GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 5 August 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-EIGHT)

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. Welcome back everybody. Mr Langdale?

MR LANGDALE: May I begin by echoing Mr Kark in perhaps two respects? Whether or not they are the only ones, I am not sure. Firstly, this. I am not going to attempt to try to cover the detail of all the evidence that the Panel has heard in this case. That is for obvious reasons: it would be tedious; it would be a waste of time and we are all conscious of the fact that the Panel have been paying close attention, not only to all of the evidence when it was given, but at various stages reading transcripts and so on. If I fail to mention something, too bad. All I can do is try to assist you in terms of the points that I think are significant and deserve to be made on behalf of Dr Barton.

The second way in which I shall be to a certain extent echoing what Mr Kark said to you is in terms of approach. I am going to deal with some general issues first of all, and then turn to the 12 patients in a similar sort of manner to the way in which he carried out his side of the proceedings.

In terms of general issues, perhaps unusually in cases of this kind, what I seek to place at the very forefront of what I say to the Panel is two aspects relating to Dr Barton herself. Number one, her honesty and integrity; number two, her ability as a doctor. In terms of her honesty and integrity, this is not just put forward on her behalf on the basis of general good character. There is no dispute about that. But because that underlying fact – I suggest it is plainly the case that she was somebody of honesty and integrity, not only in terms of her conduct at the relevant time but also in terms of her evidence given before you – provides, we suggest, enormous support for critical features of her defence.

By way of example, did she properly examine and assess patients on admission? When she says she did, the Panel is entitled to give considerable weight to that. I do not think in fact it is really in dispute any more, because of the sort of person she is. She is hardly likely to be making that up. I am just dealing with these matters in terms of the support that they give for these issues. There is of course evidence from a number of quarters that she did properly examine and assess.

Did she review every morning and visit patients in terms of seeing patients who were on a syringe driver? She says she did. There is no reason to doubt that.

Did she exercise a reasoned clinical judgment when deciding that the commencement of a syringe driver was justified, and did the patient's condition call for the commencement of a syringe driver? Again, honesty and integrity persist in relation to that. I appreciate the Panel is going to make a judgment about her clinical judgment and her decisions in the light of all the evidence that it has heard, but it is a rather important point, we suggest, to bear in mind when considering that issue.

Was there a culture – which was at one stage suggested although it does not seem as if it is being persisted in now – of starting subcutaneous analgesia too early? There was not is her plain testimony on this. Her honesty and integrity add considerable weight to that assertion even assuming that that issue is being pursued.

Did the patient's condition justify an increase in the diamorphine and the midazolam administered? Was she a doctor who was committed to her patients' best interests? In this case it seems clear, and I am not surprised it has been made clear, that the GMC are not

suggesting that this doctor was not seeking to operate and act in the context of committing herself to the patients' best interests. That is not really in dispute.

Was she a doctor who was cold or callous or rude to relatives? Again, her honesty and integrity – leave aside the other evidence that goes to support her case – assists in that issue of the case, though of course it is not the subject of any charge or allegation against her. It comes in in terms of context and other matters which of course the Panel will consider.

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Did she care about her job and did she like it? Yes she did, is the short answer, until things got too much for her in the latter part of 1999 and 2000. Was she under excessive pressure, as she has told you she was? Again, her honesty and integrity go to support that in any event, leave aside the other evidence, because there plainly is other evidence to that effect. It is clear – perhaps I will express it in a very simple fashion – if only on this basis as to what happened when she resigned. Immediately, or very soon afterwards, a full time doctor was appointed Monday to Friday to look after these patients, and indeed even more input was made by those involved in management as time passed.

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The issue of pressure generally is tied up with the whole question of lack of resources. You have heard and she herself has accepted this, that the pressure she was under meant that her note taking suffered. She was faced with a choice between full notes and patient care. Pressure also meant and you have heard evidence about this from more than one quarter, that neither she nor the nurses could sensibly employ titration four-hourly. This perhaps presents a difficult issue and a difficult issue for the consideration of the Panel. What is a doctor to do in the circumstances in which Dr Barton was placed? It might be suggested in a teaching hospital, for example, that patient care as practised at Gosport War Memorial Hospital was sub-optimal, if she was acting as she did in the context of a teaching hospital. But that cannot be suggested here.

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Was patient care – another issue for the Panel to consider generally – as good as it could be in the circumstances in which the doctor was operating? That is the critical question. The pressures that she was under, the general circumstances and the lack of resources meant that anticipatory prescribing made sense in the interests of the patients. It is worth stressing that. There was no other advantage to anyone else. It did not help Dr Barton or the nurses to have anticipatory prescribing per se; it was to try to ensure that patients did not suffer unnecessary, undue pain or distress.

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It is Dr Barton's case, and we suggest on her behalf that it is supported by the evidence of a large number of witnesses, including the consultants, that given the resources at their disposal, patients were looked after as well as it was possible for them to be looked after in those circumstances.

Note taking: can I just deal with that, albeit very briefly? Dr Barton has accepted that her note taking was inadequate. There has been no issues about that from the start of this case. Not in every respect, but in certain respects. The matter the Panel will also want to bear in mind in terms of viewing Dr Barton's position generally and her conduct, is that the fact is, established by the evidence, that her lack of full or proper note taking did not at the time, throughout the years that the Panel are considering, create any actual problem. Not one witness has come forward to say, "The lack of notes means that I was unable to carry out my nursing duties properly" or "I was unable, as a consultant, to get the full picture". Nobody has said that her notes, brief or inadequate however one describes them, in fact created any

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problem at all in terms of the treatment of these patients.

It does create a problem now. It creates a problem for Dr Barton herself, and it creates a problem for anybody trying to look back at what actually happened and trying to establish the reasons or the background in which certain judgments or decisions were made. But it is not the case here – we have heard the adage more than once – that if it is not recorded it did not happen. It is a very useful little lesson to bear in mind, and no doubt that is driven home with doctors in training, nurses in training and so on. But the reality is that it cannot be suggested here, "Well something is not recorded. You say it happened Dr Barton, but it did not happen". That would mean Dr Barton being regarded as a witness whose integrity and honesty was not something that was accepted.

Also the Panel will need to consider, when considering that whole issue, the undeniable fact – again established by more than one witness – that note taking in those days, and indeed in a palliative care setting, was, compared to circumstances and standards now, pretty brief. Indeed, things which were regarded as acceptable in those days that could now justifiably be criticised. For example, I think it was Dr Tandy who said, "One would not use the expression now". What did a consultant do when they were indicating that in effect a palliative or indeed a terminal care path had been entered by a patient? "TLC". That was the sort of thing that was current at the time. It was not regarded as unacceptable at the time and no doubt is something that the Panel will bear in mind.

It is a matter to bear in mind in terms of note taking in particular when considering the inadequacy of Dr Barton's notes, as to why she took certain actions and as to when she formed her clinical judgments as to the proper course of treatment for a number of patients. She is the author of her own misfortune. She has to live with that and one is aware of the problems it has created in the context of this case.

Mr Kark suggested at one point that the inadequacy of her notes meant that she cannot prove that what she did had a reason behind it. The Panel will obviously bear in mind that it is not a case of Dr Barton having to prove anything. I shall be turning to the question of burden of proof, albeit briefly, a little bit later, but that sort of expression is something, when it is used, which has to be treated with some caution. It is not for her to prove her case in that sense. Whatever criticism can be made of her inadequate note taking, no one can suggest the care of any patients suffered as a result, and perhaps it is also worth bearing in mind in terms of this general issue the mass of evidence – Nurse Collins is one particularly fairly recent example of it from nursing staff – that there was a full exchange of information about patients on handovers, not only between nursing staff but also when Dr Barton herself came and visited the wards, either in the morning or indeed at any other time. There was a full exchange of information about patients and their condition and the developments that had occurred.

I said I was going to say something about the burden of proof, as it were, and the standard of proof. Obviously the GMC must prove these allegations in the sense that the Panel cannot find any one of the allegations proved unless either it is admitted or the evidence proves it. Our submission in relation to that issue generally is that in examining each one of the allegations where there is a dispute, taking into account all the criticisms made by Professor Ford, the result is when one looks at the evidence, that it is impossible to be sure that she was prescribing inappropriately. Whatever question marks there may be, that is the essence of Dr Barton's case in terms of the issue of proof. I do not want to over-emphasise it. The Panel will have it in mind. The Panel know what it means, but it is a vital

consideration in this case.

It is very important to bear in mind, just by way of further illustration, the question of proving when statements are made by witnesses – this is not a criticism of him – for example, Professor Ford, that such and such, "may be" the case in respect of a patient. "May be". "Maybe Mr Packman was a suitable case for transfer back to hospital". That is all Professor Ford can say. Maybe he was not, and if the Panel find in relation to allegations and issues in this case, that it "may be" that something was the case, the Panel will realise that that is not enough to prove that that was the case. That is all I am going to say on that important issue and I ask the Panel to bear that in mind when they consider the way in which certain statements were made and certain pieces of evidence were given.

The second issue with regard to Dr Barton by way of generality is again we suggest demonstrated by the evidence. Dr Barton plainly was not a lazy, a sloppy, an unintelligent nor indeed an ignorant doctor. I add this in parenthesis because the issue as to whether she was adequately trained for her job came up at one point. It is not the GMC's case that she was not properly trained for the job that she was doing. If a very hard working, efficient, knowledgeable and experienced doctor makes decisions and exercises clinical judgments, and makes those decisions and judgments as a doctor who has the best interests of her patients at heart, if those features apply – we suggest the evidence in this case amply demonstrates that they do apply – then the Panel needs to look long and hard at any criticism of those judgments and decisions, particularly if they come from somebody – again this is not a criticism; it is the way that these things can sometimes work – who did not see the patients and did not witness the circumstances under which Dr Barton was operating. We do, and I suggest justifiably, stress this point. It is not just the defence on behalf of Dr Barton suggesting the critical aspect or the critical nature of that point; it is supported in evidence by the consultants, and indeed supported by Professor Sikora. It is critical.

Furthermore this, in terms of Dr Barton in terms of the kind of doctor she was. Her decisions and her judgments were not criticised at the time by anyone who might have been expected to raise criticism - not by the nurses. Not even Nurse Hallmann, not even Nurse Giffin, not by consultants and not by the pharmacist. It is not as if it can be suggested that there was some haven of ignorance, stupidity, somehow locked up in Gosport. It will not do. It cannot be suggested that all of those witness are somehow completely wrong.

We submit it is perhaps, as an underlying feature, almost one of the most important facts in this case. It is not just a club of doctors getting together to support each other; it involves all of those people who were involved in the care of these patients, and the pharmacist.

The Panel is perhaps entitled to look at it in this way. If there was anything obviously wrong about Dr Barton's judgments and decisions then, and I hope I am not putting it too highly, it is astonishing that it was not picked up by somebody, and the Panel will bear in mind we are not just talking about the three consultants from whom you have heard evidence; it is something like six consultants in total over a period of twelve years.

If Dr Barton was doing something so obviously wrong that an independent expert can come in and say: This looks to me to be obviously wrong, or seems to me to be obviously wrong, why did nobody pick it up? It is not being suggested that the consultants were lazy or ignorant themselves. There are two queries about Dr Barton's actions from consultants, in essence. Dr Tandy, at a later time, indicated that she would not have started Mr Pittock,

Patient A, on as high a dose as Dr Barton started him on, and you will remember only too well Dr Reid, who in the case of Enid Spurgin reduced the dose she was on, which was 80, thought it was too high and the patient was possibly being oversedated, reduced it to 40, but again, as the Panel will remember, authorising it to go up to 60 if the pain was not controlled. So hardly a huge difference but nonetheless a difference.

There is one other area of criticism in terms of Dr Barton's judgments and decisions in the sense I have been talking about, and that is the width of dose ranges in some cases, essentially the 20-200 width. I am going to summarise it in that way. Dr Barton accepts that criticism and has from the outset but, and we suggest it is an important but, that fact, the fact that the dose ranges were too high in those cases, did not in reality create any problem for any of the patients involved at the time. In other words, there is no evidence to suggest that as a result of the width of the dose range any patient received more than was judged to be correct.

There is a risk of translating the similarity of dose range with regard to a group of patients into an expression that has been used more than once - "one size fits all". One size fits all carries with it a connotation of it being disregarded as to what the patients' condition was, "You are all going to have the same medication at the same dosage". That is not what happened.

The facts demonstrate that although a number of patients were anticipatorily prescribed 20-200 mgs of diamorphine, they were not, most emphatically not, all treated in the same way. They received different doses at different times as their condition deteriorated, and at the time of their deaths were on different levels of diamorphine and midazolam. I will concentrate on the diamorphine for a moment but it is an interesting statistic and shows that, although the dose ranges were too wide, it did not give somebody licence simply to pump in as much diamorphine as anybody felt like pumping into a patient because the dose range was as it was.

Of the twelve patients at the time they died two were on 20 mgs, one was on 30, two were on 40, two were on 60, two were on 80, one on 90, one on 100, one, Mr Pittock, on 120. That is not an example of "one size fits all" in terms of the administration of the drugs concerned. It is worth noting, perhaps, that nine of the twelve patients therefore were at a level at the time they died of 80 or under.

Again, coming back to the significance of the qualities which we suggest are established by the evidence of Dr Barton, we would suggest it is prudent and fair to approach each criticism as subcutaneous analgesia being administered too early and at too high a dose or with an inappropriate mix of diamorphine and midazolam in this way. This is just a suggested way of approaching that issue.

What caused her to treat the patient in that way? Something must have caused her to do so, if one makes the assumption that she is not foolish, not ignorant and not uncaring. Was she acting out of a sudden lack of care or concern for the patient's best interest? That really does not seem to stand up to any kind of examination. Was she acting for no good reason at all? There hardly seems to be an answer to say "Yes" to that. Was she seeking to hasten the death of a patient? That cannot sensibly be suggested, and, indeed, is not being suggested on behalf of the GMC.

It is very important indeed, we suggest on behalf of Dr Barton, that that is not being suggested. This is not a doctor who is saying to herself: Well, this patient is coming to an end of their lives, why muck about, let's bring that about quicker than otherwise would be the case, hastening the death. That is not suggested, and therefore when the Panel look at the case of a doctor, if the Panel find her to be honest, knowledgeable, experienced, knowing her stuff, looking at that sort of issue, when trying to make a decision as to whether the GMC have proved she was acting in an inappropriate manner, it is really pretty critical that she was certainly not seeking to hasten the end of these patients.

Another issue to which those qualities go, was she suddenly failing to exercise sensible, clinical judgment? Well, it is rather difficult to say: Yes, I think she was suddenly failing in the case of these twelve patients to exercise sensible clinical judgment. Now, if it is impossible to really answer "yes" to those questions I have just posed by way of illustration, then it is a pretty clear pointer to the fact that her decisions must have been appropriate and in the best interests of her patients; if not "must", then at the very least one cannot feel sure they were not appropriate and in the best interests of her patients.

What was in Dr Barton's mind - again another matter raised by Mr Kark, and we submit it should be approached in this way - bearing in mind the sort of doctor she was at the time, is of the greatest possible significance as to whether her actions were in the patient's best interests.

Lastly this, in terms of Dr Barton herself: the manner in which she gave her evidence. The Panel may have been struck by that. We suggest on her behalf that not only was she patently honest; she was direct and forthright in a straightforward fashion. She knew her stuff and gave clear and reasoned answers. If ever there was a witness who could be believed on her oath, and it is not suggested really that she cannot, she was.

Also, she stood by what she had done. It is almost as if that is now being levelled as some factor to be taken into account against her. Well, I suppose somebody trying to weasel their way out of a difficulty might try and find some way of avoiding the issue as to their judgment at any particular time. Dr Barton can hardly be criticised, if the Panel think she has justification, for standing by what she did at the time. It is not a case of being arrogant, we suggest; it is not a case of somebody being dismissive of criticism. Dr Barton has accepted the things that she accepts she did not do properly, but she has made it clear in her evidence that although she took on board what Professor Ford's view was, she just did not agree with it so far as the proper treatment of these twelve patients was concerned. What is she supposed to do?

She did not consider, having thought about it no doubt for years now, that she should have done anything different with regard to any one of the twelve. That is not the mark of somebody being arrogant or blind to criticism, we suggest: it is the mark of someone who is confident that their judgment did not desert them at the time, and of someone who knows that she was acting in the best interests of her patients as she saw it. Somebody who knows that at the time she had good reason to act as she did.

May I also say this? This is not somebody - because this is something that my learned friend Mr Kark suggested in his final speech - who was convinced of the infallibility of her own judgment. That is not a fair suggestion to make in respect of a doctor who has, first of all, accepted that there were certain things she did not do as she should have done. She is not

claiming, "My judgment is infallible". She is simply saying: "I have looked back at these cases and I do not think I should have done anything different to what I did do". I will come back to the rationale for that in a moment.

She is entitled to say, is she not, "I take on board the view of Professor Ford but it is, with all due respect to him, a view of somebody who was not there and who did not see these patients, in some cases over many days, and who did not hear the information supplied by nursing staff". She is entitled to say, is she not: "I was there and I did have a proper informed basis for doing what I did."

A further point in this same context: there was a suggestion made to her in cross-examination by Mr Kark, and I am not criticising him for a moment, using his own words: You were tearing up the BNF, or tearing up the Palliative Care Handbook, or throwing it away - that was the way in which his questions were couched. She was not. Indeed, she carried the Palliative Care Handbook around with her. She was aware.

This is not a doctor being ignorant of what the content of those works was, this is not a doctor who is saying, "I simply did not pay any attention to them at all in relation to what they said". She was aware of what they said on the topics relevant to this hearing. She demonstrated, in her evidence, that she was not ignorant about medicine. She was not "tearing" these works up in the sense of paying them no heed: she was exercising her judgment built up over years to treat as best she could patients. Which patients? Patients who were on a terminal care pathway, and if she had looked to those works, the BNF or the Palliative Care Handbook, if she had looked to those works for guidance as to when to start subcutaneous analgesia for a patient whose condition meant that he or she was on that path, or guidance as to what the dosage should be for a patient in that condition, what would she have found? Nothing to assist her. It is not a criticism of the BNF; it is not a criticism of the palliative care hand: they are setting out to give guidelines in relation to certain general situations. They are not setting out to lay down for doctors as to when subcutaneous analgesia should be started; they are not setting out for doctors precisely what doses should be given in the cases of patients who are on the terminal care pathway. That, we suggest, is a pretty important point. There was not any research available to anybody as to when you can properly administer two or three times, or even four times, a previous dose when switching from oral morphine to subcutaneous diamorphine in such circumstances. As Dr Barton herself said, you do not perform research on dying patients, and Professor Sikora himself, and it can hardly be suggested he is wrong, says there is not research on that.

