 May, the following day, she is transferred. I have not taken you to each of the references but can I just remind you, whilst at the Royal Haslar she was given intravenous diamorphine on 5 May, 6 May, 2.5 mg each; and 14 May and 15 May 5 mg each. And that, you say, would coincide with your view of an appropriate use of morphine?

D A Yes, she had two series of acute deteriorations and they very appropriately used diamorphine during the management of those.

Q And that appears to have helped to settle her.
A Yes.

Q They plainly did not feel that she needed any form of constant diamorphine.

E A No, but it seems as if there is a note on the 20th:

"Still complaining of general aches and pains despite regular co-dydramol."

So she is having regular stage two analgesia just before she is transferred.

Q Let us have a look at what happens on her transfer. She comes to Daedalus Ward and

F she is in fact receiving aspirin and various other drugs – and I will come to the prescription that you wrote out and diagnosis and treatment in hospital/stroke for rehabilitation at your hospital. This is the transfer record, I am sorry.
A Yes.

Q And we see a nursing referral. History of angina and IBS. Has had aspiration pneumonia now resolved. So that problem seems to have gone. But she is still plainly

G suffering from the problems from her stroke.
A Yes, and when the nurse there mentions irritable bowel syndrome, she had considerably more bowel pathology in her past medical history than just irritable bowel syndrome; she had had a sigmoid colectomy and bowel adhesions subsequent to that, and she had had bowel problems throughout the years up to this acute admission.

Q That had been a chronic condition, had it not?

H A And we had looked after that in general practice for her.

Q She had had pain, unfortunately, through the years from her stomach.
A Yes.
Q If we go to page 18, her speech is said to be slurred slightly, but:

"Jean appears quite alert of her surroundings. Has a dense left weakness."

B What does "dense" add to left weakness?
A No voluntary movement in either the arm or the leg – a very severe stroke.

Q And she is reviewed by you.
A Yes.

Q She is described as, as you have now corrected the note, SSSR – slow stream stroke
C rehabilitation patient.
A Yes.

Q You set out her previous medical history, which I am not going to go through. She needs help with activities of daily living, she is catheterised and transfers with a hoist. Barthel zero. Did you have any plan for her?
A The initial plan would have been to assess how she coped with the major trauma of
D the transfer from the acute hospital to our hospital and hopefully she would have made a slow, gradual improvement from her stroke.

Q If we go over the page we can see that she is described as "orientated" and under the heading of pain "not controlled" is ticked:

"Complaining of abdominal pain due to history of bowel problems."
E A Yes.

Q So her pain, at this stage certainly, is the chronic pain that she has always had on and off?
A Yes.

Q If we go to the next entry:
F

"Requires assistance to settle and sleep at night. Oramorph given 5 mg. Complaining of pain in stomach and arm. Condition poor."
A Yes. So that is even on arrival her condition is said by the nursing staff to be poor.

Q Professor Ford commented as follows: opiates are not good at engaging people's ability to recover. Do you agree with that?
G A No.

Q Can we see what you decided to prescribe to this patient who was, at this stage of course, you would agree, opiate naïve?
A Yes. She had had opiates but she was not receiving level 3 opiates on transfer.

Q Absolutely. I can go back through it if you want.
H A It looked as if she was on co-dydramol but she had had no morphine for several days.

Q Exactly. Her last morphine had been on 15 May and that would have been entirely out of her system and we should regard this patient as opiate naïve, should we not?
A We should.

Q Page 20 of the chronology. You prescribed her Oramorph as required, 5 to 10 mg and that was given to her in fact three times on her arrival.
B A Yes.

Q At 14.30, 18.30 and at night.
A So that was prn; that was at the discretion of the nursing staff when they saw to her and assessed her and felt that she needed analgesia.

Q That was in fact the same amount of morphine in total as she had received by way of
C injection in the whole of her time at the Haslar.
A Certainly.

Q Then you prescribed for her what I am going to describe and I expect you would accept, your usual prescription – 20 to 200 of diamorphine and 20 to 80 midazolam.
A And hyoscine.

D Q And hyoscine. She had been at the Haslar for a month, effectively with minimal amounts of diamorphine irregularly and you approved, as you told us, of that sort of treatment.
A Yes.

Q What was your clinical basis, please, for allowing the nurses on their own initiation to start this lady on a syringe driver at these rates of diamorphine and midazolam?
E A If it was felt in my clinical judgment or their clinical judgment that this lady needed the diamorphine and the midazolam in those doses that they were able to give it to her.

Q So this was one of your "in case" prescriptions, yes?
A It was very much in case because this lady was only just medically stable when she arrived on the ward and she was at a baseline level extremely ill. Even though she was not at that point suffering from pneumonia or heart failure she was not a well lady.
F

Q But the doses that she had been given up to that stage, which you have agreed controlled her symptoms all the way through that month at the Haslar, was either 2.5 or 5 mg.
A Intravenously or intramuscularly, not by continuous infusion. So you cannot make a direct comparison between those doses and their use in the urgent clinical situation that they were used in Haslar and, in my case, to give her palliative care.

G Q Dr Barton, let us pause for a moment. If the way that the diamorphine had been used was effective, as you have agreed, in controlling such pain as she had, why did you not write out that same prescription?
A Because we did not use in those days prn subcutaneous for administration by the nurses.

Q Why not?
H

A We did not consider it appropriate in these cases. As you saw in one of the cases, I would use subcutaneous or intramuscular diamorphine in an emergency situation, but I would only want to give that either as a verbal order and then follow it up by going in to see the patient or at the time of seeing them. I did not allow the nurses to administer that; I did not write it up prn.

Q Can we just examine that for a moment? If these nurses start this patient on a syringe driver that, as we have discussed, is in effect the start of a terminal path, is it not?
A In her case it would have been. If she had been sufficiently ill that the Oramorph was not controlling her symptoms then she was on the terminal pathway.

Q Is Oramorph any more or less effective than a 5 mg injection intramuscularly?
A Equally effective.

Q So at this stage the nurses had the ability to deal with this patient in the same way that she had been dealt with for four weeks at the Haslar.
A And that is what they did, for the first day.

Q There was absolutely no necessity at this stage to set up a prescription for a syringe driver.
A The reason, as always, was that I was not going to be available. This particular weekend I was not going to be in the country so that if her condition deteriorated and she needed terminal care it had to be written up for her.

Q But Dr Barton, as you have agreed, the syringe driver does not actually deal with immediate pain, does it?
A She had Oramorph for immediate pain.

Q Yes, exactly. I am trying to understand what the necessity would be, if the nurses decided to do so, for having urgently to start a syringe driver – the palliative terminal route. What could be the urgency about that decision?
A Because the patient was deteriorating; her swallow was not very good. She pulled her tube up. She was then in a position she was not going to be able to take oral agents. We had no other choice if we felt that she needed analgesia and from anxiety and terminal distress than to give it subcutaneously.

Q Dr Barton, you did, as you told us, in an emergency you could authorise an intramuscular injection.
A I was not there.

Q Why not write it up – "Phone me before you ever administer this but it is there if you need it."
A I was not in the habit of using intramuscular or subcutaneous diamorphine in that way.

Q Instead of which what you effectively did was you handed the nurses the power to start the path for this lady's death.
A I did.

Q Let us look at what happened to this lady thereafter – and not very long thereafter, the following day. If we go to page 21 of the chronology, she is given Oramorph at 7.35 in the morning and then she is given, on the basis that a prescription that you wrote out on the Friday, two doses of 10 mg.
A Yes.

Q The prescription that you wrote out just for the oral medicine allowed the nurses to give this patient up to 60 mg a day.
A Yes.

Q For this lady who until her admission the day before had been opiate naïve.
A Yes.

Q You would agree that she was an elderly ---
A She was having the equivalent of 30 mg of oral morphine through the co-dydramol she was receiving at the Haslar Hospital before she was transferred across.

Q Are you saying that she was receiving the co-dydramol daily?
A It does say there in your chronology that she was having regular co-dydramol.

Q I will come back to that. In addition to which, in addition to the 60 mg that you allowed for, you also in fact allowed to be instituted later that day – in fact in the evening – the syringe driver.
A Yes.

Q Can we just look at the basic for that, please? In the chronology on page 21 she had GTN spray at 11.30. That would be to relieve chest pain.
A Yes.

Q She is given regular Oramorph.
A Yes.

Q Then at 18.00 hours Philip Beed comments:

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

She was actually given that day 25 mg orally, was she not?
A Yes, and counting in ---

Q Take your time, obviously. She is given 5 mg at 7.35 ---
A Three times.

Q Then 10 mg at ten o'clock and two o'clock.
A And you must count in the night time dose the night before – another five, possibly another ten.

Q Hold on ---

A You are looking at a 24-hour picture, so at the time he decided to institute the syringe driver she had had 70.

Q Go back to page 20. Within that 24-hour period we have to include the 22.45?
A Yes.

Q So that is 5 mg. Then over the page, another 5 mg given at 7.25?
A Yes.

Q And then at 2, 10 mg.
A Yes.

Q I think that is 30 mg. Yes?
A Thank you.

Q The equivalent dose in fact would be 10 mg, would it not?
A By the BNF and palliative guidelines calculation.

Q And 15 mg if you wanted to give her an increase, a small increase?
A And 20 mg if you wanted to give her what I had written up as the lowest dose available on the PRN.

Q Telling her husband, and I appreciate this was not you, that you would agree to commence the syringe driver at the equivalent dose to Oramorph was somewhat misleading, was it not?
A Yes. He was not able to do anything else at that time unless he called ---

MR LANGDALE: In case there is confusion, I put the matter to Professor Ford in relation to the amount of Oramorph that the patient had received and the conversion over to diamorphine and he agreed that it was broadly similar. I think his calculation came out at 2 mg below. That is my recollection of his evidence. So it is not right to suggest that it was not broadly equivalent.

MR KARK: I am just going on the figures that we have got here.
A And Philip Beed was not able to give lower than 20 mg of diamorphine because that was what I had given him permission to give on my PRN prescription.

Q You are not blaming Philip Beed?
A I am not blaming Philip Beed, no, but he was not able to do anything other than what I had allowed him to do on the prescription, and he did that and I think that it was not unduly misleading to reassure the husband that she was not getting a massive increase in dosage of diamorphine but a roughly equivalent dose to make her comfortable.

Q Her only complaint at this time, if we go back to page 19, was complaining of pain in her stomach and arm?
A I think possibly she was complaining of chest pain because she had GTN spray and I suspect that she was a very unwell lady. I did not see her on that day because I had left.

Q When her husband Ernest visited her, he said this: He was pleased to see her at the Royal Haslar Hospital. He described her as developing sufficient swallow for the transfer to

GWMH. He described her as being in good spirits. When he came to see her, after her admission, he thought this was on 20 May and so that would be at the time that she was receiving I think Oramorph but before the syringe driver had started. Yes?
A Yes.

Q If he has got his dates right, he described her as lying in bed in a coma. I did not know why she had deteriorated so quickly. A nurse called Phillips said she was in a lot of pain and wanted permission to double her morphine. So it may be that in fact he is referring to 21st May rather than 20th. He said: At GWMH she never made a sound, gave any indication of pain or discomfort – obviously that would be to him. Yes? Her daughter described her as unrecognisable?
A The nurse arranging the transfer, Nurse Neville, suggests "speech slurred slightly but Jean appears quite alert to her surroundings" and that was before she had her first dose of Oramorph, I admit, but she was not unconscious immediately as she arrived at the Gosport War Memorial.

Q Her speech would be slurred of course because of her stroke?
A Yes.

Q The following day, if we just follow this through, the diamorphine and midazolam are continued. You said this, and I think that this was your comment about the starting of the syringe driver: It was not started by you as you were not in the country.
A Yes.

Q The clinical notes for this patient, and you can turn them up of course if you would like to, are at page 1292 of the bundle, and the only clinical note is that made by you on her transfer on 20 May?
A Yes.

Q The next note in the clinical records is that the patient has died and that is a note by a nurse.
A Yes.

Q Again, if a visiting duty doctor had directed that this lady be put on to a syringe driver, it would be a fairly astonishing omission for such a doctor not to make a record of it?
A I do not think he visited. I think he gave a verbal order for hyoscine on the Saturday morning but he did not visit the ward.

Q No, I understand that. His verbal order was to increase not for hyoscine but to increase the hyoscine?
A Beyond the range which I had written up.

Q Yes.
A Yes, and Professor Ford did not criticise him for not visiting the patient at that point.

