GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 28 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-THREE)

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

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

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
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THE CHAIRMAN: Good morning everybody. Welcome back. Mr Jenkins?

MR JENKINS: I am going to call Sheila Joines, who was a sister on Daedalus Ward. The Panel will only need one bundle of medical notes; that is, Patient B.

SHEILA ANN JOINES, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to start off giving your full name, please.
A Sheila Ann Jenkins.

Q I think you qualified as a nurse many years ago.
A Yes, 1958.

Q You qualified as a midwife as well, I believe, and state registered nurse.
A Yes, I did, in 1960.

Q In the 1960s I think you started working at the Gosport War Memorial Hospital.
A I did, yes.

Q You had children; you followed your husband's career for a period of time and came back to Gosport war Memorial.
A Yes.

Q You had worked in the interim in South Africa in a hospital, had you?
A Yes, I did. I worked in two clinics in South Africa.

Q When we get to the 1970s you were working again at the Gosport War Memorial Hospital and between 1979 to 1997 you worked on the male ward at Gosport as sister on the ward.
A I did.

Q You dealt with various types of patient, all sorts of conditions. Can you help us with what sort of patients you were dealing with during the 1980s?
A Basically on the male ward we had a mixture of surgical patients. They were more or less lumps and bumps. We had medical patients and we also had palliative care, and towards the end we also had long-stay patients who were transferred up from Northcott Annex to the male ward. So it was quite a mixture.

Q We know about the Redclyffe Annex, we have heard quite a lot about that. Tell us about the Northcott Annex.
A Northcott Annex was a 12-bedded unit, six men and six women long stay. It was attached to Northcott House but I believe the NHS rented it from them and they were just the long-stay patients – what we used to refer to as geriatrics years ago.

Q I understand. We know that the War Memorial had two wards created and that people took up residence in about 1993 – Dryad Ward and Daedalus Ward.
A Yes.

Q I think you were sister on Daedalus.
A I was sister on Daedalus Ward, yes, stroke rehab and long-stay patients. We had eight stroke rehab beds and 14 long-stay beds.

Q When did you stop working on Daedalus Ward as sister?
A In 1997 when I retired for the first time.

Q Retired for the first time. I think you went on to be night nurse co-ordinator somewhere else.
A I did work for another eight years. I was asked to leave at 69 because I was too old.

Q Where did you go to after that?
A I have not. I have stayed retired.

Q But you were night nurse co-ordinator; whereabouts was that?
A It started off at St Christopher's. I just did Portsmouth and Havant & Petersfield and then the PCTs all separated into their own little units and I was asked if I would stay with East Hants and Petersfield so I worked from Waterlooville Health Centre and then we moved into Havant Civic Offices. Then because of the journey and the wear and tear on the car I heard that a post was coming up covering Fareham & Gosport, so I applied for the post but because East Hants did not want to lose me, I then ran East Hants, Petersfield, Fareham & Gosport until I was 69, when it was considered it was about time I left.

Q We have heard of St Christopher's Hospital before in the context of one of the patients that the Panel have been dealing with. That was Patient K, Elsie Devine, who was mentioned, I think. What is St Christopher's?
A St Christopher's, as far as I can remember, just dealt with long-stay patients. That is all they dealt with.

Q Let me take you back to Daedalus Ward. You were there, obviously, from 1993 once the ward came into existence, until 1997 when you retired.
A Yes.

Q Can you tell us what sort of patients you were receiving at Daedalus Ward?
A They were stroke rehabilitation patients, following strokes, and also long-stay patients.

Q Where were the long-stay patients coming from?
A Usually from the district more than anything else. Occasionally we got them transferred from other hospitals but usually it was from the local district, if I remember rightly.

Q At the time that you were there, did the nature of the patients stay the same?
A No, I think not so much for the long stay, but for the stroke rehab we certainly got the quota; the workload did definitely increase quite quickly actually from when the ward opened.

Q When you say the workload increased, do you mean the number of patients or do you means something else?

A The number of patients, but also the type of patients we were getting too.

Q In what way did they change, the type of patients you were getting?
A We were a stroke rehab ward but to be quite honest the patients we were getting, I was under the impression they were blocking acute beds in St Mary's Queen Alexandra and also the Royal Naval Hospital, Haslar, and the fact that they were given to us because they were blocking beds, and basically mainly because of the density of their strokes and, more
B importantly, other underlying medical problems. So although we were stroke rehab, I am afraid a lot of them were not fit to be rehabilitated.

Q What, for that type of patient, would have been written down as the reason for their admission?
A For rehabilitation.

C Q For rehabilitation?
A Yes.

Q But a lot of them were not fit for rehabilitation.
A I do not think so, no, and I think that was the general opinion, not just my personal one.

D Q Are you able to help us with what the patient or their relatives might have been led to understand was the reason for their admission?
A One of the problems we did have, shall we say with the relatives, was the fact that they had high expectations. They had been told their loved ones were coming over for rehabilitation when, quite honestly, that was not the case. So we were trying then to adjust to telling the patients that unfortunately they were not fit for rehabilitation, whereas they would have been told that they were coming over for rehabilitation.

E Q If you had that sort of conversation with patients or relatives, were those easy conversations to have?
A Not always, no. Some were but the majority were not.

Q The reason may be obvious, but tell us why.
A It is very difficult, when you have got a patient whose relatives come in fully
F expecting us to get them better to either go home again or go to a nursing/rest home, and the next minute you are saying they are not fit for rehabilitation. Eventually you have to turn round and say, "I am sorry, they are here and they will die eventually". That can be very difficult, and was very difficult.

Q Who was telling the relatives that the patient was going to be rehabilitated when in fact that was not possible?
G A Basically the hospitals they were being transferred from.

Q Where they had been bed blocking?
A Yes.

Q How was it to work in those conditions, as a nurse?
A It could be quite difficult at times. A lot of the patient's relatives were very
H understanding, but a lot of them were not and it must have been very difficult for them to

come to terms with the fact that their relative was supposed to be rehabilitated and they were just not fit for rehabilitation.

Q If you say a patient was not fit for rehabilitation, what are you saying, if anything, about the prognosis or life expectancy?
A It was very poor. A lot of the patients that we had on the ward while I was on there, I think maybe we might have got one or two home, but if they were not fit they would sometimes be seen by Dr Lord and they would go into a long-stay bed, or inevitably they were there till they died.

Q If we were to take that sort of patient, one where they had been bed blocking at an acute unit; they had been transferred on the paperwork for rehabilitation but they were not suitable for rehabilitation; if we were to look at the documentation, where would we see an accurate assessment of what was realistic for that patient?
A They would have been assessed on admission but then it all depended on whether the condition deteriorated. That may be not immediately apparent, but as time went on you would see the gradual deterioration and then it would have been noted.

Q So if one was to look at the documentation from the discharging hospital, suggesting that the patient was fit for rehabilitation, that would not be right but one might think it was.
A Yes.

Q We know that Dr Barton performed the role of clinical assistant for patients on Daedalus Ward, and that she had been providing the role of clinical assistant since 1988 until she resigned, several years after you retired from the War Memorial.
A Yes.

Q We have heard that there was a consultant who would undertake weekly ward rounds on Daedalus Ward.
A Yes.

Q Can you remind us of the name of the consultant?
A Yes, Althea Lord.

Q Just remind us, how frequently would you see her on the ward?
A I think it was every fortnight. She would come on the Monday.

Q She was not based at Gosport. She was based elsewhere, was she not?
A Yes.

Q So how regularly would patients on Daedalus Ward see a doctor?
A Dr Barton on a daily basis and Dr Lord fortnightly on a consultant basis.

Q You have told us that you were dealing with patients for some of whom the prognosis was poor.
A Yes.

Q How were the medical staff – Dr Lord and Dr Barton – coping with an increasing number of poor patients?
A I think under the circumstances they coped very well, Dr Barton especially.

Q Was there any change in the amount of time that doctors were allocated to spend on the ward over the time that you were sister of Daedalus Ward?
A There was no increase in time.

Q What about increase in other resources – nursing time?
A No.

Q Physiotherapy?
A Physiotherapy, I am afraid, it was not up to the acute wards like over at St Mary's, because I went over there to work on one of the wards. But it was a case of if we wanted physio, if they were available we would have physio, but maybe we could have had more physio input and OT input than we did.

Q What would you say about how the ward was set up to provide rehabilitation?
A In what way, Mr Jenkins, sorry?

Q Were the resources there to give rehabilitation to patients?
A Yes.

Q Does that include physiotherapy?
A Yes, physio was there, yes.

Q Can I ask about patients and when they might be admitted to the ward? How would that happen and what would happen once they were admitted?
A We would usually get a phone call – I am trying to think now. I think it was we used to get a phone call to say that a patient was going to be transferred, and then obviously we would be given times of expectation. Once they had arrived we would inform Dr Barton's surgery that the patient had arrived and she would come in and clerk the patient in.

Q We will come back to Dr Barton coming in in the mornings, but if Dr Barton arrived during the day to clerk a patient in, what sort of time typically – if there was a typical time – would that be?
A Late morning or lunchtime if the patients had been admitted in the morning, or if I was concerned about a patient, and sometimes, if the patients were admitted late morning, early afternoon, Dr Barton would come in late afternoon.

Q We have seen documentation to show that there would be a nursing assessment on admission.
A Yes.

Q And that nursing care plans would be drawn up.
A Yes.

Q In respect of the particular patients.
A Yes.

Q Are you able to help us, would there be any particular sequence in which that happened? Would you wait until the doctor had assessed the patient and clerked them in or might the nurses get on with their assessment?

A Basically I think the nurses would have been first to assess them.

Q When Dr Barton came to clerk the patient in, would you or one of the senior nurses be present?
A Yes.

Q What would happen when Dr Barton first met the patient?
B A Obviously she would introduce herself.

Q Yes.
A Then having read, if we had the notes or transfer letter sent with the patient, having read them, she would then go through the assessment with the patient.
patient.

C Q Were the notes always there?
A Most of the time, but there was the odd time, no, they were not.

Q If the notes were not there, what would there be, if any documentation, relating to the patient?
A There could be a transfer letter. As I say, it did not happen very often. I could not say how many times it did happen.

D

Q I understand. When Dr Barton undertook an assessment, you have said she read the notes.
A Yes.

Q What would she do by way of an assessment?
A Well, obviously, examine the patient, speak to the patient if they were able to reply to
E questions, document it, and write up the medications and things like that.

Q What are you able to tell us about the examination, so far as you recall?
A I always thought it was a pretty thorough examination.

Q Right.
A In my opinion, anyway.

F

Q We have seen notes made by Dr Barton on occasions when she may have seen a patient for the first time. Would you have seen her make notes?
A Yes.

Q Would you have used the doctor's notes, the clinical notes, as part of her documentation about a patient? Would other nurses have looked at them?
G A Yes, we used to have discussions about patients.

Q Once Dr Barton had carried out an assessment of the patient, had clerked them in, would there be discussion with nursing staff?
A Yes. Yes, definitely. Either in handover or, like, if Dr Barton had done the ward round in the morning, we would sit down and go through the morning's work and then discuss the patients and the treatment and whatever instructions Dr Barton had given us. It
H would have been in the patients' notes and also in the nursing notes as well.

Q We have heard that Dr Barton would come in every weekday morning, Monday to Friday.
A Yes.

Q That she would be seeing patients on another ward, Dryad Ward, in the same hospital, and that she would come then to Daedalus Ward.
A Yes.

Q There would have been a nursing handover on Daedalus Ward between the night staff and the day staff.
A Yes.

Q Was Dr Barton there for that?
A Sometimes. She might come in sometimes, but obviously if she did come in we would stop the handover until after she had gone.

Q When Dr Barton arrived, we have heard there would be a discussion between Dr Barton and certainly the senior nurse.
A Yes.

Q Usually yourself.
A Yes.

Q Which patients, of those on the ward that there were, would be discussed?
A Stroke rehab patients.

Q Right.
A Basically.

Q Stroke rehab. There were eight beds, I think you have told us, on Daedalus.
A Yes. Eight, and 14 long-stay.

Q Would there be a discussion about the other 14 patients?
A Yes.

Q If a patient's condition had changed overnight or since Dr Barton had last seen them, would anything happen with regard to that patient?
A Well, it would have been either myself or one of my other senior staff would discuss it with Dr Barton and decide what future treatment was necessary.

Q Would Dr Barton see any or some of the patients on the ward in the morning?
A Yes, if we were rather concerned about them in any way.

Q Would she see particular patients or all of the patients? Which would she see?
A Usually particular patients.

Q She would be guided by you.
A Yes.

Q If she saw the patients, again would you be present while that happened?
A Most of the time, yes.

Q We have heard that for some cases there may be pathology reports or biochemistry reports or investigations to be ordered about various patients.
A Yes.

B Q Are you able to tell us when in her working day Dr Barton would deal with those ----
A In the writing up of them?

Q Yes.
A Usually after the morning round. Or if during the morning I was concerned about any patients at all, I would ring the surgery and either speak to Dr Barton or leave a message and then she would return to do any of the necessary requests.

C

Q The picture we should have, is this right, is that Dr Barton would be in every weekday morning; she would do a ward round, having discussed the patients on the ward?
A Yes.

Q And any concerns that the nursing staff had.
A Yes.

D

Q And she would be updated on the progress of the patients.
A Yes.

Q You have said if there were any concerns later in the day you would contact her.
A Yes.

E Q That would be at the surgery.
A Usually, yes.

Q Would you have any other contact numbers for her?
A I did not have, no.

Q You have told us about clerking in patients at lunchtime or at the end of the morning, F but if Dr Barton was called back to see a patient during the day, were there typical times when she might come, like lunchtime or later in the day? Were there times that she would typically come to see a patient again?
A No, really she would come when we needed her.

Q You have told us about the patients' relatives and that there were conversations with relatives as well. Would Dr Barton have had conversations with relatives?
G A Yes.

Q In what circumstances would that occur?
A Sometimes the relatives would be concerned about their progress or lack of progress. They would sort of question it with us and we would .... or they might even ask if they could speak to Dr Barton re the further treatment, and that is how it would come about.

H Q I am assuming relatives would not often be there early in the morning.

A No, Dr Barton would perhaps say she would see a patient at two o'clock and then we would get back to the relatives and say, "Right, we've arranged a meeting," and that is how it would take place.

Q Would Dr Barton ever be there in the evening?
A Occasionally, yes.

B Q What impression did you have of how busy Dr Barton was in her work on Daedalus Ward at the Gosport War Memorial Hospital?
A Extremely busy.

Q Was that the case over all the time that you were there as sister: four years?
A I think so, yes.

C Q What would you say about her care for the patients and her concern to do what was best for them?
A I think it was beyond question. Her one aim was her patients' welfare.

Q How did she deal with relatives, in your experience?
A I think in a very caring and compassionate way. She was always very honest with them and, as I say, she always put the patients first. The relatives seemed to get on very well
D with Dr Barton. I have never heard anything said about her. She does not suffer fools gladly, but then she was always very polite and very compassionate.

Q It may sound a daft question, but you say she was always very honest with relatives.
A Yes.

Q Can you expand on that? Are there doctors who are dishonest with patients?
E A No. It is very difficult. What I am trying to say is: if the patient obviously was deteriorating and obviously the outcome was going to be death, Dr Barton would tell them but in the nicest way possible. I am not making very much sense, but that is the only way I can explain it.

Q Can I explore it? Might there be doctors who would not say that?
A No, but there are certain ways of putting it to patients' relatives – I think, anyway.
F

Q How was Dr Barton putting it?
A Very well. Yes.

Q If a patient was in need of medication, we know that Dr Barton on occasions would prescribe for patients and it would be written up on prescription sheets.
A Yes.
G

Q Where did Dr Barton get the information from about how a patient was getting on?
A Basically from the nursing staff and from observations of her own.

Q We know that nursing staff completed documentation in the ordinary course of nursing a patient.
A Yes.
H

Q Perhaps changing the bedclothes, changing dressings.
A Yes.

Q And matters of that nature.
A Yes.

Q What would happen to information about how a patient was getting on from, perhaps, the individual nurse who was looking after that patient? Would you know about it?
A Yes. Definitely.

Q Is that how Dr Barton would get the information?
A Yes.

