Prof Ford. 10 Charles Fashing.

EXPERT REPORT 2001 by Prof G A FORD

(Embraces transcripts of police interviews including LORD and BARTON

Summary:

- 21 Sep (am) Lord: MAKE COMFORTABLE, GIVE ADEQUATE ANALGESIA (3.2) 21 Sep (later) Barton: AM HAPPY FOR STAFF TO CONFIRM DEATH (3.2, 3.14) 24 Sep: Lord*: Remains unwell AM HAPPY FOR STAFF TO CONFIRM DEATH (3.2)
- No FOOD or FLUIDS given after admission, despite a high protein diet being prescribed (3.21), denial contributed to his demise (3.23)
- Did LORD* really visit ADBC on 24 Sep???????? (3.2, 3.7, 3.9). If she did, she wilfully avoided seeing me having previously cancelled my appointment with her, and MUST have known of my presence in the hospital
- 22 Sep "Explained" (WRONG if to CRSF) that a syringe driver had been commenced for PAIN RELIEF and BAD BEHAVIOUR (3.4)
- Nursing notes mention he was agitated on evening of 21 Sep, no investigation into cause, and NOTHING ABOUT PAIN (3.8)
- CONFLICT between Lord's care plan which was competent and appropriate (oral morphine as required) and Barton proceeding with subcutaneous infusion syringe driver) later on same day for no apparent reason other than BAD BEHAVIOUR (3.4, 3.8, 3.10, 3.14)
- Use of a syringe driver and dose escalation were highly inappropriate (3.10, 3.13, 3.16, 3.17), unjustified (3.13), and reckless (3.24). Dosages could have been REDUCED and antibiotics commenced given a correct diagnosis of the chesty symptoms on 23 Sep (3.17)
- 23 Sep: FAILURE to consider that respiratory symptoms were due to INDUCED respiratory depression caused by opiates (3.8, 3.9, 3.10, 3.13, 3.15, 3.19, 3.20). Highly likely that this caused respiratory depression and contributed to death through pneumonia (3.24)
- 24 Sep: No recorded reason for increasing the drug dosages (3.9)
- 24 Sep: How was it possible to determine ADBC was in pain when he had been UNCONSCIOUS since before lunchtime on 23 Sep????? (3.18)
- WRONG There WAS a post-mortem (3.22) at my insistence

Chronic Emstipation

Andlow breather