Dr Jane Barton

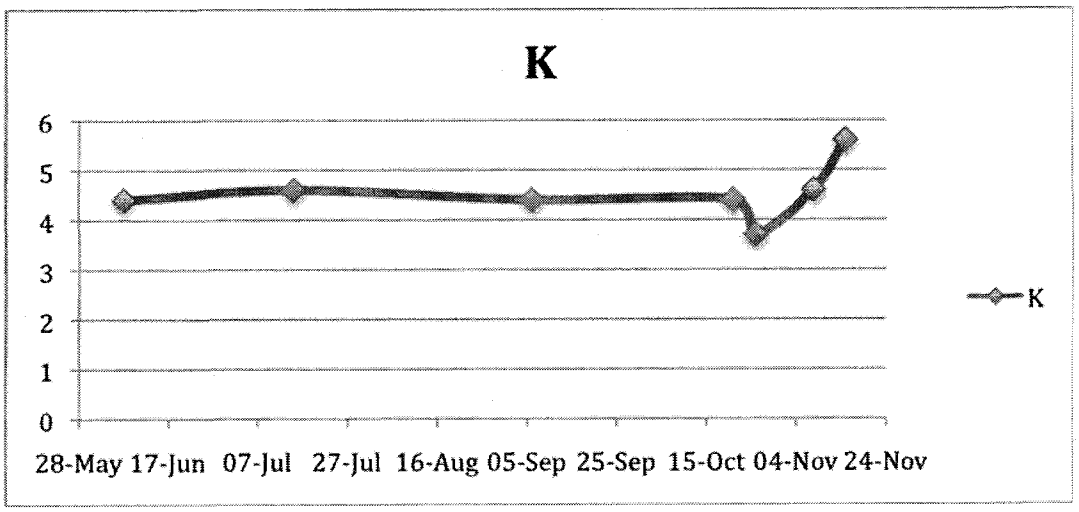
1. (S)(1) You state that my Mother had a series of diagnoses, including
    a. Multiply Myeloma – incorrect
    b. CRF – secondary to nephroitic syndrome – as per her transfer sheet this was considered MODERATE
    c. Vascular dementia – incorrect/unproven – as per her transfer sheet she is found to be 'quite alert'. And as her Consultant Haematologist stated 'bright mentally'
2. S)(1) You state that my Mother had initially responded well to intravenous fluids and anitbiotics at the QA. She had responded well and was recovered by the time of her transfer to the GWMH. Could you please clarify what you mean by initially?
3. (S)(1) You state that my Mother remained aggressive at eh QA – this is not true, my Mother was much more at ease with her hospital surrounding once she was familiar with the staff. There is a difference between being aggressive and being assertive.
4. (S)(2) You state that she was seen by the Dr Lusznat and a member of the mental health team on the 14th; but in fact it was only Dr Taylor. On the 13th it was stated by Dr Cooper in my Mother's file that my mother had CRF (No myeloma)
5. (S)(2) Taylor states incorrectly that my Mother had been deteioriating at home since Jan 99. She states that it is 'likely' that my Mother had dementia. The MMSE score was 9/30, which suggests severe dementia. The reason Taylor still writes 'likely' is because he/she notes that my Mother was deaf and may in fact not have heard the instructions/questions. For the record my Mother had 0% hearing in one ear and 30% in the other
6. (S)(2) Taylor states that my Mother should be referred to SS for residential placement. And her Geriatric physician Dr WK Jayawardena states that she is only in need of rehabilitation care. The family always intended to have my Mother return home – her care was only necessary whilst my Husband was having a bone marrow transplant in London; not at the Brompton Hospital as you state, but Hammersmith Hospital.
7. (S)(2) You state that the family had complained about my Mother's care at the QA, to clarify, my Mother was given no fluids at the QA and if we had not complained she would have suffered dehydration.
8. (S)(3) You state that my Mother had a CT scan on the 18th which confirmed the diagnosis of dementia and was reported as showing involutional and ischaemic changes. The involuional changes you speak of were recorded as 'normal for her age' and the ischaemic changes were reported as patchy low density in the white matter. Neither were significantly severe.
9. (S)(3) You state that you clerked my Mother on the day of transfer to the GWMH and recored her previous diagnoses of:
    a. Dementia – which was never diagnosed
    b. Myeloma – which was never diagnosed
    c. Hypothyroidism
    d. You fail to write up her CRF which is why she required the diuretics Frusemide and Amiloride (the later you fail to include in her prescription)
10. (S)(3) You state that my Mother's creatinine was 206, where do you get this reading? My mother had a previous reading Sept 9th of 203, and her reading of the 22nd Oct was 187.
11. (S)(3) You state that 'the plan was to get to know her, assess her rehabilitation potential, with the probability of transfer to a rest home'
    a. why then do you write up Oramorph? Why not try paracetamol?
        i. It should be prescribed with special precaution in the elderly in general, but moreso in patients like my Mother with hyperthyroidism and kidney disease.