Q Through various individuals on the ward.
A Yes. We always had a handover between night staff and day staff, and then, when the next shift came on at lunchtime, there would be another handover. Also, at the handover between day staff and night staff, any changes during the day or any changes in the patient's treatment was passed on so that everybody knew exactly what was going on.

Q If a patient's condition improved or deteriorated, would you know about that?
A Yes.

Q What about Dr Barton?
A Yes.

Q If a patient was in pain or distress at any time, again would that be information that you would know?
A Yes – or the rest of my senior staff, yes.

Q Can I ask about prescribing pain relief? We know that syringe drivers or a syringe driver was available.
A Yes.

Q Are you able to tell us how many syringe drivers were available on Daedalus Ward?
A I think I had about four. I think.

Q Again, no one expects you at this remove of time to get a precise number or proportion, but were they used regularly or occasionally?
A Regularly, I would say.

Q Right. For what sort of medications.
A Usually analgesia. Midazolam, if they were distressed, and hyoscine if hey had secretions.

Q We have seen prescriptions where a prescription for diamorphine and midazolam, and sometimes hyoscine as well, is written up in an anticipatory way.
A Yes.

Q That a prescription was written up, but that it was not administered in accordance with the prescription at that time.

A No.

Q You are clearly familiar with a prescription written in an anticipatory way.
A Yes.

Q What was your understanding of why that happened?
A I think, basically, if I remember rightly, there was a ward round with Dr Lord, Dr Barton and myself, and the only thing I can think of is that was brought up – the fact that a patient did not get analgesia when they really needed it – and I think it was a discussion between the three of us. I was asked if I approved, and the decision was that if they thought or anticipated that the patient might need stronger analgesia, it was written up beforehand. Because if we called in one of Dr Barton's partners or on-call doctors, they obviously did not know the patients and so, therefore, quite rightly, they were rather loathe to write up the stronger analgesia, and I think that is how it came about. But it was only in anticipation. It was not done on a regular basis.

Q Dr Lord was involved in the discussion about that.
A Yes.

Q You were asked if you approved.
A Yes. Was I happy with the decision, and I said, yes, I was.

Q What would happen over weekends? What doctor would be there or be able to come in to see the patients over the weekends?
A If it was not a weekend that Dr Barton was on call ... If she was on call, she would come in, otherwise we would have to get one of the duty doctors in.

Q How willing were they to come in?
A The partners in Dr Barton's firm, I never had any problems at all with them coming in to see the patients.

Q But you have said they would not know the patients.
A Some of them might, because some of them could have been their own GPs, but, basically, I think I am right in saying that a lot of them would not know the patients or their history.

Q What were the consequences if other doctors were reluctant to prescribe?
A The patients were left in pain, or discomfort.

Q What sort of levels of pain are we talking about?
A That is a bit difficult that, Mr Jenkins. I genuinely do not know how I could answer that one.

Q But you have told us there was a discussion with Dr Lord and Dr Barton ----
A Yes.

Q -- about prescribing in advance.
A Yes.

Q You were asked if you approved, and you did.

A Yes.

Q If, let us say, a syringe driver was written up in an anticipatory way and the patient did not need it at that time, how might it come about that the syringe driver was started and the patient was administered medication in accordance with that prescription?
A Say, for instance, if it was the case that the night staff had reported a patient had had a very poor night and was complaining of pain and was distressed, I would obviously see Dr Barton in the morning and it would be discussed, and either the syringe driver would have been set up soon after, or, as it was written up, I could get a message through to the surgery and the surgery would let Dr Barton know and we would get verbal authorisation.

Q You say if a patient was in pain during the night you would discuss it with the night staff in the morning.
A Yes.

Q And the syringe driver would be set up soon after.
A Yes, after we had discussed it with Dr Barton.

Q Would Dr Barton always be involved in the decision to start the syringe driver?
A Yes.

Q On Daedalus Ward?
A Yes. Definitely.

Q Forgive me, I have had raised eyebrows. That was the answer that the witness has just given. If nursing staff were to start a syringe driver on a range prescribed.
A Yes.

Q At what level would the syringe driver be started?
A Always on the minimal dose.

Q How would the syringe driver be set up? Would it be set up by nursing staff?
A Yes, two trained staff always.

Q When you were asked whether you would approve of anticipatory prescribing, what was your view as to the competence of your nursing staff?
A I had an excellent nursing team – a very good nursing team.

Q If the patient's condition was such that their pain was not controlled or it was considered appropriate to increase the dose of medication within an anticipatory prescription or a range prescribed by Dr Barton, how would that occur if there was to be an increase in the medication?
A Again, I would discuss it with Dr Barton, if necessary, on the morning round, and then maybe the syringe driver was not due until, say, mid-morning, but at the next time this syringe driver was set up with fresh medication we would increase the medication, or if we thought the medication needed to be increased I would phone the surgery and let Dr Barton know, or if we had to do it she always knew exactly what was going on with the increase in it.

Q Would there ever be an occasion when Dr Barton did not know that an increase was being ----
A No.

Q -- given to a patient?
A No, I do not think so. No. Even if it was just that we left a message, we always informed Dr Barton.

Q Yes. From your perspective as sister on the ward, how did that system work of administering medication by a syringe driver, sometimes with a doctor some miles away? How did it work?
A I thought it worked very well.

Q Did you have concerns about it, the way in which people were being treated?
A No.

Q You have told us that Dr Lord had been involved in the original discussion.
A Yes.

Q And that Dr Lord was there for ward rounds.
A Yes.

Q When she was there for a ward round, are you able to help us, roughly how long would that take?
A Anything from two to three hours.

Q How many of the patients on the ward would she see on a ward round?
A The majority of them actually.

Q What would Dr Lord know about the medication being given to her patients?
A The treatment charts were there for her to see and obviously we would report any change in medication at all.

Q Did Dr Lord express any concern about this system?
A No.

Q I want to ask you about a specific patient, Elsie Lavender.
A Yes.

Q The Panel I hope already have bundle B and I am going to ask you to reach in the bundles to your left, there should be one marked B.
A Yes.

Q I am going to ask you to turn towards the back of those pages to 1020. They have several paginations on those pages, but it is about 10 to 15 pages from the end and it should be a page which says "General information".
A Yes, I have it.

Q We have the patient's details written on this, yes.

A We have her details, the details of her next of kin, Alan Lavender, we have the hospital information. Yvonne Astridge is shown as the named nurse.
A Yes, she was my senior staff nurse.

Q An indication of the ward, the fact that it is Dr Lord the consultant and that you, Sister Joines, are the ward manager.
A Yes.

B

Q If we go over the page, this is part of the summary which indicates that this lady was seen on 22 February 1996, which we know was the day when she was admitted to Daedalus Ward.
A Yes.

Q There is an indication in the entry at the top of this lady's age and her medical
C conditions and the diagnosis that it was probably a brain stem cerebrovascular accident that she had had on 5 February 1996. There is a record that she was seen by Dr Barton, there are further entries down the page, some of which are made by you.
A Yes.

Q The first entry by you, I think, is made the following day. Just underneath where it is recorded "Seen by Dr Barton" on the 23rd.
D A Yes.

Q You have written, I think,

"Pathology phoned. Platelets 36, query too small sample. To be repeated Monday."

A I think, working it out, that must have been a Friday and obviously they wanted a
E repeat blood taken on Monday.

Q This was an investigation that would have been ordered at the hospital by Dr Barton.
A Yes.

Q You have written "Dr Barton informed", meaning about the small sample.
A Yes.

F

Q "Will review mane."
A Yes.

Q You have signed it "Sheila Joines".
A Yes.

G Q The next entry is the next day, "Pain not controlled properly by DF118" – that is dihydrocodeine.
A Yes.

Q "Seen by Dr Barton. Boarded" – that means written up for.
A Yes.

H Q Morphine sulphate tablets, 10 mg bd, twice a day.

A Yes.

Q I think if we go over the page we are moving on, plainly, in the chronology. The following day now, 25 February, I wonder if I could ask you to read it to us.

A "Appears to be in more pain. Screaming 'my back' when moved but uncomplaining when not. Son would like to see Dr Barton."

B

Q Have you recorded the following day that the patient was seen by Dr Barton?

A Yes.

Q MST you have put arrowed, 20 mg bd.

A Increased to 20 mg bd.

C Q "She will see Mr Lavender at 2.00 pm this afternoon. I did phone him". Is that right?

A Yes.

Q "Blood sugars 20" and then an arrow.

A Yes.

Q What does that mean?

D A That her blood sugars were up. She was a very unstable diabetic I believe.

Q "She will see Mr Lavender at 2.00 pm this afternoon."

A Yes.

Q How was that set up because it reads like an appointment.

A It was, yes. Mr Lavender had asked me if he could speak to Dr Barton, I have relayed E that to Dr Barton, she said to me that she would see him at two o'clock and then I would have phoned Mr Lavender and told him that Dr Barton was quite happy to see him. As I say, I can remember nothing about this patient but, having read this, both his wife and he were seen by Dr Barton and I was present at the time.

Q You have looked at the entry for 14.30 I think.

A Yes.

F

Q After the time that she was due to see him.

A Yes.

Q Are you able to help us? Were you present for the talk, does your note help you?

A I was there, yes.

G Q You have written:

"Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained."

A Yes.

H

Q Who would have explained that?
A If Dr Barton had seen him, Dr Barton. When it was a case that the patient was going – that we were thinking of putting a patient on a syringe driver because their condition had deteriorated, Dr Barton or myself or one of my senior trained staff would see the relatives, we would explain why we were putting them on a syringe driver, we would explain what was going into the syringe driver and what the effects of that were, like diamorphine for pain, midazolam to calm them down, and then inevitably they were told that it would lead to a peaceful, dignified, pain-free death. Then and only if the relatives had agreed to this would we go ahead; we never ever put a syringe driver up without the relatives consenting to it.

Q I understand. We have heard that from other nurses on Daedalus Ward. If we go on we see that at 14.40 hours you have made another entry.
A Yes.

Q Is it "Air mattress needed changing"?
A Yes, Pegasus mattress for relief of pressure areas, pressure sores.

Q "MST 10 mg given" is it "prior to moving onto Pegasus mattress"?
A Yes, prior to that. Obviously she was complaining of pain on being moved so we would have given her morphine before moving her to try and make it a little bit more comfortable for her.

Q I do not think there are any other entries by you on that page lower down.
A No.

Q But there are entries to suggest that as the days went on Mrs Lavender's pain was not controlled and she was still complaining of pain and having extra analgesia. Doses were increased and on 5 March her pain was uncontrolled, she had a very poor night.
A Yes.

Q And the syringe driver was commenced on 5 March 1996. If you had been working during that period of tine and not on holiday would you have been aware of the change in condition of this patient?
A If I had been working yes of course, because by looking at this if the syringe driver was commenced at 9.30 Dr Barton would have informed, when she came round first thing in the morning, and the agreement would have been that the syringe driver could be set up, but we would also have told the relatives which I think Margaret says she did.

Q We heard from Mr Lavender the son; we did not hear from him directly but we heard a statement from him read and we heard his evidence at the inquest summarised.
A Yes.

Q The evidence that he gave was to the effect that he had several conversations with Dr Barton; we only see one of them referred to in the nursing summary that you and I have just gone through.
A Yes.

Q Are you able to tell us, would the nurses aim to make a note of conversations that they may have with relatives?
A If they had had the conversations they would have been recorded.

Q Would the nurses aim to make a record if Dr Barton had had a conversation with the relatives?
A That would have also been recorded. about

Q If Mr Lavender is right there is not an indication that there were several conversations here; do you think it may be that things were not always recorded that could have been?
A I like to think that everything was recorded, Mr Jenkins, yes.

Q Mr Lavender's recollection of the conversations that he had with Dr Barton was that she told him, very bluntly, firstly "You will have to get rid of the cat". You do not remember this lady but we heard that she had a cat that she loved but no one else loved, it was a feral cat and used to attack other people.
A I believe so, yes.

Q Mrs Lavender was very concerned about it and attached to it. The other thing Mr Lavender recalls is Dr Barton saying rather bluntly that his mother had come here to die. You are shaking your head.
A I find that very difficult to believe. I have never ever heard Dr Barton talk to a patient's relatives in that way or in that sort of tone, I am sorry.

Q Thank you, I am not going to ask you any more about that patient but I would not put the file too far away because others may ask you about that. It follows from the documents that we have just looked at that nurses are making entries of patients' complaints of pain.
A Yes.

Q Or if they are distressed.
A Yes.

Q We know about diamorphine; in what circumstances was diamorphine or morphine administered to patients on Daedalus Ward?
A Do you mean in oral form or via a syringe driver?

Q We know it can be given in different forms – Oramorph, morphine sulphate tablets.
A Yes.

Q Dihydrocodeine is an opiate as well.
A Yes.

Q Or diamorphine via a syringe driver.
A Yes.

Q What was diamorphine in a syringe driver given for?
A To control pain.

Q Was it given in other circumstances, was it given for other sorts of condition?
A No, basically for pain relief.

Q I understand. Thank you very much, Sister Joines; would you wait there because you may be asked further questions.

THE CHAIRMAN: Mr Fitzgerald.

MR FITZGERALD: I do not know whether the Panel is considering giving the witness any break or whether to just get on.

THE CHAIRMAN: You have been giving evidence for just short of an hour.
A I did not realise.

Q It can sometimes seem to go very fast but we also are very aware that it can be very draining and debilitating, and our loose rule of thumb is that at around about the hour mark we would normally take a break. If you would like to take a break now you are absolutely entitled to have one; if you really feel that it has gone very fast and you are still tip-top fresh you might wish to continue. It is a matter for you.
A I am quite happy to carry on.

THE CHAIRMAN: Then we will carry on. We will not go beyond half an hour more or so in any event, we will take a break for lunch then.

Cross-examined by MR FITZGERALD

Q Mrs Joines, just to clarify a few things about your position, your role, you were the ward sister for Daedalus Ward for the period that we are concerned with in 1996.
A Yes.

Q You left in January 1997 having been at the hospital for almost 20 years.
A 24 years actually.

Q Was that effectively your last full-time position on a ward?
A Yes.

Q And as you explained you were 69 in 1997, is that right?
A No, I was 60.

Q I blame myself, I am sorry. You had worked with Dr Barton by that time for about ten years or so.
A Yes.

Q She was your GP.
A Yes, she still is.

Q She still is.
A Yes.

Q Is it fair to say that when the investigations started about what had happened on Daedalus Ward and Dryad Ward, particularly in relation to Dr Barton, you had a fairly clear view on that.
A I had actually left by then.

Q Yes, but when you were spoken to by the police about what had happened.

A Yes, I beg your pardon, yes.

Q You told them clearly how you felt about that.
A Yes.

Q You said this in one of your police statements:

B "In my opinion, as a result of the current investigation, many people will not get the pain-free, dignified death they would otherwise have had."

A Yes.

Q Because your view was that the investigation itself and what was going on would cause people to be more reluctant to prescribe.
C A Yes, definitely.

Q Diamorphine in particular. Your position has always been, I think, that diamorphine and the syringe drivers were never inappropriately used in your experience.
A I do not think so, no.

Q That remains your position today.
D A Yes.

Q In fact the only patient of ours that we are dealing with who you dealt with was Mrs Lavender.
A Yes, that is correct.

Q And you have been referred to just a few notes today.
E A Yes.

Q In fact, is it right that you do not remember her?
A I do not remember. Even when I saw Mr Lavender at the coroner's court I just do not remember seeing him before.

Q You do not personally remember the conversations, as to what they were.
F A No, only from what I have written in the nursing notes.

Q Quite, you are reliant entirely on the notes.
A Yes.

Q Also in relation to her care your involvement – apart from of course the fact that you were the sister on the ward – seems to be limited to a few early notes.
G A Yes.

Q The last one, I think it is right, is in relation to the conversation about the syringe driver with Mr Lavender.
A Yes.

Q You probably know that it was not until a number of days later that the syringe driver
H is actually started.

A Yes.

Q And you did not have any involvement in that.
A No.

Q We will come back to look at Mrs Lavender briefly, but that is, I am sure, a helpful overview.
B A Right.

Q You spoke a little bit about the syringe drivers and Dr Lord knowing that Dr Barton would prescribe syringe drivers in advance.
A Yes.

Q In an anticipatory way.
C A Yes.

Q That was not any sort of written policy or written protocol.
A No, it was not and I think it was just on Daedalus Ward – as far as I know it was never written down anywhere.