Q Let us just concentrate on where we are, which is the syringe driver. Yes?
A Yes.

Q Are you suggesting that the syringe driver was started by Dr Beasley?
A No.

Q It may have been altered by Dr Beasley, but it appears to have been started by the nurses?
A Yes.

Q And it was started by the nurses, this terminal event in this patient's life, because of your prescription which allowed it?
B A Yes.

Q So I accept that there is a verbal order from Dr Beasley to increase the hyoscine because there was no doubt a bubbling, which we can see is recorded at 10.20, and that is why he was contacted, but whether you were in the country or out of the country, this was an event which was started by reason of your putting your pen to the prescription sheet?
A Certainly.
C

Q And the patient died, we see, that day. Yes?
A Yes.

Q At no stage was the same sort of treatment which this patient had been receiving for a month at the Royal Haslar, which was so effective to control her problems, used at your hospital? You gave her Oramorph? Yes?
D A Yes.

Q And within a day she was on a syringe driver?
A I gave her Oramorph and she undoubtedly either had a further myocardial infarction or went into congestive cardiac failure and that caused her death, with or without the opiates administered to make her comfortable.

E Q If this patient had remained at the Royal Haslar, it is quite conceivable that she would have lived on, is it not?
A I cannot comment on what her clinical progress would have been at the hospital.

Q There was, I suggest, and it is illustrated by this patient, a culture at your hospital of initiation of a syringe driver when it was not in fact necessary?
A I disagree with that entirety.
F

Q I suggest that diamorphine and midazolam were started too early and too high. You understand that as a broad allegation against you?
A I still do not feel that unless you were there or had seen that patient that morning and knew what their actual clinical condition was in front of you that you can make a generalised statement like that.

G Q That sort of generalised complaint, though, was the substance of the complaints made 18 years before Mrs Stevens died, was it not?
A Yes.

Q And of which you were aware?
A Yes.

H Q Eight years, I beg your pardon – eight years earlier the same complaints had been

raised?
A Over that eight years, over the whole 12 years, we looked after thousands of patients. These 12 patients had been picked out because they were the most difficult cases to look after and, in some cases, the most contentious of cases to look after. We did not have a culture of initiating and using syringe drivers inappropriately or too early in patients who had reached the end of their life.

B Q Can I ask you to take up the heads of charge, please? There is just one I want to ask you specifically about and that is head of charge 14(iv). Just to put it in context, head of charge 14 alleges:

> "You did not keep clear, accurate and contemporaneous notes in relation to" all of the patients "care and in particular you did not sufficiently record,
> (i) the findings upon each examination
> C (ii) an assessment of the patient's condition
> (iii) the decisions made as a result of examination"

Then (iv) is "the drug regime" and (v) is "the reason for the drug regime prescribed by you" and (vi) is "the reason for the changes in the drug regime prescribed and/or directed by you."

You have admitted all of those except for (iv). Yes?
D A Yes.

Q May I just ask you this? If we more closely define the drug regime as meaning when the drug should be used and in what circumstances it would be used, do you accept that in general terms you did not make a sufficient record for the nurses?
A I did not make a written record. I wrote up an appropriate drug regime which was understood by the nursing staff that I worked with.

E Q By all of them?
A By all of them.

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

<u>Re-examined by MR LANGDALE</u>

F Q Dr Barton, I have a number of questions to ask of you in re-examination. I am not going to go over all the ground all over again. I am going to try to follow the order followed by my learned friend Mr Kark, but there is one question I want you to deal with at the outset which does not follow the order he took you through matters. It starts with just about the last matter he put. He was suggesting to you that there was a culture at Gosport War Memorial Hospital of starting syringe drivers too early. You have given your answer to that in terms of
G yourself. Had there been such a culture of starting syringe drivers too early, is that something that would have been apparent to the consultants?
A Yes.

Q Was Dr Logan somebody who would have countenanced in any way at all a culture of starting syringe drivers too early, in your experience of him?
H A No.

Q Would Dr Tandy have been the sort of person who would have countenanced such a culture?
A No.

Q Same question with Dr Lord: would she have countenanced such a culture?
A No.

B

Q Dr Reid?
A No.

Q I would like you to deal, please, with something relating to Dr Logan. Can you go back to file 1, tab 6. You remember you were asked questions about general matters with regard to prescribing and so on and the appropriate dosage to control pain. You said in your evidence, in answer to questions from Mr Kark, that you would go to a higher dose in order
C to give adequate pain control and to give it more quickly.
A Yes.

Q I would like you to look at a document that is in the file at tab 6, page 29. This is a letter written in July of 1991 by Dr Logan. He is writing to Steve, who is Stephen King, whose name was referred to in the papers we have already looked at in relation to the matters that were being discussed in 1991. I am not going to read all of the first paragraph but he
D says about three or four lines in in relation to the concerns which the staff hold:

> "It seems to centre round the feeling that it is wrong to start with subcutaneous diamorphine by pump for <u>any</u> patient who
> 1. Has not tried 'lesser' analgesia first
> 2. Could take oral (or rectal) diamorphine
> 3. Does not have patient-voiced pain (even though they may be obviously
> E restless and distressed)
> 4. Has not been discussed at a full staff conference."

So that was him setting out what seems to be the position. Over the page Dr Logan said this:

> "To me the important points to make in answer to these questions would be.
>
> F 1. Patients with distressing pain need adequate analgesia first – once pain is controlled reductions or changes in dosage can be made."

Is that a view with which you agreed?
A Entirely.

Q "2. The s/c route is more convenient for many patients and overcomes problems
G of vomiting back analgesics, variable absorption. The continuous infusion may allow lower total dose to be used."

Would you agree with that?
A Entirely.

Q "3. Opiates are analgesics but also euphorics, and thus psychologically beneficial
H for many patients. Many distressed, uncomfortable frail elderly are unable to report

their discomfort."

Would you agree with that?
A Entirely.

Q "4. Prompt treatment is the best."

B Again, we can take it that you agree with that?
A I do.

Q You made reference in your evidence, in terms of the drugs that you used in relation to subcutaneous analgesia, to the fact that to you it seemed to make sense to get to know a small group of drugs and use them rather than experimenting?
A Exactly.

C

Q Those are more or less your words. Looking at that same file, can we look, please, at the tab containing the BNF, so that is tab 3, page 7? On the left-hand side, about half-way down the column, it says "Guidelines". Can we see what it says for "Limit Range"?

"It is a sensible policy to prescribe from a limited range of drugs and to be thoroughly familiar with their effects in the elderly."

D

Is that something of which you were aware in terms of the BNF?
A Yes.

Q Was it something that you endeavoured to put into your practice or not?
A I did.

E Q In the same file I want us to go back to tab 6 to deal with another matter that was raised with you later on in your evidence: tab 6, page 25. You will remember you were asked questions about the meeting at which you were present, which involved Dr Logan and the other people we have already had identified more than once. You were asked about whether there was an issue as to a written policy and as to whether any of the nurses spoke out. Do you see at the top of page 25 that at this meeting, which involved all the relevant nurses that we are concerned with at this period of time, that there was general discussion and
F answering of staff questions. Does that accord with your recollection?
A Yes.

Q "Dr Logan stated he would be willing to speak to any member of staff who still had concerns over prescribed treatment, after speaking to Dr Barton or Sister Hamblin. Comments raised during discussion were",

G and there then follows a summary of comments with those things being raised by the nurses.
A Yes.

Q Was there any difficulty so far as you could tell, at that meeting, with the nurses voicing their concerns?
A None at all.

H

Q In relation to the question as to whether the nurses were pressing for a written policy, would you look just over half-way down that page? There is a sentence by itself,

> "Mrs Evans spoke to the remaining nursing staff. Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt this was appropriate".

B Does that accord with your recollection?
A Yes.

Q I want to move now, please, to the patient histories and first of all I want to move to the patient history of Leslie Pittock. In relation to this patient history I just want to ask you a question relating to the prescription on 15 January. That is in the patient history at page 15 of Patient L. On page 15, in relation to this patient, we can see dated 15 January the first
C administration of any subcutaneous analgesia. The anticipatory prescription had been written up some days before. You were asked about the amount of diamorphine and midazolam that was administered to him on that day, Monday 15 January, and it was being suggested to you that it was too high. You said you had given him the dose he needed by assessing his clinical state that morning.
A Yes.

D Q Can I just ask you this? Would there be any reason for you, your experience, your practice, your method of operating on these wards, would there be any reason for you to give him more than you thought he needed?
A Absolutely no reason.

Q You were also asked about the starting of the syringe driver and so on. It was being put to you, because that was a Monday, that if he appeared distressed over the weekend, why
E not put him on the syringe driver then? Why did the nursing staff not do that? But when you reviewed this patient on the Monday and looked at what the picture was on the weekend before, if you had thought that the nurses had not taken action when they should have done – for example, if you thought they should have instituted the syringe driver over the weekend – would you have done something about it?
A I would have discussed it with them.

F Q Moving on, please, to Patient D, Alice Wilkie, again using her patient history, I want to try to clarify the sequence of events in relation to this patient. Go, please, to page 8 of the patient history for Alice Wilkie. There we can see recorded on that page events taking place on two separate dates. At the top it is Monday 17 August, and at the bottom it has moved on to Thursday 20 August. You will remember that you were asked questions about the dating of what appears to be an undated prescription. This was an anticipatory prescription and you were being asked questions, I think, suggesting that it was written up on 20 August. You
G indicated at one point that an educated guess might be that it was, and then you said, "I cannot help you as to when I wrote up the scripts".

Just looking at the picture, in relation to 21 August, over the page, there is an entry in the clinical notes made by you referring to the previous days,

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

Does that signify to you that you were present on the day that it was administered, in other words, at the hospital on the day it was administered on the Thursday, or that you do not appear to have been present, where it says,

"Subcutaneous analgesia commenced yesterday".

B A My feeling is that I would have been present on 20th, sanctioned the start of the subcutaneous analgesia and then written it up the following day when I went in, and made a record of the fact that it had been started and that it seemed to be appropriate for the patient and for the family.

Q In that case I do need to refer you to a particular document in the file, page 145, to see if that helps. If we look at page 145 we can see that the prescription you wrote out in relation
C to diamorphine, Hyoscine and midazolam is shown on that page. Right?
A Yes.

Q Then whose handwriting is it where we can see the date, over to the right, at the top of the page where it says, "20 August"?
A It looks too tidy to be mine. It looks as if it must be Philip Beed's handwriting.

D Q Yes. We can see his initials and he is the person who administered that.
A Yes.

Q What I am trying to get at is to see if it clarifies, and maybe it does not, in terms of the date when you wrote the anticipatory prescription. If you had written that on 20th, the Thursday, what would the position have been with regard to any dates you might have put?
A It would have been the same date that Philip was going to write when he dispensed
E the prescription.

Q Because as we understand it, in one instance, I think, which was drawn to your attention, you had used the date column over on the right to give the date on which in fact you had written the anticipatory prescription, but that does not appear to have been the case here.
A Which would signify that I knew that he was going to be writing that same date
F because we had agreed to put the syringe driver up that day, once he had spoken to the family.

Q That is as far as I can take that. Looking at the same patient history though, that we were looking at a moment or two ago in respect of that issue, again at page 9 of the patient history, in relation to the history set out there, it refers in the note that you made to, "marked deterioration over the last few days", etc. Nurse Joyce records at 12.55,
G

"Condition deteriorated during morning. Daughter and granddaughter visited and stayed. Patient comfortable and pain free".

In relation to your entry on 21st, are you able to say whether the patient was unconscious or not?
A I am not able to say whether the patient was unconscious. I made no note as to
H whether she was unconscious or not.

Q If she had been unconscious at the time that you saw her, would you have considered reducing the dose of diamorphine?
A Certainly.

Q You also indicated that in relation to this same patient, if there had not been the problem caused by the disruption – that is the word I will use with regard to what was happening so far as Gladys Richards and Gladys Richards' relatives were concerned – if it had not been for that problem, Philip Beed and you would probably have started Alice Wilkie on Oramorph earlier than 20 August. I just wanted to ask you to explain why that was?
A Because there had been a general deterioration in her condition over the weekend of 17th, and he and I would probably have agreed on that Monday when I came in that she now needed some palliative care for her general distress and discomfort. We would probably have taken more notice of her general symptoms instead of allowing it to go on until the Thursday before instituting going straight on to subcutaneous analgesia.