(Reductions in dosage may be appropriate in the elderly, patients with moderate-severe renal impairment)

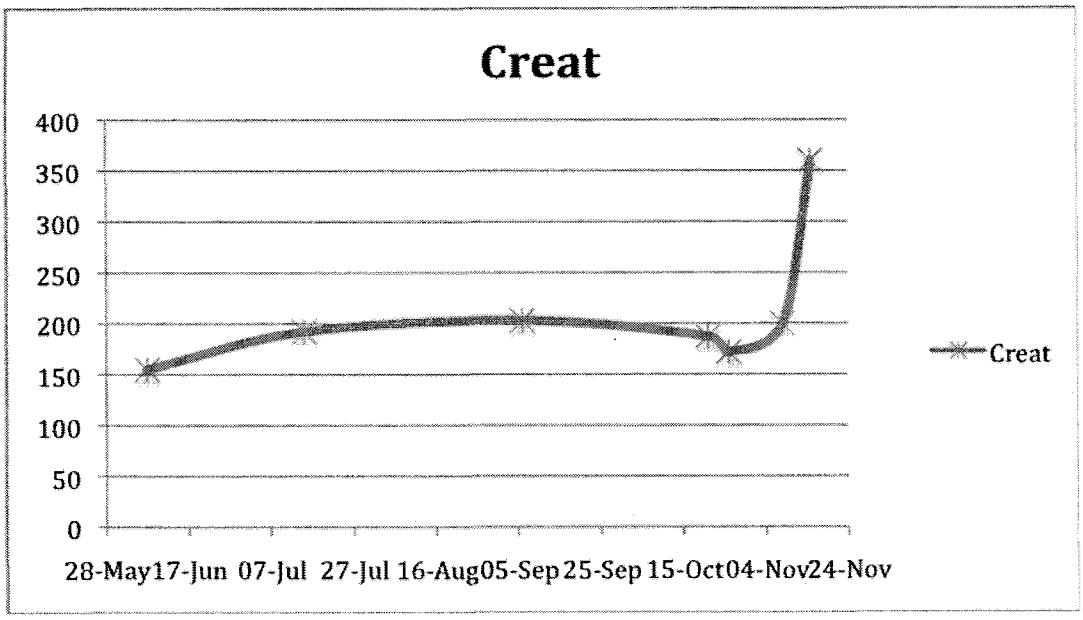
ii. 10mg is the starting dose for an adult, given in 5ml doses, this is not considered low.

iii. It is For the relief of severe pain, my Mother had never shown any signs of this – what made you think that she would in the future?

12. Her transfer letter does not state that she is suffering dementia or confusion
    a. (S)(3) why do you write up 'acute confusion' which is Delirium, my Mother was never diagnosed with this? This is a serious cognitive disorder which can require institutionalisation if untreated.
13. (Q)(3) If my Mother left the QA with a Bartel score of 12, how did she then have a Bartel score of 8 upon arrival at the GWMH?
14. (Q)(3) You write up her prescriptions to include temazapan, because you state that you followed the drugs my Mother was given at the QA, but you fail to prescribe Amiloride.
    a. It was crucial for my Mother's potassium levels to remain stable, thus to receive both Amiloride and Frusemide – why did you stop this drug?
15. (S)(4) You state that you you 'believe' you spoke to my Brother and established that my mother was unable to continue living at home as she had become too demented and frail.
    a. This is a total fabrication on your part, this conversation never took place and secondly were is the medical evidence to support this statement?
16. (S)(5) You state that my Mother's creatinine initially improved, 187 on the 22nd October, 172 on the 27th October. Though you note that this was still clearly abnormal.
    a. My Mother's creatinine had been maintained between 150 and 200 for 8 months, she had CRF, which is a SLOW progressive disease, her creatinine levels were never to be normal, but they would not have risen dramatically unless and acute on chronic episode had been initiated – usually by drugs.
17. (S)(6) You state that on the 1st Dr Reid indicated that my Mother should be started on Amiloride. The drug, which you withdrew from her usual prescriptions upon admittance to the GWMH.
    a. You said that it was used to enhance the effect of the Frusemide, but you miss that the Frusemide alone was lowering her blood potassium therefore Amiloride was required to bring it back into normal range.