Q You described it as simply being on a ward round ---
D A After the ward round, yes, we used to sit and discuss the patients, various aspects, and that is when it came up.

Q And it was discussed that this was something that Dr Barton would do and it was something Dr Lord was comfortable with.
A Yes, she was fully in agreement with it.

E Q The question of the range of diamorphine that Dr Barton would prescribe on one of those prescriptions, was that discussed, or was it simply the principle at this time?
A I think it was just the principle; I do not remember dosages being discussed at all but then, as I say, I genuinely do not remember.

Q Very well. It may follow that you do not know the answer to this question but let me just ask it anyway. If Dr Lord's view was that she was not aware that Dr Barton would
F prescribe a range of, say, 20mg to 200 mg; that she was not aware of a range that broad, does that accord with your recollection, or can you simply not say at this stage?
A I genuinely do not think I can say. I do not think we ever discussed dosage or range at all.

Q Do you remember dose ranges of 20 to 200 mg of diamorphine being prescribed by Dr Barton?
G A I seem to remember, and I honestly cannot say this with all truthfulness, but I think that the range would vary from 80 to 200 mg of diamorphine, 40 to 80 mg of midazolam and the highest was 0.06, as far as I can remember. That was the basic and we always started off with the minimum dose.

Q When you say that was the basic, can you just explain what you mean? Do you mean that this was a standard form of prescription, a standard dose range that she would use?
H A To a certain extent, yes. I think I am right in saying that.

Q Again, please do say if you cannot be sure or be clear about it, but an 80 mg starting dose on a syringe driver, from one point of view, might seem quite high. Are you saying that that would be the minimum dose that would then be started for each of those patients?
A As far as I can remember.

Q At what point would that sort of standard prescription be written for a patient, in an anticipatory way? Are we talking about on admission or after that?
A I would say after, unless of course the patient – because some of the patients were admitted in quite poor condition, to be quite honest, and it would be discussed, but obviously if the patients started to deteriorate then it would be considered and the relatives would have been seen, because we did nothing without the relatives' agreement.

Q How far in advance, then, are we talking about for such an anticipatory prescription?
A I honestly do not think I could say off the top of my head, I really do not. It was not a matter of weeks or anything like that, but I genuinely could not answer that question.

Q What was the purpose of prescribing in an anticipatory way for a syringe driver like this?
A Basically, as I explained before, that Dr Barton was not always there and if you did call in one of the partners or an on-call doctor, they obviously did not know the patient's history and therefore were rather reluctant to prescribe stronger analgesia, and that was the way that we saw to it that the patient was not left in undue pain.

Q You have also, in your evidence, said that you would only set up a syringe driver or increase a dose having spoken to Dr Barton just before.
A Hopefully, yes.

Q Was not the purpose of the prescription to enable the nurses to set up the driver or increase the dose at their discretion when Dr Barton could not be contacted?
A We could but we always did try to let Dr Barton know what was going on and get her permission.

Q Yes, you always tried, but that would not always be possible.
A There were times when obviously we could not get hold of Dr Barton, so we would increase it a bit but we would always leave a message for her to let her know what was going on.

Q On a weekend, for example, if Dr Barton is not on duty, is it right that you would not be talking to her over that weekend.
A No, we would not.

Q It may well be that you would be reluctant to call an on-call doctor because they may not be able or willing to deal with the patient in a way that the nurses thought was appropriate.
A Do you know I cannot remember. I am ever so sorry, I honestly cannot remember.

Q Not at all. It is not a memory test and if there are things you do not remember, then of course you must just say. But you were explaining that one of the reasons why it was

necessary to have these sorts of prescription was because other doctors may not be willing to write the prescriptions that you thought were needed.
A Definitely, yes.

Q So this enabled the nurses to do what they thought was appropriate, having got the prescription from Dr Barton, without having to trouble another doctor.
A To a certain extent, yes, but it was always discussed among the trained staff. It was never a decision made by just one nurse.

Q No. Can you just help with the question of where the starting dose, how that would be decided? Was it always the minimum dose?
A Always the minimum dose, yes.

Q Why would that be important, please?
A We always used to start on the minimum dose because if that was sufficient we had no need to increase it at all.

Q Why start low rather than pick a higher dose?
A I do not think I can answer that question.

Q You may be able to answer the question, what are the dangers of choosing too high a dose of morphine?
A You could give the patient an overdose. I am sorry, I realise what you mean now.

Q You were always happy with the way that Dr Barton prescribed opiates, were you?
A Yes.

Q Did you believe that she was doing that prescribing by reference to any guidelines, professional guidelines that she had?
A I honestly do not know.

Q Were you aware of any guidelines for prescribing that existed?
A I knew of the Wessex Protocol, I think it was called, re analgesia. I had never actually seen it but I did know of its existence, yes.

Q What significance did you believe it had on the ward for the medical staff?
A I thought they would be guided by it.

Q Were you aware at the time about how one would convert from a person on oral morphine to diamorphine?
A In what way?

Q I am sorry, no doubt you had numerous occasions when a person who had been able to take oral medication and oral morphine became unable to.
A Yes.

Q So they had to be changed from oral morphine to syringe driver.
A Yes.

Q Were you aware at the time about what the conversion rate was between an oral dose to a dose on a syringe driver, or would that be a question for the medical staff?
A I would have thought that would be more for the medical staff, but I do know the conversion, yes.

Q You know the conversion anyway?
A Yes.

Q Again, I am sorry, it is not supposed to be a test but can you just help us with your understanding?
A If you were, say, giving 10 mg of morphine, that would convert to 20 mg of diamorphine. It was twice, I think.

Q It may be that you have just expressed yourself in the wrong way and I just want to make sure. Do you mean that if a person was on oral morphine, to get to diamorphine you would double it, or do you mean it is the other way round?
A It is the other way round. You have got me confused now, I am not quite sure.

Q I am sorry, it is difficult especially when you are on the spot, so to speak, so do not worry. Effectively your understanding was that it would be half to get to the diamorphine level.
A I think so.

Q Just to move on to the subject of conversations with family, you have mentioned already that you would never start a patient on a syringe driver without a relative's consent.
A No.

Q Why was that important?
A Obviously the outcome inevitably was going to be death. You would have to get the relatives to agree to this, otherwise what would be the point. They had to agree, and all the time I had dealings with syringe drivers, only one patient's relatives ever asked. It was a lady. I can remember her name, Mary. She was a bilateral CVA. They were a very devout Catholic family. She had a very bad chest infection. The relatives were seen by Dr Barton and they requested that she was treated with antibiotics, which she was, but inevitably she went on the syringe driver. So we would never ever put a syringe driver up without the permission of the relatives.

Q Was that a view that Dr Barton shared with you?
A I would like to think so.

Q In your dealings with her, how receptive would she be, how receptive was she to relatives potentially expressing a different view as to whether or not someone should go on a syringe driver?
A There were never any exceptions at all. She was always very easy to talk to from the nursing point of view and from the patient's relatives point of view.

Q What if a patient's relative said, "No, I do not want my relative to go on a syringe driver. I want you to do something else"?
A We would not have put them on a syringe driver. We would have gone along with them. Like I said with this Mary, they wanted antibiotics, so she was given a course of

antibiotics. We would never, unless the relatives wanted it, have put a syringe driver up. The relatives always knew.

Q When you were describing Dr Barton's manner, one of the things you said was that she did not suffer fools gladly.
A Yes.

Q Can you just explain what that meant, please?
A She was a very honest person. She expected people to be honest with her and she was honest with them. It is as simple as that.

Q When you say she did not suffer fools gladly, what do you mean in terms of her manner?
A It is rather difficult. I am trying to think of a for instance. It is so stupid, my mind has just gone a blank at the moment. She would be very open when she was discussing things with patients' relatives and if she thought there was something they should know, she would tell them, not to the point of being rude or anything like that, but all along the patient's relatives always knew exactly what was going on with their treatment, etc. Does that make sense?

Q Yes. No doubt there must have been relatives who did not like what they were being told sometimes.
A There were some because of the expectations they were given when the patient was admitted, but it never caused a problem, if you know what I mean.

Q Another witness has said that she was a woman who called a spade a spade. Do you think that is fair?
A Yes, I do.

Q Do you think she could ever have given the impression to relatives of being somewhat brusque?
A I do not think so, no. I never found that.

Q On the subject of patients being transferred to your ward, you were asked a number of questions about people who were coming there for rehabilitation, it would say on the notes.
A Yes.

Q You made clear that there were times when that may have been written but they simply were not fit for that.
A Yes.

Q Others, presumably, could be.
A Oh yes.

Q Or at least they had the chance of it.
A Yes.

Q Would it depend entirely on an individual assessment of that patient as to what their capabilities were?
A Yes, I think so.

Q For those who had the chance of rehabilitation, would you want to do your best for them?
A Yes, of course.

Q It might sound a stupid question, but please forgive me for asking it. You are obviously not saying that one could simply write off all the patients coming to your ward.
A Oh no.

Q It would be vital for each of them to be assessed individually to see what treatment was appropriate.
A Yes.

Q What rehabilitation could take place.
A Yes.

Q And to give them a chance if they needed it.
A Of course, yes.

Q Is it right that if a patient came to you and it was apparent to you that they were still in need of acute treatment, or they deteriorated from the transfer so that they needed acute medical treatment that you could not provide, they could go back to the acute hospital?
A I never heard of that happening.

Q Did you never hear of it happening because it was never necessary?
A I think basically the patients that we had in, the majority of them were really not fit for rehabilitation. I cannot say that any of them needed to go back for the acute. I think that is what I am trying to explain. They either progressed and we maybe did get them out, but the majority of them I am afraid either went into a long-stay bed or they actually died.

Q As we have discussed already, the individual assessment of the patient would be vital to determining that patient's progress, in a sense, to determine how they would be treated.
A Yes.

Q Which included how the nurses would deal with the patient in terms of what they would try in terms of rehabilitation.
A Yes.

Q And in terms of how pain relief would be approached.
A Yes.

Q Obviously there was a nursing assessment conducted as well as Dr Barton's medical assessment.
A Yes, there was.

Q But the nurses in terms of how they approached the patient would take their lead from the clinician, would they not?
A To a certain extent, yes.

Q Would Dr Barton's assessment set the tone of how the patient was to be treated?

A Yes.

Q In terms of whether a patient was medically well enough for rehabilitation or the pain relief that would be required, are those medical, clinical matters?
A Yes.

Q You have already helped the Panel with the changing patients, the increased workload at the ward over the time you were there.
A Yes.

Q You said that under the circumstances Dr Barton and Dr Lord coped very well, you thought.
A Yes.

Q Forgive me for a stupid question, but you are not saying that the treatment that was given by Dr Barton to any of your patients was ever inappropriate.
A I do not think so, no, definitely not.

Q You are not saying that she could not treat them appropriately?
A No.

Q Was there anything that suffered, for example, in terms of note-keeping?
A I do not think so because Dr Barton's main aim was the patient's welfare. Obviously if we did a ward round with Dr Barton, whether it was myself or my senior trained staff, Dr Barton would have discussed it with us. It did not necessarily mean she would have put it in the medical notes, but the nurses would have put it in the nursing notes, so, although Dr Barton might not have recorded it, we were fully aware of what was going on because it had been discussed. And nine times out of ten it would have been written in the nursing notes.

Q In terms of Dr Barton's notes, for example, were they in any way, in your view, deficient?
A I do not think so, no, personally.

Q Did the nursing notes suffer in any way as a result of the increasing workload?
A No. I must point out I had an excellent team of nurses. I am afraid I am a bit old school and I like to think my standards were quite high and my nursing staff knew of this, and if there had been any backlash from this, they would have either come to me or gone to management and it would have been discussed, but I never found that the extra workload affected my nurses' care in any way at all.

Q We have seen in this case, in relation to Elsie Lavender, that the conversation that is recorded with the son and Dr Barton is not recorded by her but is recorded by a nurse.
A By myself, yes.

Q In the nursing notes.
A Yes.

Q That is obviously an example, is it, of something where she has been heavily involved but there is no note by her personally.

A I did not see the note, so I can only go by what I have written. But I was there, so obviously I knew what was said.

Q Can we lastly and very briefly consider Elsie Lavender. You have already made clear you have no recollection of her.
A No, I honestly have not, no.

B Q We have a document which is a chronology which basically summarises the notes. It may be the simplest way of dealing with this. In the file marked "Chronologies" in tab B I hope you will find the chronology that is headed Elsie Lavender.
A Yes.

Q If you go to page 10, I hope you can see how the document works fairly quickly. There we are dealing with 26 February 1996.
C A Yes.

Q Which is the day of the note that you made.
A Yes.

Q About the conversation with Mrs Lavender's son. You can see that the first entry there is relating to review by Dr Barton. That is her note that has been written down.
D A Yes.

Q About the family being seen: "well aware of prognosis and treatment plan." In terms of what I said about the conversation with the son, I was not quite accurate in saying there is no note; there is a reference there. It may be that the nursing note is a bit more full in terms of what is described, but there is that note. Your note is the one just underneath it.
A Yes.
E

Q You have already been taken through that. Can you see on that same note is the fact that the patient was seen by Dr Barton and the MST – which is a slow release oral morphine pill – is increased to 20 mg twice a day.
A Yes.

Q At that point the prescription is for 40 mg of oral morphine a day.
F A Yes.

Q If you go over the page to page 11, we can see that the first entries on that page in colour relate to the drugs that were either prescribed or given that day.
A Yes.

Q Again please take as long as you need to read it and understand it. We can see that
G the first bullet point deals with that MST. We start off with a 10 mg dose being administered at six o'clock in the morning.
A Yes.

Q But then that is discontinued and, in accordance with the note that had been made, 20 mg twice a day was then started.
A Yes.
H

Q That was first administered at ten o'clock in the evening. It is that same day, and obviously following on from the conversation with the son, that the syringe driver drugs are prescribed.
A Yes.

Q Those are diamorphine, midazolam and hyoscine. You can see, I think, that the diamorphine range that is prescribed is 80-160 mg.
A Yes.

Q And the midazolam is 40-80 mg. On the basis of those prescriptions, the minimum dose of diamorphine that you could have given was 80 mg.
A Yes.

Q With midazolam a starting dose of 40 mg.
A Yes.

Q On the conversion rate that you have spoken about with oral morphine to diamorphine, for a person who was on 40 mg of oral morphine that day, then the direct conversion would be 20 mg of diamorphine if one were going to do the same thing.
A This is where I am getting confused. I am sorry.

Q I am sorry. It is very important that you are not, so let me take it slowly. She was prescribed this day 40 mg of oral morphine each day.
A Yes.

Q On the conversion rate we have spoken about, that would be equivalent to 20 mg of diamorphine.
A Yes. Yes, I think so, yes.

Q Right. Here, though, we have a minimum prescription for diamorphine of 80 mg. You have given evidence about always having been comfortable, happy, with the prescribing that Dr Barton carried out.
A Yes.

Q But given that conversion rate, does it in any way surprise you or strike you as in any way unusual with your experience on the ward?
A No, because I always thought Dr Barton obviously knew what she was writing up, and I have never had any question with the amount we have ever given.

Q On a day when the patient only needed 40 mg of oral morphine, how would it be possible to know that she would need a minimum dose of 80 mg of diamorphine? How could a doctor know that?
A I am sorry, I do not think I can answer that question.

MR FITZGERALD: Very well. Those are all my questions. Thank you very much.

THE CHAIRMAN: Mr Jenkins, I anticipate that you will have some questions.

MR JENKINS: Indeed.

THE CHAIRMAN: In which case, I would suggest that you put them after the break.

MR JENKINS: I understand.

THE CHAIRMAN: We will take a break now for lunch. We will return at two o'clock. In that hour you are free to leave the building. Please do not discuss the case with anybody and please be back here for two o'clock.

(The luncheon adjournment)

THE CHAIRMAN: Welcome back everyone.

Mrs Joines, you are of course still on oath.
A Yes, of course.

Re-examined by MR JENKINS

MR JENKINS: Sister Joines, I am going to take you back to Elsie Lavender and the medical records. You have been shown a summary. I am going to take you to the documents themselves. Would you turn, please, to page 995 in bundle B? I hope you have a prescription sheet where, under the "As required prescription" the first drug that is written up is dihydrocodeine.
A Yes.