I stress that as much as I can on behalf of Dr Barton: there is a limited use to what is set out in the BNF and the Palliative Care Handbook. It is not of no use: it is of a great deal of use, both of those works in respect of a number of matters, and Dr Barton was not ignoring and was not ignorant of the content of those works about general precepts and principles.

May I deal at this moment with a phrase that was used more than once but which perhaps needs careful examination, the expression being used of putting a patient on a "terminal care pathway" when commencing the administration of subcutaneous analgesia by way of the syringe driver.

One can understand how those words can be used but, in fact, that is not a proper description of what occurred, nor indeed would it be a proper description of what is going on at this very

moment, no doubt, in the case of hundreds of patients up and down the country who are receiving such treatment.

The proper description is that the patient is being treated in this way because his or her condition requires this treatment. It may be that once subcutaneous analgesia is administered by means of the syringe driver, subcutaneous analgesia of the type we are dealing with in this case, that the end is predictable in the sense that at some point this patient is going to die. But it is because they are on a terminal care pathway that they were put on the syringe driver in the first place. The patient's condition, which may be as a result as a number of different causes, means that he or she is on that pathway, that treatment is being given not to create a situation where the patient's death is inevitable, but to treat the pain and distress caused by the patient's condition. If the patient does not receive that treatment, they are going to suffer in ever increasing degree from pain and distress.

May I just stress this too, because it seemed at one point as if an assertion was being made which I do not think can be justified on the evidence. It was an assertion made by my friend in his final speech. It is not the case that prescribing in advance means that a decision has been made for terminal care. When Dr Barton anticipatorily prescribed subcutaneous administration of diamorphine and midazolam, she was not saying, "I have made a decision that this patient is for terminal care." She is looking at a situation which her experience and her judgment is telling her may develop, may arise. It is the commencement of the syringe driver in these circumstances that indicates that the decision is, or the view of the doctor is, that the patient is on a terminal care path. That is rather important to bear in mind when it was being suggested in respect of Mr Cunningham. Because Mr Cunningham was anticipatorily prescribed subcutaneous analgesia of diamorphine and midazolam when he arrived at Dryad that the decision had been made, as he was being wheeled down from the Dolphin Day Hospital that he was for terminal care. That just is not right.

Of course, in these circumstances, the doctor has to face the fact that in treating the condition the treatment itself may or will play a part in the process of dying. We are back to double effect. It was expressed – I think I put it to Professor Ford in this way: "If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not to kill the patient." That certainly is not being suggested in the case of Dr Barton.

That approach, encapsulated in the principle of double effect, is easily stated in a few sentences, as I think I just have; but – and it is a pretty important but – it is much more difficult to apply. This is part of the art of medicine. There is no handbook giving a doctor guidelines; there is no set rule. Different doctors may properly and understandably differ in the exercise of their clinical judgment as to precisely when subcutaneous analgesia should be provided and in what combination and in what dosage. How does a doctor achieve the best balance between the control of pain, distress and agitation and avoiding the patient being – I stress – over-sedated or over-respiratorily depressed?

That is a difficult question to answer, but the doctor does have to try to achieve that balance. Dr Reid confirms: two doctors standing at the bedside of a patient, the same patient, may disagree as to precisely what should be done. Efforts, of course, have been made to try to set out certain procedures and ways of recording, steps taken, the Liverpool Care Pathway has been mentioned, but those difficulties and variations of view remain. Again, we submit a critical aspect in this case.

The point was made, I think perhaps more than once in the course of the evidence heard by the Panel, that there is some kind of indication that Dr Barton's use of opiates was inappropriate when it was stated that the deterioration in a patient mirrors the administration and the increase of opiates. That, with all due respect, is not a good point to make. There is a flaw in it. It is the condition that causes the patient to deteriorate. It is in fact that deterioration which justifies the administration of the opiates and the continuing deterioration brought about by the condition justifies the increase in the opiates. It is all very well to say, "Well, I notice that the patient deteriorated when opiates were commenced and the patient's condition continued to deteriorate when opiates were increased." How on earth can one say, looking at it from the outside, that that is the reason for the deterioration, when a patient, who is not a fit healthy patient, has already got problems, in some cases many problems, bringing about the deterioration. The administration of the opiates being administered is for a good reason when they start.

Another illustration, perhaps, of the difficulty that pertains to this world of palliative care and the treatment of pain and distress is that some light was thrown on the difficulties and variations of view by the evidence the Panel heard with regard to the difference of view as to the tolerance of patient pain levels between an acute ward in a hospital and a palliative care or terminal end of life care situation in a hospital or a hospice, for example. There is a difference, and the evidence made this clear. That evidence is important perhaps in throwing light and the importance in palliative or terminal care of taking all appropriate steps to ensure that the patient is not distressed, not in pain, not agitated. Why should they be, when the end of their lives is in sight? It is simply not acceptable to ignore those features if your goal is a peaceful and dignified passing away. These are all tricky areas. They are areas which Dr Barton and other doctors all over the country have to try to deal with and face.

May I turn now to say something about the context in which Dr Barton operated. These are not matters which reared their head for the first time in connection with the GMC case. She resigned in 2000. She had mentioned the pressures under which she operated informally. She accepts – again, this is not an example of a doctor being arrogant or dismissive of criticism – that it would have been better, in retrospect, to have put those matters in writing earlier, but she thought it right, and some people may think this is to her credit rather than her discredit, to soldier on. "That is what we did in those days," she said in the course of her evidence. You have taken on board already, of course, her job description. The documents are there in file one. I am not going to go through that, but her job obviously was to be in charge of the day-to-day running on the medical side of the hospital.

Perhaps it is no surprise, and perhaps it is a measure of her commitment and involvement with her job that she used the expression sometimes, "my hospital" and "my nurses". That is not somebody exercising some kind of absurd, arrogant commanding position. The Panel can be satisfied not only of that in terms of her evidence, but also in terms of the evidence from the nursing staff. They did not see her as somebody who strutted round the wards like a martinet, issuing orders and treating them all as if they were "her" nurses, in the sense of some kind of possession. Absolutely the reverse. They all found her – I will deal with two nurses a little bit later who had some criticism to make – to be a doctor who was approachable, discussed things with them and who was involved.

The change took place in terms of dealing with the context in which she operated: I am not going to go into all the detail about this because really there is perhaps no dispute about it.

There is no doubt at all that the patient mix changed significantly – indeed, one might almost say dramatically – in the course of the 1990s. There is no doubt at all that that had its impact on what it was that Dr Barton could properly do and what it was that the nursing staff could properly do. It means that the sources became even more strained. Dr Reid: there was a huge pressure, he said, at the front door of the hospital to move patients on, so Gosport War Memorial Hospital was put under pressure to take patients who might not be continuing care. They had not made a full recovery from their illness, and it was not quite clear in what direction they were going to go. They were more physically dependent; they were less stable medically. Every witness who gave evidence on the subject gave the same picture: doctors, nurses, Barbara Robinson on the management side and Isobel Evans on the management side. I am not going to go into that evidence in any kind of detail. The Panel have heard it. You all have it in front of you in terms of transcripts and so on. For me to repeat a point which is not essentially in dispute is going to be a waste of time.

One other aspect concerned or involved with that issue is a question that came up more than once in the course of hearing relating to the transfer of patients, and what that actually meant. Of course it is the case, and nobody disputes this for a moment, that a patient might be momentarily adversely affected by a transfer, but within a day or two they have got used to their new surroundings and the transfer has no lasting impact on their condition. But – and it is a very significant but – the fact, again borne out on the evidence and borne out on the evidence of people who saw these patients, the impact, the effect, of transfer in patients who were not in tip-top condition when they left hospital might have an extremely significant and lasting effect. Not only the actual arduous nature sometimes for an elderly, frail patient of the journey itself, but also the position where the patient had to adapt to the new surroundings, new nurses and, particularly significant the Panel may feel on the evidence, in respect of patients who were suffering from dementia.

It could be a clear event in terms of hastening their deterioration. It was something that did not go away after a couple of days. Again, this is not something which is simply being said by me. It is something which has been said by witnesses giving evidence about these matters.

Can I quote Dr Reid again: he is not the only person who spoke about it. Dr Briggs spoke about it, Dr Tandy spoke about it, but I will use Dr Reid if I may to illustrate the picture. I am trying to avoid at every juncture giving you page references because you are going to be looking at the transcripts anyway. May I just use this as an example. There are some cases where I will, and just by way of illustration I will give this one. Dr Reid, Day 16/70, dealt with this position with regard to transfer from acute hospitals. He confirmed the general picture which we have already heard about.

Also he made this point: a considerable delay could occur between a consultant such as himself assessing a patient and the actual transfer. Indeed, we have a couple of instances of it with regard to these twelve patients. He spoke of the tendency on the part of the transferring hospital to make light of new medical problems that had developed. Perhaps they were not being as forthcoming as they ought to have been about the problems a patient had at the time of transfer. Again, he spoke in that context of the deterioration from the transfer itself. I made a point which has been made by a host of witnesses. I will deal with it now, if I may, very briefly: the problems that were created, because Dr Reid himself spoke about this, with regard to relatives when they had been given an unrealistic expectation. It is an unhappy fact, but it is a fact. One has sympathy with relatives who are told, "Don't worry, your aunt, your mother, will be up in a couple of weeks. They will get her going in Gosport War Memorial

Hospital," when in fact the reality was, that was simply not on. It is not surprising that people felt confused, surprised and often angry. As you have heard from more than one source, different relatives acted in different ways. Some realised the reality of the situation and did not seek to make any issue about it. Others found it so difficult to take they did make an issue about it.

I am not going to enter into individual criticisms. People get cross and upset and angry for a whole host of different reasons, some with more justification, others with less justification. You have seen a number of relatives. You have heard evidence from them. What one does have to say – and I will be mentioning one or two instances later on – is, of course, that relatives, whether because of their distress or their hostility towards nursing staff at the news they have been told, or there is suspicion about medical care may not always give a very accurate account of what actually happened. They may just actually get it plain wrong – not out of any kind of sinister motive or any malice, but so caught up perhaps in the emotional side of things that their account may not always been as accurate as it should be.

Just by way of example, it happens more than more, and we may look at one or two instances. You get Philip Beed, for example, plainly a first rate nurse – I am going to use those words, I hope justifiably – in charge of Daedalus Ward at the relevant time. He is somebody who was careful, thoughtful and knew his stuff, and genuinely was trying to act in the best possible way in pursuing his job. He records somebody was told, "Syringe driver discussed". Would he really write that down if that had not happened? You have instances where a relative says, "I was not told anything about a syringe driver". The Panel will have to make its own decisions about those matters, but we suggest that those sort of examples are clearly illustrations of the fact that a relative, as I say without necessarily being deliberately dishonest in any shape or form, gets it wrong, or their recollection is not perhaps as accurate as it should be. It may be that in terms of one or two pieces of evidence about Dr Barton and what she said and her manner of saying it, may be coloured by that sort of approach and may not really be entirely accurate. I am not going to say any more about that in general terms now. It is a point that Dr Reid, and a number of other witnesses, made very clear as to the problems that are created not only for medical staff but also the nursing staff by that fact.

Dr Reid also, in terms of this question of transfer of patients, while I am on it in general terms, indicated that he would not expect his clinical assistant to contact him if, in this case she – Dr Barton, unless she had significant concerns with regard to a change in the patient's condition; so unless there was significant concerns on the part of Dr Barton about the change in the patient's condition, whether from transfer or, indeed, anything else, unless she had those significant concerns, he would not expect her to contact him. At certain intervals and certain points in Professor Ford's evidence, he appeared to be suggesting that perhaps Dr Barton should have contacted a consultant because the patient was not in good shape as the transfer letter seemed to suggest was the position. You heard similar evidence from Dr Tandy and, indeed, she gave similar evidence as one other example of witnesses about the problems created with regard to relatives as a result of unreasonable or overoptimistic views as to their condition.

I am going to just complete, if I may, this particular topic and then perhaps see whether it is convenient for the Panel to have a break. As I say, there is no dispute on the evidence about the increase in pressures on Dr Barton and on the nursing staff as a result of the change in the patient mix. Dr Barton does not seek to run for cover. She does not seek to hide or suggest those undeniable pressures caused her to make a decision about the treatment of any of these

twelve patients different to what have been the case if the patient mix had not changed. She is not saying that.

I come back perhaps in this context to the circumstances about which the Panel heard a certain amount of evidence with regard to her resignation. I am not going to go over it all again. The Panel have her resignation letter, and the rather disappointing responses, or perhaps inadequate response, she received when she indicated the nature of the problem and the situation that was developing.

Why not earlier, was the question raised with her? She has already given her evidence about it and I have referred to it in one context already. Her view was, "Well, if I stopped, if I had said it is all too much in 1998, what was going to happen to the patients?" She was the only applicant for this job. Nobody was fighting to be a clinical assistant at Gosport War Memorial Hospital. There obviously comes a point when even the most dedicated person has to give up. There cannot really be any criticism of Dr Barton for not walking earlier. She hung on as long as she could and I would suggest on her behalf that that is to her credit and again shows a genuine person, genuinely involved, trying to treat patients properly.

It is important to remember that Dr Barton had hundreds of patients receive treatment from her on Dryad and Daedalus Ward. I think the figure was given of perhaps 3,000 in all. There are 12 – 12 – in relation to whom the GMC makes allegations. It cannot be suggested on the evidence, and bearing in mind those basic facts, that she was some trigger-happy doctor so far as subcutaneous analgesia via syringe driver was concerned. Or that she was in the habit of starting that medication too early and at too high a dose. If there was such a culture on those two wards at the hospital, or if that was her general approach, then perhaps it is remarkable that not more cases were brought before you for your attention.

Consultant supervision and cover: again, Dr Barton is not trying to hide. She is not running for cover at the lack of cover she had herself. It was, the Panel may think, inadequate and put her in a position – again she does not suggest this changed her treatment of these 12 patients in any way – where she was not encouraged, nor indeed was it requested of her, that she should consult the consultants with regard to important decisions, such as whether it was appropriate to make a clinical judgment as to whether a patient was on a terminal path, or whether a change in the condition of a patient justified the commencement of subcutaneous analgesia.

Whatever were the failings, and the Panel is not dealing with charges of failings but it is an issue the Panel has had to spend a certain amount of time on, of the system that operated at that hospital with regard to the consultants, Dr Barton is entitled to pray in aid, is she not, in support of her case the fact that no consultant ever said to her that she was doing anything wrong or anything unwise or unsound with regard to the treatment of her patients? They did not query her procedure of prescribing anticipatorily, save Dr Reid on one occasion. He asked her about it and was satisfied by her explanation and by her rationale. Indeed, I do not think it is any longer being suggested that anticipatory prescribing was something that could be criticised in these circumstances. It is the dosage and the range that is being criticised.

No consultant queried her prescribing variable doses, or doses at a particular kind of range. One has to say this, and I agree with what Mr Kark said really, that the evidence shows clearly they were aware; there really cannot be any doubt about that. They did not suggest that any patient was receiving too great a dose, or an unsuitable dose mix. They must have

been aware. One cannot suggest that all the consultants all saw all of these 12 patients we are concerned with in this case, but they must have been aware of what Dr Barton's methods and procedures were with regard to palliative or terminal care patients. The one occasion was when Dr Reid reduced the dosage in the patient I have just mentioned. Clearly he did not think that what Dr Barton had prescribed and had administered was so excessive as to warrant any mention by him to Dr Barton. He did not pick her up on it. He did not query in any way, nor did any consultant query her recording of her findings and the reasons for her decisions.

One has to be able to say this in support of Dr Barton, does one not? It really would have been expected of them that they would have done that if it had seemed to them to be of any consequence or caused any problem with regard to their treatment or their advice with regard to patient care. That is an important point. It is important too to bear in mind that these consultants, although under pressure themselves, were neither ignorant nor uncaring. None of them – they made this clear in their evidence – whatever experience and whatever Dr Barton's responsibilities being the day to day care of the patients at Gosport War Memorial Hospital, whatever those circumstances were, none of them they indicated in their evidence would have hesitated to correct or reprove Dr Barton if they had thought that what she was doing was wrong or needed changing.

What Dr Barton was doing was not rocket science so far as the consultants were concerned. This was their field of course. Dr Reid, when he arrived at Gosport War Memorial Hospital had not had that much experience with syringe drivers, but he was not in a situation where he was saying to himself, "Goodness me, what are syringe drivers? What on earth do they do?" He was a consultant for goodness sake. He made it clear, as I say, that he would not have hesitated to say something if he had thought something was wrong, and he was quite capable of forming his own opinion as to the correct dosage for a particular patient, as we know.

The evidence of all three of the consultants operating at the time with regard to these 12 patients is very important support - it cannot just be brushed away – for the propriety of Dr Barton's treatment. She is entitled to say, is she not, in support of her case that what she did was justified and proper, and that her consultant supervisors did not disagree with her judgments. Even if those three consultants did not review every one of the 12 we are concerned with, they must have seen and reviewed many patients who were being treated in similar fashion.

Whatever Professor Ford says by way of criticism, looking at matters from some distance of time, they cannot, can they, all three be wrong? They were there. They knew Dr Barton. They knew how she operated and how Gosport War Memorial Hospital was run. Is it really being suggested that they have all got it wrong with regard to the approach adopted and Professor Ford has got it right?

I am going to turn to what the consultants had to say about Dr Barton, again briefly, but it may be convenient if we break now. It is entirely a matter for the Panel.

THE CHAIRMAN: Yes, we will break now and return at 11 o'clock.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Mr Langdale?

MR LANGDALE: I will move on to the question of evidence given about Dr Barton by the consultants and doctors and again I am taking this very briefly. I am not going to quote great chunks from the transcripts. The fact that I take it briefly and do not do that, does not mean to say that I do not ask the Panel to place great weight on what they have to say about Dr Barton.

Dr Briggs is an example of the kind of thing you heard about: how hard she worked; wholly committed to her patients' best interests, etc. Dr X, who no doubt the Panel will all remember, was a very experienced doctor. She had known her for years. If she had thought there was anything untoward or questionable about Dr Barton's prescribing, she would not have hesitated to take her up on it. "I would have written it", as she said graphically and no doubt credibly, "all over the notes". You will remember the sort of witness she was and will have no doubt that that sort of action might well be consistent with her if she took a certain view.