18. (S)(6) You state that on the 9th November 'we' had the first indications of biochemical deterioration with a creatinine of 200
    a. Who is we?
    b. My Mother creatinine has been between 150 and 200 for months, why was this seem as a deterioration?
    c. If you were aware of something else, which suggested a biochemincal deterioration, why did you not transfer her back to the QA?



19. (S)(6) You state that due to my Mothers general condition you commenced Thioridazine on the 11th November.
    a. Thioridazine is effective in helping symptoms such as hearing voices, loss of energy, thought disturbances and difficulties communicating with others as well as other symptoms of schizophrenia.
    b. Before commencing treatment with thioridazine, baseline ECG should be performed and serum calcium, magnesium and potassium levels measured and corrected in all patients. This was never done for my Mother.
    c. It should also be subscribed with special precaution in patients with CRF since the potassium wasting diruetics can cause the patient to become Hyperkaelemic, and the drug increases creatinine levels. As far as I can see from my Mother's blood tests after you commencing this drug that is exactly what happened.
20. (S)That same day of the 11th, when My mother had apparently required this antipsychotic drug I visited her with my Daughter. She was returning from having her hair washed and we sat with her whilst she chose her food from the menu. Not one member of staff spoke of any deterioration in her behaviour and we did not note anything either.
21. (S)(6) You state that you wrote up Trimethoprine also on the 11th November as you were concerned that she might have had such an infection. You state that you wrote up the prescriptin so that the antibiotics could be commenced as soon as possible in the event of a positive test – Which wasn't due back until the next day.
    a. (Q) The Trimethoprim was indeed written up on the 11th, and commenced at 0800 hours – this was 30minutes prior to the administration of the Thioridazine and was continued at a dosage of 200mg to be given twice daily for 5 days.
        i. Can you explain this?
    b. It is well advertised that Trimethoprim although not directly related to causing renal failure is to be used in caution when anyone suffereing renal disease, as it causes not only an 'artificial and thus reversible rise in serum creatinine, but also puts the patient – much like Thioridazine at risk of hyperkalaemia with non-oliguric renal failure. Those patients are seen, just like my Mother to have deranged blood

results after just 4 days of treatment (with Trimethoprim alone).