Q It is dated 22 February 1996.
A Yes.

Q And we can see that it is signed by Dr Barton just underneath the date. From the boxes to the right, we can see that it was given on a number of occasions. On 22 February, a couple of times. On 23 February, it would appear – the third row down on the left-hand side and the fourth row down on the left-hand side. Then to the right of that, at the top, on 23 February and again on 23 February. Do you have all that?
A Yes.

Q Are any of those signed by you?
A Yes. 23.2.96 at 1800 hours, two tablets.

Q Below those two entries there for 23 February, there is one entry for 24 February.
A Yes.

Q And then there is a jump, I think, to 3 March.
A Yes.

Q The 22 March is the day that drug is written up and it is the day when it was first given on a couple of occasions. Can I invite you to turn to page 975, Dr Barton's clerking in note.
A Yes.

Q For Mrs Lavender. "Transferred to Daedalus Ward GWMH." There is reference to the history. The Panel have had this read to them on a number of occasions. In the penultimate line: "Assess general mobility."
A Yes.

Q "Then:

B "? Suitable rest home if home found for cat",

and she has written her initials after that. If we go back to page 995 and look at the page after, page 996, we can see that there is a whole series of further drugs written up as a regular prescription for Mrs Lavender and I think all of them on that page were written up on 22 February, the day of admission.
A Yes.

C

Q Digoxin. Co-amilofruse. Insulin for her diabetes. Thiosulphate. And there is another drug, which might be an inhaler, towards the bottom of the page.
A Yes.

Q If you go over to the next page, page 997, you can see another drug which may be an inhaler.
D A Yes.

Q Salbutamol, also written up on 22 February.
A Yes.

Q That was the pain relief that was prescribed and administered for Mrs Lavender on the day that she was admitted.
E A Yes.

Q Dihydrocodeine. We have seen already from page 995 that it was given again the next day, on 23 February.
A Yes.

Q On a number of occasions. If you are able to flick back to page 975, we can see that
F Dr Barton has made an entry for 23 February as well.
A Yes.

Q You will need several fingers. You and I have already looked at one of the pages further on. Page 1021 is the one we have looked at.
A Yes.

G Q We have seen the entry for 22 February, we have already seen the entry for 23 February, and where it says "Seen by Dr Barton" on 23 February. .
A Yes.

Q We looked at your entries for 23 February and indeed your entry for 24 February.
A Yes.

H Q We see:

"Pain not controlled properly by DF118" –

dihydrocodeine, we have said it was. "Seen by Dr Barton – boarded" – meaning written up – "for morphine sulphate tablets."

We know that that was written up, and we have that prescription written up at page 997.
A Yes.

Q It is in the middle of the page at page 997: "MST 10 mg". The date when it is written up is 24 February.
A Yes.

Q Again if we look just above the morphine sulphate tablets there, we can see trimethoprim which is a drug given for urinary tract infections.
A Yes.

Q Which Dr Barton has written up on 23 February.
A Yes.

Q When she saw Mrs Lavender then. We know that the pain was not well controlled because we have looked at other documentation. We have looked at page 1022.
A Yes.

Q "Appears to be in more pain." And "Son would like to see Dr Barton." We know that on 26 February Dr Barton did see the patient that day and the morphine sulphate tablet was increased.
A Yes.

Q Up to 20 mg twice a day.
A Yes.

Q We know that later that day, again from you entry at page 1022, you gave a PRN dose of morphine sulphate tablets.
A Yes.

Q In anticipation of moving Mrs Lavender ----
A Yes.

Q -- to the new mattress. That is 26 February and if we look for the prescriptions relating to 26 February, we can see at page 995 that Mrs Lavender was not getting dihydrocodeine then.
A No.

Q As we have agreed, it stopped on 24 February. We know that she had been receiving morphine sulphate tablets which had been started and then increased to 20 mg a day. On 26 February we can see Dr Barton writing up diamorphine via syringe driver.
A Yes.

Q As an anticipatory prescription.

A Yes.

Q It was not needed at that point and it was not given at that point.
A No.

Q If you still have your finger in page 975, we have Dr Barton's entry for 26 February,

B "Not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress."

And that is something you had provided.
A Yes.

Q "Institute SC [subcutaneous] analgesia if necessary."
C A Yes.

Q What would you anticipate that would mean if subcutaneous analgesia was to be introduced? Would you anticipate that would be the same dose or an equivalent dose to what she was on?
A You mean in the syringe driver as compared to what she was taking orally?

D Q Yes. If subcutaneous analgesia is necessary, Dr Barton is suggesting it should be instituted by that note.
A Yes.

Q She was on, certainly, 20 mg of morphine sulphate tablets twice a day and PRN medication as well. If it became necessary to start the syringe driver would you anticipate that would be at an equivalent dose of what she was on or not?
E A I would have said slightly increased.

Q I understand. If we follow what actually happened with Mrs Lavender, we find that the medication was continued – she continued to get the morphine sulphate tablets for a number of days and we see that on page 997.
A Yes.

F Q There is morphine sulphate tablets 10 mg in the middle of the page.
A Yes.

Q That has gone on until the 26th in the morning, and then someone has put a line through the morphine sulphate 10 mg prescription.
A That was me.

G Q And there is a prescription for morphine sulphate tablets 20 mg and we see that that was given in the evening of the 26th.
A Yes.

Q Dr Barton has signed as the prescriber, and that continued to be given for a number of days until 3 March. If we go back to your notes we can see at page 1022 that by 4 March she is complaining of pain. She was having extra analgesia as required, including Oramorph, and
H the tablets were increased to 30 mg twice a day.

A Yes.

Q We have got that at page 992 I think.
A Yes.

Q But the patient's pain was uncontrolled according to the nursing records – we have seen that at page 1022 – on the 5th, and I think it was at that time that the syringe driver was written up by Dr Barton. Can I take you back to the prescribing records and ask you to look at page 991.
A Yes.

Q The diamorphine was written up and it is dated 5 March 1996.
A Yes.

Q And given. Are you able to help us whether you were involved in the administration of the syringe driver?
A No, my signatures are not there at all.

Q You were asked about the syringe driver being written up – what would you say about the history of Mrs Lavender's pain before any syringe driver was actually instituted?
A According to the notes it was obviously uncontrolled in spite of having the MST increased.

MR JENKINS: Thank you very much, that is all I ask.

THE CHAIRMAN: Mrs Joines, we have now reached the point when members of the Panel, if they have any questions of you, have the opportunity to put them. Do not look so alarmed; let me see first of all if they have any. Mr William Payne is a lay member of the Panel.

Questioned by THE PANEL

MR PAYNE: Good afternoon.
A Good afternoon Mr Payne.

Q I have one question for you. You have given us some background into the system for the instigation of the syringe driver and the anticipatory prescriptions.
A Yes.

Q You told us – correct me if I am wrong – that it was done predominantly with consultation with Dr Barton before you instigated the syringe driver.
A Yes.

Q But on occasions you would contact her either by phone or in some form immediately after it had been started, am I right?
A Yes, sir.

Q But you would still contact her.
A Of course, yes.

Q This was put in place in case the patient needed it to control the patient's pain.

A Yes.

Q What happened with that anticipatory prescribing regime when the doctor was on annual leave, say she was away for a fortnight?
A We would obviously go to one of her partners preferably.

Q For what?
B A To ask permission again if we could give it. Although it was written up and we were – I have got to be careful how I say this. Although we could have given it we would still like a doctor's permission to have given it.

Q Yes.
A Obviously if the doctors had come in and read the notes they would have seen that Dr Barton had said that this could be written up and it could be given when it was necessary.
C

Q You had no problems with the doctors doing that.
A No.

Q The doctors never queried that or refused to do it.
A No, sir, never.

D Q So there was no difficulty with the other doctors then.
A No.

Q It is just that you said that it was done because some doctors were not happy about writing it up.
A I meant the initial writing up of it, not when it was already written up. Say, for instance, Mrs Lavender was on dihydrocodeine, if I had asked one of her partners or the duty
E doctor they would be a little bit reluctant to write them up, actually write on the prescription chart, whereas when Dr Barton had already written it up we were just getting their permission to go ahead with what Dr Barton had already written. Does that make sense?

Q Yes, it does and it does clear things for me; thank you very much indeed.
A Thank you.

F DR SMITH: You were asked earlier why you would ask the family before you started the syringe driver and you answered more or less this, "Obviously because the outcome was inevitably going to be death". Would you like to just explain what you meant by that?
A I am trying to think how to explain this. Obviously when Dr Barton had seen the relatives and explained and when you do put up a syringe driver of diamorphine et cetera inevitably the end result is a peaceful, dignified, pain-free death. We would always let the relatives know of this because sometimes the relatives have no idea that their patients have
G been admitted to my ward, they thought for rehabilitation, when actually the outcome could be death. Does that make sense?

Q Yes, but why inevitable?
A Because usually the patients are in such poor condition anyway. They are in a lot of pain, they are distressed, so you give them the appropriate medication. Diamorphine can suppress the respiratory system et cetera so inevitably it could end in death.
H

Q So whenever a syringe driver was started the patient then died, is that what you are saying?
A A lot of the time, yes. I have known of cases, not personally, where patients have had syringe drivers put up on a temporary basis but as far as I was concerned on my ward when they did have syringe drivers put up it inevitably resulted in death.

Q Did you ever question that?
A No, no, because of the patient's condition beforehand. To my way of thinking every patient is entitled to a dignified, pain-free, peaceful death and if that means putting up a syringe driver I agree with it. I have never had any reservations, and I have put up hundreds of syringe drivers over my 24 years at Gosport War Memorial and I have never once regretted any of it. It is so nice to see the relatives seeing the patients calm and peaceful; it relieves their state of mind as well and most importantly the patient.

Q Some relatives have said that they asked for the syringe driver to be either reduced or stopped.
A Not on my ward, I am sorry, sir, they have not. I have never ever had a patient's relative query, never.

Q What would have been your response if they had?
A If they felt strongly enough of course we would have consulted Dr Barton and we would have stopped it. We never forced them to have a syringe driver put up on their relatives but I have never ever had anybody ask that of me and I have never had anybody query the treatment we gave the patients.

DR SMITH: Thank you.

MRS MANSELL: Going back to pain relief for patients, if we look at Elsie Lavender we have an assessment by Dr Tandy and an assessment by Dr Lord. Both of them are of the view that she should be given a chance for rehabilitation.
A Yes.

Q May not go back home, not to become independent with rehabilitation. Then when she arrives on the ward you are attending to the pain and giving analgesia, but then we see a reference on 25 February and "Appears to be in more pain, screaming 'My back' when moved." When would you think that there may be a cause for that pain that needed to be assessed?
A We would have realised it straightaway and that is why she was referred to Dr Barton, because she had the pain. Is that an answer?

Q What you are saying is that you would have been content to have moved down the route of analgesia to control the pain without questioning whether there was another reason for that pain if Dr Barton did not see another reason.
A I am sorry, if a patient was in pain they obviously needed pain relief.

Q Sometimes with very elderly frail people pain is a product of the aging process.
A Yes, I agree.

Q Sometimes it can be caused for other reasons. With this patient she came in and she had had an injury and one would have expected the pain, maybe, to have been getting less.

A Yes.

Q But here we suddenly have, several days later, that she is actually screaming with pain.
A Yes, it was my entry.

Q That is why I was asking about it. What was the cause of that pain, what was the cause of it getting worse?
A I do not know, that is why I referred it back to Dr Barton.

Q And so pain often led to analgesia rather than investigation.
A Not necessarily. I am sorry ---

Q In this case it actually led to analgesia, did it not, it did not lead to investigation.
A I suppose so, yes.

Q And that did not cause you any concern.
A No, my main concern was to get the patient's pain relieved.

Q Could the analgesia then get in the way of achieving the objective towards getting the patient better or actually dealing with the rehabilitation side?
A I suppose it could, but then I do not think I am that qualified to just state it in that way. I rely on Dr Barton or I relied on Dr Barton being the doctor rather than me being the nurse. I can just pass on what I observe.

Q What was the point of having joint discussions between the nurses and the doctors? Were you not a clinical team in effect?
A To a certain extent, yes, but if I refer a patient to the doctor I go by what the doctor says, surely.

Q Right, without questioning whether there should be ---
A Because I had no questions, that is what I am trying to say.

Q So you did not want to ask in yourself why was this patient screaming with the pain in her back. You did not want to ask what that was about.
A I assumed it was all to do with her condition anyway; she was a very frail lady in the first place. She came over with minimal use or movement in her arms – from rereading the notes. As I say, I cannot remember anything about this patient at all; I am sorry I cannot, but to my way of thinking I would have referred her on to Dr Barton for the relief of pain, but I cannot comment on the fact whether I thought at the time that there was some other reason because this lady came over with very limited movement. She was almost immobile so I assumed it was – sorry, I cannot think of the word now, my mind has gone blank – the result of her stroke.

Q When I as a lay person look at the nursing notes here and I look at 22 February, this person moved in with a possibility for rehabilitation, albeit slight.
A Yes.

Q Then I move to 26th or 27th when Dr Barton is actually meeting with the son and is saying the prognosis is discussed, and then the son is happy for you just to make Mrs

Lavender comfortable – which actually we have heard from a lot of evidence is equivalent to thinking of the person moving to terminal care.
A Obviously as far as I can make out, and as I say I cannot remember, Mrs Lavender's condition had deteriorated to a point where there was no point in giving her further treatment. The prognosis was discussed with Mr Lavender, the son, and he did agree to making her comfortable.

B Q When we actually read through the notes it is difficult to track that through, this deterioration. I wonder what you have to say about that because the nursing notes do not actually evidence that very clearly.
A There were times when I was not on duty so I cannot say. I can only rely on my team to put things down. If I was there 24/7 ----

Q Several of the entries on this one are actually yourself.
C A Yes.

Q So I am not picking up from a nursing perspective the pattern of deterioration and moving from potential rehabilitation to end of life care but you cannot help us.
A I am sorry, I cannot, no.

THE CHAIRMAN: Thank you. That does conclude the questions from the Panel, Mrs
D Joines. It just remains for the barristers to have the opportunity to ask any questions that may arise out of the questions that the Panel asked and it should be fairly short.

MR FITZGERALD: No, thank you.

Further re-examined by MR JENKINS

E MR JENKINS: We need to look at the nursing care plans because we have just looked at the summaries so far, so I am going to ask you to turn if you would, please, to page 1006. This is a nursing care plan, the named nurse is Yvonne Astridge, it is dated 22 February 1996 and the problem or need is said to be "Indwelling urinary catheter".
A Right.

Q It is dated 22 February, so the day that Mrs Lavender was admitted to Daedalus Ward.
F A Yes.

Q I do not think we need to trouble with much of the detail on that but if we can go to page 1005 I think this must be the continuation sheet of that nursing care plan, talking about the catheter.
A Yes.

G Q We do not need to trouble too much about the detail but nurses have made entries as the days have gone.
A Yes.

Q Including on 27 February a reference to haematuria.
A Yes.

H Q Is that blood in the urine?

A A Yes.

Q If we go one page further towards the front of the bundle we have another nursing care plan at page 1004.
A Yes.

Q But this one is stated on 24 February a couple of days after admission, plainly.
B A Yes.

Q And the problem is set out, "red and broken sacrum".
A Yes.

Q We see entries down towards the bottom of the page under the heading, "Nursing Action", and we see entries on a daily basis, so certainly on the night of 25th as well. What
C can you tell us about this particular problem, the red and broken sacrum, from this document? The problem is first noted on 24 February.
A Yes.

Q In other words, two days after admission. Are you able to tell us whether that problem would have been there on 22nd or whether it would have arisen after admission?
A It could have been there, but I think from this is resulted on 24th rather than on
D admission because I think that problem would have been put on, I should have hoped, the day of admission. This is dated two days after.

Q I understand, and if we look at what happened on 24th, the broken area was sprayed.
A Yes.

Q On 25th there is reference to the sacral area. I cannot read it, I am afraid, because of
E the quality of the copying, but it may be, "black and blistered". That night,

"sacrum very red and sore. Broken area sprayed with Betadine. Nursed on side".

A Yes.

Q On 26th there is the compound Betadine applied again.
F A Yes.

Q On the next couple of days, 27th and 28th, "area blackened and blistered.