Dr X is somebody, it is worth bearing in mind, who, in addition to her general experience, had worked in a terminal care unit as an SHO looking after some 32 patients on her own with terminal care, with a consultant and registrar who would visit two or three times a week. She indicated that diamorphine then had a dual role. It would relieve distress and have a very helpful effect in relation to congestive cardiac failure. Midazolam, she said, was a very useful drug which relaxes a patient so they are not as anxious and distressed. One of the main duties of doctors in palliative and terminal care, she confirmed, is to relieve a patient's distress. She stressed too the underlying fact which was there throughout all this; that is, the need to see and examine the patient before deciding what medication to prescribe and in what dose.

Dr Victoria Banks, a witness from whom the Panel heard, is a consultant in old age psychiatry. She gave evidence with regard to her dealings with two patients, Mr Pittock and Mr Cunningham. She had fairly regular discussions with Dr Barton about patients. She did a clinic in her surgery and regularly met her and other general practitioners in the practice every month. "A really very accomplished doctor", was what she said. "She has, in terms of managing her patients, always for my service made very timely referrals, very appropriate referrals". Again, I am not seeking to go through all the detail of her evidence but I ask the Panel to take that into account, somebody standing slightly aside from Gosport War Memorial Hospital.

Dr Reid was a man who had been a consultant in geriatric medicine at Southampton for some 16 years before he came to Gosport, then a consultant in the same capacity and medical director also in relation to the relevant PCT that operated at the time. He regarded her as a very experienced and good general practitioner, assiduous in attention to her duties. The nursing staff he found to be fulsome in their praise for the support Dr Barton offered them. Her patients were being well looked after. He did not really see very much of her seeing relatives, but he had nothing to cause him to suppose that she did not handle relatives properly.

Dr Barton was responsible to him. She was entitled to expect him to correct her if she was doing anything wrong, and also entitled to expect him to advise and guide her where necessary. He said he would not hesitate to exercise his proper supervisory duties. If he had

felt that the use of a syringe driver was inappropriate, he would not have hesitated to say so. He never ever felt that. He also said this, which is perhaps worth bearing in mind, that every time when he did his ward rounds and there was a patient who was on a syringe driver, he would ask why it had been commenced. So again that is direct supervision, if you like, by Dr Reid. He too spoke about the pressures on her, as I have already reminded the Panel. As he put it, "It was not her fault. It was the fault of the way the thing was set up", and he dealt with the position as to what the changes had been when Dr Barton resigned, ending up in due course with two junior doctors covering a mere – I say "mere" – 30 beds, together with an associate specialist giving half of his time. That was in the second phase of what happened.

Dr Reid also gave evidence about the nursing staff generally, as to how he saw them. He was very impressed by their quality. When it was suggested to him that Gosport War Memorial Hospital was not necessarily a very good or safe place to be, he made that rather telling remark, did he not? If his own mother had been in a similar circumstance he would not have hesitated to have her as a patient in that hospital. That is not just hot air. That is pretty significant.

He said also that it was not unusual that there were no policies in place at Gosport for the prescribing of opiate analgesia. He did not remember them being in place anywhere, including Southampton. It is worth bearing in mind too – I am not going to ask the Panel to turn it up – the document at D5, which was his document, in December 1999, his attempt to write down a clear policy for the prescribing of diamorphine. The Panel will remember the doubling up and so on. He says now, looking back on it, that that probably was wrong, but obviously that was the accepted practice at that time. Dr Barton was not doing anything remotely odd or strange so far as he was concerned. Again, he confirmed that he had spoken to Dr Barton about the pressures of her job and her saying to him that something needed to be done.

You will remember Dr Barton's evidence in general terms that when she spoke to the consultants, because she also spoke to Dr Tandy and Dr Lord – it may not have been Tandy; I may be wrong, but another member of the hospital management – she was told, "Well, there is really not much that can be done. Resources are limited. I will see if I can do anything", and nothing actually happened.

Dr Tandy, another consultant, gave her evidence. She was very happy with Dr Barton's care. "She knew the patients. She cared about them. She put their interests first. The decisions she made were generally sensible. Her note keeping was not of a high standard, but what was probably more important was that she saw the patients rather than writing a large amount in the notes". From patients referred in from other community hospitals she said, "Her standard of note keeping did not seem to be out of the ordinary". That is another example of the sort of way people did things in those days. In fact, Dr Tandy said in some cases her note taking was better. She confirmed she was time pressured. She, Dr Tandy, would not determine what the appropriate dose was for a patient without having seen the patient recently. I quote: "You need to see the patient in front of you to make a decision as to what level of pain relief is appropriate".

She thought Dryad a well-run ward, the nurses she regarded as efficient and very good in particular at bed sores. "Quite often we sent patients down from the acute ward and I was not expecting them to get better and in some of these patients they did very well."

With regard to transfer back, she too confirmed the picture, it might not be in the patient's best interest. The toll of ambulance journey, she referred to. Also, if you think the chances of them doing well if they are given full medical treatment are poor, then you would think hard about sending them up the road, as she put it. It is not always in their best interests for patients who are unlikely, cannot be sure, patients who are unlikely to benefit from further aggressive treatment.

B And then Dr Grunstein, whose statement was read. Again you have the transcript for that, and can I stress this, because Dr Grunstein was somebody who was a consultant in the very early part of this period in 1992. He regarded Dr Barton as an experienced doctor, a very good doctor, she enjoyed her work, and "her heart was in it". A liking for these elderly patients, she was assiduous in making herself available, an outstanding, caring, and considered GP. A good clinical assistant, she knew her stuff. He was conscious she did not write much, but she did make proper assessments. He could understand the use of C anticipatory scripts; he placed confidence in her, we thought ourselves lucky to have her as a colleague. Hardly a sign of a doctor who is likely to make major clinical mistakes.

Dr Lord: a good, committed doctor. She was sensible, she liked working with older people, kind and caring and ready to go that extra bit for her patients. Again, hardly consistent with a doctor seeking to give too high doses and the wrong drugs.

D She confirmed the picture about changing needs from the patients. "Her notes were brief, probably too brief". She did not pick her up on it. "The patients were not let down by that", perhaps another significant indication from Dr Lord.

That is all I say about the doctors and the consultants speaking of Dr Barton, those who came into contact with her. As I say I have taken it very briefly but we submit it is rather important evidence in considering whether Dr Barton was likely to be making inappropriate decisions E about patients. However, one learnt of a further view and a further view with regard in particular to the prescribing of subcutaneous analgesia and the administration of it by syringe driver from a consultant who did not give evidence before you but who was involved in these very issues in 1991, and I am going to turn, if I may, to the situation with regard to 1991, and this of course was Dr Logan, and it would appear on one view he has got it wrong as well as to what should or should not happen with regard to patients in this sort of situation.

F Defence for Dr Barton say he had not got it wrong at all; he had got it right.

I am going to invite the Panel, if you would be so kind, please, to turn up in file 1, tab 6. At page 2 on the internal page numbering in tab 6 you have the note by way of a summary of the meeting at Redclyffe Annexe in July 1991 and, again, the Panel are familiar with it, I am not going to go through it all, but in relation to the consideration of these documents the Panel, we suggest, should have very much in mind the evidence of Isobel Evans, the patient care G manager who dealt with these matters throughout this period of time, throughout the second half of 1991.

It has been suggested that somehow nurses felt that they were, or a nurse felt that some were banging their heads against a brick wall. I think as one Panel member put to it one of the nurses, "... you felt as if you were being given the run around". I respectfully suggest that when one looks at what actually happened and what Isobel Evans tried to do, that just is not H the case. I put it as firmly as that. You will remember when Isobel Evans was asked whether

her view was affected by her being on the management side rather than the nursing side, although she was a nurse by background, she said "No", and the Panel may have been rather impressed by the way in which she gave her evidence and by what she actually said about what had happened, because it is important to note that some of these allegations - although they are general, they are not specific - are similar to some allegations made in this case. It does not mirror this case but it is important to bear in mind that not all of these points, and it is the ten points set out on that page that I am concerned with, were ever being put forward by all of the nurses.

What Isobel Evans sought to do was record any point that any nurse had made, and in relation to these points the Panel will bear in mind that lying behind all this, leaving aside the view of a particular nurse who seems to have been very much the one who was raising these points, behind all this obviously lay a kind of clash at that time between the day staff and the night staff. I am not worried about the reasons for that but one can see, and it is reflected in some of the evidence, how the night staff, of course, would be seeing patients who were basically asleep, who were not needing the same kind of attention that patients required during the day. The day staff are the people who are more likely see distress and agitation and so on when patients were turned and treated during the day, but there seems to be a kind of clash that went on between those two staffs, a clash borne out by the evidence of Isobel Evans.

She stressed that not all these ten points were the concerns of all the nurses; she said in relation to point 4 that "... patients' deaths are sometimes hastened unnecessarily". That was the view of one nurse, and it is not an allegation made against Dr Barton in the sense of any kind of intention on her part or, indeed, any nurse's part, and this was in the context, Isobel Evans made clear, in the context of use of opiates on a regular basis rather than as required. You may remember the evidence of Isobel Evans that, in fact, the bone of contention, or the concern, seemed to be a reluctance or maybe a refusal on the part of a nurse, maybe more than one, to recognise that it was not just cancer patients who required subcutaneous analgesia. It is back to what appears to have been a kind of split in views - to a degree slightly reflected by Professor Ford - firmly rejected by Professor Sikora, that somehow the patient who has got pain, distress and agitation, and who is at the same time suffering from a carcinoma of some kind, is entitled to receive better or different pain relief than a patient who is not suffering from a carcinoma, and certainly that was a view that was expressed by I think it was Nurse Giffin, referred to by Isobel Evans, and that is a very far cry from there being any actual evidential basis to show that in 1991 patients were being given inappropriate doses of subcutaneous analgesia and the use of syringe drivers.

And in relation to syringe drivers it was perhaps noteworthy that it was Isobel Evans who said she was the person who actually introduced syringe drivers at Gosport War Memorial Hospital. I am not going to go into any more of the detail but one can see how she, Isobel Evans, Mrs Evans, was ready, at the bottom of the page, page 2, she felt that both Dr Logan and Dr Barton would consider staff views as long as they were considered on proven facts rather than qualified statements.

Then over the page, and I am not going to go through all this, the issues are fully set out by her. This is hardly a case of management ignoring the views of the nurses or the issues involved.

Then over the page, on page 4, she indicated what steps she was going to take. She was going to invite Kevin Short to talk to the staff on drugs and ask Steve King from Charles

Ward, Queen Alexandra, if he would be prepared to contribute to the discussion - not somebody trying to shut out the nurses or trying to shut them up, but somebody who is seeking to take steps to alleviate their concerns and treat them sensibly. Then matters progress and I am not going to go through all the detail but you will remember that there was a letter from the RCN officer, Mr Barnes, at one stage, to Mrs Evans, saying it was a matter of concern that complaints were not being acted upon, they now expect a clear policy to be agreed as a matter of urgency.

B

You will remember, too, her evidence that she was rather surprised that the nurses, instead of coming to her and saying: These are specific instances, this is what we are still concerned about, went to the RCN.

Again, when one looks at that, what happened? The RCN, on behalf of the nurses, never took up or pursued a grievance, and you heard that rather significant piece of evidence from
C Isobel Evans, how the RCN representative had said to her informally, having looked into these things, that he could not see what the problem was, could not understand their concern.

That is hardly a sign of nurses being given the "run around", hardly a sign of them facing a brick wall of difficulty or opposition, and indeed the picture goes on and we seek to stress this in terms of some of the suggestions that have been made about this, that as we go on, every effort was made - it is difficult to see how any other course of action could have been
D taken - every effort was made by not only the patient care manager, Mrs Evans, but also Dr Logan and Dr Barton to make themselves available to have a meeting with the nursing staff and try to deal with these issues.

Can we move on, please, to page 17 in this particular section, because it is another illustration of how the nurses were not being shut out or shut up.

E On page 17, Mrs Evans writes to a number of people, Night Sister, Dr Logan, Dr Barton and the hospital manager, Mr Hooper, Bill Hooper. In the third paragraph down:

> "I am therefore writing to all the trained staff asking for the names of any patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately."

F Well, what on earth was she supposed to do? She is trying to get the information on which she can act. Last paragraph:

> "I am relying on your full co-operation and hope on this occasion everyone will be open and honest over this issue so we are able to address everyone's concerns and hopefully resolve this issue in a constructive and professional manner."

G And then the correspondence goes on with the RCN talking about raising a grievance and so on, but they never did, as I have said.

Then on to page 21, please, where again Mrs Evans is placed in an impossible position. She is the one who perhaps could have been forgiven for feeling she is banging her head against a brick wall. On 5 December 1991:

H

> "Due to the lack of response to my memo of 7 November Dr Logan will be unable to comment on specific cases. However, we have arranged a meeting for all members of staff ... to discuss ... ",

and so on.

> "It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have...",

and she gave evidence. It was the fact she learned they had gone to the RCN and what was said in the RCN correspondence that made her actually mention that, to say that if anybody is trying to suggest that anybody feels threatened, of course they are not, and you will recall also her evidence that these nurses, the ones raising these concerns and these issues, were not the sort of nurse who would be afraid to speak up. She specifically said: "I do not think they had any problem about speaking to a consultant about these issues."

Then can we look, please, at the note on page 23 of what happened on 17 December at the meeting at Redclyffe Annexe. We have the list of people who attended, which include in particular Nurse Giffin, Nurse Tubritt and Nurse Turnbull. As I say, Isobel Evans said, "I would not accept there was a problem with these nurses dealing with doctors. The individuals concerned were not the sorts to be intimidated." That is her direct quote.

Can we just look at what actually happened without reading out every word? At point 2 on that page there is mention about Dr Logan having spoken to the staff on drug control of symptoms.

> "The aim of this meeting is to allay staff fears by explaining the reasons for prescribing. As no one challenged any statements at this meeting or raised any queries, it was assumed the problem had been resolved and no further action was planned" ---

that is the meeting of 20 August.

Then she goes on at point 3:

> "Staff were invited to give details of cases they had been concerned over but no information was received...".

Point 4, last sentence:

> "Everyone was therefore urged to take part in discussions and help reach an agreement on how to proceed in future."

Some other comments made by Isobel Evans, before I move on. She spoke about her feeling as to what really lay behind this and, as she put it in her evidence, the worst culprit, as she put it, was Nurse Giffin, and she gave her reasons. This was not something which she was, as it were, conjuring up out of thin air. She said in relation to her at Day 32, something like page 57 or page 58, I am not sure exactly:

> "I have got to say that the worst culprit had to be Staff Nurse Giffin, who was a very vocal lady and seemed to be of the opinion that if she was not trained to do anything in 1961, then she should not be expected to do it now. Any change she was resistant to and if she did not think it warranted change, then it should not be changed",

and she also spoke about the influence she had, Nurse Turnbull, a very caring nurse, easily swayed and worked a lot with Staff Nurse Giffin, so I think once doubts were put into her mind she rightfully wanted them answered, and then in relation to Nita Tubritt, from whom you also heard, a good nurse, who had the patients' interests at heart, but she was a bit disappointed, was Isobel Evans, over this particular issue because she thought they had built up quite a good rapport, so she could come to her if she had concerns. She could not fault her as a nurse.

So that perhaps gives again a further clue as to what really was behind this.

She was asked, Isobel Evans, whether there was some sort of hierarchy and she said she did not think that applied, we were very friendly, not intimidated in any way; she spoke about the irritation of Dr Logan as a result of a sense of frustration, of trying to deal with a problem without anybody saying what the problem was, and again, I think it was you, sir, who asked was there a general upscaling of opiates at this time, and she said guidance was coming out from Mountbatten, et cetera; we were doing our best to follow those.

She was asked if there was any connection between the increase in the number of patients and the increase in the pressure on staff and their concerns. She said:

> "Only in so far that a higher number of patients coming in now required terminal care. Diamorphine use was becoming more common because more patients required it".

That is obviously later history but I put it in on this occasion rather than coming back to the evidence of Isobel Evans specifically. She also made this other very important point:

> "If you asked the staff they did not suggest" - I stress that, they did not suggest - "that patients were being given too much diamorphine. They denied it. It was the fact" - this is the thing that troubled them – "it was the fact that patients did not have cancer."

Then over the page, page 24, just these points though obviously one has to look at the whole thing. Point 4, at the top:

> "What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain.
>
> "5. No one was questioning the amounts of Diamorphine or suggesting that doses were inappropriate",

and there is a clear example of how 1991 does not mirror the allegations in this case. That was not what was being suggested by nurses who were ready to make their views known at this meeting, it would seem. There is record of the fact that there was a discussion about these things.

Then, what Dr Logan said, half way down the page, sub-paragraph (a) was this. I am not going to read all the sub-paragraphs, but there is Dr Logan, who knew perfectly well, obviously, what Dr Barton was doing. There is Dr Barton at the meeting with one of the consultants supervising her giving his views as to what was appropriate in terms of palliative or terminal care. I am just going to pick up some of the paragraphs. I am not saying they do not all matter. At (f), Dr Logan was making the point:

> "f. That diamorphine has added benefits of producing a feeling of well being in the patient.
>
> g. The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgment based on knowledge of patients condition, to enable patient to be nursed comfortably.
>
> h. It was not acceptable for patients who are deteriorating terminally, and require 2 hrly turning, to have pain or distress during this process. They require analgesia even if they are content between these times."

Over the page, there is general discussion at the top of the page and answering of staff questions. It is not as if the staff were all sitting there liked stuffed dummies, far from it. Dr Logan said he

> "... would be willing to speak to any member of staff who still had concerns ... after speaking to Dr Barton or Sister Hamblin. Comments raised during discussion were:-
>
> (a) All staff had a great respect for Dr Barton and did not question her professional judgment.
>
> (b) The night staff present did not feel that their opinions of patients condition were considered before prescribing of diamorphine.
>
> (c) That patients were not always comfortable during the day even if they had slept during the night.
>
> ...
>
> (e) Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms."

Isobel Evans commented another example of the effect in change of type of patient – they were getting more terminal cases. Then this, just before half way down the page:

> "All staff agreed that if they had concerns in future related to the prescribing of drugs they would approach Dr Barton or Sister Hamblin in the first instance for explanation, following which if they were still concerned they could speak to Dr Logan."

That is not shutting them out, or shutting them up. They are specifically being asked, and no nurse has suggested at any time they did not feel they could speak to Dr Barton. Indeed,

these are the same nurses who had great respect for her. It has never been suggested for a single second, save in the case of one nurse, Nurse Hallmannn, who I will come to in a moment, that Dr Barton was anything other than approachable. Where it is being said or complained on behalf of the GMC, "Things did not change," no, they did not, because what was being done in 1991 was in the view of the consultant correct, proper and in the patient's best interest. Dr Barton was obviously there with him. Not one nurse ever came along and said there was any concern after 1991 about such matters.