Q If there was a culture of starting too early, if there was any truth in that suggestion, what would you have expected to be the position?
A There was no culture of starting syringe drivers before they were absolutely necessary. She would only have got subcutaneous analgesia when it was appropriate for her.

Q On please to the next patient in terms of the sequence, Patient E. Can we look please at that patient's history and go to page 10? Again I am simply concerned with the sequence of events to see if we can clarify. If we look at page 10 with regards to Patient E, that shows the position when she was transferred back, having gone back to the Haslar to have her hip sorted out; the transfer back on Monday 17 August. We can see that at some stage on that day she was reviewed by you.
A Yes.

Q The evidence was that when she was transferred back, that Leslie O'Brien, one of her daughters, had got to the hospital at about lunch time and the lady, Gladys Richards, was screaming and she summoned assistance and spoke to Nurse Couchman. It appears that you were not at the hospital at that time.
A No. She was not screaming when I clerked her into the ward on that Thursday.

Q What I am trying to get at is, is it possible that you in fact saw her at some time after that incident rather than before?
A After she had had a dose?

Q Yes.
A She had been made comfortable on the bed and had had a dose of Oramorph.

Q If we look at page 11, we can see that she had had a dose of Oramorph, because Oramorph was administered.
A It was administered at 13.05.

Q First of all looking at the bottom of the page, it was administered three times during the day. Right?
A Yes.

Q That was 5 mg. As you rightly point out, at the top of the page Nurse Couchman recorded that shortly after one o'clock,

> "In pain and distress. Agreed to give Oramorph to 1.5 mg. Dr Barton contacted and ordered an x-ray".

Is it consistent, therefore, with that note that you came in later to see the patient?
A Yes, and ordered an x-ray but did not make a note of it.

Q Yes, we can see with regard to your entry in the clinical notes, it talks about the readmission, "Remained unresponsive for some hours" in relation to what happened at the Haslar.

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

A Yes.

Q So looking back at that, what is your view as to the sequence of events? That you saw her in fact after the arrival incident, at some point after Oramorph had been administered?
A And that she was now comfortable and on discussion an x-ray was ordered to check that the prosthesis remained in the right place.

Q It turned out, I think, that there was no problem revealed by the x-ray.
A Yes.

Q Then on please to Patient F. You were asked questions about matters, not only this particular passage but also about other matters, but I am focusing on just one passage relating to page 17 of the patient history. Patient F page 17. On page 17 there are two dates shown, one of them is Wednesday 19th, and the other is Thursday, 20th. We have got the entry by Nurse Hallman, which we have looked at more than once, setting out what the position was on the morning of the Wednesday, 22 July 2009

> "Oramorph 10 mg given. Doctor notified. Pain only relieved for short period. Very anxious",

and so on. The commencement of the syringe driver, and then on the Thursday 20th, the day after,

> "Condition appears to have deteriorated overnight. General condition continues to deteriorate",

And so on. "Ruby rousable and distressed when moved". It was being put, I think, that her condition had deteriorated because of the subcutaneous analgesia. Was this patient, so far as you can judge it, unconscious?
A No.

Q Can we look, please, in relation to her, at one document in the file – another reference to a document in the file I need to make – at page 388, Patient F? Bearing in mind that we were just looking at the dates of 19th and 20th, and we see what the nursing care plan shows for the night before and the following two nights at 388, showing on the 18th that she settled and slept well from 10 o'clock until midnight.

"She woke very distressed and anxious and said she needs someone with her".

That is also recorded on the patient history. She is given Oramorph with little effect.

"Very anxious during the night. Confused at times".

B Then we move on to the night of 19th, that is the night, as it were, after the syringe driver has been established in the afternoon of the 19th,

"Comfortable night. Settled well. Drowsy but rousable. This am sips of oral fluids tolerated. Syringe driver satisfactory".

Does that indicate to you a patient who was unconscious or not?
C A Not unconscious, not over-sedated.

Q The night of 20th is set out in the patient history. Then on to Patient G. I would like you to look at the patient history, please, for Mr Cunningham. Then on to Patient G, Mr Cunningham. Again, I would like you to look at the patient history, please, at page 14. Looking at page 14 it deals with matters which took place on 23 September, the Wednesday, when he was reviewed by you and Nurse Hallmann has recorded that fact and what the
D situation was, and relates to
Mr Farthing asking in terms of the deterioration if it was due to the commencement of the syringe driver, and he was informed that Cunningham was on the small dosage which he needed. Then became a little agitated at 23.00, so 11 o'clock in the evening.

"Syringe driver boosted with effect. Seems in some discomfort when moved."

E Mr Farthing's evidence was that he was unconscious and unrousable; what do you say about that?
A He was neither.

Q When you reviewed him on the morning – if it was the morning – of Wednesday 23, was he unconscious and unrousable?
A I am unable to say from the recorded here, but I imagine that he was not otherwise
F I would have taken the chance to review what was put in the syringe driver.

Q I was going to ask, if he had been unconscious and unrousable would you have checked on that?
A Then I would have reviewed his medication.

Q And perhaps we can just look on to the following day, please, Thursday 24, when you
G saw him again – page 15:

"Reviewed by Dr Barton on the Thursday. Remains unwell. Son has visited again. Subcutaneous analgesia is controlling pain – just."

Does that indicate to you a patient who is unconscious and unrousable?
A Not at all.
H

Q Then in relation to Patient H, Mr Wilson, if we look on the patient history for Mr Wilson to page 13, on the date 4 October, top left, the section dealing with his situation – that is when he is in Queen Alexandra still, of course – one can see on the last two lines of that entry.

> "Morphine 2.5 mg given at two o'clock in the morning as unsettled and uncomfortable."

B

That is an intramuscular injection.
A Yes.

Q Because you were asked later on questions by Mr Kark about the amount of subcutaneous analgesia he was given later and a reference was made to the fact that this was a massive increase – those were the words used by Mr Kark – on what he had had back on
C 5 October. Bearing in mind that that is intramuscular or intravenous, what do you say about that?
A It is very difficult to make comparisons of the two because that is a stat dose given for acute pain and I was looking at giving a steady infusion dose to control pain. But the actual amount of morphine in the system would probably have been very comparable.

Q Still on the same patient, a more general question. You were asked questions about
D whether you would take into account his previous alcoholism and the liver problem or liver disease, whatever the correct expression would be, and it was suggested to you that you had not taken those things into account in prescribing your anticipatory prescription. I would like you to deal with that. What impact did the history of his previous alcoholism and liver disease – in what way did you take that into account and why did it have no bearing on what you actually did?
A If he needed adequate analgesia he needed an opiate.

E

Q The question was also put to you that his alcoholism and his liver problem meant that the opiates would be more potent in treating pain. Do you agree with that or not?
A I do not think they are more potent. I think they may be handled by the body in a slightly different manner, but I do not think that they are more potent in any way. I think they would be equipotent with somebody who had a normal liver in the effect that they had on relieving his pain.

F

Q Looking at page 26 of the patient history for this same patient, that shows the situation on 15 October, a Thursday, and we can see in the second box down on the left a note that his condition had deteriorated overnight. You indicated in your evidence that this deterioration mirrored his cardiac failure, not the effect of the opiates.
A I did.

G

Q I would like you just to explain that. On what basis are you saying that that mirrored not the effect of the opiates but the effect of his cardiac failure?
A Because he had become chesty. He had retained an enormous amount of fluid while in Queen Alexandra. He was verging on the edge of cardiac failure when he arrived with us and that night he undoubtedly tipped into cardiac failure, and Oramorph would have been a very appropriate drug to give him to help relieve his symptoms. That is not the picture of Oramorph toxicity.

H

Q On that same issue, in relation to his background of alcoholism and the liver disease, and the suggestion that you should not have given so much Oramorph, did you, seeing this patient, see any signs that the Oramorph was having any adverse side effects in relation to him, such as encephalopathy or anything else?
A I did not at any stage see any signs of encephalopathy in this patient.

Q I move on to Patient I. If we look at the patient history for Patient I, Enid Spurgin, it was suggested to you at a certain point – and we can pick it up at page 11 of the patient history – that the 25 mg of Oramorph that she received as a result of your prescription on that day was too high.
A Yes.
Q The evidence of Dr Reid was that in his view it was perfectly sensible. But leaving that aside for the moment, the suggestion is that it was too high, too much in other words. Looking at the next day, on page 12, 27 March, the following day – and bearing in mind what the note says half way down on the left, "Still in pain" – what do you say to the suggestion that the Oramorph she had received was too high?
A It patently was not enough rather than too high a dose to relieve her symptoms.

Q You will remember in relation to this same patient the suggestion being made that you should have referred her back so that an orthopaedic surgeon or an orthopaedic team could have considered her position. You have given your reasons as to why you did not think it appropriate to transfer her back, but can I just ask you this; would there have been any problem, any difficulty for you in referring her back if you felt it was appropriate?
A You can see how easy it was to do when you looked at Gladys Richards falling on the ward and dislocating her prosthesis. It was the matter of making a phone call. But I did not feel that in her case it was clinically indicated to ask at that point for an orthopaedic opinion.

Q I will move on to Patient J, Mr Packman. Once again, I want to ask you about something in relation to the patient history. In relation to Mr Packman, would you turn up please page 10 of the history? When dealing with the review by Dr Ravindrane when he admitted him to Dryad Ward on 23 August you were reminded of the evidence of Professor Ford to the effect that a vast majority of wards would have tried to remobilise this patient. I am going to remind you of what Dr Reid said about this patient; he said that he would disagree fundamentally with any suggestion that the patient had been sent to Dryad because there was a potential for mobilisation. In Dr Reid's view he had no such prospect. In relation to what you said when you saw him yourself, which I think was some time later, which was 26th, three days later, were you able to form a view as to whether mobilisation was something that was still worth considering or something that really was, for practical purposes – my expression – not on?
A It was not on.

Q In relation to that particular time when you saw him – and this is page 13 of the patient history – you were indicating to the Panel what you understood was the view of Dr Ravindrane in relation to whether this patient was somebody who was suitable for transfer back. Looking at page 13 we can see the note that was obviously available to you and which you used to form your view about this. I would like you to explain a little bit more about this. Dr Ravi, as he is described in the note, is told about the problem and says, "Discontinue the clexane" – no difficulty about that.
A Yes.

Q And asking for repeating tests on the haemoglobin today and tomorrow and "not for resuscitation". We know what "not for resuscitation" means in a particular set of circumstances but I would just like you to indicate to the Panel more fully than you already have done, if it is possible, as to why this did not mean simply not for resuscitation for what I am going to call the sense we have seen it with regard to other patients, and that it gave an added meaning in the case of this patient. I would like you to explain that.
A In my view it went further than simply saying not for cardio pulmonary resuscitation; it meant that he knew that we did not have available at the Gosport War Memorial intravenous infusions, the capacity to cross match and administer blood and the facility to do endoscopy and to try and determine the cause of the bleeding. So when he put "not for resuscitation" he meant that Mr Packman was to stay where he was and to receive palliative care.

Q Was there any uncertainty or doubt in your mind as to that meaning?
A No and that accorded completely with my clinical impression when I met Mr Packman that week.

Q It was suggested – if we can look on to the last page of this patient history, at page 20 – in terms of the death certificate where you had recorded – although it is not set out there I think you had recorded myocardial infarct, is that right?
A Mm.

Q The suggestion was made to you that you did not put "GI bleed" on the death certificate, as either one of the causes or the cause of his death, because it might cause an inquiry as to why he had not been treated. What do you say to that?
A There is no way that that sort of inquiry would be instituted. The family take the death certificate down to the registrar and the registrar registers the death. Unless it is something that is completely inappropriate or something that they will not accept the registrar will register the death. There is no question of anybody instituting any inquiry at that point.

Q If anybody had instituted any inquiry – and can we look back at page 14 – what would they have seen with regard to your review of the patient shown at page 14?
A That my clinical assessment of this patient was that he had that morning had a myocardial infarction.

Q And what else were you considering, does your note show?
A The possibility that he had had a gastrointestinal bleed.

Q Was there any attempt by anybody to hide anything with regard to the possibility or the record of any history which was consistent with GI bleed?
A There was no attempt to hide anything.

Q I move on to Patient K. I am going to ask you about the time that you were asked particular questions in relation to the fentanyl, and I think probably the best page to use – to remind ourselves – is page 14. With regard to Patient K, Elsie Devine, you were asked a number of questions about the fentanyl and we looked at the literature and so on, and you explained your reasons as to why you thought it was appropriate in her case, and so on, and there does not appear to be any particular criticism of the use of fentanyl by Professor Ford. What Mr Kark was putting to you was that when you take into account the fentanyl that she had received – and she had received, as it were, 24 hours of fentanyl so it was at its top level.