"Black areas covered with Inadine and small white pad",

and that continues. Are you able to help us whether this lady's state, so far as just that
G problem is concerned, is stable or whether there is any change?
A There is obviously some breaking down in the tissue.

Q Thank you. Let us turn to another care plan, page 1008, if you would. This is a different problem, 22nd February it started, a leg ulcer on the right leg and dry skin.
A Yes.

H Q The desired outcome was to aid healing, and the nursing action to be applied is listed,

"Dress alternate days with Kattostat".

Would that be right?
A Yes.

Q Someone has entered something on 1 March, but if we go to the preceding page, 1007, this is the same date, 22 February, and it refers to the right leg ulcer and it being dressed.
A Yes.

Q Again, the pagination does not perhaps help us to understand this, but are you able to help us as to whether that is part of the same care plan as the page we have just looked at, 1008?
A Yes.

Q Again, nurses making entries on a daily basis.
A Yes.

Q Let us go to 1010, very quickly.
A Yes.

Q This is a care plan in relation to Mrs Lavender being unable to care for her hygiene needs without aid, and I am going to suggest that the preceding page, 1009, records the care plan and what actually happens in relation to Mrs Lavender.
A Yes.

Q Dealt with on a daily basis and nurses making records.
A Yes.

Q I want to look at a couple more. Page 1013, if you would. This perhaps is where it gets most relevant for Mrs Lavender. Turn to page 1012. On 22 February, "restricted mobility", is the problem that Mrs Lavender seems to be having. This is a problem that was recognised on the day she came in, 22 February.
A That is correct.

Q The desired outcome is to,

"Increase mobility and encourage independence".

A Yes.

Q The nursing action is listed as to,

"Assist Elsie to transfer from bed to chair with two nurses. Refer to physiotherapists".

Is that right?
A Yes.

Q We see that there is an entry for 23 February, the day after she was admitted, where it is recorded that she transferred with two.
A Yes.

Q Meaning that she could go from bed to chair.
A But with the aid of two nurses.

Q I understand. If we go on to the next day, 24 February, there is an entry from Margaret Couchman.
A Yes.

Q "Bed rest due to painful joints".
A Yes.

Q It may be obvious, but from that note was Mrs Lavender transferred to the chair that day?
A No, she was kept in bed because she was complaining of painful joints.

Q What about on subsequent days?
A Again she was kept in bed so obviously there was no relief of any pain at all.

Q I think that continued, if you go back to page 1011, the preceding page.
A Yes. She remained on bed rest right up until the time they put her on a syringe driver.

Q Are you able to tell us, would the nursing care plan have been adhered to by the nurses making entries on this document?
A Yes.

Q The desired outcome was to increase her mobility and encourage independence. Are you able to tell us whether nurses were seeking to do that or not?
A Yes, of course. She would have been referred to physio and be seen by physio and obviously she just had to remain in bed because her joints were so painful.

Q Let us go to the next nursing care plan at 1014. This is dated a little after admission, "Painful shoulders and upper arms". The desired outcome is to,

"Relieve pain and make Elsie more comfortable".

A Yes.

Q The nursing action is written up as,

"Position patient for comfort. Elsie can lift her arms if given time and dependent on pain. Administer analgesia as prescribed and monitor effectiveness".

A Yes.

Q What you were asked by Mrs Mansell was about people choosing between investigating or giving pain relief.
A Yes.

Q I want you to help us. If a patient with painful shoulders and upper arm, just for example, is given pain relief, what may be the outcome in terms of their mobility?
A Obviously if they were given pain relief, their mobility would increase.

Q Increase?
A Yes.

Q If we go over to the earlier page, 1013, we know that throughout this period Mrs Lavender was given pain relief in various forms and in increasing levels.
A Yes.

Q I wonder if you can help us. Does this appear to be part of the same nursing care plan as the one we have just looked at?
A Yes.

Q "Painful shoulders and upper arms".
A Yes.

Q We saw on page 1014 that it was started on 27 February and on page 1013 this one starts.
A Yes.

Q The first entry is 27 February.

"Analgesia administered. Fairly effective. Able to help when dressing this am".

Are you able to interpret that for us?
A Yes. In fact because she had had pain relief she was able to move her limbs.

Q What about the next day, 28th,

"Right arm less painful. Able to lift it above head height".

A Yes, and so again the analgesia did help.

Q On 29th,

"Able to move arms for washing and dressing".

By 1 March,

"Complaining of pain in shoulders on movement".

A So obviously the analgesia she was receiving was not sufficient.

Q We see by 4 March,

"Seen by physio. Exercises".

A Yes.

Q We have seen the earlier care plan suggesting that physio should be provided.
A Yes.

Q There is reference to turns of the head and neck retractions every two hours. "Analgesia increased". Are you able to help us with why the analgesia may have been increased?
A Obviously with doing the exercises that increased the pain. She obviously needed reminding, which I would think she was rather reluctant to do them. Whether that was for pain I cannot comment, but obviously the analgesia was increased because she was in such pain.

Q We have seen a similar entry on the summary to the one we see on the 5th,

"Pain uncontrolled, patient distressed. Syringe driver commenced".

Let me turn to another care plan, page 1015, this is I think the seventh care plan we have looked at. This one deals with constipation due to medical problems.
A Yes.

Q It started on 1 March. We see the desired outcome and bowel action to be monitored. We see over time, between 1st and 6th March 1996, Mrs Lavender's condition changes.
A Yes.

Q By 3 March there is a reference to continuing to leak faeces.
A Yes.

Q And a leak of faecal fluid or faeces continues over the next few days.
A Yes.

Q If one is looking for the condition of the patient in the nursing records, where do we have to look to see the full picture?
A In the nursing care plans.

Q There is another care plan on the next page, 1016. This one is started on the day that she is admitted, 22 February,

"Requires assistance to settle for night".

The desired outcome is to,

"Ensure patient has adequate sleep",

And I think this time we go forwards to 1017.
A Yes.

Q "Settled and slept well" is the first entry. "CO", sore shoulders.
A Complaining of sore shoulders.

Q On 23rd,

"analgesic given before settling. Comfortable night".

I think there is reference to DF118 x 2 given, and again dihydrocodeine that we have seen was administered.
A Yes.

Q Again, we have seen an entry for the next day and there are signatures for a number of dates, and it is not clear whether "dittos" have been put in or whether no entries have been put in.
A These would all have been done by the night staff. This was a night care plan for her. Where it says on 26th, "nursed on alternate sides", they do not do it now, but that would have been a ditto up until 1 March. So in other words, on 26th, 27, 28th and 29th her care did not change. She was still nursed on alternate sides, obviously because of her sore sacrum.

Q By 1 March it appears that Mrs Lavender refused medication.
A Yes.

Q It took a while to persuade her to take them is what we heard, but eventually took them.
A Yes.

Q Then we have, "leaking faeces +++".
A Yes.

Q How many pluses can you have?
A In some cases quite a lot.

Q It appears that the leakage "PR" – per rectum?
A Yes, per rectum.

Q Continued for the next couple of days. Again, so when you were asked about the nursing summary and a question of where is it recorded that the patient is deteriorating, do we need to look at the care plan for that?
A Yes. I am sorry, I might not have understood the question.

Q You were asked questions by Dr Smith about putting up a syringe driver.
A Yes.

Q You talked about the condition of the patient and you talked about a dignified and pain-free death.
A Yes.

Q The patients where a syringe driver was actually instituted, what if anything can you say about the prognosis?
A The prognosis would have been poor in the first place for us to have put up the syringe driver.

Q If a syringe driver had not been put up for those patients?

A They would not have had the calm, peaceful, dignified death, which would be upsetting to them, the relatives and the nursing staff I might add.

MR JENKINS: Thank you very much.

THE CHAIRMAN: Mrs Joines, that truly is it. Thank you very much for coming to assist us today. We are completely reliant on the presence of witnesses such as yourself to help us understand clearly circumstances and situations that often go back many years, and we are most grateful to you for coming to assist us today. You are now free to leave.

(The witness withdrew)

MR JENKINS: Sir, I am going to call Surgeon Rear Admiral Farquharson-Roberts. This witness dealt with Patient F, Ruby Lake, but I was not going to ask about any of the treatment that she received.

REAR ADMIRAL MICHAEL ATHOL FARQUHARSON-ROBERTS, Sworn
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to give us your full name, please.
A Michael Athol Farquharson-Roberts.

Q You are a medical practitioner?
A I am a registered medical practitioner. Pending the changes I am still on the Specialist Register.

Q I am going to ask for your professional qualifications.
A I am a Bachelor of Medicine and of Surgery in the University of London 1971. MRCS and LRCP in 1971 and FRCS by examination in 1976, and I have a certificate of accreditation from the Joint Committee of Higher Surgical Training in Orthopaedics dated 1983.

Q I think you were a consultant orthopaedic surgeon at the Royal Hospital, Haslar.
A Yes.

Q Are you still there?
A No, the Royal Hospital, Haslar has closed and I am now on the retired list for the Royal Navy.

Q When did you retire from the Haslar?
A I left Haslar at the end of 2000 to go on a sabbatical year before going into naval administration.

Q We know that the Royal Hospital Haslar would deal with patients, including patients who were not military personnel or members of their families.
A The Royal Hospital Haslar and its immediate predecessor, the Royal Naval Hospital Haslar, functioned as the district general hospital for the Gosport area in addition to being a military hospital, yes.

Q There were two facilities, I think, in the Portsmouth/Gosport are which would deal with trauma cases. One was the Queen Alexandra Hospital and the other was the hospital where you were a consultant, the Haslar.
A That is correct.

Q Are you able to tell us from the second half of the 1990s the respective size of the orthopaedic and trauma departments at the Queen Alexandra Hospital and the Haslar?
A In terms of beds, I am not absolutely sure but in terms of consultants my understanding is the Queen Alexandra has had five consultants and the Royal Hospital Haslar had, I think, toward the end, seven or eight, but then QA was increasing the number of consultants through the period as well.

Q Would it be right that trauma cases would be dealt with as emergency cases both at the Haslar and also at the Queen Alexandra?
A Yes.

Q If a patient fell and broke a hip, how are those cases dealt with surgically? By which I mean, are they treated as emergencies? Does one wait until the patient stabilises? How are they dealt with?
A Best practice was then and I believe is now that your patient should ... I was brought up to believe that you should not let the sun go down on a fractured neck of femur; in other words, they should be operated on either within the working day they come in or within 24 hours of coming in. Published evidence subsequently, up until the point I left clinical medicine, was to the same effect, that the patients did better the quicker they were operated on. After initial immediate resuscitation, you get them operated on as quickly as possible.

Q I understand. If we need to know the reasons why, one type of case would do better than others, please tell us, but I do not know that we need to know the reasons behind that research, as it were.
A Obviously it is multifactoral, but in general the quicker you operate the better.

Q I understand. Are you able to tell us what the pressures were, if any, on beds at the Royal Hospital Haslar and the Queen Alexandra Hospital in the late 1990s, the second half of the 1990s?
A Can I first of all give the basis on which I gained the information?

Q Of course.
A I was head of orthopaedics at Haslar up until 1996 and I then became clinical director of the surgery and anaesthetic services, so I was responsible for everything from accident and emergency through to theatres, ITU and everything while we still had one. In the late 1990s, and I am not sure of the date, that was made a joint appointment with the clinical director of surgery at Queen Alexandra Hospital Cosham, so I was in a management position, albeit at some remove, at Queen Alexandra as well as at Haslar. Haslar we were under much less pressure in terms of beds and in terms of theatre space than Queen Alexandra Hospital Cosham and also in terms of pressure on junior staff – and consultant staff, come to that.

Q Again from your position, would you have known how busy things were at the Queen Alexandra Hospital?
A Yes, they were much busier. They were much busier than we were.

Q If a surgical unit is operating on patients, do you need a bed to put the patient in after the operation?
A Yes.

Q If you are operating on a patient ----
A Sorry, with trauma patients, yes. I mean obviously there are day cases and so on, so it does not apply to every patient. The patients we are talking about, yes.

Q I should make it clear we are dealing with fractured neck of femur.
A Fractured neck of femur – you have to have a bed.

Q Broken hips.
A Yes.

Q Operations of that type?
A Yes.

Q If there are no beds in which to place a patient after an operation, what consequences are there for the surgeons and what they might wish to do?
A You have the patient in a bed before they go to theatre, so you have a bed to put them in afterwards. The pressure is when you have more backing up in the accident and emergency department. The pressures are on to speed up your throughput.

Q Are you able to help us: what was the level of pressure on beds in the late 1990s, both at your institution, the Haslar, and the Queen Alexandra Hospital?
A We felt we were under pressure, but we were well aware that it was nothing like the pressure the Queen Alexandra was under.

Q How does a surgical unit orthopaedic department deal with pressure when there is pressure on beds?
A Shorten the stay day. In other words, get the patients out quicker if you can.

Q You say, "If you can". What if you cannot?
A You end up cancelling routine admissions. That is the only way you can do it. If you do not have a bed to bring a routine admission in, a patient who is coming in to have a total hip replacement, to have their carpal tunnel done – you cancel those patients because you do not have the beds to put them in.

Q A routine admission, does that involve elective ----
A That is for elective surgery, yes. QA and Haslar, both patients were done from the same beds. The ideal is .... I am sorry, this is getting contentious. In my opinion, the ideal is to have your trauma beds and your elective beds separated

Q I understand. Can we look at the differences that there may be between elective cases and trauma cases if the operation to be undertaken is a hip replacement or a surgical repair of a fractured neck of femur, as an example? For elective cases, can one plan when the operation will take place?

A Oh, yes. I mean, you plan when the operation will take place and fairly predictably – unless something happens – you can predict when that patient will go home and when the bed will become available again.

Q If one were to decide in a given case that there would be, let us say, a hip replacement, what steps, if any, would be advised in the period leading up to the operation?
A I am not entirely sure what you mean, so please do stop me ----

Q If you wanted to set up an operation for some weeks in advance, and, let us say, the patient was not in great shape some weeks before the operation, can one do anything with the patient?
A The practice has evolved and is still evolving with regard to that, but in the middle 1990s the practice would be to bring the patient into hospital 48 hours beforehand, stabilise them before they went down to theatre.

Q In the case of a trauma patient, let us say a patient who had fallen and broken their hip, fractured the neck of femur.
A By definition, they are not elective. They turn up on the doorstep and they have to be treated straightway.

Q Again, do you have the option of 48 hours with a patient in a bed before you undertake an operation?
A As I have already said, the ideal is to get them to theatre as quickly as possible. Sometimes pressures on theatres and sometimes the state of the patients' health preclude that. It may be that the patient's health does not allow it and you have to undertake or have a colleague undertake general medical treatment to get them fit enough to undergo an anaesthetic of whatever form you chose, or the other problem may be there may not be theatre time and the patient may wait to get to theatre.

Q Let us deal with a case where there is a fractured neck of femur, say a patient has fallen and been waiting some time before help is called, an ambulance, a relative, and they are taken to hospital. What can one anticipate as the outcome of that type of patient as against a patient who has an elective hip replacement?
A Let us start with the brutal truth. A fractured neck of femur is a pre-terminal event statistically. I cannot remember the exact figures but of the order of 70 to 80 per cent of patients with a fractured neck of femur are dead within a year. That is not the truth with total hip replacements. Looking around here, I suspect there are quite a few people – and I cannot remember the statistics – who have had hip replacements who expect to go on for quite a few more years yet. It is a different beast. Someone with a fractured neck of femur is already unwell. They have osteoporosis to get the fracture. They are relatively inactive, which is part of the causation of the osteoporosis. As I have said, all too often, with the best will in the world it is the start of a slippery slope. People are going to die. A fractured neck of femur is often a marker of the last couple of years.

Q I understand. A pre-terminal event.
A Yes.

Q Does the patient's age make a difference?
A Yes.

Q So far as the statistics are concerned?
A Yes.

Q In a fall and a fracture trauma case?
A I saw younger patients with fractured necks of femur. They tend to be more traumatic, in the sense they happen in road traffic accidents or with a freak accident. With younger people it is not such an event, in the sense of pre-terminal, it does not have an effect on their lifestyle. We are talking mainly about the elderly patient, and the elderly female by and large.

Q Is that because males do not live that long?
A No, it is function of osteoporosis. Women tend to get osteoporosis. They suffer a dip around the menopause when total body calcium drops, and then they run the parallel line to males (who do not have a menopause).