Then, lower down the page:

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

Again, comments by Isobel Evans. She did not think there was any difficulty in the nurses speaking out at the meeting. "They certainly had plenty of opportunity to speak to me on a one to one basis. They did not. They denied claiming that the doctors were prescribing the wrong drugs. They were adamant they had no complaint about the amount of diamorphine being prescribed. It was more the type of patient who was being given diamorphine." She spoke again about some nurses having a resistance to the notion that it was better to give continuous pain relief rather than wait until pain came back before giving the pain relief. It always came back that "they don't have cancer."

Again, without my reading all of it, please turn to page 27. I would like the Panel to be paying particular attention to this, where Dr Logan set out his account of the meeting. He sets out what Staff Nurse Giffin was saying. She was not afraid to speak up at the meeting. We can see what it was she said. I am not going to go through it all because it has been summarised, in a sense, by Mrs Evans.

Lastly this, in relation to this topic, at page 29. This is Dr Logan, the consultant at the time, writing to Steve King. "Dear Steve" is Steve King from Queen Alexandra. He sets out on the first page what he thinks of the contentions or the concerns. On the next page, page 30, he sets out his view:

> "1. Patients with distressing pain need adequate anal first – once pain is controlled reductions or changes in dosage can be made."

I am not going to read out what he said about syringe drivers, because that was not the issue. As is made clear in the correspondence in this section in 1991, the use of syringe drivers was not a concern. It may have been initially, but it is made clear in one of the letters it no longer was. Paragraph (3) of Dr Logan's letter:

> "3. Opiates are analgesic (something) also euphoriant, and thus psychologically beneficial for many patients. Many distressed, uncomfortable frail elderly are unable to report their discomfort.
>
> 4. Prompt treatment is the best.
>
> If you do not agree on any of this please give me a buzz."

That is what he says. That is the situation set out. Is Dr Logan wrong? It would seem that Professor Ford would take issue with a number of those things. We suggest plainly he was not.

I am going to turn now to deal with the nurses. If I was to go through the evidence of all the nurses from whom you have heard we would be hear till possibly Monday of next week – I do not know. Again, I am fully conscious of the fact the Panel heard the evidence, they read transcripts, and I am simply not going to attempt to go through their evidence. Of course there was some variation between their evidence; I am not suggesting they were all the same. I am going to deal with two particular nurses – Nurse Hallmannn and Nurse Giffin in a moment, but may I just say this generally about them. They were a pretty good bunch. That is a rather loose expression but the Panel will know what I mean.

The Panel may have been particularly impressed with some of them. There is inevitably a variation in any group of people, but they may have been particularly impressed with Philip Beed, Sister Joines, Nurse Astridge and Nurse Collins, one of the more recent one that you heard from. All of them are genuine people. All of them genuinely were trying to tell you what the picture was. Of course – of course – one takes into account that they are all part of a group, in a sense; but they are all different human beings. They were not just all towing some kind of party line in relation to either their care of the patients or, indeed, of their views of Dr Barton. They none of them in 2009 had any reason to worry about anything to do with seeking to be calling or sucking up to Dr Barton or in any way being influenced by her. She left the hospital in the year 2000, nine years ago. These are genuine opinions expressed, you may think, by genuine people, and all of them – and this includes really Nurse Hallmann and Nurse Giffin – confirm the picture of Dr Barton. These are the people who knew her day in and day out – hard working, good doctor, best interests of patients, approachable, thorough examinations, did assess patients, ready to talk about the patients with the nursing staff and thoroughly involved with her patients. That is my encapsulation of the thrust of their evidence. Their view was that patients were not put on syringe drivers too early or at too high a dose. I will come back to Hallmann and Giffin in a moment.

They all spoke of the change in the patient mix and its consequences for them. They accepted – not every one of them because I do not think every one of them was asked about it but a number of them did – but their note-taking suffered as a consequence as well. They accepted that. They spoke about what they saw of patients in relation to the effect of transfer, from the acute hospitals in which they have been treated. They all seem to have gone on some kind of training course or another, in some cases more than one – none of the training courses were telling them that they should be doing anything different, it would appear. A number of them, certainly two or three, maybe more, spoke about the concerns that they had, that once the investigation had started into Gosport War Memorial Hospital patients were receiving less analgesia than they needed. If those general comments are right with regard to the nurses, what else can one say about them. There is no doubt that they were delivering a high standard of care on those wards. There is no evidence to suggest that they were not, and positive evidence to suggest that they were.

There also seems to have been a high morale in general terms. Of course people fall out with each other in any field of activity, but in general terms there seems to have been a good morale which existed, which hardly seems too likely with nurses who were not all blind and ignorant, even if they were not trained medical doctors. It could hardly be the case if Dr Barton had been prescribing inappropriately in massively unnecessary doses of diamorphine

and midazolam. As I say, they are not doctors but they built up their own experiences. They have seen patients on 20 mg of diamorphine coupled with midazolam. They did not find all patients were necessarily respiratorily depressed or over-sedated as a result. They saw it day in, day out. When they saw a prescription by Dr Barton and administered it. They were not doing this as if they were blind, ignorant people. They were people who had experience and had views, and they were all conscious of the fact that if they thought a dose was being administered that was inappropriate, either as to amount of dosage, or as to dose mix, they would have said something.

Their evidence – again, I stress they are not doctors – cannot just be ignored when allegations are made in these twelve cases that Dr Barton was doing something that was wholly inappropriate and so obviously wrong that an independent expert can criticise.

You heard evidence, obviously, from Dr Reid, apart from others, about it and it may have been rather telling that he said he felt they were mature and sensible staff. "It was a pleasure to work on that ward." You will remember, too, Surgeon Rear Admiral Farquharson-Roberts described in this way, and he was a man capable of speaking directly: "It had a nice feel," he said about it. It is rather a telling phrase: "A good hospital". You will remember too, not strictly speaking nursing staff, the evidence of Patrick Carroll, the occupational therapist, who gave evidence comparatively recently to you, about Dr Barton's involvement. He is not somebody who is part of a loyal core of nurses who are going to be rather inclined to be in support of Dr Barton, if such a suggestion is being made. He is somebody looking at it a little bit from the outside. His evidence is quite telling in respect of what it was like to be working on that ward.

May I say this before I turn to just two nurses, Nurse Hamblin and Nurse Giffin? None of the nurses called – and you heard from a lot of them, called both on behalf of the GMC and on behalf of the defence – with regard to these twelve patients has expressed any concern about the use of syringe drivers, nor of the medication administered, and they include Hallmannn, Turnbull, Tubritt and Giffin – sorry just to use the surnames. It is not meant in any disrespectful way. It is not suggested that in any one of these twelve cases that a nurse, without proper authorisation, or in some way started subcutaneous analgesia. We will come to the instances where it looks as if it was a nurse's decision in a moment or two, but that perhaps is a very significant piece of evidence. Can it really be that over the years covering 1995 through to 1999, that any one of these nurses somehow failed to see something that was obviously and proper going on in relation to these issues.

There are some differences of understanding as to precisely how the procedure should work with regard to the decision as to commence the use of the syringe driver, but again none of the twelve that we are concerned with was affected.

Lastly this before I turn to the two, just one further point if I may. Patients were closely monitored and watched. They were, the nurses confirmed to you, taking note of what was happening all the time – not every single second of every single minute – but there was a continuing monitoring and observing process taking place. It is not the case that people were not watching and monitoring the effect of the opiates being administered via syringe driver.

First of all, please, Nurse Giffin. Nurse Giffin unfortunately, as we know, has died since these events, and her statement was read. Again, I am not going to go through all these detail of it. She felt that Sister Hamblin targeted her and Sister Hamblin did not like the night staff.

She referred to patients going on to syringe drivers when not in pain. She said that she got on well with Dr Barton and felt she was competent. Her complaint was that the correct dosage of diamorphine was given, but doses would automatically increase once they got used to it. That was the way she put it in her statement. She is there throughout the relevant period. I remind the Panel of what it was that Mrs Evans said about her. I appreciate she has not been able to give evidence to challenge that, but that is the evidence you have heard.

Nurse Giffin plainly was somebody who would not hesitate to speak out if she thought any of these patients was being treated inappropriately in terms of this sort of matter. She was alive to it. I think in relation certainly to Gladys Richards, one of the people she was involved with – I will come to that later when I turn to Gladys Richards – but it is noteworthy that she does not make any complaint or raise any issue about Dr Barton's treatment of any of these twelve nurses.

May I come, then, to Nurse Hallmannn. This arises in a slightly different context. It has nothing to do with the 1991 group of patients. Nurse Hallmannn is somebody, you will remember, who in (I think it was) 2000, but the dates do not perhaps particularly matter, made a complaint or raised a grievance. I cannot remember what the precise expression was with regard to an allegation of harassment by Dr Barton, but really in particular Sister Hamblin. That was the main thrust of her complaint. In fact, that complaint was not upheld. It was investigated and the finding was, as it were, against her and the view was taken that the complaint was not justified.

I am not seeking to go into the history of that, but it shows, perhaps, that Nurse Hallmannn's evidence has to be treated with some caution, where she raises certain issues. For example, she suggested that Sister Hamblin and Dr Barton had a social relationship – completely untrue – and also with regard to her complaint, whatever she says about it, the fact of the matter is that in no document that she produced in support of her complaint did she raise a single word about any fears or concerns she had about the use of syringe drivers. She told you that she had made mention of that to Barbara Robinson and been told she need not put it in, or something like that, but the Panel may find it very difficult indeed to accept that if syringe drivers were part of her complaint, she most certainly would have put it in. As I say, there is not a word about it there.

However, that is not to say she was not somebody who did have concerns about syringe drivers. That is a different issue. It is a question of the reliability of her evidence generally. She says that she was concerned – again I am cutting it all short; the Panel will pay full regard to everything she said no doubt – because she might find a patient who the day before had been eating and drinking, the following day when she returned in the late afternoon or whenever it was, the patient would be on a syringe driver. Well, no doubt she did have that kind of concern. The question is of course, what had happened to the patient between those two times.

She said if she asked Sister Hamblin, she would not get an explanation. Sister Hamblin would just say, "Because". "Every patient" – she said this and again something I have to say with due respect to her, she is plainly 100 per cent wrong – "that was admitted to Dryad Ward had diamorphine and midazolam on a syringe driver written up for them on admission". That is just not true, or should I say, it is just not accurate. The relationship she had with Sister Hamblin deteriorated. She had a conversation with Dr Barton one day, "I hope I have not upset you. I may have upset you", and Dr Barton saying, "It is not that but

you do not understand what we do here". I will come back to what Dr Barton had to say about it in a moment.

She says that she spoke to Barbara Robinson about thinking the doses were too large to start off with. That was not a matter that was raised with Barbara Robinson. She also thought that doses were increased too quickly.

B Dr Barton's evidence about Nurse Hallmann, if I can briefly refer to that, please, is at Day 25/62. She was asked about Nurse Hallmann speaking to her about concerns about a particular patient being given subcutaneous analgesia. Her response was,

> "It was a wider issue than that with Shirley. Shirley had come from a background in which she had not had a great deal of experience in palliative care. She freely admitted that herself. She did not feel it easy to make the judgments about when and
C what palliative care to be using in certain patients and that was the original reason for suggesting a spell up on the acute unit: to give some more opportunity to see how it was done up there, exposure to more patients, more experience, people who were more experienced in doing it. That was the reason for suggesting that she take the temporary post up at Queen Alexandra, to widen her experience a bit. She felt uncomfortable sometimes about making the decision about what sort of palliative care a patient needed".

D She added,

> "She did not feel she was experienced enough in assessing a patient and what level of pain relief they might need at that point. From what I can remember of that particular patient, she felt that opiates were not appropriate in that patient" –

E This is not one of the 12 patients we are concerned with –

> "at that time from her assessment of the patient, but what happened on the subsequent night shift was that the night staff reported back that the patient was definitely very uncomfortable and restless and needed opiates".

Dr Barton said she would listen to her judgment if Nurse Hallmann expressed a concern and,
F

> "On listening to her judgment, I would have made the decision in that case not to go ahead with the opiates at that particular point in time. I would have said to her, "Well, let's wait and see." On subsequently receiving the report from the night staff that the patient had definitely required opiates, I had gone ahead with them. It was not a case of waiting until she went off shift and then rushing back on to the ward and saying, 'Let's start the opiates'; it was a case of the ongoing assessment of the patient".

G She said there was no question of her trying to get rid of Nurse Hallmann by seeking to transfer her to the Queen Alexandra:

> "I thought she was a good nurse, but I thought she had deficiencies in the areas in which she was expert. I had no criticism of her general nursing ability at all".

H

That was Dr Barton's response to that. Nurse Hallmann also gave evidence about the situation at Jubilee House where she worked for a period of time after she left Gosport War Memorial Hospital. Again, the evidence of Angela Southam, which was read to you, shows that her account as to the medical cover is not really accurate.

Note this if you would, please, with regard to Nurse Hallmann who was critical of a number of things. She said she never saw Dr Barton being rude or harsh with relatives; outspoken and forthright, yes. She said that general patient care on the ward remained excellent. "Dr Barton was a good and experienced doctor, caring about her patients and operating" as Nurse Hallmannn saw it, "in their best interests. At all times she [Dr Barton that is] maintained a civil and professional attitude towards her".

It is also worth bearing in mind that Nurse Hallmannn makes not criticism, raises no concern about the treatment of any of the 12 patients with whom she had any dealings. I will just give the surnames, if I may: Lake, Cunningham, Wilson, Packman, Spurgin. She did not consider that anything was untoward, that the doses were too high or commenced too early in any of them. Clearly she is somebody who would have said something if that was her view.

Anticipatory prescriptions.

THE CHAIRMAN: Before we get on anticipatory prescriptions, Mr Langdale, that might be a convenient moment to break.

MR LANGDALE: I am in the hands of the Panel.

THE CHAIRMAN: We have had another good dose, as it were. We will absorb that over a coffee or a tea and return, please, at 12.15.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Mr Langdale?

MR LANGDALE: Thank you. Anticipatory prescriptions. Again, I am going to cut down what I otherwise might have had to say to the Panel because it seems as though really there is not so much of a complaint about this as one might have thought at the beginning of the case. You have heard evidence from more than one doctor that it was a necessary practice.

Dr Briggs regarded it as a very necessary practice. His evidence about that is at Day 2/38. He said it was an essential practice. A dose range, in his view, was justifiable. He also made the point that where patients are self-administering and are properly given a range of dose, they may need to deal with symptoms,

> "it would be seem natural to me that trained staff, such as nurses, can be trusted to help administer appropriate doses of drugs",

And that supports Dr Barton's view of the nursing staff.

Dr Reid had come across variable doses before he got to Dryad Ward, though rarely. He had a discussion with Dr Barton about it; he accepted the reasons that she gave him. That is at Day 16/33. I am not going to go over the issue about whether he had or had not seen 20 to

200. Really his position over that was to say, "I must have seen it but I cannot say that I recall seeing it". That may be the fairest way of summarising it, but plainly he had seen it on more than one occasion.

He said he had come across anticipatory prescribing elsewhere and, "We practice anticipatory prescribing on our palliative care ward in Queen Alexandra today":

> "it is usually the type of patient who again has been very ill, it is not really clear which course their life is going to take, in other words are they going to recover from this illness or might they soon become terminally ill; in other words, the timescale I am thinking of is becoming unwell within the next few days".

He did not have any concern about the type of drugs involved in such prescriptions. Diamorphine, midazolam, haloperidol – he could not remember the fourth. I think he probably means Hyoscine, but I am not sure.

> "if somebody is very frail, been seriously ill, in whom one did not know which direction their course were to take, I think it is not unreasonable, in fact good practice, to think about anticipatory prescribing, because I think it is better that doctors who are experienced in doing that [palliative care] do it",

Rather than leaving the prescribing to out of hours junior doctors who may know little about informed palliative care prescribing. He was perfectly happy with the practice. He also said that the luxury of taking a gradualist approach to the administration of opiates is not afforded to a doctor who cannot be there save for limited periods of time. That is Day 16/77.

> "a difficulty, if the starting dose is too low, is that the patient, when the time comes to start on the opiate, will have suffered unnecessary pain".

What is critical, he said, is the doctor's own judgment with regard to a patient the doctor has seen and about whose situation the doctor knows. In relation to those parts of his evidence I have strayed from the strict field of anticipatory prescribing, but he gave his evidence about it very much as part of a piece and I do not want to have to go back to it in a separate context. That is talking about what you actually do in relation to administering opiates, as opposed to the anticipatory prescribing.

A balance has to be struck, he said, between the nursing and medical care dealing with the pain control problem and the pharmacological approach. It requires judgment. Experience counts for a lot. He agreed that doctors might perfectly genuinely, perfectly sensibly come to a different conclusion as to the appropriate dose on which to start, citing by way of the sort of genuine difference you could get as 10, 20 or 40 mg of diamorphine.

Dr Tandy was aware of Dr Barton writing variable doses. She had come across them before. You may remember that one of the things she could recall was that as a junior doctor she had been working on a ward where she had been asked to write up large, variable doses for palliative care wards. She remembered one that was up to 150 at its top end. She was at that time taken aback by it, but was told it was routine.

Dr Lord said it was a reasonable practice. She had not quite registered, she said, that the dose might 20 to 200 and said that with hindsight maybe 20 to 200 mg was too wide a dose range.

Then in relation to part of the same issue, although it is not anticipatory prescribing as such, with regard to the use of opiates, if I can remind the Panel about certain aspects of the evidence given there. Dr Reid said morphine or diamorphine is usually for pain control, but also for patients who might be distressed in the terminal stages of an illness where it was unclear whether the distress was mental distress, physical distress or a combination.

If I can just pause there, Professor Ford, at first sight, might have been thought to have been saying, "Diamorphine, only for pain", as simple as that. He was prepared – this is not a criticism of him in any sense – to accept that there was a body of opinion which regarded diamorphine as something that was also appropriate to be used in relation to distress in a more general sense – something which Professor Sikora also referred to. It is clear too that it was the view of Dr Logan back in 1991. So it is not the case that the Panel should approach this issue on the basis that the evidence is clear and unequivocal from Professor Ford about that matter. Diamorphine can be used perfectly properly, there is a body of opinion, to relieve not just pain but also distress. We will see that cropping up in the case of one of the patients, the lady who was on diamorphine at Queen Alexandra. We will come to it a little bit later. She was being given diamorphine subcutaneously for distress. It cannot seriously be suggested that Dr Barton was following some aberrant, peculiar strange notion of her own and that it could not be used in that regard.