22. (Q) Why were the side-effects of the drugs my Mother was given not considered as part of her relapse?
23. (S)(8) You state that on the 16th November my Brother visited (Henry Devine) and 'we' attempted to make him aware of the marked deterioration.
    a. Who is 'we'?
    b. Where is this attempt noted in the records?
    c. To clarify no attempt was made and no member of the family was informed either of my Mother's deterioration or of her drug change.
24. (S)(8) You state that on the 18th my Mother was seen by a psychiatrist, I will return to this point, as the chronology of your statement is incorrect.
25. (S)(9) at 0915 you commenced my Mother on a Fentanyl patch, allegedly to calm my Mother.
    a. But in 1999 Fentanyl transdermal patches were only licensed for the relief of chronic intractable pain due to cancer.
    b. You state that you administered this because of the team's concern for her obvious discomfort and yet you leave my mother for the fentanyl to take affect – up to 12 hours? Her discomfort was so obvious and serious that you did not even administer light pain relief? You had written up Oramorph upon my Mother admission because you wanted pain relief to be available to my Mother in case she experienced distress and discomfort and a doctor was not available to write up a prescription for her. Yet my Mother was in such pain and your team were so concerned that this was no given with her Amilioride that morning? Or did my Mother only start having pain when Gill Hamblin came on Duty?
        i. Who was this team?
    c. Fentanyl patches are only to be subscribed to opioid tolerant patients (Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid). To be clear, on the morning of the 18th, after the Fentanyl had been administered for approximately 2 hours (keeping in mind that the patch takes up to 12 hours to relieve any symptoms of pain. My mother was sat drinking tea with her ex daughter in Law (Sandra Briggs)in the Lounge. (my Mother who you allege was not drinking or eating well at this time) Sandra was so unaware of any terminal restlessness or pain that they asked if they could take their chat to the hospital coffee shop – this request was denied. Later that same day my Brother (Henry Devine) visited his mother and recorded no behavioural concerns.
        i. During both of these visits neither were notified of my Mother entering the terminal phase, experiencing pain – or even the fact that a strong opioid had been initiated. (for whatever purpose)
26. (S)(8) To return to your statement regarding my Mother being visited by a locum staff grade psychiatrist. In their statement they do not clarify or suggest that they have seen either the restless or aggressive behaviour for themselves. They also record that my Mother is refusing her medication.
    a. My Mother took her Amiloride that morning? Her refusal of frusemide/thyroxine was not until 0800. This was not written on the medical or nursing notes, only that the drugs were ceased. Any previous refusals had been written on her chart at 'refused'
    b. The psychiatrist also notes that her physical condition is stable – yet you state that you started the fentanyl when you already had knowledge of her creatinine having risen to 360? The timings of both statements do not tally. This means that the psychiatrist visited my Mother between 0800 and 0915, however the blood results were available after they left but before 0915.
27. NOTE: According to the FACTS as outlined by Max Millet these tests were not available until Lunchtime? How then does Barton use them to prescribe the Fentanyl?

28. (S)(9) You state that upon arrival on the ward on the morning of the 19th November you found my mother to be in an extremely aggressive state, hanging onto the bars in the main corridor. She could not allow anyone to approach her or administer any of her usual medication.
    a. What medication? You ceased all medications on the 19th? (no effort was made to try and give my Mother her Frusemide or Thyroxine after her initial refusal) In fact you crossed the Thyroxine out to show that it wasn't going to be administered ever again up until the 30th November?
    b. Gill Hamblin states that you were telephoned that morning and you prescribed the Chlorpromazine drug from your surgery over the phone? and yet you state you witnessed my Mother holding onto the bars in the corridor and decided to administer the intramuscular injection? Which is true?
        i. Chlorpromazine should be avoided in patients with liver or renal dysfunction.
        ii. For severe mental or emotional disorders Adults—At first, 25 to 50 mg, injected into a muscle. The dose may be repeated in one hour, and every three to twelve hours thereafter. Why did you see that 50mg was appropriate for an elderly frail woman? To sedate an Adult the recommended dose is 25-50mg and this should be reduced in the elderly.
        iii. Chlorpromazine is not for use in psychotic conditions related to dementia. Chlorpromazine may cause heart failure, sudden death, or pneumonia in older adults with dementia-related conditions. Do not use chlorpromazine if you have brain damage, bone marrow depression, or are also using large amounts of alcohol or medicines that make you sleepy. (yet you had already administered Fentanyl which causes drowsiness and then went on to administer Diamorphine and Midazolam)
        iv. If you have certain conditions, you may need a dose adjustment or special tests to safely use this medication. E.g. Kidney disease.
        v. Older adults may be more likely to have side effects from this medication
29. (S)(9) You state that my Mother had already received opiates in the form of the Fentanyl, and had been resistant to this to a degree. I state that her behaviour was in fact descriptive of Fentanyl toxicity not resistance. How do you explain that my Mother was either opioid tolerant or resistant?
    a. Toxicity symptoms
        i. Respiratory depression
        ii. Convulsions
        iii. Renal failure
        iv. Agitation
        v. Vivid dreams
        vi. Nightmares
        vii. Hallucination
        viii. Confusion
    b. Symptoms of a Fentanyl overdose can include: slow or difficult breathing, severe sleepiness or sedation, **cognitive disturbances, dizziness or faintness, confusion, and other abnormal reactions.** Patients experiencing any of these symptoms while on the Fentanyl patch **should receive immediate medical attention.**
    c. Fentanyl is strong medicine for serious pain. The Fentanyl patch should only be used when other less potent medicines have not been effective and when pain needs to be controlled around the clock. As far as I can see there is no justification for administering the Morphine and Midazolam in addition to the Chlorpromazine.
30. (S)(10) You state that at this point it was clear that my Mother's renal function had deteriorated markedly, superimposed on her dementia, and she was no dying.
    a. I have no doubt that after 1 week of kidney damaging drugs and an overdose of fentanyl that this was now the case.