Q If we are dealing with patients in their seventies, in their eighties, or in the nineties, what do the figures suggest as the likelihood of a full recovery or even a partial recovery or rehabilitation for those sorts of patients?
A I cannot advise you with a full, up-to-date knowledge of the literature because I have been out of clinical practice since the end of 2000. However, the older you are, the more likely you are to perish.

Q I understand.
A And the more likely you are to have co-morbid illness, other illnesses: congestive failure, bronchial disease.

Q Can I ask you about where patients would be transferred to in the second half of the 1990s if they were transferred out of your then hospital, the Haslar.
A The ideal would be to get them back to the community, to home, with social service support in the home if they needed it, with community nurse support. That would be the ideal. There are some patients, however, who would not make it back. There are some patients who just would not get back into the community. Some, after all, have not come from the community in the first place. They have come from old people's homes anyway.

Q We have heard of some patients being transferred to the Gosport War Memorial Hospital.
A Yes, it was the community hospital for the Gosport Peninsula.

Q Can I ask you about physiotherapy that was available for your patients? I am talking about trauma patients – fracture neck of femur, elderly patients. What physiotherapy was available for them at the Haslar during the second half of the 1990s?
A In my belief, it was outstanding. We had full hydrotherapy facility, full occupational therapy, and full physiotherapy, as befits a hospital designed and built to treat military patients.

Q Outstanding physiotherapy. As the surgeon, would you have a role in saying what physiotherapy you would want your patients to have, or would it be an independent decision for the physiotherapists to make?
A The way we ran it, I was the consultant in charge of the firm and when I went on a ward round I would go around with the physiotherapist. The physiotherapist, he or she, was a

professional whose opinion I had to defer to and respect. I am not a physiotherapist. I cannot conceive of there being a disagreement between a physiotherapist and the consultant surgeon as to what was needed.

Q I understand. My question really was designed to find out what level of physiotherapy the patient would get. Would you have an input in saying, "This is what I would like for this patient"?

A I would not need to. The physiotherapists would be able to give the physiotherapy they thought appropriate. We used to have a ward physiotherapist. One physiotherapist I think looked after two orthopaedic wards and worked there full time and was responsible for the initial care, getting the patient first mobilised before they could go down to the physiotherapy department and have more aggressive physiotherapy.

Q How well staffed was the physiotherapy department?

A Very well staffed indeed.

Q Can I just ask you about ward sizes? You have told us there was a full-time physiotherapist for two wards.

A There were 28 beds on each ward. I am sorry, one was 27 and one was 28.

Q Did you know what physiotherapy they had at Gosport War Memorial Hospital, then?

A I knew one of the physiotherapists there socially, but I believe there were two or three. I do not honestly remember.

Q You have told us that the pressures on beds were rather greater at the Queen Alexandra Hospital than they were at your hospital.

A That is my belief, yes.

Q If a patient is transferred post-operatively at a time when they are not entirely stable, might that have a consequence for their prognosis?

A Can I walk back a little? We would refer a patient to Dr Lord, who was the consultant geriatrician, or one of the other consultant geriatricians, who would usually come and see the patient at Haslar and agree for their transfer, would make recommendations regarding further treatment before they were transferred, and would then make a bed available and transfer them to the Gosport War Memorial – at which point the patient would leave my care. We would get them as good as we could get them before they went.

Q I understand. I am not suggesting that the policy was in place to transfer out unstable patients.

A I am sorry, you misunderstand me. You are not working with fit, young men. I am thinking of the trauma that is coming back from Afghanistan. You are not working with that. You are working with people who have co-morbidities, other illnesses as well. We would get them as good as we could get them. They would not necessarily be fully stable in the sense that you mean.

Q Once you had got them as good as you could get them, was it appropriate for them to stay in a post-surgical bed?

A No. A post-surgical bed was just that. They had as much care as the orthopaedic unit could give them. We would not transfer them if they needed continuing care. If they had a significant wound problem that needed particular care; if they had a particular chest problem

that needed particular care, we would not transfer them. If they had something that we deemed was capable of being managed within the community hospital, we would transfer them.

Q Can I ask about the Queen Alexandra Hospital and about the management of the Queen Alexandra so far as you were able to judge it from your position? You have told us your position was one where you knew very well what was going on there.
A My perception was that they were transferring patients somewhat earlier than we would have done at Haslar.

Q And you were transferring as early as you could.
A As early as we felt able to, yes.

Q Are you able to help us with what would be said to relatives or the patients if they were transferred out from your hospital, the Haslar, after let us say a repair of a fractured neck of femur?
A With the best will in the world I was not able to see the relatives of my patients, all of my patients, necessarily even the majority before they were transferred or discharged. My juniors would advise, knowing that they would be in mind – if I can use a naval phrase – as to what I felt about the patient. The majority of the transfer and the advice to the relatives would necessarily be done by the nurses or the occupational therapists – again we had a very good occupational therapy department.

Q Again, it may be you cannot answer this but if a patient was treated at the Haslar, let us say an elderly patient, and they had broken their hip, they had come in for an operation, they had been got as good as you could get them and they were then transferred out to, let us say, the War Memorial Hospital in Gosport. Are you able to tell us what would have been said to the relatives as to what might be provided for the patient at the War Memorial?
A That they were going to a community hospital. Fortunately a lot of the relatives knew the hospital and were aware of what it could do. We would say that we would send them there for continuing care but the probability is – the few times that I was able to talk to the relatives I said "Look, your mother, father et cetera is not going to be fit to go back to where they were before; they are not going to be able to go back to that level of care".

Q I think at the Haslar as a consultant you would have had junior doctors providing care for your patients.
A Yes.

Q How big was your team or your firm?
A It varied from time to time but I had a pre-registration houseman who I shared with one other consultant, an SHO who was exclusively mine and a registrar who I usually shared with one other consultant – a specialist registrar, this was under the old training scheme.

Q Indeed. How many patients would you have had on wards in your name?
A 25.

Q At any one time.
A Yes.

Q I think you know Dr Barton.

A A As a colleague, yes. Socially we meet at the same cocktail parties.

Q I think it is a relatively small world in that part of the world so far as medicine is concerned.
A Yes.

B Q But you would not describe yourself as a friend of Dr Barton; you know her as another doctor.
A I was thinking how to put this – we met outside briefly. The meeting was with a handshake not a mouaw mouaw – can I put it that way; does that give you an idea?

Q I hope it does. The Panel may ask you questions about that but I will not.
A I am sorry, I am not an expert on current social mores.

C Q I am sure the Panel will take it as far as they need to. Would it be right that GPs locally would refer patients to you from time to time?
A Yes.

Q Would you have had Dr Barton refer patients to you?
A Yes.

D Q Are you able to comment on the way in which patients were worked up by Dr Barton before they were referred to you or the quality of the letter that she might write?
A My impression always was that I got a good quality referral of a patient who needed to be seen.

Q Would there be a range of quality in referrals?
A Oh yes – "Bad back, please see."

E Q Dr Barton was not at that end of the range.
A Far from that end of the scale.

Q I do not know, again, maybe you cannot help us, but would you have had any impression of the sort of care she gave to her patients from contact you had with the patient?
F A My practice when I saw a fresh case was to sit down and read the referral letter with the patient. Occasionally a level of censorship was necessary but I was quite good at that. A number of times a patient would chime in and say "Ah yes, Dr Barton, she is very good". I hope I am not making Dr Barton blush but they did.

Q I think you had a family relative who was treated in the War Memorial Hospital?
A My father died in the War Memorial.

G Q Are you able to tell us, was he there for one period of time or more than one?
A He was admitted twice, separated by about two and a half months I think.

Q Do you remember which ward he was on?
A I cannot remember, I am afraid. I know he was on two different wards on the separate times that he was in.

H

Q We know of a GP ward, a ward with GP beds, Sultan Ward, and the Panel has heard a lot about two other wards, Dryad and Daedalus.
A I think he was on Daedalus but I am not sure. He was on two different wards on the occasions that he was in.

Q Wherever he was, was it before 2000?
A He died in December 2000.

Q Are you able to tell us whether Dr Barton had any role in his care?
A I honestly do not know. He was looked after by Dr Lord who was the consultant geriatrician; that is as much as I remember I am afraid.

Q Would you have visited your father in the hospital?
A Daily, unless I was away for some reason. Either I or my wife did.

Q You are a man who would have spent much of his professional life in hospitals but what did it feel like for you going into the Gosport War Memorial Hospital? Did you have a sense of how things were going?
A I was also five years on the orthopaedic specialist advisory committee when the specialist advisory committees did hospital visits, so my experience is actually very wide of hospitals. Gosport War Memorial gave you – I have not been in there for a long time – a very, very good impression; it was a nice feel. Forgive me, but when you go on board a warship you can feel, before you even meet any of the sailors, if it is a happy ship – you can feel it. It is the same with the War Memorial. It was a good, efficient hospital, you could feel it – and it was clean.

MR JENKINS: Thank you very much. Would you wait there because you may be asked questions by some others?

<u>Cross-examined by MR KARK</u>

Q One thing I am not going to ask you about is social greetings.
A I did say that I had no expertise.

Q You in fact made a fairly lengthy statement to the police about Patient F, Ruby Lake.
A Yes.

Q You could not remember her yourself, I think, you were working with the notes.
A That is right.

Q There is a very limited amount that I want to ask you about her, but just coming back to the Haslar, this is not being suggested and I just want your confirmation – you certainly at your hospital were not shifting patients out of beds before they were ready to go.
A That was my edict as head of department and that was my practice.

Q You had expressed a certain view about the QAH, but people from the QAH may or may not agree with you, we do not know, but that was your view about the QAH.
A That was my impression, founded as co-clinical director and also on the basis of reports, informal reports received from my staff who visited and who then reported back to me, yes.

Q You said about fractured neck of femur that it a pre-terminal event and you gave us some pretty dreadful statistics about the likelihood of somebody – an elderly person presumably – surviving for longer than a year.
A Yes.

Q You said they had got osteoporosis to get the fracture.
A By and large, yes. It is an osteoporitic fracture. I am talking about the vast majority of fractures. Fractured neck of femur in the elderly is an osteoporitic fracture.

Q In elderly people.
A Is an osteoporitic type fracture, yes.

Q So if an elderly person falls they are more likely to get a break than a young person.
A If you fell over on the floor now I would be very surprised if you got a fractured neck of femur. If an 85 year old lady did I would not be surprised if she got one, let me put it that way.

Q You spoke about the quality of the physios and the physiotherapy generally at your hospital which I think you described as excellent.
A I said outstanding I think.

Q Outstanding. Occupational therapists very good.
A Yes.

Q Were your nurses very good?
A Yes, my nurses were and are outstanding. I can give you figures to prove that if you like.
A Nobody is going to suggest that your nurses were not outstanding, all right, we can take that as given. I do just want to ask you a couple of things about the notes of Ruby Lake, and if you turn to your left you will see a file – you can put B away if there is a slot to put it in, but could I ask you to take out file F? Could you turn to page 511 – it is the page numbers with a line either side, right in the middle at the bottom?
A Yes.

Q Just so we can orientate ourselves we are looking at a note, I think, by you on 10 August 1998.
A Yes.

Q The note that you have made is for,

"All necessary treatment and resuscitative measures".

A Yes.

Q Right. I think when you spoke to the police – and we can show you a copy of the statement if you would like to see it obviously – you do not remember making that note but you say:

"I do remember that I had as head of department given instructions that, for the avoidance of doubt, consultants' direction and guidance as to the management of patients was to be recorded in the clinical records, preferably in their own hand, when there was any possibility that it might be thought in the best interests of a patient for care to be modified."

A Yes.

Q Can I just ask you about that and why you thought it appropriate to make this note about this patient?
A Again, I am casting back ten years but I believe that at the time there were some reports in the wider press that patients were perhaps having care withheld. I think this was at the time of the, "Not to be resuscitated" at the bed end and I wanted it to be perfectly plainly understood that if a decision like that was taken it was taken at consultant level and it was not taken by a junior doctor. It was important that a consultant made the decision, which is why I made that ruling and told my consultants that they were to make the decision and record it.

Q Quite. It is two things, is it not? First it is to be decided at consultant level and, secondly, it is to be noted.
A That is right, yes.

Q Because were the decision different as it were – and we have seen in patient notes the record sometimes "Not for 555" and there are various versions of that but it is an extremely important decision, is it not?
A Yes.

Q You would expect any significant change in the patient's management to be recorded.
A Yes.

Q Can we please go to some nurses' notes at 613? This is in the day or so just before this lady is transferred. We have to bear in mind that this was a lady who indeed had fallen and had a fractured left neck of femur.
A Yes.

Q So she had the possibility of being rehabilitated but she is an elderly patient and there was a possibility, obviously, that she would die.
A Yes.

Q We are looking at 16 August and we can see that in the afternoon it is described as a comfortable afternoon – please glance at the earlier note, the seven o'clock note. She had previously had IVI fluids; she has had codeine phosphate for analgesia on her shoulder to good effect. Then "comfortable afternoon. Oxygen saturation 96 per cent on air" – which is reasonable, I think.
A Yes.

Q "Went out with family around the grounds. High in spirits on return. Legs re-dressed, clips removed left hip. Wound leaking".

Clips removed – would that be a form of suture?
A At that time my practice was to use clips rather than sutures to close the wound.

Q So this is the point at which they are taken out.

"Distal end of wound slightly open. Skin closure achieved with steristrips. Good oral intake of fluids. Sacrum redressed".

Then we can see Ruby had quite a good night's sleep after settling late and frequently calling out. "Taking good amounts of oral fluids." I cannot read the next word, something satisfactory.

A It is diuresis satisfactory.

Q Thank you. "Due to go to Gosport War Memorial Hospital." This patient is recorded as we see as being able to go round the grounds with her family, high in spirits and sitting out in chair. For this lady, who was I think transferred on the 17th it is not a particularly pessimistic outlook.

A No.

Q She is described by your SHO, if we look at page 519 again, 18 August,

"Well, comfortable and happy. Last pm spiked temperature 38.5, now 37.3. Mobilising well. To GWMH today."

Is that your SHO's note?

A It says ward round – "WR SHO" so I presume so, yes. I am afraid I do not recognise the signature or remember the bleep number.

Q I was just about to ask you was this the SHO that you have described as being your SHO.

A Most likely, unless that was a weekend. If 18 August was a weekend it could have been the duty SHO not mine, I do not know.

Q And you cannot tell us who it was.

A No.

Q Okay. Finally, could you please go to page 571? We are looking at a sheet of "as required" prescriptions and this is while this patient is still at your hospital – indeed, I think she has just arrived there because she is admitted to your hospital on 5 August, if that helps you. We can see that she is prescribed diamorphine intravenously – is that a variable dose we see?

A It looks as though it is 3 to 5 mg.

Q Is it your prescription or not?

A No.

Q Underneath that we see morphine and then "directions" – is that PCA?

A Yes, patient controlled analgesia.

Q Does that mean that the patient will have a button?

A It does, yes.

Q So the patient will be attached to a drip.
A Yes, usually. As I remember – and I am afraid this is years ago – there will be a separate PCA sheet giving the actual settings for the PCA.

Q So it will be set at a certain rate and then she can increase it if she feels that is necessary.
A No, it is set at a set dose and she can then administer the dose.

Q Is this pre-surgery?
A I cannot remember the date of the operation, I assume so. No, PCA would be given post-op. We did not give PCAs on the ward pre-operatively.

Q You could not, could you? The anaesthetist would have to do it.
A Our hospital's practice was that the anaesthetist or the anaesthetic department would set them up.

Q So this is immediately post-op. There is one drug I wanted to ask you about in the middle that we have heard about but have not actually seen, I think. That is Naloxone.
A Yes.

Q What is Naloxone for?
A I am not a pharmacologist and I am not a therapeutic, but my understanding is that it is an antagonist for morphine and morphine-derivative analgesics, reversing their effect.

Q I think you described it in your statement as, it is used as an antidote to a morphine overdose.
A Yes.

Q This is available, presumably, so if the patient for any reason was over-sedated, this could be administered very quickly.
A It appears, I note, it says on the PCA charts, so I think the PCA chart would be a better guide than this document.

Q But that was your understanding of its use.
A That would be my understanding of its use, yes.

MR KARK: Thank you very much.