It is quite important. It is another illustration of the fact that things are not just set out as precisely as one might think with regard to some of the things being said. Dr Reid also said that fentanyl similarly was appropriate for a patient in pain and for distress. Dr Tandy, with regard to Oramorph said if someone is a little confused and is uncomfortable, sometimes if you just take the edge off the pain they actually respond to you much better and are more settled and able to do more. She said that in the context of Mr Pittock at Day 18/33.

Dr Tandy confirmed also that if you stop or decrease doses of, for example, diazepam or benzodiazepines, abruptly, that patient who is being treated with that medication will get a withdrawal reaction and become very agitated. You will remember that it is one of the considerations that Dr Barton applied with regard to patients who were being taken off certain medication when she commenced the administration of opiates.

With regard to prescriptions for diamorphine generally, Dr Tandy said you tend to start at the lower dose and build up very quickly, which is easier to do in a hospital because there are lots more people around in a big hospital like Queen Alexandra. On that same question, the use of opiates, I have already referred to the evidence we have heard as to what Dr Logan was saying about it in 1991, and Dr Lord also. May I just remind the Panel, without asking the Panel to turn it up, of the Palliative Care Handbook at Tab 4 of your bundle, pages 4 and 5, where it refers to pain and the components of pain? It is rather important to bear in mind what components of pain may be in terms of symptoms exhibited by patients who are in pain, but it may not immediately exhibit itself as actually pain in the normal sense of the word.

In terms of the level of dose and increases, Dr Briggs for example indicated at Day 2/39, that if a patient was already on oral morphine and therefore not naïve, you would therefore need to initiate a higher dose via the syringe driver. He quoted the example that if a patient was on 50 or 60 mg per day of Oramorph, then you might need to start at 80 mg of diamorphine in the syringe driver. That was his view.

Dr Reid, as we know, thought doubling the dose every day would have been appropriate. That was his understanding then. He thought the conversion factor for oral morphine to subcutaneous diamorphine was two to one. He accepted that that has been amended to three to one.

Dr Tandy's understanding was that the appropriate conversion was half the Oramorph to get the right diamorphine dose on a strict conversion. She said, "It is different advice now".

A separate issue which I think I can take quite briefly, but which is nonetheless, we suggest, quite important. It is the evidence about the pharmacist who used to visit the hospital every week, maybe more. The evidence we heard from a number of witnesses was that the pharmacist was extremely thorough; she would go in regularly. As Barbara Robinson put it, "She would be like a dog with a bone, so if there was anything she was not quite happy with ever, she would see the ward sisters or see myself and tell us about it. I never had any complaints from the pharmacist about the amount of diamorphine being prescribed". The lady pharmacist concerned was Jean Dalton. There cannot really be any dispute about this. Barbara Robinson said, "She would definitely have come to me or written to me if there had been a problem. She looked at the diagnosis of the patient. She would compare that with the treatment they were being given. She would look to see that things were written up correctly on the prescription chart. She would cross-reference the controlled drugs. She was very very thorough in cross-referencing controlled drugs".

That was all evidence given on Day 32, pages 73 to 74. She would look at the question of drug interactions and if there had been inappropriate prescribing for a patient's condition, she would have expected the pharmacist to be aware of it. That was her role. She also indicated in answer to questions by the Panel that the control drugs register does indicate the precise dose given each time, so that the pharmacist in looking at the controlled drug book would see what dose had been given. She did not need, in that sense, to see the notes.

Philip Beed, on Day 9/51 to 52, dealt with this. He confirmed that the pharmacist would check all the patients' drug charts, "Check our controlled drug record and check our stock levels. If any of those had any cause for concern or there was anything needing discussing or checking, she would bring those to the attention of the nurse in charge to deal with, or bring it to the attention of the medical staff if that was necessary. The pharmacist would see what the patients were being prescribed, what was being administered and see the dose ranges and dose combinations". The pharmacist never expressed any concern to him about the dose ranges. She was somebody he thought who was pretty thorough in carrying out her job.

Similarly, Margaret Couchman at Day 7/16 to 17 talked again about the pharmacist looking at the treatment cards every week to see what the patients were taking, whether the drugs were the right drugs, whether the doses were correct. If she felt they were not, then she would leave a note for Dr Barton. She would come across from Queen Alexandra every week and go through all the material as a regular occurrence. She would see everybody's prescription and what they were prescribed.

The evidence, although I have summarised it very briefly, we suggest is very important, because here is another person who has no interest in supporting a doctor or a nurse if they think that that course of action or whatever is being done is wrong. The person who has looked at all these prescriptions carefully over the years, it would seem, who did not suggest either to a consultant, or to Dr Barton or to any nurse that the doses of diamorphine and

midazolam and so on were inappropriate, too high or anything of the kind. Dr Barton is entitled to submit to this Panel, we suggest, that if they were so obviously wrong that an independent expert can say, "There was something inappropriate about this looking at it without having seen the patient", it would be remarkable that an efficient, thorough pharmacist – there is no dispute that she was – would not have picked up on it and said something.

B

It is another indication, perhaps contrary to the assertions of Professor Ford, that what was being prescribed here was appropriate. Dr Barton's practices were not something which should properly be criticised.

May I turn and say something about Professor Ford generally? I will be saying something about his evidence when I turn to the evidence with regard to the twelve patients, but can I just remind the Panel of certain things he said?

C

On Day 20/7 he was talking about the BNF and guidelines, and perhaps it is important to bear in mind what he said. This is not something with which the defence take issue.

> "Guidelines do not apply to every patient. They provide a framework of care based on evidence which should be looked at by doctors as the basis to underpin their practice. Patients do not always meekly follow guidelines for a number of reasons. One is they have other comorbidities, or there are other issues you have to weigh up, and guidelines do not attempt to cover every clinical setting a doctor may face. If guidelines could do that you would not need all the training and experience that is necessary to be a good doctor. If you go outside the guidelines you need to be able to explain and justify, not in a defensive way but in a clear logical way why you have chosen to treat an individual patient under your care outwith established guidelines."

D

E

He said, Day 20/8, with regard to palliative care:

> "There is no strict agreed definition. It often does not mean palliation of symptoms in patients who are expected to recover."

Relief of pain, Day 20/9, one of the "primary and most important duties of a doctor". He spoke also about confusion and restlessness, I am not going to repeat that, on Day 20/18.

F

In terms of conversion, Day 20/21, if you have a patient who is adequately controlled when you convert you would switch using one third. If you have someone who is still in pain and you are converting, clearly you would need to increase it.

He spoke about, Day 20/42, the decision that a patient should be treated by a palliative care regime. It always slides into terminal as well because there is not that absolute hard and fast boundary, but this is what he said in relation to the decision to treat with a palliative care regime. "It is a very challenging area of practice; the culture has changed in the last 10/15 years. Development has taken place with regard to guidelines and protocols like the Liverpool Care Pathway. The culture has changed."

G

Another illustration of that I suppose is he was saying that he would not have been surprised in those days to see that TLC in effect was not exactly a code but a signal or a reference or a statement that the patient was really entering end-of-life care.

H

Having said that, just by way of generality with regard to Professor Ford, matters which seem particularly pertinent, may I turn to general matters, and this is the last thing I seek to say to the Panel before turning to individual patients, general matters with regard to Dr Barton's evidence. This will save me repeating these points every time one comes across a patient raising similar sorts of issues. This is a very brief digest, not remotely of all her evidence but of certain particular points she was dealing with.

B

She spoke obviously about the change in the nature of patients and the change in the nature of patients meant things became very different. She felt she was trying to do a job in the wrong surroundings. It turned into something more worrying, Day 25/25.

> "We began to feel we were not able to give appropriate care to a lot of the patients we were looking after. The hardest thing to deal with was expectations of relatives. We did not have intravenous fluids; we did not have the facilities you have in the district general hospital where one would have had a team of people working with you."

C

She estimated that 10-15 per cent of the patients who arrived were not really in a suitable state, Day 25/29.

> "It is not possible just to slot a patient back into a bed at the referring hospital."

D

The Panel may remember her clear, obviously accurate and practical evidence about what you actually had to do, what the realities were in terms of sending somebody back. Leave aside the correctness of the decision, as she did not for a moment suggest that the problem about transferring a patient back meant she would not transfer a proper case back, but it is not a decision to be taken just like that, and in considering of the patient's best interest and the patient's welfare one needs obviously to have to consider the practicalities.

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Palliative care, she said, does not imply that the patient will not recover; it implies they were unlikely to recover, Day 25/31. In relation to the reasons for giving oramorph in general terms, she said in her evidence or spoke in her evidence at Day 25/46, without reading out every word of it, she was asked what would create a situation or the sort of situation where there would be a need for the administration of oramorph and what its advantages were. She said:

F

> "Continuing pain, distress, anxiety in a patient undergoing palliative care. I was well aware of the analgesic ladder, both in general practice and in the hospital setting, and like one of my consultants mentioned in his letter earlier on, I felt that a small dose of oramorph was much more beneficial to the patient than large doses of Step 2 analgesics, which were unpleasant to take and had unpleasant side effects associated with them, whereas a small dose of oramorph will often give a slight feeling of euphoria and well-being to the patient in addition to controlling their symptoms of pain and discomfort."

G

She spoke about the problems with large, unpleasant-tasting difficult tablets to swallow and so on. "I think in those days", she said, quite a revealing remark, "we were not frightened of opiate use in the way we are now."

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There is a clear indication, and it is supported by evidence from consultants and certainly supported by the view of Dr Logan, that oramorph might be appropriate in those circumstances, important, we suggest, to bear in mind when you come to patients where the allegation in the charges is that the actual prescription for oramorph was not in the patient's best interests or inappropriate.

Subcutaneous analgesia. She said that the administration of it signified that the patient was moving into end-of-life care, terminal care, and where we would be focusing on making the patient comfortable and peaceful, Day 25/48.

She spoke about doses of diamorphine and she said:

> "10 mgs of diamorphine over 24 hours did seem in practice a very low dose. 20 mgs as a starting dose seemed a very satisfactory starting dose. I did not ever see any major side effects or problems with that dose."

Now, she has been prescribing to patients for years. She is entitled to say, is she not, considerable weight should be given to my experience and my observation of what happened with patients who were started on 20 mgs, I did not see major side effects or problems with that dose, nor did any consultant ever suggest to Dr Barton, or obviously if they thought it they would have said it, they must therefore not have thought it: What are you doing starting patients on 20? Why not 10?

That obviously was a shared view, it was not something she was ever criticised for or picked up on, and she has given her rationale for commencing at that sort of dose.

She spoke also about the fact that initial loading injections, a topic raised obviously by Professor Ford, was a luxury. It would involve drawing up an administration by two trained nurses every four hours. I am not going to go over all the evidence she gave about the difficulties and practicalities of doing that.

Midazolam. She did not feel that 20 mgs was a high dose, and indeed was able to point to the fact, if one is going by the BNF, if it is your Bible, as it were, that what the BFN says for the dose range for midazolam is 20-100 mgs in 24 hours.

She also made some further comment about midazolam, Day 25/51 when asked about what the point of it was and what she was trying to achieve. She said:

> "I think the Professor mentioned this concept of terminal restlessness. I do not know if anybody has ever done any research into what it is but it is a very distressing symptom, both for the patient and those looking after the patient. It was very good at controlling that. I also felt that as a sedative it replaced the antipsychotics and antidepressants and other drugs that had been present in a lot of these patients, particularly the end-stage dementia patients, so that it would cover any withdrawal or restlessness they got from not being able to take those drugs any more, and it was a drug I became familiar with through using it over the years and comfortable with using."

She made the further point that the protocol or the Wessex guidelines makes the point that you should use a small number of drugs and be thoroughly comfortable and familiar with

them, and the possible problems you are going to get with them, and I had the three that I used routinely really or made available routinely."

There is a perfectly reasoned, sensible, and at the time not criticised view as to what was appropriate in terms of midazolam and why she prescribed it. She made the point with regard to anticipatory prescribing that it was not done for her personal convenience; it was not done for the convenience of the nursing staff, it was done for the comfort of the patient to ensure the maximum comfort and dignity of my patients.

One can see there is some force in that point. If she was not concerned about that, why on earth should she bother? She would be perfectly entitled to say, "I will wait until I come round next and if the patient is in pain, really too bad, the patient will just have to wait until I arrive".

I am being blunt about it but that is really what we are talking about. No problem for her, if she wanted to do that, if she had been hard-hearted or callous, shall we say, about patients having to wait and suffer pain and discomfort until the doctor got there.

You will also remember her evidence about how it would not be feasible, she had never come across it, to prescribe variable dose prescribing for individual doses of diamorphine, individual injections.

I had a very low threshold for anticipatory prescribing of oral opiates. They were valuable in managing all kinds of post-operative, post-travel pain, and pain on transfer into the ward. She was also asked about two areas which are quite difficult areas in terms of what it was a doctor was supposed to do and what it was that could legitimately trigger a doctor's concern, because when you administer sedatives, when you administer opiates, an effect is going to be obviously sedation and also an effect on the respiratory machinery of the body, respiratory depression. You are always having to try to deal with, in administering these drugs, the fact they will have, to varying degrees, certain consequences.

We are all very familiar with that as a result of the evidence given in this case, and the crunch question comes, when a patient is receiving subcutaneous analgesia, in this case diamorphine coupled with midazolam, the patient's condition may be causing the deterioration and so on; they may be playing a part as well. As the experts have said, the only way of actually checking precisely what is going on, and even then it is not precise, is to stop the lot and see what happens. Well, we have heard about the obvious disadvantages and consequences of that, and if you are dealing with somebody who is dying, being blunt about it, is that really sensible? It is a situation, a question, that has to be addressed. Dr Barton legitimately, properly we suggest, and genuinely, took the view: I am not prepared to have my patients when they are in this situation suffering unnecessary pain, unnecessary discomfort, unnecessary distress.

What really would the benefit have been of these patients being on a lower dose and running the risk, a real risk, of them experiencing unnecessary pain and discomfort? It is a judgment, a balance. It is all too easy, perhaps, to say: Oh, well, you have got it wrong.

Without seeing the patient and taking into account legitimate concerns on the part of the doctor, it is really rather hard to conclude that she was somehow acting in an inappropriate fashion.

Just on this question of how do you judge drowsiness and over sedation and respiratory depression and the process of dying, what she said about it - and I am only going to quote a couple of passages really found at Day 25/74. She was asked: How do you tell with a patient who is drowsy when on subcutaneous analgesia whether it is the analgesia that is causing the patient's drowsiness or the patient's condition, and so on.

> "A I do not think that you can completely untangle which particular aspect is causing it. I imagine that a major overdose of an opiate would make the patient completely drowsy, unrousable, unconscious; there would be no fluctuation in the conscious state at all, whereas during the normal process of dying there would be a natural fluctuation as there would be possibly with the course of the terminal illness. That is the only way I could think to distinguish between those three threads.
>
> Q Were you aware of the fact that diamorphine and midazolam might of themselves be causing at least some element of the drowsiness?
> A Yes, but I was prepared to accept some level of drowsiness in exchange for adequate relief of pain and other terminal symptoms".

She was asked whether it was her experience that you can keep the patient who is going downhill in a sort of static state where you just keep pain control at a certain level and things do not change. What is the process in your experience over all these years? Anything but. There is what the nurses kept recording in the notes as 'further deterioration', which means that the periods of being less conscious would become longer; the periods of wakefulness would become less. The patient would take less interest in their surroundings. There would be fewer involuntary movements. The whole system, the whole body system, is gradually winding down into death. It is not something you can measure, it is only something you can make an assessment of by observation and by experience, by being there and knowing what you are looking for. That is what these nurses did."

Well, that is pretty compelling evidence from somebody who is a good doctor, somebody who had built up a considerable body of experience. She also said, Day 32/9, when asked about a similar issue, "How do you recognise when the patient was getting too much," in the sense of an overdose. She said:

> "A I suppose it is a very difficult picture. When somebody is dying anyway and all their organs are shutting down and they are drifting in and out of consciousness, are they over-sedated? I suppose if they were deeply unconscious, you might say "we are giving too much of the sedative or too much of the opiate; we will reduce the dosage" but the process of dying is so closely mirroring the bad effects and the good effects of the opiates and the anxiolytics are so close to what you are trying to achieve that it would be difficult to be absolutely sure".

There is somebody facing up to the problem and giving a reasoned view as to how she approached that problem. As Dr Reid said, it may be that the dosage required to treat the patient's symptoms of pain, distress, agitation and so on, becomes so high that the patient becomes unconscious and virtually comatose, but that may be all part and parcel of what is going to happen when you are properly treating. They may be over-sedated in the sense that they are heavily sedated, because they need those treatments to control the symptoms they are suffering. And it would appear on all sides that those concerned with palliative and terminal

care are well aware of that; that a patient may well reach a stage when their pain is being controlled, has to be controlled to such an extent that they become virtually unconscious. If they do not, if you do not treat them, they become less unconscious but they are going to suffer pain and distress.

Lastly this in terms of Dr Barton's evidence with regard to general matters, before I turn to individual patients, with regard to Professor Ford; how she saw his viewpoint, as it were. When the point was put to her, you faced the criticism from Professor Ford and that she says that she felt what she did was right. Her position had not changed on that.

> "A I have felt throughout that Professor Ford's criticism has been perfectly appropriate with the benefit of hindsight and looked at by a secondary care specialist with tertiary specialisation in palliative care – not a community hospital run by a part-time jobbing general practitioner: a completely different world of nursing, medical, everything treatment. I could not have provided the sort of care that he had at his fingertips in my cottage hospital".

That is Day 31/2. Also at Day 31/16 she was asked again. In this case it was a question from you, sir, about the position of Professor Ford. She said:

> "A I am sure one's whole outlook on palliative care could be very different working in a specialised tertiary unit. He talked about one-to-one nursing care, he talked about hourly observation" --

in parenthesis, that is medical observation –

> "he talked about being able to titrate the doses of his opiates. I am sure I could have practised different palliative care under those circumstances, but this was what I had. This was what I had available to me, this was the level of cover that I had, and this was the sort of hospital that we worked in. I had to tailor my palliative care to what I had available".

That, perhaps, is putting it spot on in relation to which one cannot criticise Dr Barton.