A Steady level, yes.

Q Taking it off, the chlorpromazine having been administered at half past eight in the morning; the syringe driver started an hour later with the diamorphine and midazolam, both at 40, that this was wrong and it was – my words – far too much. What were you thinking in terms of how the changes were working and the effect of these drugs? The fentanyl is coming off ---

B A And the level is beginning to reduce in the bloodstream.

Q What sort of calculation are you making, even if it was not a precise calculation, as to the diamorphine and the midazolam being infused and therefore coming up and the fentanyl going down?

A The BNF calculation for fentanyl is up to 135 mg of oral morphine, so if you divide that by 3, it comes out as a figure of 40 mg of diamorphine.

C

Q If you are using the one-third?

A If you are using the one-third. I did not need additional pain relief sedation, so I was minded to do a direct conversion from the transdermal to the subcutaneous delivery system and give her the same level of pain relief, but I needed to add in the midazolam. At that point of time, I did not want to go on giving her intramuscular chlorpromazine. I wanted to give her sedation and relief from her restlessness and agitation by adding the midazolam to the

D diamorphine. That was the rationale for changing over from the transdermal patch to the subcutaneous administration.

Q Did you consider in your assessment of the correct dosage of these drugs that the midazolam was going to have a profoundly sedating effect?

A I was hoping that it would have a sufficiently sedating effect to make her comfortable and less aggressive and less frightened.

E

Q I have used the expression "profoundly sedating" because I think that is the expression my learned friend Mr Kark used, referring back to what Professor Ford said. "Profoundly sedating": I appreciate it is not a medical term.

A I would not have expected it to produce profound sedation.

Q I am asking you the question on the assumption that that is over-sedation or

F equivalent sedation.

A Yes.

Q Lastly, Patient L, Jean Stevens: can we just note certain things with regard to the picture so far as she was concerned? You were asked questions about why you had not followed the same approach in terms of the administration of diamorphine as had been adopted by the Haslar. I want to ask you to consider these matters in relation to what appears

G to have been the reason for administering diamorphine at the Haslar and the reason you applied when you sought to administer diamorphine.

A The two scenarios were completely different.

Q I just want you to demonstrate that. Sorry, I cut across you. I was going to ask you about the patient history, just to illustrate the point, and if I have cut you off from saying anything, please go ahead and say something further. Looking at page 8, we can see that

H

small doses of diamorphine are administered to keep her comfortable; in other words, no record of pain control. All right?
A Yes.

Q That is intravenous I think.
A I certainly did not have the facilities to administer intravenous diamorphine or intravenous anything to anybody at the hospital.

B

Q What I am concentrating on is what the records show as to why diamorphine was administered at Haslar. If we move on to page 9, we can see at the bottom of the page Dr Lord's notes, and we heard evidence from her about it: diamorphine was to be administered for distress.
A Yes.

C

Q And indeed, at the top of page 10, it was administered apparently for distress. There does not appear to be any mention of it being administered for pain. Correct?
A Correct.

Q And then can we look, please, at page 13 in the patient history? 14 May, still at Haslar: does it show diamorphine, bottom left, being administered?
A Yes.

D

Q And the purpose?
A To assist the settling, with good effect.

Q So again no mention of being administered for pain. Is that right?
A Not overtly in pain.

E

Q Then on page 14, 15 May, diamorphine given with good effect; no mention of pain. The following night she slept well without diamorphine. Then, when we come to her admission to Gosport War Memorial Hospital, page 17. She is on a prescription, is this right, from Haslar for PRN, in other words subcutaneous diamorphine as required.
A Yes.

Q When you were concerned to prescribe diamorphine, and can we look at page 21,

F

page 21 shows the reason why Philip Beed from whom we heard evidence commenced the syringe driver, and does that set out that it was for pain relief?
A Yes.

Q So what do you say to the suggestion that small intravenous immediate doses of diamorphine which had been administered apparently to relief distress and administering subcutaneous analgesia for pain relief ---

G

A No, you are not looking at two similar scenarios. If we had been able to do it, to give small doses of intravenous diamorphine would have acted immediately and given instant relieve from presumably the cardiac pain that she was suffering, or the acute pulmonary oedema that she was suffering. She now needed something more steady state throughout the 24 hours to relieve pain and discomfort.

Q Was that what you had in mind when you wrote out your anticipatory prescription?

H

A It was.

Q Lastly, and I hope it really is lastly, this: page 19 of the patient history. Page 19 refers to a particular point with regard to this lady, 20 May, top left-hand corner, "Complained of abdominal pain due to history of bowel problems. Oramorph given on arrival". Is that right?
A Yes.

B

Q Was the Oramorph being given for abdominal pain or for some other reason?
A It would have been appropriate to give it for abdominal pain for or generalised pain and discomfort following the transfer to the hospital.

Q Professor Ford said that you would not treat chronic abdominal pain with opiates. What do you say to that?
A I can see no reason why you should not treat chronic abdominal pain with opiates,
C provided that you had a pretty fair idea what was causing the abdominal pain, which we indeed knew. We knew she had a history of adhesions and had had a sigmoid colectomy.

Q Does this come back to the point I think you made earlier in your evidence: for abdominal pain by itself you would not necessarily use opiates?
A If it was a new symptom and you did not know the reason for it, you would not, but we knew about this lady's pre-existing problems.

D

Q The matter you were asked about in relation to this same topic was Professor Ford's view about opiates and patient recovery. He in effect was saying that if you are intending to rehabilitate or re-mobilise somebody, you would not start with opiates. What do you say about that?
A We had hundreds of patients in whom they would have had opiates for a specific problem or on arrival who came off their opiates and went home or went to their nursing
E home. It was not an automatic pathway on to terminal care.

MR LANGDALE: Thank you. That is all I ask by way of re-examination.

THE CHAIRMAN: We will rise now and sit again at 2.05 when I understand, Mr Jenkins, you have a witness to interpose?

F

MR JENKINS: Yes.

THE LEGAL ASSESSOR: I just raise the issue of when Dr Barton is able to communicate again with her counsel, because that may be something very much in her mind at the moment.

MR LANGDALE: Sir, as I understand the position to be, she is still technically in the witness box and, apart from a 'good morning' or a 'good afternoon', unless there is
G a particular thing she wants to raise, there will be no communication between her and her legal team. Subject to those two minor exceptions, I shall be proposing to treat her as if she was still in the witness box because plainly she is. She has further questions to come.

THE CHAIRMAN: You are absolutely right. Thank you very much indeed.

H

MR LANGDALE: I can also add that Dr Barton knows that if at any time she thinks, having reflected on something, that she wants to communicate something, she simply needs to indicate to us that she wants to communicate something and it can all be sorted out.

THE CHAIRMAN: Thank you.

(Luncheon adjournment)

B

THE CHAIRMAN: Mr Jenkins, before we begin, there are two preliminary matters. I will raise the first if I may. Best laid plans of mice and men: I announced this morning that we would rise on Tuesday at 3 o'clock to accommodate the need for a member of the Panel to be elsewhere. During the course of the morning that panellist has been told that they are now required at the front end of Tuesday instead of the back end. The amount of time that we will lose is going to be about the same. The proposal now is that we will start business at 11.30 on the Tuesday morning and then finish on Tuesday at the normal time or perhaps a little later.

C

Does that cause any difficulties? I am just hoping nobody has made arrangements in the interim?

MR LANGDALE: I am sure we can work around it. Thank you.

D

THE CHAIRMAN: I understand there is also a matter concerning the presence of the Doctor in the room when the forthcoming witness gives her evidence.

MR JENKINS: She was told to wait outside or that she would be outside and we have sorted out with Mr Kark's agreement that the Doctor should be in.

E

THE CHAIRMAN: I have to say that I agree too.

MR JENKINS: She is obviously entitled to hear the evidence.

MR KARK: That certainly did not come from our side. The Doctor can be here during the whole of the case.

F

THE CHAIRMAN: I think it is an administrative input from somewhere down the line. Everybody in here is agreed. We will proceed in the normal way.

YVONNE ASTRIDGE, Affirmed
Examined by MR JENKINS

G

(Introductions)

Q Please give your full name.
A Yvonne Astridge.

Q Would you give us your professional qualifications and experience?
A I am a state-registered nurse. I qualified in 1981. I have been practising as a nurse since then. I only stopped for two six-month periods during that time.

H

Q I think you worked in London hospitals at the start of your career?
A Yes, I did. I trained at St Thomas' and then did work at the Royal Free and St Thomas' and did some agency work.

Q Did some of that involve looking after elderly patients?
A Absolutely, yes; the majority of patients are elderly.

B Q Did you then work in Abingdon in Oxfordshire for a couple of years?
A Yes, I was in a hospital there, in the GP unit.

Q Did you then work as a nursing officer at a nursing home for a period in the 1980s.
A Yes.

Q Did you subsequently go to Gosport War Memorial Hospital?
C A Yes, I did.

Q Are you able to tell us roughly when you got there? Was it in the Eighties?
A It was in the Eighties; it was in the late Eighties to my recollection – '87/88.

Q In the 1990s, which is the period with which we are concerned, were you still working at the War Memorial Hospital?
D A Yes, I was. I did not leave until '97/98.

Q What role were you taking on during the 1990s?
A I was a senior staff nurse on Daedalus Ward.

Q I think we have heard that the sister at that time was Sister Joines.
A Yes.
E

Q And we know that the ward manager was subsequently to become Philip Beed. Were you there when he was there?
A Yes, I was.

Q For the early and mid 1990s, Sister Sheila Joines was in charge of the ward on the nursing side. What do you do now?
F A I am a clinical manager of something called the multidisciplinary response team, which is a community team of nurses and therapists whose main aim is to prevent acute hospital admission. We crisis-manage health problems at home.

Q To summarise, you have been a nurse and a senior nurse for 25 years and more?
A Yes.

G Q Can I take you to a file on your left labelled B. This is in relation to a patient we know as Elsie Lavender. I think you remember the name but perhaps not the patient.
A I remember the name simply because of being asked for the police statement, yes.

Q I understand. I think you were asked as long ago as 2004 by the police and you gave a statement to the police about entries in the medical and nursing records for Elise Lavender?
A Yes.
H

Q I am not going to take you through these notes in any detail at all, but, just to reorientate ourselves, the Panel have spent six and a half weeks looking at these documents, so they are pretty familiar with most of them. I wonder if we can just go through very briefly, just to remind ourselves of this lady? If we were to look at page 136 in the records, and it is not done deliberately to confuse but you will find that there are two numbers at the bottom of every page. The 136 I want you to look at is an ambulance report form. This shows us the date of 5 February 1996 in relation to Elsie Lavender. It is an ambulance form showing that she was found at the bottom of the stairs and it gives her address in Gosport and her age as then 83. If we were to go over the page to 138, we will see this is a clerking note by a doctor; he described it as an EA, meaning emergency admission, via casualty. If we go over to page 139, we will see part of that clinical note at the hospital. If you look about eight lines down, you will see as part of the history the word, "Social. Lives in house with stairs. Bed downstairs".

If you look six lines below that, it says,

> "Can walk about 10 yards. Uses a stick. Does not usually go upstairs".

A Yes.

Q If we go on a few pages in the notes to page 143, again another entry in the medical records at the hospital where she was treated before going to the War Memorial Hospital, we see towards the bottom part of that page, "D/W son", which would normally mean "discussed with". Yes?

A Yes.

Q "She fell down the stairs. Large pool of blood at the top of the stairs ?Hit head at top of the stairs and fell down the stairs".

That I think is the event that led her to be in hospital in the first place.

A Right.

Q If we go on, and the Panel will remind themselves of the evidence we have heard, we see that some 10 or 11 days into that admission, Mrs Lavender was seen by a Dr Tandy. The Panel have the letter relating to that at page 935 in the notes, and Dr Tandy has written under "Diagnosis",

> "1. Probable brain stem stroke. 2. Insulin dependent diabetes mellitus.
> 3. Registered blind. 4. Now immobile. 5. AF",

Which we have heard would refer to "atrial fibrillation".

A Yes.

Q We see the terms of the letter, and over the page at 936, Dr Tandy offering the view that the most likely problem here is that there was a brain stem stroke leading to her fall. In other words, causing her to fall down the stairs.

A Yes.

Q We have got an indication, lower down in the letter,

"I will get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible".