MR JENKINS: Sir, I have only three or four questions and will be very brief. I am entirely in your hands.

THE CHAIRMAN: We will continue, if you are content.

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

MR JENKINS: Are you able to identify when you last saw this lady before her discharge on 18 August?
A I did ward rounds on Mondays and Thursdays and usually on Saturday mornings.

Q Do you want to look at page 517?

A "Ward round MFR on 14th". Sorry, consultants in hospitals, particularly in the Navy, are recorded by means of a three-letter abbreviation and my three-letter abbreviation was MFR.

Q That is a junior doctor's note or is it your note?
A It is a junior doctor's note. I think I now remember and I think I recognise the name. I think that was the then Surgeon Lt Coltman, I think, remembering the name, who is now Surgeon Commander Coltman.

Q We even know what he looks like because we have had him giving evidence.
A I think that is his note.

Q I think if you look over the subsequent couple of pages, there is nothing to indicate that you saw this patient in the days leading up to her discharge. She was discharged on the 18th.
A No.

Q Page 519, again it is the ward round by junior doctors.
A Probably.

Q There is no criticism at all.
A No. I can only be in one place at a time.

Q Of course. I think if we look at the nursing records, you have been asked to look at some but if I can take you to page 612, we can see a number of entries. Let us start on 15th, which is the day after you saw her.

"Some pain due to arthritis in left shoulder".

Page 612,

"She was frequently assisted to turn and move up the bed to make her comfortable. She was fully alert. Full assistance given with hygiene. Sacrum broken on both left and right buttocks and the sacral cleft. Dressing was applied".

There is reference to loose stools. There is reference to her left hip being redressed which was of course the operation site.
A Yes.

Q There was pain, she complains, in her left shoulder and chest. Over the page, it would seem she had a restless night's sleep. Left shoulder chest pain increased at one point and there was an ECG done. Some investigations were done which showed a high urea result and there is reference to her previous fluid overload and chesty cough. The doctor wanted her to be reviewed, and query intravenous infusion fluids needed. I think she had had them in the past. I do not know that we need to look up the documents. There is reference to codeine phosphate being given for shoulder pain. You dealt with the oxygen saturation and the rest of the note to 1900 hours on 16th,

"She had quite a good night's sleep after settling late and frequently calling out".

That was on 17th. I do not think you looked with Mr Kark over the page at 614, which is the rest of the day before and the day that she was transferred out,

"Seemed confused this afternoon. Reluctant to move herself up and out of bed".

It may be, it is not entirely clear, "from bed to chair".

"Phone call from Gosport War Memorial Hospital to move mane to Dryad Ward".

There is reference to her being pyrexial and paracetamol given. On the day of transfer,

"Increased shortness of breath. Recommended on oxygen therapy".

Again, does that suggest to you that she was stable at that time?
A It sounds as though – a retrospectoscope is a very easy instrument to use, but it sounds as though she is beginning to get ill.

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

THE CHAIRMAN: We will take a break now. You will be taken somewhere, I hope, where you can get some refreshment and when we return I anticipate there will be questions from the Panel. We will return at five minutes to four.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. We are at the stage of questions now from the Panel and Dr Roger Smith is a medical member of the Panel.

Questioned by THE PANEL

MR SMITH: Rear Admiral, I should point out that we deduced that I am the oldest person in the room so please be kind when you answer these questions.
A I am sorry, I thought I was the only pensioner here.

Q You talked about the dreadful mortality of people who fall over and break their hips in this group, and you operate on them. Why do you operate on them?
A The survival is better if you do. There was a time, back 40 years ago, when there was actually a very big series – I am trying to remember where it came out of – of treating patients on traction and they actually did very well. However, that was in the days when it was almost one to one nursing care, so you do have the option of non-operative treatment, but nobody does these days because you can get them out of bed quicker, it is less demanding on facilities and the survival is better. If you leave a patient unoperated on, the longer they are left unoperated on, with modern standards of care, the more likely they are to die quicker.

Q So it is a matter of balancing risk.
A Yes.

Q It has been suggested by some witnesses that in the transfer process the referring hospitals were somewhat over-optimistic about the chances of the people they were transferring. It has even perhaps been suggested that they may have been slightly misleading

in the transfer information, perhaps in order to free up beds. Two things out of that really. One is, the nurses in the two institutions, the Memorial Hospital and Haslar; it has been suggested that patients were more mobile in Haslar because the nurses were sailors. Do you think there is any basis in that?

A Could I address the first point? I formed the same impression, but it is only an opinion with regard to early transfer. With regard to the nurses, a lot of the nurses in the War Memorial were ex-QARNNS – Queen Alexandra's Royal Naval Nursing Service. In 1996 very few of the QARNNS had actually been to sea so could not properly be termed sailors, but they were and are very high quality nurses. Recruitment, we pick the best. We are able to, so we tend to get very good quality nurses in the Armed Forces. That is one of the reasons why the survival rate in Afghanistan is so good, very good nursing care. One of the reasons.

Q The lady to whom you have been pointed, and you still have the file, was transferred to the Memorial Hospital. Notwithstanding that as Mr Jenkins pointed out, there had been things going on in the last 24 hours or so which might have pointed to some sub-co-morbid event occurring, and notwithstanding that Dr Lord, I think two days earlier, had not been over-optimistic about the lady's chances of rehabilitating, nevertheless, if I just take you to page 461 in that document, it should be the physiotherapists.

A Yes.

Q If I get my dates right, on 14th, which starts, "Brighter today", it says,

"Walked short distance with a frame and one".

Then on 17th it says,

"Bright. Sitting out in chair. Mobilised with Zimmer frame and supervision".

If they wrote that, what confidence would you have that they were being realistic in what they had written?

A One hundred per cent. I mean, people would not write something that was not true, certainly not in my department.

Q In a generality, if you had operated on an old lady's hip in an emergency and she is one of this group – it is this lady; let me not beat about the bush, it is this lady -- and you have applied your skills to somebody with a very high mortality, and when she gets to the rehabilitation hospital things go wrong in that she develops a lot of pain and she cannot wait there, she is in terrible pain. Her hip shortens – sorry, her leg shortens. She has to have a lot of pain relief. Bearing in mind that she is frail, she is at very high risk of dying and you have done the operation, is there any point in you knowing about that deterioration?

A First of all, can I pick you up? She did not go to a rehabilitation hospital. She went to a community hospital. That is the first thing. The second thing is I do not remember – if you want me to I will check the notes, but I think she had a DHS, a dynamic hip screw for a fracture. The whole design of that is to allow the fracture to collapse down. As I said, it is osteoporotic and soft bone, so the fracture will, if you like, crunch down. So shortening is to be expected and, regrettably, with it pain. Would I be expected to be told? If she had been still an in-patient it would have been brought to my attention on the next ward round, yes.

MR KARK: Can I just correct one error? I do not think this was the patient with the shortened leg.

MR LANGDALE: That is quite right. It is not this patient.

DR SMITH: Then I think I should not ask the question. I apologise. I think it would be wrong of me to ask this witness, albeit he is an orthopaedic surgeon, about another patient. I will not ask it.

MR KARK: Sir, the Panel is perfectly entitled to ask this witness questions if they are satisfied that this witness has the expertise to comment.

MR LANGDALE: Sir, I am guessing that Dr Smith is thinking of asking questions about Enid Spurgin. The problem is, and I quite accept what my learned friend Mr Kark has said, is that the witness will be presented with a completely fresh page and I suppose one could invite him to consider all that is known about the patient from the documents, but it seems to me that it might produce more confusion than clarity. However, I quite accept it is for the Panel to decide.

THE CHAIRMAN: I think Dr Smith has decided not to go there. There is just a very little from me, and I am a lay member. You indicated to Dr Smith a few moments ago that people would not write what was not true, certainly so far as your own hospital is concerned and that is a view that you are absolutely entitled to.

A It would be a disciplinary matter if someone had done so.

Q Can I put things from a slightly different perspective? Evidence that we have heard has been alluded to which is indicative of two things: on the one hand some nurses were of the view that the notes, the written material that accompanied patients or the transfer letters or that which came shortly thereafter was sometimes at variance with what they themselves found. Of course we have been exploring what the possible reasons for that are. One is clearly deterioration during transfer. Another possibly is that there was a difference between what the patient was actually like at the time the notes were produced. The reference to the sailors, I think, from the witness concerned was intended to convey her view that many of the nurses at Haslar were male nurses, sailors but male nurses, and that they somehow were taking more of the weight of the patient on their own shoulders when seeking to mobilise them, and that might be an explanation. Your comment on that, I think, would be helpful.

A I am not aware of the proportion of male to female nurses in 1996, however the QARNNS was and remains predominantly a female service. Queen Alexandra's Royal Naval Nursing Service remains predominantly a female service. I think, I am sorry, that that is fanciful.

Q I will not ask you to comment on the views in respect of QA unless you feel able to comment on the way in which they might have approached the transfer and the writing of transfer letters and records. We have heard that you have got some experience of that hospital and some responsibility there at the time, but not at the same level as you had at Haslar.

A My impression, formed from reports made to me by subordinates, was that they tended to transfer patients quicker than we did, earlier than we did. That was my impression. I appreciate that I am under oath and I am hedging round because I cannot give it didactically to you and say that that was so, but that was certainly the impression that I had at the time and that my nursing officers had at the time.

Q I am most grateful. That is very helpful. Still sticking with what appeared from official sources, if you like, and what appeared in writing, I think you said that when you were considering transferring somebody to Gosport, "We would refer patients to consultant geriatricians who would decide if they would be taken on". You referred specifically to two of the Gosport consultants. Do I understand from that, that the decision to take a patient from Haslar into Gosport would be one that would be made by a Gosport consultant?
A Yes. We could not admit the patients direct. We had no rights to admit the patients direct. It had to be by the consultants saying, "I will take over the care and management of this patient". I did not have and as far as I know no consultant had at Haslar, admitting rights to the War Memorial Hospital.

Q Thank you, that is extremely helpful. The other side of the coin is what might have been communicated to relatives of patients who were being transferred, or indeed to patients themselves. I think you have indicated that your hospital would say that, "We are sending them on for continuing care", but that when you spoke to relatives you would be a little more specific. I think you said, "I would say they are never going to be fit to go back to where they were before".
A I would try never to say "never". I would try and say, "I don't think she is going to be. " You always have to leave a little bit of hope. With patients and patients' relatives, I try to avoid being absolutely hard line. That was just my personal practice. I would not say, "You'll never go home." It would be, "I don't think she'll get back there. I really don't." That would be the line I would take.

Q I do not know the extent to which you will be able to comment on this, but evidence we have heard from a number of receiving personnel, if I can put it that way, at Gosport, is that they took the view that relatives were coming in believing that their patient relative had been transferred for purposes other than that for which they were transferred, and, more specifically, believing that the prognosis for the patient was a great deal rosier than it was. An example being, we are told, of relatives gaining the impression that the relative was being transferred to Gosport for a few weeks of rehabilitation, after which they would be able to return home or move on elsewhere.
A We formed the same impression, that that did happen with patients – not from Haslar – yes. But we formed that as an impression, not as firm evidence.

Q Very well. So far as Haslar is concerned, your view of that type of occurrence is that it could not have happened, would not have happened?
A I can only speak for my own directorate, from the surgical directorate, and inevitably most of the patients came from the orthopaedic, with which I had day-to-day contact. It would not have been done at my direction. It would have been done against it. I cannot say that somebody did not – I do not know for sure – but certainly it was not the way I directed the department should be run.

THE CHAIRMAN: That is very clear. Thank you very much. That concludes the questions from the members of the Panel. You are almost at the end. Now we just have to give the barristers the opportunity to ask any questions of you that may have arisen out of the questions the Panel have asked.

Further cross-examined by MR KARK

Q I have two very short matters in clarification from the Chairman's questions. You said that you did not have admitting rights from your hospital to GWMH. It would require, what, a GWMH consultant to refer?
A Yes.

Q Do you know if the same was true of the QAH or not?
A I do not know.

Q You were also asked about some evidence we have heard about a witness suggesting that there was a greater preponderance of male nurses at your hospital and therefore taking greater weight. You made, I think, a facial expression of exasperation, and also said it was fanciful. I just want to examine with you what you describe as fanciful.
A First of all, we did not have a preponderance of male nurses. I know that people have the impression that naval nurses are, but they are not. There is a preponderance of female. That was the first reason for my expression of slight disdain – not exasperation.

Q I am sorry.
A Second, I do not believe that a nurse would consciously or unconsciously lift the patient more. They would be aware of how much they were helping the patient. They know that. They are professionals.

MR KARK: Thank you very much.

Further re-examined by MR JENKINS

Q In answer to the Chairman's question about what might be said by junior doctors to relatives of a patient who was to be transferred out, are you able to tell us whether your juniors would have known precisely what facilities and what types of treatment were or were not available at the War Memorial Hospital?
A It is most likely that the patients' relatives were spoken to by members of the nursing staff and the answer would be yes. Junior doctors tend to come and go, and it may be that at the beginning of a turn a doctor was not aware of the facilities at the War Memorial Hospital and might have a different impression, but I hope that they would have sufficient sense to ask.

MR JENKINS: Thank you.

THE CHAIRMAN: That really is it, Rear Admiral. Thank you very much indeed for coming to assist us. It is only when witnesses such as yourself come before us that we are able to make anything like a realistic stab at assessing what was happening in a particular place at a particular time often many years ago. We are extremely grateful to you for coming to assist us in that regard today. Your testimony is complete and you are free to leave. Thank you.

(The witness withdrew)

DR JOHN HOWARD BASSETT, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to give us your full name, please.
A John Howard Bassett.

Q Dr Bassett, I wonder if you would give us your professional qualifications, please?
A MBChB, MRCGP, DCH, BRCOG.

Q I think you are a general practitioner in Lee-on-Solent.
A I am.

Q Which is, what, two miles around the coast from Gosport.
A On the Gosport Peninsula, yes.

Q I think you have been a general practitioner there for more than 20 years.
A Twenty-four years. Since 1985.

Q I think you are now the senior partner of the practice.
A Yes.

Q Is that where you have been throughout that time?
A Since 1994, a full partner of the practice.

Q I think you know Dr Jane Barton as a GP colleague in the Gosport area.
A I do indeed.

Q How long have you known her?
A As long as I have been a GP in Lee-on-Solent. Certainly within the first couple of years of joining the practice I would have met her. I could not say exactly when, but in the first couple of years.

Q How many GPs, roughly, are there in the Gosport area, would you say?
A Roughly 35 GPs.

Q Over the time that you have been there, would you know them fairly well, know how they are regarded, and know what their reputation is?
A Definitely, yes. More so in the 1980s and 1990s than possibly now, because there are probably more part-time GPs who have perhaps less commitment to the practice as partners than we would have done then and our association in the Gosport Peninsula with the hospital and the Gosport Medical Committee is probably less now than it was certainly in the 1980s and 1990s when we were a very close-knit community of general practitioners.

Q I understand. Might there be professional links, by contact with the same nursing staff, by contact with patients who might move from one practice to another?
A Yes. First of all, we were all members of the board of Gosport War Memorial Hospital and we all, certainly in the 1980s and 1990s, had admission rights. We had a Gosport Medical Committee which met quarterly to discuss patient affairs and the running

of the hospital as much as anything. As well as that, we had regular GP educational sessions to which all the GPs would be invited, and, socially, we had an active Gosport GPs cricket club which ran for 25 years. It only folded two or three years ago, and I was one of the youngest in the team, to give you an idea, at the end. Partners, wives and husbands were involved in that. It was very much a family affair, so we got to know all the GPs.

Q You have told us that you would know Dr Barton both as a GP locally and through the Gosport Medical Committee. Was that the committee of medical staff who might admit patients to the War Memorial Hospital?
A It was indeed.

Q We also had a minor injuries unit which was run on a rota with the GPs in those days, in the 1980s.

Q Would you have had contact with Dr Barton through the Medical Committee?
A Yes, I would have done.

Q Were you also involved in Gosport Primary Care Group in the 1990s?
A I was. Very much so. The Gosport Primary Care Group, for those who are not aware, was a forerunner to the Primary Care Trust, and really, in its infancy, was advising or working with the Family Health Service Authority, as it was, on the commissioning of services for the Gosport Peninsula.