b. Why was my Mother not titrated onto the diamorphine knowing that the half-life of the Fentanyl would have been 17 hours or more? This patch was already delivering up to 135mg of Morphine and you decided to then increase this by another 40mg?
c. Morphine in adults is a starting rate of 60mg a day (BNF palliative Care formula PCF), 20-40mg a day under the Wessex protocol and far exceeds that as advised for the elderly of 30mg a day or less.
d. This does would be accelerated in Opioid –naïve patients (as my Mother was) the PCF advice a minimum dose of previous opioid. E.g. at least 240mg of codeine a day, and this is based upon the entry criteria used by the company in their initial trials for fentanyl.

31. (S)(11) You state that you visited my Mother every weekday morning and had met my Brother on at least 2 occasions.
    a. This is a total untruth, the first and only time you met my Brother was when my Mother was already unconscious and dying.
32. (S)(11) You state that you returned on the evening of the 19th to meet with the rest of the family as you were aware of how important it is to keep relatives informed.
    a. Not once did you keep the family informed of my Mother deterioration or change in treatment.
33. (S)(12)You write up initially that my Mother died of renal failure – this being rejected write chronic glumerulonephritis.
    a. Blood in the urine – which my Mother didn't have dark brown-colored urine (from blood and protein)
    b. sore throat – which my Mother only complained of a sore mouth of after the drugs were administered
    c. diminished urine output – which my mother didn't have
    d. fatigue – which my mother didn't have
    e. lethargy – which my mother didn't have
    f. increased breathing effort – which only developed in the last days of her life due to the respiratory depression of the drugs
    g. headache – which my mother didn't have
    h. high blood pressure– which my mother didn't have
    i. seizures (may occur as a result of high blood pressure) – which my mother didn't have
    j. rash, especially over the buttocks and legs – which my mother didn't have
    k. weight loss – which my mother didn't have
    l. joint pain – which my mother didn't have (only in her knee which she was due to have a replacement on)
    m. pale skin colour – which my mother didn't have
    n. fluid accumulation in the tissues (edema) – which she had had for years and was never proved to be a result of glumerulonephritis.

    The death certification clearly was given a cause which you place purely on the comment, 'likely to be longstanding glumerulonephritis" from Judith Stevens, who may I remind you had no concerns regarding my Mother's health because she didn't want to see her for 2 months.
34. (S)(14) You state that the fact that my Mother still responding to me by squeezing my hand at the sound of my voice on the 19th and 20th and that suggested that the medications she was given were reasonable and in the best interest of my Mother.
    a.

Diagnosis

- Multiple Myeloma
- Chronic renal failure
    - Secondary to nephrotic syndrome
- Vascular dementia
- CRF likely to be longstanding glumerulonephritis

Said Gran was aggressive at QAH but said she stopped once she got to know the staff. This was only one night after she had been given

Dr Lusznat's dementia test was carried out at an inappropriate time when Gran has not been allowed to settle and put at ease. She also didn't know the facts behind Gran's admittance to the [redacted]WMH. She was not going long-term in a home. She was coming home.

CT Scan showed dementia, but remember 20% of the population over 80 have dementia.

- The progression of vascular (multi-infarct) dementia is slow when patients have good blood pressure, good diabetic control and don't smoke.
- Often memory is affected 1st. People forget important facts such as family names – which Gran did not. (see letters/cards)
- Later as the illness progresses, people get confused about things like where they are, what day it is etc. (but remember gran didn't know the hospital and had no reason to know what day it was – in fact it is very common in retired people not to know the day)
- In the Later states people lose the ability to wash, dress, feed themselves (Gran was able to do all of these things up until the drugs were administered)

REMEMBER thyroid problems (which Gran had), depression, infection (which Gran had), and [redacted]itamin deficiencies can all be mistaken for dementia.