We have got the corresponding note in the clinical notes for that record back at page 151 of the medical records. The Panel have seen it before and will recall that on the second page of the notes, at page 152, towards the bottom of the page Dr Tandy has written,

"Impression: probable brain stem stroke".

B

A few lines down she has written,

"Sounds as though only just managing at home prior, but would like to get back",

Meaning, presumably, the patient was hoping to get home.

C A Yes.

Q If you would look just over the page, just above the signature in the top one third of the page Dr Tandy has written,

"I am not sure whether we will manage to get her home but we will try".

D A Yes.

Q We know that it was a few days after that that Mrs Lavender was transferred to Daedalus Ward. We have got Dr Barton's entry at page 975, and we see five dated entries by Dr Barton. I do not know that people have remarked on it before, but if you were to turn the page to 976, you will see this relates to an admission to hospital seven years before when in fact it was Dr Barton who was admitting Mrs Lavender years before. We have nursing

E records for Mrs Lavender starting on page 1003. The pagination, I am afraid, may not be the most helpful for the nursing records and perhaps you could tell us, but would page 1003 be a continuation sheet of the nursing care plan?

A Yes.

Q It is not the first part of the nursing care plan.

A No.

F

Q If we go over the page to 1004, this is the starting page of a nursing care plan.

A Yes.

Q It names you as the named nurse for this patient.

A That is right.

G Q Can you tell us, how is the named nurse selected, or how was it in the mid-1990s?

A At that time it was usually the person who admitted the patient because they were the person that gathered the details as they arrived.

Q So as we go through the nursing documentation and a number of care plans, we see your name a number of times. Let us stay with 1004. You are named. Did you write the entries dated 24 February 1996 on that page?

H A No.

Q She was admitted two days before.
A Yes.

Q If we go to page 1006, a couple of pages on, that is obviously the start of another care plan relating to an in-dwelling urinary catheter. That is dated 22 February 1996, the date she was admitted. Is that your writing?
A No.

Q It is not? There are other care plans, again 1008 is another one. This one is the same date, 22 February. This one deals with a leg ulcer on the right leg. I think we have seen the previous care plan dealing with the reddened broken sacrum, on page 1004. Are you able to tell us whether your writing is on any of those?
A No, it is not.

Q What about 1012?
A I did the one on 1010.

Q That is you?
A Yes.

Q I am grateful. I was not going to take you through a number of your entries, or the detail of them, but I think if we just flag some up I think we can see your signature. If we go to page 1003, I think we have got your signature along the line for 2 March 1996. Is that you? There are two signatures at the end of the line for 2 March, "All dressings replaced", and yours is the higher of the two signatures on that line.
A That is my name but not my signature.

Q Why would that be done, that somebody would sign on your behalf in your name?
A At that time the requirement generally was that a trained nurse should countersign everything that an untrained nurse had written, and I suspect that what has happened is the person who wrote it put my name there as well to save me having to do it.

Q Does it follow that you would have been involved in that episode of care for this lady?
A Probably. It means that I was in charge of what happened to that patient during that episode, yes.

Q I understand. I think we have the same thing happening on several occasions. If you go to 1011, the same date, 2 March and your signature written above somebody called J Ross.
A Yes, it is somebody who has obviously done the same thing.

Q A couple of pages on, 1013, which may be an important page for other reasons, but on 2 March the same thing happening.
A Yes.

Q If we go on to page 1015, yet another care plan for Mrs Lavender, this one dealing with constipation, there is another entry for 2 March detailing an enema that was given. Is that your signature along the line?
A Actually it is not.

Q But would you have been present, assisting with the care of the patient?
A I am assuming that as my name is put there, then yes.

Q What we see with this patient is, in addition to the diabetes, the diagnosis of probable brain stem stroke, her difficulties with upper limbs and pain, and the fact that she is registered blind, we see that Mrs Lavender is experiencing pain on a number of occasions over a number of days. We have just looked at page 1013. It is not clear whether this relates to the
B care plan on 1014, the care plan relating to a problem of painful shoulders and upper arms where the desired outcome was to relieve pain and make Elsie more comfortable. That would certainly fit in with the dates, I think. If we look at the first entries, 27 February, and the dates follow on, on page 1013, the care plan contents deal with pain.
A Yes.

Q Again, is it clear from that document, amongst others, that Mrs Lavender was
C experiencing pain over the period that she was in Gosport, and the pain was not being controlled by the medication that she was being given?
A Yes.

Q I think if one were to go to page 1022, this is not a care plan, but the summary or a continuation rather of the summary. There are entries over a number of days about pain, drugs prescribed and being given for pain.
D A Yes.

Q By the time we get to early March, 4 March, the patient is still complaining of pain, getting extra analgesia as required, meaning Oramorph, and the morphine sulphate tablets being increased by Dr Barton.
A Yes.

E Q The following day it suggests her pain was uncontrolled and at that time a syringe driver was started.
A Yes.

Q If we go back one page, that is the summary that shows the admission to the ward and I think, do we finally arrive at your signature?
A You do, yes.
F

Q Did you know what Dr Tandy's view was when you made that entry, that this was a probably brain stem CVA, meaning cardiovascular accident?
A Yes. Yes, I would have done, because we got the faxed copy of the letter regarding the patient before the patient arrived.

Q I understand. You say you give the date, 5 February, which was the date the
G ambulance crew rescued her.

> "She now has problems with her grip in both hands and also experiences pain in arms and shoulders. Can transfer with two nurses. Seen by Dr Barton. Medication prescribed".

H

"Transfer with two nurses", we know that on Barthel activities of daily living charts, whether a patient was able to transfer at all or whether they needed some help or two people to help, that was a relevant consideration.
A Yes.

Q Where was that information coming from, "Transfer with two nurses"?
A Generally speaking when somebody came through the ward you would type that from the transfer letter you got from the nurses from the ward the nurses came from.

Q In your experience in the mid-1990s at Gosport, was the information on the transfer letter as to how the patient was doing, was that always borne out by the patient that you saw?
A No, it was not.

Q In what way was there a mismatch between the two?
A Quite often the letter would actually state that the patient could walk or transfer with two people, but when they came to the ward it became apparent actually that maybe they could transfer, but it was with difficulty and they certainly could not walk any distance. I suspect it may have had something to do with the fact that a lot of the nurses at the naval hospital were sailors.

Q Sailors?
A Yes, gentlemen who were quite burly.

Q At the Royal Haslar?
A Yes, and they actually took a lot more weight of the patient than would generally be recommended.

Q I understand. I was not going to take you through any more of the records save to ask you if you were involved in giving medication to this lady. We have got prescription sheets in the bundle. They start at 995 in time.
A Do you want me to look through and tell you what I gave?

Q I think the first drug there, is recorded as an "as required" prescription, and it is hydrocodeine, written up by Dr Barton on the day that we know Mrs Lavender was admitted on the ward, 22 February. Are you able to help us with the handwriting for any of the occasions when that medication was given? Is your writing there?
A It is not. Do you want me to identify it?

Q No, I do not think it is necessary. I just need to ask when you gave any medication. If you go on two pages to 997, you will see in the middle of the page morphine sulphate tablets were written up, 10 mg is the first of them, and that prescription is dated 24 February, so two days or so into her admission at Gosport. Can you tell us if your writing is there as any of the nurses giving medication for that morphine sulphate from 24 February?
A Not the MST 10, no.

Q MST 20 is written up as well, below.
A Yes, I gave it ---

Q That is from 26 February we see is the first time that that was given so clearly an increase in medication for Mrs Lavender from about that time. You were going to say you gave some of those?
A Yes, I gave it at 10 a.m. on 27th and 2nd.

Q If we go on we can see that the prescription was changed. I should ask you to go back to page 992 – going on in time but going back in the pages. The second entry down says "Oramorph" and it is also written in as MST. The date is 4 March 1996.
I think you will tell us that neither of those entries for administration are by you?
A That is right, they are not me.

Q If you go back one further page to 991 we can see what the Panel are familiar with – a syringe driver written up on 5 March 1996 and diamorphine has been written up at a dose of 100 to 200 mg and were you involved in the administration or setting up the syringe driver on 6 March?
A Yes.

Q And Mrs Lavender had had the same dose the day before, on 5th?
A Yes.

Q I think if we go to a different part of the records we have looked at page 995 before and we can see that a syringe driver was prescribed, as it were – diamorphine, midazolam and hyoscine have all been written up on 26 February 1996 at a different dose and the diamorphine then at 80 to 160 mg, but never given.
A Yes.

Q Of the syringe driver that you instituted on 6 March what would you say about the reason for giving it and the appropriateness of giving it for this patient, as far as you can recall?
A I cannot remember the patient at all. The only information I have is from the documentation. Looking at the amount of pain that this lady had that was very difficult to be controlled and the prognosis I would suggest it was put up because she was in a great deal of pain and distress.

Q But if you had had concerns about any dose that a patient was written up for, what would you have done?
A I would have spoken to Dr Barton about it.

Q And if you could not get hold of Dr Barton or she was not able to speak to you at that time, would you have given the drug?
A If I had had concerns?

Q Yes.
A No, I would have got somebody else in.

Q I am closing that file now because I have asked the questions I want to ask. Can I ask how approachable was Dr Barton during the time that she was looking after patients on the ward you were working on?
A I always found her extremely approachable – very easy to work with, more than happy to listen to what was said and engage in conversations about patients.

Q Were all doctors as easy in conversation with nursing staff as Dr Barton was?
A No.

Q I am going to ask you to expand on that. You do not have to identify any doctor but you have obviously worked with a lot of doctors over your 25 years in nursing.
A Yes.

Q Tell us, there is clearly a range of modes that doctors may have when dealing with nursing staff.
A Yes. Some doctors do not listen to what nurses say, do not take on board the information that they are given and disregard information that they are given regarding patients generally and also their beliefs and their families, and act without consideration for the information that they are given.

Q How common is that nowadays or was it in the 1990s.
A It is getting less common.

Q Good. How common was it in the 1990s?
A Some of it depended on how long you worked with a doctor for, as a generality, because obviously there is a relationship of trust that needs to be built up. It was more common than it is now.

Q And so far as patients on Daedalus Ward were concerned, we know that Dr Barton was only there for a limited period of time. I am not going to ask you what hours she was there because I think we have heard all that information over the last six weeks or so, but can you tell us how important was it for Dr Barton to receive information about her patients from nursing staff?
A It was very important because we are the people that were there 24/7 and we are the people that can relay the information about what is actually going on with the patient.

Q If a patient's condition changed or the family wanted to speak to the doctor how would Dr Barton learn that information?
A We would tell her. If she was not around at the time, if she was at the surgery we would ring her if it was urgent; and if it was not we would wait until we saw her either first thing in the morning when she came round or later in the day when she came back. We would ring her at home, yes.

Q How did she deal with receiving calls when she was not in the hospital or when she was at home?
A Very well. She always appeared – what is the word? – happy to receive the information. You never got the impression that actually you were wasting her time or telling her inappropriate things. Even in her own time she was more than happy to talk about patients and their care.

Q I do want to ask you about her level of commitment to medical care for the patients on the ward. So far as you were able to judge how committed was she to patients?
A Extremely. I have no doubt about that. It is unusual to find doctors who are happy to talk to you about their patients in their own time.

Q Was that the impression you got, that some of Dr Barton's time that was her own time was spent dealing with patients?
A Absolutely.

Q And attending the hospital.
A Yes.

B Q Can I ask about how busy Dr Barton was during the time that you saw her on the ward and during the times that you might have been making phone calls to her or trying to communicate with her about patients?
A My impression at the time was that she was a very busy lady. She would come in first thing in the morning, then go to her own practice and then come back. When she left us she was always going somewhere else to do something else with patients.

C Q Can you tell us about consultants on Daedalus Ward? We know that there was a period when one of the consultants was on maternity leave or was off for a long period of time.
A Sorry, I am trying to remember.

Q Do not worry about that; are you able to tell us how often you saw a consultant on the ward?
D A Once a week.

Q And that was for a ward round?
A Yes.

Q And what we have heard is that Dr Barton would attend for a ward round every second week.
E A Right.

Q What would you say about the level of medical cover that there was for the patients that you had on Daedalus Ward in the 1990s?
A I would say it was too little. The patients became increasingly complex and the workload went up – very slowly – as the patients would come to us less well than they did initially. Certainly generally over that ten-year period-ish originally the continuing care
F patients that came to us are patients that these days would go nowhere near continuing care funding.