Q I understand.
A There were ten practices in Gosport, 35 GPs. Each practice had a member on the Gosport Primary Care Group and I was one of those. I was the prescribing lead in the Primary Care Group, of which Jane was chair person.

Q She was chair of the Primary Care Group.
A She was.

Q For a short period of time or a number of years?
A Off the top of my head, several years, yes. Two or three years. At least three years, I would have said.

Q All right. From your knowledge of Dr Barton, both from committees on which you served, the Primary Care Group which Dr Barton chaired, and from other information from patients and other members of the caring professions locally, how would you say Dr Barton provided care for her patients?
A First of all, my experience with the Primary Care Group. She was a very competent, efficient leader of the group. She was supportive to me as prescribing lead. She was well respected by the members of the group, which comprised not only of doctors but nurses, managers/representatives from the Family Health Service Authority, and pharmacists – so a good range of health professionals and managers. I have to say that when Jane was asked to stand down from the committee in the late 1990s we were all shocked. I have to say that at the time we all offered to resign ourselves from the committee, and it is a testament to Jane that she was insistent that we should all carry on.

Q Forgive me, I was going to suggest it was about 2002 that she stood down when there was an investigation.

A Yes.

Q Does that sound as if it might be right?
A Yes, whatever year it was.

Q Do you have patients who have been treated over the years at the War Memorial Hospital?
A I do.

Q What we have heard is that it is a community hospital and that there would be many patients who are local residents in the Gosport area who would be treated there. You will have patients of your practice treated there.
A Yes – not under my care, these days, because I am not on a bed board, but certainly in the past, yes.

Q Would you at an earlier time have treated patients on Sultan Ward, which is the ward that we heard in the 1990s was a GP bed ward?
A Yes – not as many as perhaps some of the Gosport GPs, because of the distance from Sultan Ward, but certainly our practice admitted patients to Sultan Ward.

Q For any patients of yours that were treated on the wards where Dr Barton was a clinical assistant, are you able to help us with what level of care they were receiving – so far as you understood.
A I think Dr Barton in her role in the hospital would have been more involved with the patients who came under elderly care. The patients on Sultan Ward were under my care as a GP, if you like, but our paths would have crossed. Certainly I was not aware of any concerns about level or standards of care.

Q I am grateful. You were the general practitioner for a patient whom the Panel are considering, a lady called Gladys Richards.
A Yes.

Q I think you are concerned about issues of confidentiality, touching on Gladys Richards and the care that she might have received.
A Yes.

Q I would like to ask you some questions, but very few, about her.
A I am concerned about confidentiality. I would just like reassurance from the Chairman that it would be appropriate for me to reveal some aspects about Mrs Richards.

THE CHAIRMAN: We are at present in open session and, as I indicated earlier, a transcript is made and, indeed, it is published. Is the suggestion that we should hear part of this evidence in closed session?

MR JENKINS: Sir, no, not at all. I wonder if I might clarify one matter with Dr Bassett.

THE CHAIRMAN: Yes, please.

MR JENKINS: I am only going to ask you about her medical health.
A Yes.

Q I will not ask you about anything else.
A Yes. I know.

Q If those were the extent of the questions that I asked, and if the Panel are happy, are you content for me to ask you those questions in open session?
A I am, yes.

MR JENKINS: Sir, that is the basis. I know that Dr Bassett has had some concerns about confidentiality – understandably – but he knows that the Panel have access to medical records dealing with Mrs Richards.

THE CHAIRMAN: It is not that so much as the fact that this is a public session, it is open to the public, and there are frequently members of the press in attendance. If he has concerns about anything about this patient's health being asked in public, then he needs to be aware of the fact that it is not private, it is not limited to the people in this room.
A I do not think they are concerns. It is just a statement of fact, if you like, of the condition of the lady. It is nothing more than that.

Q If you are happy to be asked, in effect in public, about the health position.
A I think it would help to clarify.

MR JENKINS: I should add that I will be asking Dr Bassett no more than the sorts of questions that other witnesses have been asked about the 12 patients in this case in relation to Mrs Richards. I will just ask about her condition and his observations of it. I have to say from the perspective of this side we do not think there is any need for concern.

THE CHAIRMAN: That is absolutely fine. It is your witness; I do not think there is any assurance that I can give or reassurance that I can give other than that we are happy to hear if you are happy to tender evidence.

MR JENKINS: I am going to go on, Dr Bassett. You will have been this lady's GP for a short time or a long time?
A Four years.

Q I do not know when you last looked at any medical records for her, but are there reasons why this lady's condition may have stayed in your memory over the last ten years or so.
A There are.

Q There has been some publicity.
A Yes, because of the publicity.

Q What we know is that she was a lady of 91 when she had a fall and broke a bone in her hip.
A Yes.

Q With what regularity would you have seen her in the period before she was admitted to the War Memorial Hospital?

A Probably in the six to nine months before she was admitted to the War Memorial I saw a fair amount of her. She was the age you have just described, a very frail lady with severe dementia who was really quite agitated and difficult with a tendency to wander and certainly a risk of falling within the nursing home where she was living, so it was not a surprise to me that she was admitted with a fractured neck of femur to the hospital.

Q I understand. What we know – and the Panel have the medical records in front of them and I am looking at the records for this lady, page 108, which is an assessment in February 1998 by Dr Banks. Six months before she was admitted to the War Memorial Hospital she was described as a lady who has severe dementia and who, since Christmas, seems to have deteriorated further.

> "Her speech is very mumbling and incoherent although occasionally she comes out with a few audible understandable words."

Does that reflect the patient that you knew?
A It does. I asked Dr Vicky Banks to review Mrs Richards, mainly because I was concerned about her agitated behaviour, the calling out and the effect on other residents in the nursing home, and her tendency to wander which was a risk to her own health for that reason.

Q I understand. Dr Banks went on in that letter, again six months before the admission to the War Memorial Hospital,

"This is a lady with severe dementia with, I think, end stage illness, and as a result it is not surprising that she does spend considerable periods of the day asleep. She obviously needs some help to relieve the distress she experiences when she is awake"

- and there is reference to haloperidol and other forms of medication.
A She was on small doses of haloperidol and I do remember that it was of some benefit. As I say, I felt more confident in prescribing it with the endorsement of one of my psychiatric colleagues.

Q We have entries – for those who want to follow the entries in the medical records – at page 172 that she was admitted to the Accident and Emergency Department at the end of July 1998 and the indication was that she had started falling over over the last six months or so, and that the quality of her life had decreased markedly over the last six months.
A That would be a very accurate representation.

Q That is at page 172, Patient E. The earlier record that I had been reading from was page 108 and page 110.

This lady underwent an operation following her fall and she was then admitted to the War Memorial Hospital and then transferred back to the original hospital for a further procedure. In your view how frail was this lady at about the time that she fell?
A Extremely frail. Fractured neck of femur in an elderly person has a high mortality rate anyway and somebody in Mrs Richards' clinical state, with severe dementia, very agitated – there would be no hope whatsoever of rehabilitation because of the lack of response to any sort of physiotherapy. It is a two-way communication so it did not surprise me at all when I heard that she had died.

MR JENKINS: I see. Thank you very much, Dr Bassett. Would you wait there because you may be asked a few questions by others?

Cross-examined by MR KARK

Q Just in relation to your last comment "no hope whatsoever of rehabilitation". When had you seen her prior to 30 July?
A Without her notes I could not possibly tell you.

Q Can you give us a clue?
A I guess from the point that she was in the nursing home – her general state certainly in the last six months was very, very poor. I cannot imagine that her clinical state would have improved so I could not actually tell you the date, no.

Q We have just heard from a Rear Admiral who was a surgeon at the hospital from which she was transferred, telling us about the quality of care at that hospital and the quality of the nurses and the quality of the notes. The note that was made at that hospital on 3 August following the operation was –

> "All well on ward, sitting out. Has nursing home place for family not happy for her to return to GWMH."

Then she is reviewed by Dr Reid who describes her as:

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

The day before her referral she is described as:

> "Fully weight-bearing, walking with the aid of two nurses and a Zimmer frame. Needs total care with washing and dressing."

On what basis do you say she had no hope of rehabilitation? Are you saying no hope of going to a rest home?
A In my experience as a GP patients with a fractured neck of femur – I did not see her after she broke her hip but in my experience elderly patients who break their neck of femur have a high rate of morbidity and mortality following the operation if they survive the operation, and particularly with severe dementia I would have been surprised if there had been a major recovery even back to her pre-fracture state if you like.

Q I understand that and we understand that there is a high mortality rate but this lady was operated on. She was transferred, apparently in a state to be transferred to the GWMH and yet you are saying she had no hope whatever of recovery.
A I would have been surprised. Maybe it was the wrong word to use, "no", but little hope. I would have thought it would be unlikely. It would not come as any great surprise if she did not survive the episode of what is a major event anyway, a fractured neck of femur in a lady with very severe dementia.

Q I understand that, but that is a different way of putting it, is it not.

A That would be perhaps the most appropriate way.

MR KARK: Thank you.

Re-examined by MR JENKINS

Q We are fortunate that we do have some medical records for Mrs Richards. I am going to ask you to turn to your left – do you have a file with the letter E on it?
A Yes.

Q I have read to you Dr Banks' assessment of Mrs Richards in February 1998 and I am going to ask you to turn to page 90 if you would in that bundle. There are lots of different numbers on these pages, it is the typed number with a little line at each side. It may be that there is a large handwritten 9 on that page.
A I am with you.

Q Dr Banks' request for DV from Dr Bassett.
A Yes.

Q DV refers to?
A Domiciliary visit.

Q We have got Mrs Richards' details and her date of birth and we have the date of this at the bottom, 4 February.

MR KARK: Sorry, does this arise out of cross-examination?

MR JENKINS: Yes, it does.

M R KARK: This is six months before the period that I asked the doctor about.

MR JENKINS: It does; we are going to go through the medical records and we have the GP records towards the end of the picture. I would say of course it arises out of cross-examination – unless there is any objection from the Panel. This is he GP who knew her for four years.

THE CHAIRMAN: The element that was being asked about is a full half year later. In order to deal with Mr Kark's point is it necessary to go back so far into the patient's history?

MR JENKINS: He did say he did not have his medical records and he would need to look at them. We have got them and I am going to come on to them – they are towards the end of the bundle and I was going to put it in context if I may.

THE CHAIRMAN: If you think it is going to help the Panel, Mr Jenkins, then do so.

MR JENKINS: I do. Page 90.

> "Severe dementia for some years. Very confused. 0 out of 10 on dementia scale. Wandering and worried that she might fall downstairs. Howling throughout the day. May also be depressed. Expressed a wish to die. Not eating, not taking medication."

There is a reference to you seeing her before Christmas and the Panel will see what is said.
A Yes.

Q Can I take you towards the very end of the bundle, page 773?
A Yes.

Q These are Lloyd George cards I think.
A They are; sorry, excuse my writing.

Q If it is your writing I think we can read it.
A I call it functional – the level of a five-year old but readable.

Q Is that your entry for 4 February?
A It is indeed.

Q Can you just read it to us?
A 4 February:

"Wandering downstairs. Constant howling. No appetite. Staff having to keep close eye. More confused, 'Let me die, let me die'. Only having haloperidol PRN – suggest 0.5 mg regularly, three times a day (TDS). Taking Trazidone [an anti-depressant] 50 mg, two at night. Very confused, denies headache or other pains."

The note on the side is

"Urgent DV Dr Banks. Discuss with Dr Banks end stage dementia. Agrees continue regular haloperidol."

Q If we go over the page do we come to early March 1998?
A Shall I read that?

Q Please do.
A

"Fell about five days ago. Discomfort right shoulder. Bruised and low back pain. Right lower lateral chest. Chest clear. Had been better on haloperidol 0.5 mg three times a day though occasionally wanders. Massaging hands with lavender oil soothes and relaxes. No serious injury. Paracetamol 500 mg TDS [three times a day]. Continue haloperidol 0.5 mg three times a day."

Q Is there then a repeat of paracetamol on 19 March?
A Yes.

Q Then an upper respiratory tract infection, a cough.
A

"Cough, chest clear. Advice only. More settled, less agitated. Slightly more drowsy but more acceptable. Continue haloperidol one ml twice a day."

Q If you go over the page is that an entry in someone else's handwriting?
A That is one of my partners.

Q About one of the daughters being concerned about the medication.
A Yes.

Q "Query in pain. Calling out and holding ribs."
A Yes.

Q Was this lady able to communicate effectively verbally?
A No.

Q Then do we have an entry a couple of days later on 9 June, "Daughter concerned re haloperidol"?
A Yes.

Q "Staff report agitated ++ if she did not have it."
A Yes.

Q "Permitted if she is not well. Daughters feel she should not have it." Can you read the rest of it?
A Sorry, "Granddaughter in agreement with it." The daughter felt that she should not have the haloperidol.

Q Advice to?
A "Nursing staff."

Q Is the advice recorded over the page at 776?
A "Continue as prescribed. Refer family to me." I felt if there were divisions in the family – if there was a clinical need between myself and the nurses for the medication, endorsed by Dr Banks, then I felt that was in the best interests of the patient. If there were divisions within the family, if some people felt she should and some she should not, I felt it was appropriate for me to air it, to discuss it with the family.

Q You felt the advice to the nursing staff should be to continue as prescribed.
A Yes, that was my judgment.

Q Why?
A Because she was more settled on it. It was not for the good of other residents it was because she was actually distressed and these were small doses, and she was at risk with her wandering.

Q Is it the next day, 10 June, "Two daughters seen."
A Yes.

Q "Collapsed three days ago."
A Yes.

Q Is it "Recovered since"?
A Yes, it is, sorry.

Q Is that "pros and cons" ---

A "Pros and cons of the medication discussed and the care at the home."

Q Then a month later, towards the bottom of the page: "More agitated, screams out".
A Yes.

Q "Fire".
A Sorry, that is "Fine at night. Resettled, fearful."

B

Q Did you increase the haloperidol?
A I did, one ml twice a day.

Q If we go over the page, 23 July, this is a few days before she is admitted to hospital.
A Yes.

C Q "Fell at the weekend?"
A "Fell at the weekend. To Haslar. Admitted, fractured nose."

Q Fractured?
A Nose. "Left wrist noted to be swollen yesterday." This is why I was called, I think. "Better today, not obviously in pain. Tubigrip." I guess the nursing staff were concerned that it may have been an injury that was missed to her wrist, hence the call for me to visit her.

D

Q Is the next entry yours for 19 August.
A The V is for visit, T is for telephone. "Mrs Jane Page, principal nursing home inspector. Complaint about the home from Mrs Lang, the daughter, to social services. Allegation of over-sedation. Discussed the reasons for treatment with haloperidol and trazidone and previous open discussion with daughters."

E Q Does the last entry relate to Dr Barton?
A Dr Barton, further fall. Telephone call from – yes, it would have been from Dr Barton. "Further fall. Fracture/dislocation of the hip. Developed bronchial pneumonia and died peacefully."

Q Thank you. Is it from that history that you are able to give the view that you have?
A It is indeed. As I say, that is the first time. The reason Mrs Richards stuck in my F mind is because of the contact – some patients even from some years get stuck in mind – it was because of the contact I had with the family. The actual sequence of events I could not recall exactly because this is some time ago.

MR JENKINS: Thank you very much, Dr Bassett. Would you wait there because you may be asked one or two more questions?

G THE CHAIRMAN: Thank you, Doctor. As I indicated, members of the Panel have an opportunity to ask questions of you. I am going to look now to see whether members have questions – there are no questions from members of the Panel. It follows therefore that your testimony is at an end.

Thank you very much indeed for coming to assist us today. It is only through the presence of witnesses such as yourself that this Panel is able to embark on the difficult task of piecing H together a true understanding of the situations and circumstances that pertained, often months

or indeed years before today. For your assistance in that regard we are extremely grateful. Many thanks; you are free to leave.

(The witness withdrew).

MR LANGDALE: Sir, in terms of tomorrow – one witness, not going to take too long, Mr Jenkins assures me – and then the expert witness, the length of whose evidence in total it is difficult to predict, but I anticipate both witnesses will be completed tomorrow, but we will have to see.

THE CHAIRMAN: Very well, thank you very much indeed, Mr Langdale. We will rise now and meet tomorrow at 9.30. Thank you.

The Panel adjourned until 9.30 am on Wednesday, 29 July 2009