There is one further point that was made and I am going to deal with it now rather than having to come back to it. That is in relation to the suggestion that she was somehow completely ignoring or tearing up – whatever expression my learned friend used – the guidelines and the *BNF*. At Day 28/79, and on to page 80, she was asked about the guidelines with regard to this particular case. I think it was dosing with the elderly.

> "Q Are you saying in effect that you ignored this particular part of the guidance?
> A I was aware of this guideline.
>
> Q Did you take any account of it?
> A I certainly took account of it but I still then used the appropriate dosage of the drug for the particular patient.
>
> Q Can I ask you this, did you at any stage reduce the amount of opiate that you were prescribing, taking into account the fact that your patients were very elderly?

A I took into account the fact that they were very seriously ill and in the terminal phase of their lives".

It may be that that is a repetition of something that I said yesterday, but I do not think it is. That perhaps again is an important reflection in relation to Dr Barton not ignoring the guidelines in the sense that apparently was being suggested to her.

B I am going to turn to the patients. Albeit there is five minutes to go before it is one o'clock, it would probably be sensible to stop now.

THE CHAIRMAN: I think so. We shall break now and return at five to two, please.

(Lunch adjournment)

C THE CHAIRMAN: Yes, Mr Langdale.

MR LANGDALE: The individual patients. What I am going to ask the Panel to do, if they would be so kind, is to have in front of them when I deal with these patients the chronologies. I am going to be basing what I say to a degree on that, and I shall also be cross-referencing to the heads of charge as I go through this.

D Starting off obviously with Patient A, Lesley Pittock, I am going to move on straight away, if I may, with regard to this gentleman to page 9. Can I make it clear that in relation to the patients, Mr Kark has perfectly properly and perfectly sensibly summarised Professor Ford's evidence in relation to all of them. I am not going to repeat his summaries. I shall be making reference to what Professor Ford said but when I do, I am not setting out to cover everything that he said. You have it. There is no dispute about what he said; it is just what issues arise form it.

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Looking at page 9, obviously with this man I do not need to repeat the history that he had, the troubled and difficult history. If one looks at page 9, one can see what the situation was with regard to Dr Lord – in fact the day before he was admitted to Dryad.

F The first entry there where he was reviewed when he was on Mulberry Ward, she is talking, she said in her evidence, in terms of things to occur – high-protein drinks, bladder wash-out of hours, et cetera. She said, "My directions were with regard to his care prior to transfer." She thought they would be followed, and they would try to carry them out, i.e. on Mulberry Ward. In correspondence at the bottom of the page, she set out that the overall prognosis was poor. Dr Lord's evidence was she did not feel she would be able to get him better or that they would not be able to get him better to go to a residential home, or anything of that kind. The outlook was not good. "He was very unlikely to get less dependent," was how she put it.

G Dr Barton, in relation to that overall "prognosis poor": "That signalled to me that he was for palliative care." (Day 25/77) It meant that everyone continued to try, but they were realistic about the fact that their efforts were probably not going to bear fruit, and that "he was going to continue to deteriorate despite our best efforts." Not only was that pretty practical. It turned out to be exactly right, because before the admission of any opiates this gentleman did continue to decline. Indeed, six days later, Dr Tandy was saying "For TLC", so Dr Barton's view was exactly right. The following page, page 10, where he is admitted to Dryad she sets out the description. It does not appear as if there is any real criticism actually of the

H

assessment or the review that she conducted on admittance. One has to be careful with regard to the allegations with regard to inadequate note-taking. It is not the case that every single time there was an event which Dr Barton should have noted, but she did make an inadequate note on some occasions. It is accepted that she did.

Over the page, please, we can move on to the 8 and 9 January. In terms of the drugs that this patient was on, looking at the top of page 11, Dr Barton said: "I would have been well aware that withdrawal of these could have quite an unpleasant withdrawal reaction with regard to the sertraline and the diazepam." She therefore allowed for that when she thought about appropriate doses of opiates and tranquilisers. (Day 25/78) One then has to bear in mind, in relation to 9 January, just above the existing entry – it may, in fact, have been added on a separate page, a new page – the review by Dr Barton:

> "Painful R [right] hand in flexion. Try Arthrotec. Also increasing anxiety and agitation. ? sufficient diazepam. ? needs opiates".

There is the doctor, clearly thinking about the situation, not suddenly saying, "Right. He has increasing anxiety and agitation. I am going to start on opiates." She is somebody who is considering the question, considering it carefully and having it as a possibility in her mind that this man is going to need that. It rather runs contrary to the idea that every time in later patients she prescribes or has administered opiates, that somehow it is going straight onto them without her thinking. Plainly she did in this case. She was in the habit of doing so. Generalised pain is recorded on that day. He receives arthrotec. Then we move on to page 12, Wednesday 10 January, reviewed by Dr Tandy. This is where she has called up the wife who agrees, in view of the poor quality of life, that he is for TLC. As Dr Tandy said, "That is not in current use today as an expression. It meant that the focus should not be on prolonging life, but on making sure he is comfortable. I add in parenthesis, this is a clear example of the sort of assessment made about the patient's condition that justifies a doctor's judgment that palliative care is what the patient needs. It is not putting the patient on the palliative or terminal care path. It is as simple as that.

A number of questions have been asked by the Panel – perfectly understandably – about how one challenges these assessments and so on; what is there to protect the patient's interest. There is a classic example of what actually it comes down to. Dr Tandy has not been criticised for a moment. Dr Tandy obviously will have seen Dr Barton's note with regard to query the need for opiates. As Professor Ford said, and he does not criticise the assessment by Dr Tandy. "Anyone who saw him would realise this man was near the ending of his life," so really he is on the terminal care path because of his condition, nothing to do with anything else.

Dr Barton, who saw the patient with Dr Tandy: he was "to commence on Oramorph four hourly this evening." Interestingly, with regard to this patient, who is opiate naïve, Professor Ford does not suggest that the prescribing and administration of Oramorph was in any way inappropriate. It is interesting because on a number of occasions with regard to other patients, he said, "Instead of putting this patient on Oramorph they should have been put not a step 2 analgesic – co-dydramol or co-proxamol" – whatever it might have been. It seems a little strange that he should be saying that, perhaps, with regard to other patients, whereas with this patient he does not criticise at all. There is an example of Dr Barton, in conjunction with Dr Tandy, considering that Oramorph was the appropriate treatment with a patient who is opiate-naïve and no criticism can be levelled at her for doing that.

It appears to be undated, but it appears to be on the same day: if you look at page 13, still on 10 January, Dr Barton wrote up an anticipatory prescription – 40-80 diamorphine, 20-40 midazolam and hyoscine as well. Obviously when writing that up, as she indicated in her evidence, one would assume that when he reached the stage of requiring subcutaneous analgesia the Oramorph would no longer be controlling the pain. Inevitably it was not going to be a straight conversion. You heard from Professor Ford's evidence about what would be a straight conversion, and so on. He could not from the information in the notes understand the reason for such a large increase. It is important to realise – I keep stressing it – this is anticipatory. This is not Dr Barton thinking, "This patient now needs 40 in terms of diamorphine." It is, "I can see the situation arising when he will need it. Obviously his patient, even on Professor Ford's view was going to require, as his condition deteriorated, some form of subcutaneous analgesia.

Then, over the page, to page 14. Dr Barton increased the anticipatorily dose for diamorphine. There is nothing in the notes as to why this happened, but this Panel can safely proceed on the basis that there must have been some reason. One cannot safely conclude that Dr Barton increased the lowest dose, in the case of diamorphine 80 to120, midazolam staying at 40 to 80, unless there was a reason for it. Dr Barton's evidence was that she saw him again on that date, although it is not recorded. "He was in such discomfort he was going to need more diamorphine and more midazolam, when he went on to subcutaneous analgesia." This is on 11 January. It is not administered to him. Therefore we suggest, with respect, the Panel should conclude plainly there was something to justify the increase.

Her view was that if that was going to cause respiratory depression or lowering his conscious level, that was a price that might have to be paid in exchange for giving him adequate pain and symptom relief. (Day 25/80)

As Professor Ford said, "This man is dying," but his criticism was that treatment should still be appropriate to his needs. What is appropriate to his needs? Does the evidence show that it was not? In our submission, plainly the evidence does not show that because we can look at the history as to what happened with regard to this patient. So there it is, on Thursday 11 January the anticipatorily prescription is in place.

Four days later, looking at page 15, diamorphine is administered. It is not a case of Dr Barton instituting the administration of diamorphine and midazolam immediately it is available. It is, I stress, four days later, ten days after his admission and five days after it was clear that he was nearing the ending of his life; that situation with regard to Patient A, if I can use this as an example, is totally inconsistent with an allegation of a culture of starting too early and at too high a dose.

When he starts on the diamorphine and the midazolam and the hyoscine, when it is being alleged that this was inappropriate or not in his best interests or was excessive to his needs, this patient remained on diamorphine and midazolam for nine days. We say in respect of the allegations made, if I can put it in a sentence, the proof of the pudding is in the eating.

How can anybody say in relation to the course that was followed and the condition of this patient, that that was in fact too high when it was administered? It might be, if you look just at what is recorded here, and as Professor Ford said, "I cannot find any indication in the notes for going on to a syringe driver as opposed to oral administration of morphine". It is not in

the notes. But obviously – Dr Barton said in her evidence it was clear to her because this was a Monday – he had deteriorated over the weekend. The fact that it is not in the notes does not mean that it did not happen.

Dr Tandy said she might have used the variable dose range, but would have used a lot lower starting dose. She also said, "If pain is adequately controlled by 30mg orally" she would have started on a lower dose. But if pain was not controlled, then "more" – that is more diamorphine. If she had seen the patient at the time and the patient was very dozy, she would cut back, but not if not dozy. It depends entirely on how the patient was. If a larger dose is used, then when topping up you obviously have to use a larger top-up. "I would not have written up midazolam as well. It is a high dose of midazolam", but she added, "If the patient was very very drowsy would cut back. If doses happened to be about right for the patient", then she would not necessarily cut back, again repeating that it would depend entirely on how the patient was. That can be found at Day 18/37.

One can see what happened with regard to Mr Pittock. He continues having the diamorphine and midazolam provided to him. It does not control his pain and agitation. Dr Barton said with regard to 16 January on page 16 that she would have reviewed him again that morning. If she had felt that the diamorphine and midazolam were producing significant adverse effects, she would have reduced the dosage. That appears at Day 25/81.

One can see the notes on the second box on the left on this particular page,

> "Condition remains very poor. Some agitation was noticed when being attended to. Seen by Dr Barton",

And so on. It is clear that what he was receiving did not succeed, therefore, in completely controlling his pain and distress. I move over the page to page 17, where the diamorphine is increased on 17 January. The increase, Dr Barton told you, was because he was becoming inured to the dose of diamorphine; was beginning to get symptoms of pain, agitation and distress. We will see what happens over the page in a moment. That is the 17 January. In this particular case the prescription has been put ahead of the events on that date, so we move over the page to page 18 to see what was happening. If you look at page 18, still on 17 January, we see Nurse Douglas recording the medication being increased and a reason being given. It is not a lying reason. It is not an invented reason. It is a real reason.

> "patient remains tense and agitated, chest very bubbly...Daughter informed of deterioration",

And so on.

> "Dr Barton medication reviewed and altered. Syringe driver renewed".

There you have it. That is the reason for the increase. If he had remained on the same dose you are increasing the risk of him remaining or possibly becoming more tense and agitated. As Dr Barton said, in her view it was not the opiates that were making him tense and agitated, it was his underlying condition and his approaching death. That is not fiction on her part. It is not Scotch mist that she is talking about. This was a patient who was dying. Those are symptoms which patients exhibit in the process of dying – Dr Barton, Day 25/82.

Professor Ford suggests well, this may have been the opiates causing him to be like that. That is just a "may be". That is just a possibility. It is not hard fact. It is not proof by a very long measure. The same argument: the proof of the pudding is in the eating.

Dr Briggs was asked about this. I am looking at the bottom part of the page where, on 18th, there is further deterioration. There is still difficulty controlling his symptoms and Dr Barton suggested, "Try Nozinan". Dr Briggs indicated in his evidence in relation to the question of deterioration – again it may be something that it is worth the Panel bearing in mind so far as his description goes – when he was asked what he made of "further deterioration" he said this. He summarised Mr Pittock's condition. You remember Dr Briggs saw him not very long after this. He described his history, his physical condition, the long history of agitated depression, wishing to end his life and so on and developing an aggressive affect with people who cared for him, indicating he was in a very distressed and unhappy state. Then he said this:

> "So I would have interpreted him as suffering greatly from the inevitable deterioration as a consequence of his age, so further deterioration here would indicate to me that Mr Pittock was suffering greatly and that he required increased medication to relieve that suffering".

There is a competent, sensible doctor giving that evidence. It seems difficult to suggest that one can ignore it or say that it is incorrect. There is further deterioration, as I say, on the 18th. Dr Barton said, "I wanted him comfortable and free of all those wretched symptoms he was suffering". That appears at Day 25/83. Over the page, relating to the condition continuing to deteriorate, Professor Ford accepted of course that this was a difficult area. This man was dying. What level of attention and care do we expect to see?

Over the page, page 20, the further prescription is set out. We then move on to Friday 19 January, diamorphine being administered. Over the page on page 21,

> "marked deterioration in already poorly condition...Breathing very intermittent. Colour poor".

Further on, Saturday 20 January, the doses are given. Dr Briggs at the bottom on the left,

> "Has been unsettled on haloperidol in syringe driver. Verbal order to increase Nozinan 50 mg to 100 mg".

There, the Panel may think, is a rather good example of nurses monitoring the patients. He is being watched. He is being observed. Dr Barton's point in questions asked by the Panel at Day 31/7, was that patients were being constantly monitored by experienced nursing staff who would notice and remark if there were any obvious signs of adverse effects. The nurses are assessing them 24/7. That is a very good example. What do they do? They notice the symptoms and they contact Dr Briggs because it is out of hours or at a weekend. As Dr Briggs' evidence made clear, the nurse had become concerned that the patient had become more agitated and very restless; she felt maybe the haloperidol was causing it.

Over the page to page 22, again it sets out the history in regard to Dr Briggs being contacted and the verbal order and so on, and Dr Briggs comes in on the following day. It is also worth noting in relation to the nursing care plan for 20 January – I am going to give you the page

without asking you to turn up the file. You can see the nursing care plan set out on page 22. Over on the right there are some page references, page 218 to 228. If you care to take the opportunity when it arises, it is worth looking at on page 227, I suggest, because it shows,

> "Now unable to cope with dietary fluid intake. Please give regular mouth care".

This is a man, therefore, who is not comatose, not over-sedated, otherwise that comment would be unnecessary. He is going downhill and he is going downhill because of his condition, not because of the opiates.

Dr Briggs spoke about his rationale, about reducing the number of medications; it would avoid any problems with mixing drugs and consolidate the prescription into a more simple form. He had seen the doses that this patient had received. His evidence,

> "They are quite large doses, but I was aware that in spite of them he remained agitated and unsettled. The dose would have alarmed me if he had been showing signs of respiratory depression and physiological stress as a result. The indication was that he had developed a tolerance to the drugs and therefore a higher dose was safe to administer".

There is a doctor applying his mind, applying his knowledge to this particular case. He does not say to himself, "There is something wrong with the opiate dose". He is quite prepared to change a particular drug if he thinks it is wrong. He was not conscious when he saw him, but he was not in a coma, he said about Mr Pittock. When he saw the patient he was not awake on the occasions when he saw him. He said in cross-examination that he would have noticed if the skin colour suggested excessive respiratory depression. The fact that he noted the respiratory rate indicated that he had a concern lest the patient be over sedated or over-dosed. The fact that he had not written anything to that effect would indicate that he was happy that the patient was not inappropriately dosed. If he had been unhappy, he would have done something about it.

That is positive clear evidence setting out the real picture. Dr Briggs spoke – I will give you the page reference – at Day 2/47 clearly and gave a good rationale as to the issue that arises with the risks that can properly be taken with the admission of diamorphine and midazolam in an end of life care case. It is a justified risk, he said. As we can see on page 23, the administration continued. His condition remained poor and indeed on page 24 we can see Mr Pittock died, bronchial pneumonia, on 24 January.

There are two other matters with regard to evidence so far as he is concerned. Dr Tandy said, because she had not seen him after the TLC date which we have looked at, "They probably would have told me" – the medical or nursing staff – "the next week that he had died on the syringe driver and I clearly was not concerned".

Linda Wiles, the daughter of Mr Pittock, gave evidence about the situation at Day 2/26 and 27. Again I am not going to read it all out. She said,

> "He stopped eating and drinking properly and was eventually admitted to Mulberry Ward, which is a psychiatric ward at the Gosport War Memorial Hospital".

She then carries on in respect of the move to Dryad Ward.

> "I knew that my father was not eating or drinking. He would lie in bed all of the time and ignore everyone. He believed that he had Parkinson's Disease. I understood that my father was going to Dryad Ward for terminal care. This was never actually said to me, but my knowledge of the type of patient that Dryad took led me to believe this".

She visited her father regularly. In former times he had become extremely frail and just seemed to have lost the will to live.

> "The nurse told me that my father's skin was breaking down and that he cried out when the nurses turned him. I remember that morphine was mentioned to me for pain relief, but I cannot recall if I was told that my father was already receiving it or was going to receive it. I knew that his body systems were breaking down and that he would have been uncomfortable. I was not alarmed by the thought that my father was being given morphine. I considered it to be appropriate care".

Later on she said,

> "The family acknowledged that invasive or aggressive treatment would be inappropriate in my father's case. By this I mean to force-feed him or use ECT to try and lift his mood... I did not speak to a doctor as I was kept fully informed of my father's condition by the nursing staff".

She is a retired, qualified mental nurse. Again that is an important piece of evidence, not great in its ambit, but significant in relation to the allegation that this patient was somehow not properly treated.

Can I turn please to the charges with regard to Mr Pittock? I turn first to Charge 2, and in relation to 2.b it alleges this,

> "In relation to your prescriptions described in paragraphs 2.a.ii and 2.a.iii,
>
> i. the lowest doses prescribed of diamorphine and midazolam were too high;
> ii. the dose range was too wide;
> iii. the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs".