Q We have heard that continuing care patients – some of them – would be there for years.
A Mm.

G Q They would be ambulant, they would have minimal medical needs.
A Yes.

Q And few nursing needs.
A Yes.

Q They just were not able to live in the community at that time.
H A Yes.

Q But the mix changed, clearly.
A It did.

Q What sort of patients were you getting as time went on in the 1990s?
A We were getting rehabilitation patients – stroke rehab patients initially on Daedalus, which in themselves they were sicker people and needed more care than the continuing care patients did. They became poorly more often. They were more difficult and more complicated to manage from a medical point of view and a nursing point of view than the type of continuing care patients that we had had. The continuing care patients, as the criterion started to change, also started to become more complicated and iller – taking more time.

Q Were patients being transferred to Daedalus from other hospitals?
A Yes, they were, and generally over time they were coming to us iller than they had been originally. It is very slow; you do not sort of notice it because it happens slowly. But was there any increase in nursing cover ---
A No.

Q ...over those years, to accommodate the change in the workload that you were dealing with in Daedalus?
A No.

Q Was there any change in the cover by doctors over that period of time?
A No.

Q So how would you say the nursing staff were able to deal with the change in the complexity of the work that you had to do?
A We had to learn fast and we had to react more quickly and get things done in a faster way. Probably, as always happens, if you get busier and busier there are things that perhaps you do not do as well as you would like.

Q Yes. What do you mean by that?
A I am looking at that documentation I did not sign, and that is what I am thinking.

Q If nursing is done properly the records would be full.
A Yes.

Q Tell us, as a consequence of increased workload over time, were there any consequences for the paperwork generally?
A I think generally, yes, because it is really hard to... Generally we go into nursing because actually we want to make people better and if you have a patient who needs something done now – you know, if they want the toilet they want the toilet, and if they need something done they need it done now. And if as a result you forget to do your paperwork because you are doing something else for the patient to make a difference now, then that is what goes.

Q What about Dr Barton and the increased workload on her – how did she seem to be coping with it?

A I have to say that she always seemed cheerful and committed to her job. She was always approachable. It did not seem to affect her in that sort of fashion.

Q What about her paperwork or notes that she was keeping?
A It is difficult because I think they were briefer than perhaps they could have been. But when you work with somebody for a long time and you see what they do, that just becomes the norm.

B

Q Did the brevity of her medical notes ever cause any problems?
A Not that I can recall, no. We always had the conversation so we knew what was happening.

Q Can I come back to the state of patients arriving with you. What you have told us already is that some patients were described, perhaps coming from the Haslar, as more
C mobile than in truth they were.
A Yes.

Q What about the medical state of patients, leaving aside their mobility – did that change over time? You have told us that they were iller as patients arrived.
A Yes, they were. They would come over with temperatures, perhaps, whereas previously they would have been medically well and they come with a temperature and you
D have to find out why they had a temperature and treat them accordingly – that sort of thing. But generally speaking they came frailer – there were more drips and drains and tubes.

Q We know with this lady – because we have looked at the record, your commencement of the summary – that you had Dr Tandy's note or letter because you copied out some of the contents of it.
A Yes.

E

Q Dr Tandy, clearly one of the consultants agreeing to admit this patient.
A Yes.
Q If you got transfer letters written by doctors from other hospitals were they always accurate as far as the medical condition of the patient?
A I am not sure that the nursing staff ever got transfer letters from other doctors from other hospitals. We would get nursing transfer letters and if patients were transferred from
F QA they would just come with their notes.

Q You have given us an example of patients who might come with a temperature. Can I just ask, were the patients always stable?
A No.

Q They were not, when they were transferred?
G A Yes.

Q I do not know, but as nurse I think you were second in command on Daedalus Ward.
A Yes.

Q Did you ever say anything about that?
A I think it was well known and certainly Dr Lord knew.

H

Q Would it have been your place to say anything?
A It would have gone up the chain of command nursing-wise and that would have been well known – my boss and my boss's would have known that actually these patients were generally sicker.

Q In your experience if patients who were sicker over time or patients transferred when they were not stable what consequences might there have been for those patients?
A They did not have access to the facilities of an acute general hospital so we could not scan them and treat them possibly in a way that they may have needed, and some of them needed to go back.

Q Was it always possible to send them back?
A It is a while ago, is it not? I think that if they acutely needed to go back and they were really poorly, really ill, then they went back. But if we felt we could manage it we would keep the patient with us because actually an ambulance ride from wherever they had come from is an exhausting, traumatic thing, and patients who are unwell do not respond well to extra transport. So if we felt we could manage it my recollection is that we would keep them and try and manage them.

Q I understand. I am going to ask you to expand on what you mean by "do not respond well to transport". You do not just meant that they were not happy?
A No.

Q You mean more than that?
A Yes, I do. It is exhausting for patients and patients who have had a stroke are exhausted already. It is very tiring; they get cold; they can get disorientated; it is uncomfortable and in fact for people who have pain an ambulance trip can be a very painful thing.

Q What about patients who may be disturbed in some way, perhaps because of dementia or confusion? How did they respond, if you can help us, to being transferred from one environment that they may have got used to to a new environment?
A Any confusion that they had would worsen. It is a new environment; not only is it the journey, it is the fact you have got different people at the other end and a different environment.

Q As time went on during the 1990s, would you have had as much time to talk to relatives as you did once you first moved to Daedalus Ward?
A Not as much as I would have liked, no.

Q If patients are iller, do you need the same or more time to talk to relatives?
A You need more.

Q Tell us why that is?
A Because it takes time for people to come to terms with what is happening to their families and quite often they just need time to sit and absorb what is actually going on and to be able to ask questions at a later date. It is quite often several conversations as opposed to one when they are ready for those conversations.

Q You say "when they are ready"; why do the relatives need be ready?

A Because when you are stressed and anxious and scared ---

Q Are you talking of the relatives or the patients or even the nurse?
A It depends on the day. The relatives: because if you know a member of your family is unwell, it is a very frightening thing because the ultimate disaster is possible. You might lose them. People come to terms with that in very different ways and over very different timescales. Some people are able to take that information on board; other people are not. Other people get very angry at situations or do not ask questions because actually they do not want to be told what they know they are going to be told.

Q Are nurses always able to have those conversations or might there have been some conversations that nursing staff would prefer that the doctor had? Do you know what I mean?
A I do.

Q If someone is perhaps in the terminals stages or something very serious has happened, would the nurses always feel comfortable having that conversation and getting that information?
A To some extent I think it depends upon the relationship that you have with the person to whom you are giving that information. There is also an element of the professional expectation, that relatives expect to hear news from the doctor because they are the people that know, in inverted commas. I am not disputing that they do know, you understand; it is just that they are the people the patient's relatives have that view of.

Q As time went on and you were dealing with iller patients, you told us there was a greater need for nursing staff to have conversations with relatives.
A Yes.

Q What would you say about the need for the doctor to have conversations with relatives as patients got iller over time?
A There was more to talk to them about because of the possibilities of the progress of their disease.

Q You have told us that there was no more doctoring time because none was allocated. Are you able to tell us how Dr Barton was able to deal with those conversations with patients and their families?
A She would ask if relatives wanted to talk to her. Quite often we would know that she wanted to know that so that when the relatives come in we would ask them if they would like to talk to her.

Q Was this conversations between you and Dr Barton about when she might speak to the relatives or whether the relatives would have wanted her to speak to her?
A Yes, and if the relatives asked us to speak to the doctor, then we would talk to Dr Barton.

Q Would you arrange it with Dr Barton so that she would come in and appointments effectively would be arranged with relatives?
A Yes.

Q Would you have been present during any of those conversations that Dr Barton may have had with relatives?
A Yes.

Q How did she deal with those conversations?
A My recollection is that they were always very calm, that she explained what was happening, what was wrong with the patients, what the likely outcome was going to be and asked if they had any questions for her.

Q What would you say about her manner? The Panel have heard some concerns expressed by relatives that she was brusque or rude. What would you say from the conversations you will have witnessed?
A I would say when I was in the room I never walked away thinking: oh, that was a bit not right. Dr Barton calls a spade a spade and she is very clear about what is happening. I do not remember at all a time when I think she was actively unkind or certainly not rude. Some patients and relatives have difficulty receiving the information because they actually do not want to hear it and they become angry.

Q Again, it may be difficult to recall but are you saying patients became angry because of the way Dr Barton was talking to them?
A No, because they did not want to know that Mum was dying.

Q You have used the expression "Dr Barton would call a spade a spade".
A Yes.

Q Of the conversations that you saw, was that an appropriate way to deal with matters or did you feel it was an inappropriate way?
A I think it felt appropriate to me from the conversations that we had, that I was present for. She explained what was happening and the likelihood of the prognosis. It was given with an explanation. It was not, "Oh, by the way, your mother is dying" – sorry, but it depends what you mean by brusque. I think it was just clear actually.

Q What you have told us is that some relatives got angry
A Yes. I have one recollection of one family who did get angry specifically, but we had been very gently trying to explain that Mum was not well and was not expected to live because she had stopped eating and drinking and she was not responding to anything that we were doing, so we tried to have those conversations with them and they were just blanking the information.

Q What would you say of the level of nursing care and medical care that was given to the patients during the time that you and Dr Barton were dealing with patients on Daedalus Ward?
A I thought it was good. I thought the patients were well looked after and comfortable and their relatives the same actually.

Q And you include the medical care in that as well, I think?
A Yes.

THE CHAIRMAN: Mrs Astridge, you have been giving evidence for about an hour and normally after an hour we reckon a witness may have had enough. If you would like to take

a break now, you can certainly have one. If you are happy to go on for a few more minutes, then we will do that.
A I am happy to go on.

Cross-examined by MR FITZGERALD

B Q Mrs Astridge, just to fill in the background very briefly, you were senior staff nurse on Daedalus Ward during 1996.
A Yes.

Q The reason that you have only been asked about one patient, Elsie Lavender, is because she is the only patient that you dealt with personally in this case.
A Right.
C
Q You remained in that position until about 1998; is that right?
A About then. It gets a bit vague after a while, I am afraid.

Q You then went off to work in St Christopher's Hospital in Fareham for about six years?
A Yes.
D
Q And then you returned to the Gosport War Memorial Hospital: is that right?
A Yes.

Q You took up a position as the clinical manager on Dryad Ward?
A Yes.

E Q In 2004?
A Yes.

Q That was the position that we have been talking of as sister?
A Yes.

Q And you did that from 2004 till when?
F A Two years ago.

Q Before you came on to Daedalus Ward in 1996, is it right that you had had some training in setting up syringe drivers or did you have that on the job in the ward of Daedalus?
A It was on the job.

Q When we talk about training in that context, does that mean training really in how the
G driver functioned in terms of how you would set it up, how it would operate?
A Yes.

Q Rather that of course the medication to be used or correct doses, matters of that nature?
A Yes, although we did have access to some Countess Mountbatten training as well, if I remember rightly.
H

Q I will come back to that in a moment. You were obviously one of the people who were spoken to by the police. Particularly in 2004, you made two statements. There is a copy of this if you would like to see it. If I just read a paragraph from the statement you made in October 2004, you said: The term 'Wessex Protocols' refers to the palliative care book used for guidance in what drugs are to be used in that care. I believe that these guidelines were used at the Gosport War Memorial Hospital.
A Yes.

Q And so the guidelines are from the Countess Mountbatten body – is that what you are talking about?
A Yes.

Q Those guidelines that we have been referring to in this case as the Wessex Protocols?
A Yes.

Q Was it your understanding that those guidelines would be followed on the ward?
A Yes.

Q Is it as a result of that that you were comfortable with the use of diamorphine on the ward?
A Yes.

Q You still have the file for Elsie Lavender, is that right?
A Yes.

Q First of all, you have no recollection of Elsie Lavender?
A No.

Q When you were referred by the police to certain entries in the notes, the same entries that you have looked at today, you had no recollection of the notes?
A No.

Q That is no criticism whatsoever; it is the passage of time and no doubt you dealt with a huge number of patients but you simply did not remember.
A No.

Q And so anything that you have to say about the patient or what happened is based simply on what we have there in the notes?
A Yes.

Q In terms of your own dealings with her where there was any mention of pain or discomfort, you have been referred to two entries, but firstly from the admission, because you wrote up some notes of admission, did you not ---
A Yes.

Q They are in our bundle at page 1021. It might be sensible just to look at it so that you can follow what I am saying. The first entry for 22 February, that is your writing?
A Yes.