(taken from Professor Marion McMurdo, honorary consultant in medicine for the elderly; Head of ageing and health at University of Dundee)

Bartel score was assessed by JB as 8. How had it dropped 4 point in 5 days? Where did JB get her information, and where is this Bartel test in the notes?

J Taylors mini-mental test is null and void. Gran was likely not to have heard the questions. She knew the season and month; she knew Dad was going into Hammersmith Hospital and where we all were and that we would hopefully be out for Christmas.

JB writes up Oramorph upon admittance. This is used for severe pain associated with cancer or severe injury. Why write it up for a lady who had just recovered from a urine infection. Gran was not in there for any thing else. Especially concerning when it should be used with caution in

1. Elderly people
2. Decreased kidney funtion
3. Hypothyroidism

JB states that Gran couldn't live at home because she was too demented and frail. This was completed delusional of JB. It was only because of the bladder infection that Gran was there and care was to be temporary.

9th November JB states Gran had the first indications of biochemical deterioration – creatinine of 200. But in June her creatinine was 160 and Dr Judith Stevens was not concerned, in fact she remarked that this was 'normal' for her age; then again in July her creatinine was 192, and Dr Stevens was not concerned and left Gran for another 6 weeks. On the 7th September her she saw Dr Stevens again and was sent away for another 8 weeks. Most importantly when her creatinine increased why were her fluids not increased to bring the levels down?

On the 11th November JB wrote up Thioridazine, which is a potent antianxiety and antipsychotic agent because on the 10th Gran had refused her night sedation and was wondering around the ward. These actions are not part of a psychotic disorder. Why move from no drugs to Thioridazine.

- Thioridazine may cause heart failure, with sudden death, or pneumonia in older adults with dementia-related conditions. It is NOT to be used to treat symptoms of dementia (Cerner Multum, Inc Rev. 10/11/08)

On the 11th November JB also wrote up Trimethoprine for a suspected urinary tract infection. Why didn't she test for this BEFORE starting drugs and increase the fluids. This could have been the cause of the confusion NOT dementia. JB states that the tests were clear and the drug was not given. BUT on the prescription chart it shows that care nurses Barker and Bell administer it twice daily. How can this happen? It was started at 8am on the 11th and continued for 5 days and JB didn't know??

On the 16th JB says she (we) "attempted" to make Harry aware of Gran's deterioration. What does 'attempted' mean?

On the 18th Locum psychiatrist said Gran was deteriorated mentally – what time was this and after how many drugs? What did they 'actually' witness for themselves?

JB states that creatinine increased on the 18th to 360

- Gran was showing signs of reacting to the anti-psychotic drugs and possibly Neuroleptic Malignat Syndrome which causes agitation and delirium. Why else would she suddenly be holding onto the bars in the main corridor?

JB administered the fentanyl patch, which has the highest potential for abuse and associated risk of fatal overdose due to respiratory depression. It is for use in OPIOID-TOLERANT PATIENTS ONLY. Use in non-opioid tolerant patients may lead to fatal respiratory depression. The concomitant use of fentanyl with potent cytochrome P450 3A4 inhibitors may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving Fentanyl and potent CYP3A4 inhibitors should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted. Gran was given Midazolam, which falls into the above category. It should also not used within 24hours with any other drug which affects the CNS or respiration. Gran was given 3 other drugs within 24hours; Chlorpromazine, Midazolam and Diamorphine.

JB states that Gran had been resistant to Fentanyl patch that is why she prescribed Diamorphine. How did Gran show she was resistant? Why did JB administer the Diamorphine when the Fentanyl was still in Gran's system. Why did she administer the Chlorpromazine when the Fentanyl was still in Gran's system, and more over why was the risk of hypertension not eliminated by allowing Gran to lay down for at least 30 minutes after the drug was administered? Instead she instructed her nurses to walk Gran to her death.

Midazolam is typical when preparing terminal sedation, but typical initial dose for diamorphine and Midazolam in the naïve patient are 10mg of each over 24hours.