It is a little difficult to separate these out because when you look at paragraph 2.a.ii, it is referring to the prescription of oramorphine as well as diamorphine – this is on the undated anticipatory prescription which appears to have been on 10 January; the charge says between 5 and 10 January. It does not actually cite in the charge anything to do with midazolam, which was prescribed. Whether that is a mistake or not I do not know; maybe it is deliberate. When one looks at that and then looks at what the complaints are in relation to the prescription at 2.a.ii,

> "i. the lowest doses prescribed of diamorphine and midazolam were too high",

That must embrace also therefore 2.a.iii which does mention midazolam. We say that is an allegation which is not actually made out in any event because this is an anticipatory prescription. How can one say that the lowest doses were too high when they were

prescribed? You might be able to raise an allegation that the lowest doses were too high when they were administered, but with an anticipatory prescription there is a genuine difficulty. How can any Panel, this Panel or any Panel, or indeed anybody, say, "I am sure that when that prescription was written out anticipatorily, the lowest doses were too high"? Because the prescription itself is set out, written down to cater for a future situation. Therefore we say that that really is a difficulty with regard to that charge.

B The dose range was too wide: that is really no longer being proceeded with. That allegation is not being sustained. The prescription created a situation whereby drugs could be administered which were excessive. That is admitted because in theory, with the prescription there, any nurse could have come along and administered subcutaneous analgesia, diamorphine at 80, midazolam at 40 without a care in the world, in the sense of completely ignoring everything that the procedures demanded. That of course never happened, but that is the basis of admitting the charge. It created a situation whereby the drugs "could" be C administered. In theory it did. Whether in fact in terms of anticipatory prescription that admitted, proved element is something which can properly amount to a sufficiency to support a finding of serious professional misconduct is very much open to question, because if anticipatory prescribing is not being criticised, it is not being suggested that the practice was something that was unacceptable in the circumstances, then the proper finding would be that that admitted fact would be insufficient to support a finding of serious professional misconduct to be part of this Panel's considerations when my speech and whatever the Legal D Assessor seeks to say to you is done. Any anticipatory prescription, any advance prescribing leaves it open to the possibility of a nurse going ahead regardless and administering drugs which were excessive to the patient's needs.

But if anticipatory prescribing is acceptable or has not been proved to be something that is not acceptable then it is difficult to see how one can say it would be serious professional misconduct to write such a prescription.

E

Then in relation to 2.c. we simply say when the allegation is made that this was excessive to the patient's needs: Look at the evidence, look at the rationale, look at what happened to this man, these drugs, these opiates, midazolam, were not excessive. It is pure speculation for anybody to say, well, they were excessive because his condition deteriorated, in a man who is on the terminal path in any event and has been on the terminal path for some days with his condition deteriorating before opiates were ever administered. The proof of the pudding, in F my shorthand description.

Then, in relation to 2.d, this is the Nozinan on 18 January. Well, the criticism with regard to the Nozinan is not so much that it was excessive to the patient's needs, it is because you should not really mix the drugs, and it is worth noting that when Dr Briggs took this patient off the haloperidol he increased the Nozinan, as it were, to match it, and Professor Ford is not critical of Dr Briggs' actions in increasing the Nozinan to match the haloperidol which is now G no longer being administered. So we say in relation to that part of the charge 2.d it is not right to say that that was excessive to the patient's needs. It may have been better to have simply increased the haloperidol and so on, but Dr Barton was trying to do something to cater for the situation as she found it, and if it was excessive, then why is Dr Briggs not being criticised for increasing the Nozinan when he took away the haloperidol?

The same arguments apply in relation to the allegation at 2.e with regard to the suggestion H that the prescriptions were inappropriate and not in the best interests of Mr Pittock.

That is all that I seek to say about his case.

May I turn, now, please, to Patient B, Elsie Lavender, and here I am going to follow the same pattern, if I may, with regard to the patient history, and in her case, because the Panel will be remembering the general picture with these patients, even if I myself have completely forgotten which patient was relevant with regard to something I was saying earlier on, we will come across in any event, Mr Kark, if I may say so totally sensibly, gave a brief résumé of the basic picture and I am not going to repeat all that. I am going to ask, if you would, please, to go perhaps to page 5 of the patient history.

Where Dr Tandy is reviewing or seeing this patient when they are in Haslar before she gets to Daedalus. I am not going to read out all the things but the Panel will remember her diagnosis as "The most likely problem is brain stem stroke leading to fall." Dr Tandy also indicated, and this is found at page 935 of the notes, that she understood that she had had her neck X-rayed. "I assume it was normal." He does not establish it for sure, but that is the situation.

It is worth noting that on 16 February, this date, this is eleven days after her fall, she is in continuing pain. No one at Haslar, if the criticism is being levelled at Dr Barton for not taking steps to investigate further as to what the cause of pain was, seems to have been trying to assess the cause of pain: no one at Haslar sought to have a further X-ray, assuming one was taken in the first place.

Dr Tandy's view was, as shown in the clinical notes: "Not sure we will get her home but we will try."

Four days after this: "Still in Haslar, still in pain, Haslar not thinking it right to investigate the source of pain before transferring her."

It is all very well to criticise Dr Barton saying you should have done this, you should have done that; Dr Barton's view was that it was certainly initially not surprising she was suffering from pain because of the fall. Why, if there is not force in Professor Ford's criticism, did not Haslar see to it that she was X-rayed before she was transferred to Daedalus?

When she was transferred on 22 February, that was 17 days or 18 days after her fall.

If we can move on, please, to page 7 of the patient history, dealing with the actual transfer itself, this patient obviously with comorbidities, insulin dependent, diabetes, atrial fibrillation, blindness, chances of recovery on any showing perhaps small.

Dr Barton's evidence. She felt she deserved the opportunity to try some general rehabilitation but, and again here is an example of Dr Barton being realistic, not unfair or unkind or affecting the way this patient was treated, being realistic. She was not very hopeful in terms of her rehabilitation in view of the comorbidities and the amount of pain she had even at that time.

So far as Dr Barton is concerned, in relation to this patient, at this stage she said this, Day 25/87, where she was asked why not try and find out what was causing the pain. She said:

"A I, like Dr Tandy, assumed that there had been normal x-rays taken at Haslar Hospital before her transfer and I would have been thinking in my mind was I going to find any cause for this pain that was treatable, and the answer was there was not.

Q What about the particular history of this lady, who was then 84, I think, I may have got the age wrong, having fallen down the stairs in the way that she had, a significant fall, perhaps. What was your view about the likelihood of pain remaining?
A If she had crushed a cervical vertebra or a thoracic vertebrae she would still have considerable and significant pain even at this time after the original injury, but other than adequate analgesia there would have been nothing I could have done for her. There was nothing that was remediable or treatable.

Q Would you explain that, please? Supposing she had had that sort of injury.
A There would be no operation or procedure that could be done to make it more comfortable for her. Somebody suggested immobilising the neck in a collar. I think she would have found that even more uncomfortable. She was a small, tubby lady and those proper neck collars are seriously uncomfortable to wear. So there was not anything we could do for her, other than give her adequate pain relief.

Q What about sending her back?
A What could they do at the acute hospital? Nothing further.

Q Explain that.
A They had an MRI, they could have put her through and determined if there was cord compression or not, but, again, there would be no treatment for that either. The treatment is expectant pain relief and gentle mobilisation when it becomes possible, if it becomes possible".

She also indicated in her evidence, Dr Barton, in relation to the problem with grip in both hands:

"A She could have had a neuropathy associated with her 40 years of insulin dependent diabetes. She could have had a specific nerve problem, perhaps, in the carpal tunnel in the wrist. I did not think that the difficulty with grip was necessarily anything to do with the acute injury. It might have been pre-existing.

Q And what were the prospects when you put 'Assess general mobility. ? [Query] suitable for rest home if home found for cat.' What were the prospects if she had in fact got a crushed vertebra? That was the thing.
A She might slowly, slowly improve sufficiently to go to residential care, given enough time.

Q Yes. Then the analgesia that is given was dihydrocodeine in respect of this lady, as we can see at the top of page 8, when she comes in – all right?
A Yes.

Q May I ask you this: she has this pain. Why not put her straight on to Oramorph?

A Because, having come across on what I felt was a decent step two analgesic, I thought it was better to assess how she responded to that before starting on an opiate".

Another example of Dr Barton applying her mind to a patient situation and acting, the Panel may think, totally sensibly.

B Professor Ford does not criticise her assessment in relation to this particular admission, and we can see how matters progessed.

Professor Ford indicated, if one looks at the top of page 8 because that is where dihydrocodeine is being prescribed, PRN, "perfectly reasonable", he said. As I said, it is worth bearing that in mind to show that Dr Barton does not just, regardless of anything, put a patient straight on to oramorph if they have got pain.

C

Passing down, please, to the bottom of the page, Saturday 14 February:

"Pain not controlled properly by D.F. 118. Seen by Dr Barton – for MST 10 mg BD [twice a day]."

D Professor Ford does not really seem to be taking any exception to the MST. You may remember he said something about you do not usually convert from D.F.118 to MST, but there does not seem to be any real criticism of that administration of that particular opiate. What Professor Ford's criticism really is with this patient is there should have been a further assessment with regard to A. Well, Dr Barton gave her evidence to this Panel about it and gave, we suggest, coherent sensible evidence about it, having seen the patient, and she indicated that really, once the MST had started, the patient, if not actually being on, was certainly getting near to, terminal pathway.

E

At the bottom of page 9 on the left, "the son would like to see Dr Barton". It is worth bearing that in mind.

Over the page, Monday 26 February: "Reviewed by Dr Barton. Not so well over the w/e. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute sc [subcutaneous] analgesia if necessary."

F

and there is a note made by somebody else below that, in fact Sister Joines:

"Son and wife seen by Dr Barton. Prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained."

G Well, you saw Sister Joines. Has she written down something that is untrue? The Panel may have little difficulty in concluding she was writing down what had happened. You did not actually see Alan Lavender, the son of Mrs Lavender, who describes Dr Barton as being pretty abrupt. "You do know your mother has come here to die", and so on. Maybe another good example of relatives, with all the stresses going on, and perhaps a sense of shock, a close relative, on the pathway to death, really I am going to call it misremembering. He said in what he told the inquest, I think, that he had had more than one conversation on more than one day with Dr Barton, and all he can remember is apparently: "You can get rid of the cat, you do know your mother has come here to die".

H

Well, faced with that choice, we would suggest that the proper and safe and prudent course is to assume Sister Joines was writing down what had happened. Sister Joines gave her evidence about her being present; she also was used to seeing Dr Barton speaking to relatives, and Dr Barton explaining why somebody was on a syringe driver and what was in it and so on. That was Sister Joines' habit as well. She had never put a syringe driver up without informing relatives. "I find it very difficult to believe that Dr Barton spoke like that to a relative. I have never heard her do so", and it is the case. The Panel will decide whether it accepts the evidence or not that in every single case of any patient amongst these twelve who was on Daedalus ward, there was a clear record of consent being obtained in relation to the use of the syringe driver. There is, we suggest, a very clear indication.

Dr Barton's evidence.

Something had happened over the weekend, this being a Monday, as you can see,

> "Not so well over the weekend" in her note. "She has definitely deteriorated. She is now moving from palliative care, gentle rehabilitation, to end of life. So when I examined her and assessed her on the Monday morning, I needed to see the family to explain that to them." (Day 25/90)

Once again, it is worth bearing in mind on that Monday Dr Barton writes up the prescription for diamorphine and midazolam. This is four days after admission: it is not, of course, administered on that day, this is an anticipatory prescription. I anticipated that should her condition continue to deteriorate there would come a time when she would no longer be able to take - and perhaps I can pick up what she said about it at Day 26/49,

> " ... when she would be no longer able to take oral analgesia or her condition would merit other than just pain relief and I would want to administer it subcutaneously. She was now not opiate naïve, so I would not be starting at 20 mg of diamorphine; I would go in at a higher dose.
>
> Q Why 80 as opposed to 20?
> A Why 80 rather than 40? Because I anticipated that I might well need a higher dose of diamorphine when the time came to use it. Because of the nature and severity of her pain, which was not typical of cancer pain or pain that we have seen in some of these other cases following recent surgery or anything like that; it was a very atypical sort of pain.
>
> Q If you were, as it were, doing the half calculation on 40 mg of oral morphine, MST, divide that by two, you get 20.
> A Assuming her condition was stable and she did not require an increase.
>
> Q You allowed for an increase to allow for the fact that if subcutaneous analgesia has to be started, it is going to be pain not being controlled by MST.
> A Yes.
>
> Q What I want you to deal with is, why not put the lowest dose in the range as 60? Why choose 80? I wonder if you could help with that.

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

And in terms of the midazolam:

B

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

and she went on to deal with the Hyoscine and I am not going to trouble you with that.

Now that is an anticipatory prescription about which criticism is made, and you have heard
C Professor Ford's evidence about it. At this time she is on 40 mgs of MST. It is 8 days later, I stress 8 days later, that this prescription is administered. Maybe Dr Barton anticipated too soon, it does not matter, because her reasons for doing this she has explained. She was not doing it for fun. This is not for pleasure. It does not help her; it is to enable this patient to avoid unnecessary pain and suffering and it is another case where one can knock on the head very firmly the suggestion that the minute there is some kind of possible justification, a subcutaneous infusion of analgesia is administered. That is on 26 February.

D

The picture continues. There are complaints of pain and so on. The MST dose increased. Dr Barton's evidence:

"I would have noted the marked deterioration in her overall condition. She was now definitely going downhill."

E That is the way she described it. That did not mean to say that all nursing care stopped. As you can see from the records, nursing care continued. It continued to be good nursing care, we suggest.

May I move on to page 13. That deals with Tuesday, 5 March. Dr Barton's review says:

"Has deteriorated over the last few days. In some pain, therefore start sc
F [subcutaneous] analgesia. Let family know."

Not eating or drinking: Dr Barton's evidence. She would have re-assessed her on that date. Obviously she did. She comes to a medical conclusion, a clinical decision, about what the position is and what should be done about it.

"Patient's pain uncontrolled. Very poor night."

G

That is the note by somebody else.

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

That is Nurse Couchman. There is a relative being informed about it yet again. Over the
H page, one can see the prescription. It started off, lowest dose 100, midazolam lowest dose 40.

Dr Barton's evidence: "I was assessing the level of pain and distress at the bedside. I was well aware of the risks of over-sedation." She said she wanted to give her adequate pain relief. This is Day 26/51.

> "A ... I wanted to give her adequate pain relief and relief of her symptoms of what were now becoming terminal restlessness."

Dr Barton's response was, "Why not lower the dose?"

> "A And run the risk of putting her through another 24 hours of discomfort like the weekend and then the Monday she had already had. She needed an adequate level of pain relief and relief of restlessness".

That is on the same page of the transcript. This was, if one applies some rule of thumb, as it were, on the face of it a high dose but Dr Barton has justified her reasons for doing so. The next day, 6 March:

> "Further deterioration."

It is in fact a further note reflecting the position on Tuesday the 5th. It is slightly confusing on the patient chronology.

> "Comfortable and peaceful..."

and so on. Dr Barton's further note, which was in fact on that Tuesday. By this stage she was unrousable – this is later on on the 6th, as Nurse Astridge indicated. Nurse Astridge (that is the nurse who treated her) said she would not be able to say this was because of opiates.

> "Pain while controlled"

- it indicates on page 15.

> "Syringe driver renewed at 9.45 a.m."

We can see that that evening, on 6th March, this lady died.

In Professor Ford's view it was very likely to have contributed to her death. "Very likely" he said. She may have died from other causes. There we are. It is a question of speculation. One does not guess at this. One only proceeds on the basis of what is established, and it is established so that one is sure. That is far from proof.

She indicated, it is clear from Dr Barton's position, this was not too early. She had been on MST for ten days. The pain was still not controlled, and no one really has given a sensible alternative to what Dr Barton did. We suggest it is speculation by Professor Ford as to what further assessment and the cause of pain would actually have done. Dr Barton's evidence is, we suggest, credible on this point and comes from a doctor who plainly was not ignorant or foolish.

May I turn, then, to the charge, please, with regard to this patient. Charge 3, or allegation 3, on page 4 of the document containing the charges. Again, when one looks at 3.a.iii., which is

admitted in terms of, obviously, prescription. Perhaps it is a little confusing, or it may be difficult to disentangle, because what is alleged there is that you increase the prescription of MST and prescribe diamorphine and midazolam. One cannot, perhaps, criticise Dr Barton for increasing the prescription of MST to control pain. The diamorphine and the midazolam are, of course, anticipatorily at that stage. Then, looking at the allegation at 3.b.:

> "b. In relation to your prescriptions for drugs described in paragraphs 3.a.iii. and iv."

which is 5 March administration. That is when the subcutaneous analgesic commences:

> "i. the lowest commencing doses prescribed on 26 February and 5 March 1996 of Diamorphine and Midazolam were too high."

In relation to the anticipatorily part, which is 26 February, it is rather difficult to see why they should be categorised as "too high", because it is anticipation.

> "ii. the dose range ... was too wide,"

That is admitted and I am not going to trouble with that any more. In relation to the prescription on the.... It does not really much matter, because the issue is just the same.

I can move on, please, to 3.c:

> "c. Your actions in prescribing the drugs described in paragraphs 3.a.ii., iii. and/or iv."

It is difficult to see how, in relation to 3.a.ii. there is any case left with regard to the MST and I do not think it is really being maintained that there was. I cannot now remember, but I do not think there was any specific criticism by Professor Ford once she is on the MST, that it should not have increased to control the pain. His issue with it is, "You should have investigated the cause of the pain."

In relation to that, I have really made the same points about these prescriptions as I have already in the case of Mr Pittock. The same arguments apply. In relation to 3.d.i, she -

> "i. did not perform an appropriate examination and assessment of Patient B on admission."

That has really gone. It cannot be suggested that that is the case, and I think that is something that Mr Kark conceded. If I may say so, that is an illustration of the kind of point I had in mind when I indicated that we might have arguments with regard to certain parts of the charges at the close of the GMC case, but it did not seem sensible to take up time dealing with that. I hope it is proved right, because the Panel are in a much better position to judge it all in relation to all the evidence.

Then 3.d.ii, she –

> "ii. did not conduct an adequate assessment as Patient B's condition deteriorated."

We take issue with that. She was assessing her. She has given her view as to why she did not think it right to seek to refer her back or have certain procedures followed. In our submission she plainly did conduct an adequate assessment as her condition deteriorated.

She –

"iii. did not provide a plan of treatment."