Q It has been written up on admission and it is the one where it says that she experiences pain in the arms and shoulders?
A Yes.

Q And that she can transfer with two nurses. You have clarified I think that sometimes that sort of information, for example on whether a person could mobilise, would simply come from the transfer letter?
A Yes.

Q Sometimes presumably it would come from looking at the patient and dealing with them?
A Yes.

Q Is it right to say that because you do not actually remember the patient, you cannot say in this case where that has come from?
A That is right.

Q But there is obviously a reference to experiencing pain there and that is your entry?
A Yes.

Q The only other entry which you have made, or in fact not made by you but your name appearing, is on 2 March, and that is on page 1013. Do you have that?
A "Slight pain in shoulders when moved".

Q Yes. So it is the entry for 2 March: "Slight pain in shoulders when moved". Your name features along with someone else's.
A Yes.

Q In fact it has been written out by the someone else but it is an indication that you must have been present at the time?
A Yes.

Q And so, in terms of your experience of this patient and any pain that was being registered, that is it really, is it? You have not been referred to any other notes or anything else that shows that you have personally seen what condition she was in?
A Not that is here, no.

Q If you look at the drug chart on page 991, this is where we see the syringe driver being started. This is the page of the drug chart with diamorphine and midazolam on it.
A Yes.

Q The first administration is on 5 March.
A Yes.

Q That was not you, was it?
A No.

Q Do we see that in fact your role here was limited to recharging the driver with the same quantities of diamorphine and midazolam on the morning of 6th?
A Yes.

Q After it had been certainly running for a day.
A Yes.

Q There is no other note by --- Excuse me. We will see what other note there is in fact about her condition if we look at page 1023, please. First of all, it is right to say, apart from what we have looked at already, there is no other note by you of this lady's condition approaching the syringe driver being set up, is there?
A That is right.

Q But what we do have on page 1023 is, at the top of the page, an entry for 6 March and is that your writing?
A Yes, it is.

Q So this is you and the entry says: Seen by Dr Barton. Medication other than through syringe driver discontinued as patient unrousable."
A Yes.

Q And when you made your statement to the police you confirmed that "unrousable" means that she was deeply asleep or comatose?
A Yes.

Q Having seen that you recharged the driver at around 9.30 in the morning or so, and this is a reference of being seen by Dr Barton, does that suggest that that must have been after Dr Barton's morning round that you wrote the note?
A Yes.

Q Because she would normally come in first thing in the morning.
A Yes.

Q And that is when the condition would have been reviewed.
A Yes.

Q And obviously a decision made that the other drugs would have to be stopped because she was not in a condition to take anything other than through the syringe driver.
A That is right.

Q What the Panel know from the notes is that when the syringe driver was started, the day before, the 5th, the starting dose of morphine was 100 mg.
A Yes.

Q And the starting dose of midazolam was 40 mg.
A Yes.

Q This was a patient who had, at that point, been on an oral dose of morphine of 60 mg a day.
A Yes.

Q Would you agree that the starting dose of morphine is very high?
A I think it is difficult unless you can actually see the patient in front of you.

Q In terms of adding midazolam to the mix for such a patient, what would you say about those as doses of an opiate and a sedative? Would you say the same?
A I would really.

Q Did you have any knowledge yourself at the time of the conversion rate, the proper conversion rate between oral morphine and diamorphine?
A Yes, it was in the Wessex Protocol Guideline book.

Q So you would normally expect that guideline, that conversion rate to be followed?
A Generally. If we were setting up a syringe driver the nurses would follow that guideline, yes.

Q Do you think, and please say if you simply do not remember or cannot say, but do you think that you actually gave any consideration in this instance as to whether or not it was an appropriate dose, given that it had been set up the day before by someone else?
A I do not think I can say. I do not remember the lady at all.

Q Just one or two very quick matters in addition to that. You were making the point that as time went on, your years on Daedalus Ward, your workload increased.
A Yes.

Q At one stage you said that you thought the medical cover was too little.
A Yes.

Q But you have also mentioned that Dr Barton seemed to you always to remain chatty and comfortable in what she was doing.
A She was cheerful, yes, and approachable.

Q Approachable, and that the care that you provided for patients on the ward was always good.
A In my opinion, yes.

Q So you are not saying, are you, that as a result of how busy you were or because of a lack of medical cover, that Dr Barton's care for the patients suffered?
A No, I am not.

Q The last topic is about transfers that you received from the acute hospitals. You first spoke about transfers and how their mobility might be represented in a transfer letter compared to how they would be when they got to you.
A Yes.

Q When you were explaining how there might be a difference, you said that sometimes they would come from a hospital where there were maybe burlier men doing the job of supporting the patient.
A Yes.

Q And therefore I suppose the note would not be inaccurate, so to speak, but there may be a difference from what you would experience.

A Yes. However, with manual handling guidelines and manual handling issues, I would probably question whether what they were doing was actually in the patient's best interests, or theirs actually.

Q Correct me if I am wrong, but you are not saying that the mobility of the patient was actually being misrepresented to you in the letters.
A No.

B

Q You also mentioned that some of the people who came to you were so poorly that they needed to go back to the acute hospital.
A Yes.

Q And that that could happen if the person was acutely unwell.
A Yes.

C

Q But that sometimes, weighing up the dangers or risks of transferring back, if you felt that you could manage the patient more appropriately on the ward, then you would do so.
A Yes, that is my recollection.

Q So is it right that for each patient there will be a weighing up of the risks of transfer.
A Indeed.

D

Q As against what was going to happen if the patient did not get the acute treatment.
A Absolutely.

Q And that would very much depend on the particular patient.
A Yes.

E MR FITZGERALD: Those are all the questions I ask. Thank you.

Re-examined by MR JENKINS

MR JENKINS: I am just going to ask a few questions arising out of what you have just been asked. For any acutely unwell patients who have arrived at Daedalus Ward, you told us you had to weigh up whether it was in their best interests to stay or to be sent back.
F A Yes.

Q You told us about the consequences that might flow if an unstable patient was transferred in to Gosport.
A Yes.

Q Would you have thought it appropriate to consider the possible consequences of
G transferring them straight back, a double transfer?
A I think we did.

Q You were asked about syringe drivers and any training that you had had, and you said that it was training on the job. Are you able to tell us roughly when you got it?
A No, I am sorry.

H

Q It is a difficult one. What we have heard in the evidence is that Dr Barton came to Gosport as a clinical assistant in 1988 and that it was about that time after she started that syringe drivers started to be used. We know that some concerns were raised in 1991, but I do not know if you were involved in that at all, concerns raised by nursing staff.
A I think that was at Redclyffe Annex and I heard about it but was not directly involved in it.

B Q We know that those issues were raised during the second half of 1991. Are you able to tell us whether you had had your training by then or whether it came later?
A I am sorry, I really cannot remember.

Q I am just using that as a fixed point because we know the date of when those concerns were raised. You told Mr Fitzgerald that there was also some training from the Countess Mountbatten.
C A Yes.

Q We have heard of the Countess Mountbatten. Remind us, is it a hospital, a hospice?
A It is a hospice.

Q It is a hospice?
A Yes.
D

Q Are you able to tell us who from the hospice came to give training or did you go to them?
A It was different things over the years. So there was times when they came to us and actually I believe the first time they came to us was after the 1991 incident, in answer to your question.

E Q We have heard the name Dr Bee Wee.
A It rings a bell.

Q I think we have heard he was a consultant at the Countess Mountbatten.
A I think so.

Q You have been asked about the Wessex Guidelines and you told us those were
F followed.
A Yes.

Q The Wessex Guidelines, we know, involve approaching pain relief by going up in stages, as may be appropriate.
A Yes.

G Q When you say they were followed on Daedalus Ward, do you mean they were followed by the medical as well as the nursing staff?
A Yes, I think so. It is difficult because I just remember reading the book and following what it said, so I probably would not have thought directly what was happening with the medical staff because I always associated it with the little green book you looked into to find out what you did next. But there was certainly a step by step approach.

H

Q If a patient presented who appeared to be in quite severe pain, was the approach taken that you would always start at the bottom?
A Yes.

Q Or might people come in at a slightly higher stage on the ladder?
A There is always some element about balance, seeing the patient and what that patient needs at the time. There is no point giving someone paracetamol if they are in lots and lots of pain. You need to do something about it.

Q I understand. You have made the point that you need to see the patient in order to assess what treatment they should get.
A Yes.

Q Your attention was drawn to the records with Elsie Lavender and the fact that you have got entries referring to pain on 22 February 1996, the day she was admitted, and also on 2 March, three days or so before the syringe driver was instituted.
A Yes.

Q We have seen other entries in the records for different dates between those and following those where other nursing staff have indicated that Mrs Lavender was in pain; that her pain was not controlled with what she was on.
A Yes.

Q As the named nurse for Mrs Lavender, would you have been aware of any other entries made by other nursing staff?
A I would have been aware of the condition of the patient on handover, because it was always discussed.

Q At handover did you discuss every patient?
A Yes.

Q So for the entries that we have at 1021, towards the bottom of the page it is Sister Joines on 24 February, the day that we have seen already Dr Barton changed the prescribing,

"Pain not controlled properly by DF118" –

that is dihydrocodeine, I think.
A Yes.

Q "Seen by Dr Barton. Boarded for MST 10 mg b/d",

meaning twice a day.
A Yes.

Q "Boarded" means?
A Written up.

Q Would you have been aware of that?
A Yes.

Q Over the page, if you would, another entry by Sister Joines the next day, the 25th,

"Appears to be in more pain, screaming, 'my back' when moved, but uncomplaining when not".

Would you have been aware of that?
A Yes.

Q Reference to the son,

"Would like to see Dr Barton",

and then the following day, another entry by Sister Joines,

"Seen by Dr Barton MST to 20 mg b/d".

In other words, the morphine sulphate tablets were increased, doubled from 10 mg twice a day.
A Yes.

Q There is then an entry by Sister Joines about a conversation with the son and his wife that afternoon, 26 February. An entry just below that, the same afternoon, saying, "mattress needed changing" and so more morphine sulphate was given prior to moving Mrs Lavender on to it.
A Yes.

Q As we look further down the page, knowing that this is just one page amongst many dealing with this lady, would you have been aware, before you set up the syringe driver on 6 March, of the complaints of pain recorded here on the 4th?
A I would have been, yes.

Q She was getting Oramorph PRO as required, on top of the morphine sulphate tablets she was getting, and then the morphine sulphate tablets were increased by Dr Barton . That is two days before you gave --
A Yes, I would know the history about what has been going on. If I was not on duty that day obviously I would not be told then, but when I came back, yes, I would know about what had happened to the patient since I had not been there.

Q Obviously the entry for 5 March that, notwithstanding the change in medication, her pain was uncontrolled and she had had a very poor night. Did it happen from time to time that it was difficult to get on top of the pain?
A Yes, it did. Some people respond better than others to different pain killers. Sometimes it can be very difficult to control.

Q You were asked about the entry over the page at 1023, that the medication other than that through the syringe driver was discontinued because Mrs Lavender was unrousable. Tell us, were patients sometimes unrousable even if they were not on a syringe driver but were dying?
A Yes, absolutely.

Q If patients are dying, leave aside patients who are receiving opiates, but patients who are dying without opiates, they could sometimes be unrousable, could they?
A Yes, definitely.

Q Tell us why that was on your understanding?
A It is part of the dying process. As people die things shut down and they just go into coma. Some patients, not all, obviously. It just depends on the patient.

Q I understand. As an experienced nurse, now 25 years in nursing, would you draw any inference from the fact that this patient was said to be unrousable on the 6th as to what had led to that?
A I would not. I would just assume it was because she was dying.

Q I misled you, I think, I called a CVA a cardiovascular accident. It is a cerebo vascular accident, a bleeding to the brain.
A Yes.

MR JENKINS: Thank you very much.

THE CHAIRMAN: Thank you, Mr Jenkins. Mrs Astridge, I mentioned that a time would come when members of the Panel would have the opportunity to ask questions of you. I am just going to see if there are any questions. I am told that there is a need for a break first, so we will come back in 15 minutes. During that time, you will be taken somewhere and hopefully given some refreshment, but please do not discuss the case with anybody during that time.

(Adjourned for a short time)

Questioned by THE PANEL

THE CHAIRMAN: Welcome back everyone. Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Good afternoon, Mrs Astridge. These questions have been asked of many people, many witnesses as we have gone through the course of the hearing to date but I would just like to hear from you as well. Patients arrive, like this patient, the one that we have been talking about, Elsie, and they would come for mobilisation, rehabilitation, etc.
A Yes.

Q And then move through, maybe into palliative care and then into terminal care.
A Yes.

Q Talk me through about the standards that were set and how those decisions were actually made.
A The patients would be assessed when they arrived on the ward. Then there would be nursing assessments and medical assessments and physiotherapy assessments. A plan would be made for their rehabilitation. We would follow, nursing staff would follow physiotherapy instruction regarding moving and handling and positioning, which is very important in stroke rehabilitation. If they became more unwell, then obviously medical assessment would be made to decide what was happening and why. If it was decided that actually the patient was

palliative, then discussion would be had with the relatives and the patient if at that point they were able to participate in the discussion. Plans would be made for if they deteriorated further. Is that what you wanted?

Q That is what I am looking at and understanding. If I look at this patient and the notes on this patient, what we know is that once someone moves to the syringe driver, with the analgesic levels at the level that they are, it is the end of life, end of life care.

B A Yes.

Q But what I do not see is where those decisions were made, that the pain was not controllable or able to be dealt with in any other way other than through the analgesic route. For instance, if I look in here, we are moving to a terminal care stage.

A Yes.

C Q What I do not see is how that assessment is actually being made and recorded.

A I do not think it is being recorded, particularly. I cannot remember this lady but looking through the notes, there has obviously been a discussion with the family about the fact that this lady has got a poor prognosis, and in the notes there are notes about the fact that her pain is not being adequately controlled. In fact she is being kept in bed because the pain is so bad, movement is so painful for her.

D Q Right. But that seems to fluctuate, does it not? On the 2nd, here I have got,

"Slight pain in the shoulders when moved",

which I think is signed off by you.

A Yes.

E Q Then on the 5th I have got that then she has physio and three turns of the head to right and left, etc.

A Yes.

Q Which all seems to be part of the rehabilitation and mobilisation. The next one I am into, "Pain uncontrolled" and then we are on to the syringe driver and the sort of quite a high dose of analgesia. So we have moved from one treatment, which seems to me as a lay

F person, one treatment path to another treatment path and I cannot see the full assessment that has been made to move us from one to the other.

A Looking at what I have seen, because I cannot remember, the lady's pain probably would fluctuate because she has had increasing amounts of analgesia as she has gone along. So as the analgesia is increased one would hope the pain would be better, but my interpretation of what is written in the notes is actually, it might be better now but the next day it is worse. So again it is uncontrolled so the analgesia has been increased.

G

Q I suppose what I was looking for from how you described how decisions were made when going from one stage to the next stage, is that if that was common practice then I guess I would have expected to have seen in here how that assessment was made that you are now into the terminal stage with this patient.

A I know that these days we use something called the Liverpool Care Pathway where the documentation is really clear and expectations of how things are going to be managed is

H

actually done. Then I do not recall any sort of formalised documentation about that process. Is that what you are asking?

Q It is a way because you set out there, when I asked you how it was generally dealt with, as though there were some reasonable standards in place and I am looking at how are they actually demonstrated, how do I know that they were being followed? Or how do I know that a patient does not drift into terminal care that was not at the terminal care stage of life?

A There was no formalised way of documenting that sort of procedure in those days, that I am aware of. It was just a sort of set way – people would document as they went what they thought on the plans for the day, and actually this is what we are going to do because of X.

Q So how could you ensure that the patient was being properly protected – that the interests of the patient were being properly protected?

A I think if somebody has pain we need to sort it out, in all honesty. It is very clear that this lady, the pain was not being controlled and it needed to be controlled.

Q But then it becomes quite difficult, does it not, to determine whether it is the analgesia that sent this person into a state of unconsciousness or the lady's process of dying that is sending her into unconsciousness if there is not the clarity before about that terminal stage – that they are actually now at the terminal stage of dying.

A I would agree but I do not think in those days that people actually documented that as such.

Q That to me actually left the patient potentially – and I am not saying that it is that situation – it could have potentially left the patient open to moving into a terminal care pathway without a full assessment of a patient, but an assessment more focused on their pain rather than a full assessment of their condition.

A I think I see what you mean but it is about the medical assessment of that patient that is where we should be.

Q So you are saying that you do not get that medical assessment documented, but they are now moving into that terminal stage?

A I certainly do not think that we did in those days, no. It is different now.

MRS MANSELL: Thank you.

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

DR SMITH: Just recapping, you worked on Daedalus for ten years as a senior staff nurse.

A Yes.

Q I think we have heard that through that period drivers were used but they were not used profligately because there were not many drivers, but they were not an unusual thing for you to handle, is that right?

A That is right.

Q Your attention has been brought to a prescription, an "as required", what

I guess we have been calling a prn prescription, for diamorphine and midazolam – it is on page 995, bottom left hand corner. That prescription was not actually carried out.
A That is right.

Q You are the senior staff nurse.
A Yes.

Q And often as not you may well be the senior nurse because sister is on her day off, or whatever?
A Yes.

Q How do you know when to start that treatment?
A It would never be started without discussion. It would be discussed with Dr Barton, the patient if they were able to have that discussion and if not their family and their next of kin. It would be used because they were dying and that discussion had been had.

Q It would be used because they were dying?
A And they were in pain obviously and they needed the medication, yes.

Q I am sorry I am going to ask you the same question that Mrs Mansell asked in a way, and in that context. How do you know when the patient is dying?
A If the prognosis is very poor; if it is an end stage of their life and if they have the symptoms that need those drugs then that is when we would use it.

Q And it is not written down?
A The fact that they are dying?

Q In this case that you have looked at, that you are involved with today, nothing is written down that helps you come to a conclusion on that, I think you said, because all you have is the notes?
A Yes.

Q And there is nothing in the notes to tell you that that change has happened?
A No, I would take the inference from the fact that there is documentation that Dr Barton says she has talked to the family regarding the poor prognosis. But that is an assumption reading notes back, yes; so I would agree.

Q What if Dr Barton had gone on holiday and left that prescription behind?
A We would talk to another doctor who was covering her.

Q You would always talk to a doctor before carrying out the prescription?
A As far as I am concerned I always did, yes.

Q You always would?
A Yes.

DR SMITH: Thank you.

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

MR PAYNE: Good afternoon. It is just to carry on from my colleague's question there. You said that nurses setting up the syringe driver would use the guidelines.
A Yes.

Q Am I right in thinking, though, that you can only work within the parameters of the prescription?
A Yes, indeed.

B

Q So if the prescription says this the guidelines do not mean anything, do they – you have to follow that prescription?
A We can refuse to give the prescription but apart from that yes, we have to use the prescription.

Q You could not either go lower or higher?
C A No.

Q That is not your decision to make?
A No.

MR PAYNE: Thank you very much.

D THE CHAIRMAN: Mrs Astridge, we have heard a lot about a phenomenon that has been described as anticipatory prescribing.
A Yes.

Q That is something with which you are familiar, is it?
A Yes.

E Q Could you very briefly explain to us what the purpose of anticipatory prescribing is or was so far as you understood it at that time?
A My understanding is that it was there in case the patient needed it; in circumstances where we could not get a doctor quickly enough. If the patient has pain you do not want to wait until maybe on a weekend when the only doctor on call is out doing lots of visits and does not actually get back to the ward or get back to you for six hours or so.

F Q So if a doctor could not be got hold of or was not available what was it that you would do?
A Not with the syringe drivers but with analgesics I would give the analgesic if somebody had pain.

Q Thank you. You say not with the syringe driver ---
A Excuse me, unless it had already been discussed at an earlier date with
G Dr Barton that actually the next step would be to do that and would be the appropriate thing for that patient, yes. So on a weekend maybe if we had had a discussion with Dr Barton that actually this patient was now terminally ill and actually if they needed more analgesia that was the right thing to do, then that is what we would do. We would not need to talk to one of her partners about it.

Q So merely writing up an anticipatory prescription for a syringe driver would not, in
H your view, be sufficient authority for nurses to implement or to administer the driver?

A Not without prior discussion, no.

Q And in your experience, you are telling us, there always was such prior discussion?
A Yes.

Q What would be your view of circumstances in which nurses did not seek specific authority and there had been no prior discussion – if there were such a situation how would you regard it?
A I would want to know why they had done that, if it was a member of my staff.

THE CHAIRMAN: Thank you very much. We are going to turn now to see whether Mr Fitzgerald has any questions arising out of the questions that have been asked by members of the Panel?

MR FITZGERALD: No, thank you.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: I do have a couple.

Further examined by MR JENKINS

MR JENKINS: What you have told us just now is that there was no formalised way then in the documentation of writing up that the patient was dying.
A That is right.

Q You have said more recently there is the Liverpool Care Pathway.
A Yes.

Q Which has its own documentation?
A Yes, it does; it is gold standard.

Q We have seen lots of care plans and those deal with particular problems or concerns – bedsores, ulcers and problems with incontinence. Would anyone ever write a care plan up for the patient dying and how it should happen?
A Actually yes, but I think we came to write those later than this lady. We were more writing about symptomatic control in those days.

Q You were asked by Mrs Mansell about the indications that there are about pain for Mrs Lavender and you said that her pain probably would fluctuate because she had analgesia.
A Yes.

Q What do you mean by that? Do you mean she had tablets?
A Yes, because her tablets have been increased steadily and her pain would probably be better when they were increased, but it was clear from the fact that every couple of days her pain control was increased that actually it was not adequate – her pain grew and she needed more pain killers.

Q What difference would a syringe driver make to fluctuating levels of pain?

A You get an even dose of pain killer over a 24-hour period. If you take tablets you get highs and lows of concentrations.

Q What you said is that for any syringe driver that was written up, in answer to the Chairman, you have indicated that the fact it is written up does not mean that it should be given.
A That is required; it is as required and if it is not required do not give it.

B

Q And you have said that on Daedalus Ward where you were working there would always be a conversation with a doctor?
A Yes.

Q Dr Barton normally.
A In my experience, yes.

C

Q What conversation are you able to tell us, typically, would there have been between senior nursing staff and Dr Barton when the syringe driver was written up originally? Is that question clear?
A Yes.

Q We know that the syringe driver was originally written up for Mrs Lavender on
D 26 February. She was never put on that prescription at all; it was never instituted then, but instituted a number of days later.
A Yes.

Q On a separate prescription by 5 March, so a week or so later. Are you able to tell us what sort of discussion there would have been with the doctor before the original prescription was written up?
E A It would have been along the lines of this lady is obviously ---

MR KARK: I am sorry, this is purely speculative, about this patient at least.

THE CHAIRMAN: I think that must be right. If she does not have a recollection that should be it.

F MR JENKINS: That is fine. But are you able to tell us in general terms what your recollection is about discussions between nursing staff and the doctor before the doctor would write up an anticipatory prescription?
A Yes, we would talk about the condition of the patient, what the expected outcome for that patient was, and that you may or may not need to use this.

Q Before a syringe driver was ever started, if it was Dr Barton that was to approve the
G institution of medication would there have been regular contact between her and the nursing staff over the days since the prescription was written up?
A Yes.

Q And the syringe driver started?
A Yes.

H Q That would be contact when Dr Barton was there on the ward?

A Yes.

Q Or over the phone?
A Yes.

Q If I can just ask you to look back at this case – Mrs Lavender – page 1022, we know that that original prescription for a syringe driver was written on 26 February.
A Yes.

Q And we see from Sister Joines' note that that was the day that the son and his wife were seen by Dr Barton.
A Yes.

Q And the note suggests that the syringe driver was explained to the son.
A Yes.

Q Would that be typical, in your experience?
A Yes.

Q Whether noted or not?
A Yes.

MR JENKINS: Thank you very much, Mrs Astridge, that is all I ask.

THE CHAIRMAN: Mrs Astridge, that brings you to the end of your testimony. Thank you very much indeed for coming to assist us today. It is always very difficult for Panels to try to piece together forensically, as it were, what has happened often months or years in the past and we do rely on the testimony of witnesses such as yourself to assist us in that process, and for that we are most grateful. Thank you very much for coming and you are free to go.

(The witness withdrew)

THE CHAIRMAN: Tomorrow is a non-sitting day. As I indicated yesterday, the Panel is clearly going to require some considerable time to go through the transcripts of the doctor's evidence before they will be in a position to put their questions. What I am going to propose is that we give the Panel Friday morning to do that; so if I say not before two o'clock and then at two we aim to begin.

(The Panel adjourned until Friday 24 July 2009 at 2 p.m.)