That, with respect, is not borne out because if you look, for example, at the entry for 26 February, to which I drew the Panel's attention Dr Barton, having initially had a plan in relation to this patient suggesting that they try to get her mobilised if possible, indicated that the family was seen and well aware of the prognosis and treatment plan. It cannot be suggested there was not a plan. The plan was to control this lady's pain and distress and other symptoms, in order to keep her comfortable, instituting subcutaneous analgesia if necessary. That was the plan. When one is treating a patient and seeking to provide, obviously, all appropriate nursing care (nobody is disputing that for a moment), but one is seeking to control pain, agitation and distress by the means of subcutaneous analgesia, that is the plan. There is really not much more you can say about it. We suggest there simply is no basis for that allegation at all and, in particular, borne out by what Dr Barton herself wrote in that review of the patient.

She –

"iv. did not obtain the advice of a colleague when Patient B's condition deteriorated."

We suggest that although that is factually correct she did not, there was no reason to, and it is difficult to see how there can be any case on that. Even if there was a case on that, we would submit that would not amount on any showing to serious professional misconduct. I do not mean this in any kind of hostile way – the kind of sweep-up charge at the end: the same arguments apply. If they have any force in what I said earlier, they have force in relation to this.

Sir, I think a little break would be convenient.

THE CHAIRMAN: Absolutely. We shall break now and return at twenty past three, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

MR LANGDALE: It is apparent, sir, I am not going to finish this afternoon in relation to these patients. I make no apology for that because I obviously have to cover a number of matters with regard to them. Rushing through does not help anybody, but I do try to confine myself to points that are, I hope, appropriately made.

The third patient, Patient C, Eva Page. It is worth noting with regard to this patient, this is a lady who had carcinoma of the bronchus and depression and so on. If you look on page 2 of

this history, although it does not actually, I think, specifically set it out, I think the Panel's attention was drawn to the fact that at page 299 with regard to the patient's medical records and other records, on 12 and 13 February, there is an entry. This is at Queen Alexandra with regard to the need being palliative care. Son agrees with regard to there not being invasive treatment. So at that stage that is the position. As Professor Ford himself indicated, any intervention would have been inappropriate, so we are dealing with that sort of situation when we come to look at the history with regard to this patient. There is general deterioration obviously.

If we look on to page 4, we can see where the situation is reviewed by Dr Lord. The transfer to GWMH for continuing care and the date of her admission to Dryad Ward is 27 February. There is the review by Dr Barton at the bottom of the page. We can see the description there with regard to the situation.

> "Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death."

There does not appear to be at real criticism of that. As Professor Ford said, she was plainly very ill when she came into the Gosport War Memorial Hospital. It was entirely reasonable and appropriate in terms of the general situation described there, and as Dr Barton said, she was on the palliative care route on admission.

Over the page, page 5, Oramorph is prescribed on the day of arrival in Dryad. No criticism of that.

On page 6 one can see developments on 28 February. This does not involve Dr Barton. Page 6, 28 February, distress, and so on.

> "Oramorph ... given with no relief. Doctor notified. S/B [seen by] doctor for regular thioridazine and heminevrin nocte."

As Dr Barton pointed out in her evidence – I think it is Dr Lang in fact – here is an out of hours doctor, an on-call doctor, who is presented with a patient he did not know who was presenting with these symptoms. He very properly prescribed a major tranquiliser and a sedative for the night. The pain obviously continued. Morphine continued to be administered at that stage. Over the page, page 7, Sunday 1 March, you can see what the position was. It was not the case that she had any Oramorph on that day. Then Monday the 2nd: Dr Barton says:

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

Dr Barton's evidence about this is at Day 26/63:

> "A I always felt at that time that it seemed very unfair that if you had a diagnosis of cancer, then it was legitimate to give you opiates to relieve anxiety, distress, fear of dying, aguish, all of these things, but because your illness was equally terminal but caused by heart failure or a severe stroke or something else medical, you were denied opiates, they were not appropriate to use simply because you did not have cancer. I never understood that concept".

She is not alone in thinking that and it is rather important to bear in mind, giving that review of the patient on 2 March.

Over the page on page 8, the patient on that day is reviewed by Dr Lord, so one can see that Dr Lord would have known that Dr Barton was considering opiates. Dr Lord commences the fentanyl patch, or it is commenced. She knows about it. It is interesting in this case: apparently because she is a cancer patient, Professor Ford says, "I think the decision to use fentanyl was reasonable. I can understand the rationale. It is quite a high dose of opiate, so you have to be aware of the adverse effects." Of course you do, but it is significant that fentanyl is all right for this lady, it would seem, in the view of Professor Ford, because she has carcinoma although the symptoms in terms of the pain, distress and agitation are exactly the same as a patient might exhibit who has serious problems, although not as a result of carcinoma. There is a mistake, obviously, in the note, as Dr Lord pointed out. She was not on subcutaneous diamorphine at that time. She had had an intramuscular injection, not subcutaneous diamorphine. Dr Lord in fact, as we know in these cases, signed the fentanyl prescription.

She had been very distressed that morning. There is an example of somebody being given this medication without there being any particular significant note of pain in the notes. It is exactly the same situation as we see with other patients who have not got cancer and criticism is made because there is not enough notification in the notes of pain to justify the administration of opiates. It is well worth looking at this patient's history to see how that suggestion may not be sensibly borne out with regard to other patients.

Then Dr Barton's anticipatorily prescription, undated, on that page, page 9, which we have moved onto. In relation to the general picture so far as Dr Lord was concerned, so far as the intramuscular injection of diamorphine was concerned, Dr Lord: "I thought it appropriate to continue diamorphine. Difficult to keep her comfortable. She was very distressed. There was concern with somebody so agitated, there could have been a spread to her brain. She was not for further investigation." The fact that she was drowsy, she was asked about. "This is no ideal sedative or analgesia which does not have side effects. You get respiratory depression with all of them. It is always a balance. If you are trying to achieve pain control, no agitation and no anxiety, then you accept side effects." She repeated again at another point in her evidence that the balance was difficult to achieve and particularly if the doctor was not there all the time.

Carrying on in relation to page 9, Dr Lord said with regard to Dr Barton's anticipatorily prescription: "She may have seen that prescription. It seemed pretty likely that she did. She may have seen that prescription but she also said if she had seen 20 to 200, I could have asked about the range." That is the way she put it. Dr Barton, in terms of her evidence about this, said this at Day 26/57. This is in relation to the picture as it emerged.

> "A ... when I came in the next morning..."

that is, after the fentanyl had been started –

> "I would be able to make an assessment of whether the fentanyl was doing the business. The other reason was..."

This is in relation to the subcutaneous anticipatory prescription and so on –

> "she was no longer now able to take her thioridazine. She might well need an anxiolytic and a terminal restless drug in the form of midazolam, and the only way that I could administer that drug would be subcutaneously. There was no other way of doing it. At that point, therefore, I would have to make the decision to change over from the fentanyl patch to the subcutaneous infusion".

She said it would be the case that the patient would have been taken off the fentanyl. It is not recorded, but Dr Barton says that that is what would normally happen, and she did not form any conclusion that in fact it had been still on, because calculations may vary as to whether one thinks the fentanyl was still on or still off. Since it is impossible to be sure that it is still on, I suggest that the Panel should properly and fairly proceed on the basis that the fentanyl patch had been taken off.

Dr Barton also explained, on Day 26/58, about her understanding that the level reached by fentanyl after 24 hours; if you take the fentanyl patch off it is going down. It goes down at the same time as you start the subcutaneous infusion. That takes time to build up and she was satisfied in her own mind that the crossover point would occur without the patient receiving too much by way of analgesia. The increase in the dose on top of any fentanyl dose is not significant, we suggest, with a diamorphine of 20. If she had had a fentanyl patch for 24 hours, there would be 45 in her at the time the fentanyl patch peaked at that time.

We have heard Professor Ford's criticism about this. Although he understood that fentanyl was appropriate, he was concerned about the rationale for diamorphine and midazolam being applied and was concerned about the combination of what was left of the fentanyl with the diamorphine and the midazolam coming in. The question is, why prescribe further drugs? If the patient was expressing terminal agitation and restlessness, in this case as a result of carcinoma, then it was perfectly reasonable we suggest, in terms of what Dr Barton did, to prescribe midazolam because that is precisely what it is for, and to increase the opiates. If the patch was off, it is an increase which was hardly significant.

Professor Ford indicated that the administration of the opiates may have been a contributing factor. That is a possibility, but it is far from being established in this case and in our respectful submission about this, it is clear that with this patient, with this unhappy condition, with the rapid deterioration set out on page 10 in the notes –

> "Rapid deterioration in condition this morning. Neck and left side of body rigid. Right side flaccid. Syringe driver commenced"

– it was perfectly proper care and a perfectly justified prescription. Dr Barton's evidence is that she saw her that morning and instituted the commencement of the syringe driver. She thought the rigidity and so on was because she had had some sort of cerebral event, maybe a stroke. We suggest that in relation to that patient it cannot sensibly be argued that she received inappropriate treatment or anything that was not in her best interests.

Looking briefly at the charges with regard to this patient, on page 5 of the document containing the charges, Head of Charge 4 – again I am not going to repeat the point every time – the question of the dose range, we say in the circumstances it is admitted but that would not be sufficient to justify a finding of serious professional misconduct in any event.

The charges set out material which I think I have dealt with in terms of our submissions with regard to the propriety in every instance with what Dr Barton did.

May I move on please to Patient D, Alice Wilkie? This is the lady – I am just summarising it very briefly – who was suffering from advanced dementia and urinary tract infection. "UTI" one can see on the very first page. She has been seen in Queen Alexandra Hospital, and we had the history set out there. I am not going to trouble with any of the detail. We can see if one looks at page 4 that when she was there on 4 August she was reviewed by Dr Lord. The overall prognosis was poor. They were keeping the option open of transfer to Daedalus Ward, continuing care for four to six weeks' observation and then they would decide on the placement.

We can move on to 6 August, two days later on page 5, when she reached Daedalus Ward where Dr Peters dealt with her admission. The referral letter is set out on that page. I do not need to trouble with the detail of that. She is now in Gosport War Memorial Hospital. The nursing notes on page 6 reflect the position. People are aware of the situation and you will notice on page 6 with regard to the situation, at the bottom on the left Sister Joyce has recorded,

> "Does have pain occasionally but cannot advise us where".

There is a similar note on the assessment sheet. She moves into Daedalus Ward where daughter Marilyn Jackson was there. She was reviewed by Dr Lord on 10 August. Dr Barton in relation to this patient has indicated that her notes were less than adequate in relation to her noting what had happened because at that stage the ward, as she said, was a bit chaotic because of relatives of another patient. We can see the review by Dr Lord on the 10th. On the 12th one has got the situation where she is physically unchanged; very needy; not expected to return to Addenbrooke. That is on the CPN notes.

Matters go on until over the page on page 8, on Monday 17 August, deterioration is recorded,

> "Condition generally deteriorated over the weekend".

There is a note by Philip Beed,

> "Daughter seen. Aware that mum's condition is worsening. Agrees active treatment not appropriate and use of syringe driver if Mrs Wilkie is in pain".

There you have another situation where a nurse has recorded what happened in terms of somebody being told about or discussed with in terms of the use of a syringe driver. The relative in this particular case is Marilyn Jackson, and she says the syringe driver was not mentioned. Well the Panel has to make a choice as to which evidence, that of the nurse or that of Marilyn Jackson, is accurate and reliable. One comes back to the same question: is it conceivable that Philip Been, being the sort of person that he was and the Panel have seen him, that he really would have written that down if it had not happened? Perhaps the simple correct answer is that he wrote it down because it did happen.

Marilyn Jackson is somebody who was obviously concerned about a number of things. It is worth bearing this in mind in relation to her evidence about the state of her mother. What Marilyn Jackson said was that when she saw her mother – this is before, I stress this, before

she was given any medication for pain – was very sleepy and very unresponsive. She was deteriorating. Not eating or drinking. Less mobile. Using a hoist. She spoke to Philip Beed about her mother and he said she was not well.

> "I could se she was going to die in there. I said I did not want my mother to suffer".

The important point in particular is that there is a patient who, before opiates are administered, is very sleepy and unresponsive. It is perhaps another illustration of how sensitive relatives can be, shall I say, about these matters. Marilyn Jackson thought that that was the result of neglect at Gosport War Memorial Hospital. I do not think anybody can sensibly suggest that that is remotely the case. It is the kind of reaction, perhaps, that people have when faced with these sorts of situations. It is clear that she was a lady where an aggressive intervention was not going to occur, as Professor Ford himself indicated.

So far as Dr Barton is concerned with regard to their being no record by her until that point – that is in relation to the 17th – she said at Day 26/61, after the note about the clerking in of the patient earlier on,

> "it suggests to me that I may have been not there for a few days. When I came back, we were faced with a situation on the ward that we had mayhem occurring".

Then we have the CPN notes for 12 August, two days after Dr Lord has seen the patient:

> "... physically unchanged. Very needy, not expect... the page of the chronology, where she had been clerked into Daedalus Ward – I cannot offhand te nursing and the medical staff".

I think that is all I really need to say about that. It is a case then of moving on to the situation where Dr Barton anticipatorily prescribed the diamorphine, midazolam and hyacine. It is undated, but it appears, the Panel may think, as if that would have been written up on 17 August. It is difficult to see how Philip Beed could have been discussing the use of a syringe driver without Dr Barton having already indicated that it might be something that would become necessary to do. If the suggestion is being made that her deteriorating condition is to do with the opiates, the Panel would really have to find positive, conclusive evidence so that the Panel could be sure that that was the case. In this case we suggest that that plainly is not there.

Professor Ford expressed a concern about the administration of the diamorphine and midazolam on Thursday 20 August, but there was no indication of pain. The Panel will remember the evidence of Marilyn Jackson, that she got the signal by her mother, her mother indicating that she was in pain.. She summoned the nurse who appears to have been Philip Beed, and the subcutaneous analgesia was administered at 13.50 that afternoon.

Dr Barton indicates that she saw her on 21 August. If we look at page 9 we can see that,

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

Again, that is not invention on her part. Obviously there is more than one member of the family visiting, but that is something clearly shown by Dr Barton. She was asked whether it had occurred to her that the deterioration she observed on that date, or the state she was in on 21 August, might have had something to do with the diamorphine or the midazolam. She said not at all because the deterioration was well underway and proceeding, and she was hoping that the subcutaneous infusion would make the deterioration more comfortable for her.

B

She was asked too about Marilyn Jackson's allegation that she had apparently walked on to the ward ignoring Marilyn Jackson and her two daughters and had said, "It will not be long now" and had walked back out. She said, "It was not my custom to go into a room and make comments like that". It does seem difficult to square that with what Dr Barton recorded that day, "Family aware and happy".

C

In terms of her death, which is recorded on page 9, in the early evening of 21 August, Professor Ford said in his view the drugs contributed to the deterioration,

> "But you cannot conclude the effect of the drugs in terms of it affecting death. She was going to die in the near future".

D

The Panel may feel in relation to this patient that really one cannot sensibly criticise what Dr Barton prescribed, what was done by Philip Beed to relieve the patient's distress and anxiety and so on, in the early afternoon of the 20th, and in respect of Dr Barton's view on 21 August when she saw this patient.

E

In relation to the charge, may we look briefly at that please? The allegation is that the dose range was too wide. I have dealt with that and the same arguments apply in respect of what we have already said. This is the 20 to 200 one. The possibility that drugs could be administered to Patient D which were excessive; it was only a possibility and the same arguments apply with regard to whether that is sufficient enough to find a basis for serious professional misconduct. The allegations are that her anticipatory prescribing was inappropriate and not in the best interests of Patient D. We say in this case in particular, the GMC are very far away from getting anywhere near proving in the circumstances that that was the case with regard to this patient.

F

It is again, speculation to suggest that her deterioration was caused by the opiates. She was deteriorating, unfortunately, anyway; it was somebody who was unrousable and sleepy before any such medication was administered at all.

G

I move on please; to Patient E, Miss Richards. Looking at the patient history, matters start in February of 1998 with the assessment by Dr Banks. The Panel will perhaps remember that she indicated, although it does not show in this record of the correspondence, that this lady was at "end stage illness"; in other words, end stage dementia. The Panel will also remember Professor Ford's evidence about what end-stage dementia means. I am not going to read it out again. The day was Day 23/7. The decline, increasing frailty, less activity, food intake down, wasting away, more withdrawn, and so on. Death usually from bronchopneumonia or other complications.

H

Dr Bassett, you heard from, was the GP whose patient this lady was, she being 91, I think, at the time, we are concerned with. She was taken to Haslar on page 2 on 29 July after the fall

and so on, I do not need to go over that. She is treated with mild opiates when there. We can see on page 4 Dr Reid indicating on 3 August that he found her to be "Confused but pleasant and co-operative" and so on; "Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH."

Dr Reid's evidence: that he felt her prospects for remobilising were not good. With patients who have dementia it is quite difficult to make progress.

Dr Bassett: she was extremely frail. He would have been very surprised if she had recovered to her pre morbid state.

Page 5, in she comes to Daedalus ward. There is the contrast between what is said in the referral letter and what the nurses actually found on arrival. There is no doubt about it, she was not able to walk with a zimmer frame or, it appears, with the aid of nurses. She needed to be transferred with a hoist. Philip Beed himself gave evidence about that; she needed the hoist.

Lesley O'Brien, one of the daughters, the daughters who gave evidence at this hearing, did not like the suggestion that her mother was frail. She said she was not frail. Again, a matter for the Panel to consider. It is hardly likely that people are going to record that somebody is frail if they are not. Bear in mind, too, the evidence of Dr Bassett whose patient she was.

Another example not of somebody deliberately inventing something but seeing things in a way which in the end is perhaps an unreliable way, affected no doubt by all the emotions that came into play with regard to this sort of event, and obviously the daughters were there watching like hawks, it would seem, what was going on, writing notes and so on, and making their presence felt and their presence very obvious.

Again, Professor Ford did not think the mission review by Dr Barton was to be criticised except he would have expected to see some plan with regard to mobility. Well, Dr Barton's response to that is obviously one had to take a look at a patient like this before you made any sensible assessment as to what was appropriate.

And then, on that day, the day of admission, oramorphine is administered twice on that day, and then an anticipatory prescription is written up with regard to that. It is worth bearing in mind with regard to any criticism made of that anticipatory prescription that it is anticipatory. Professor Ford criticises the administration of oramorph; he says there is no rationale in the notes for morphine at this point. "Co-codamol would have been appropriate. Need to identify the source of pain and there should have been a clear indication as to the reason."

Well, Dr Barton dealt with this in her evidence and her position really is very much the same. "I saw the patient, it seemed to me to be appropriate," when she was asked, Day 27/4, why prescribe oramorph, and it is administered soon after with a patient who is not obviously in pain. Dr Barton said this:

> "A The snapshot view that I gained of that patient when I examined her on the bed that afternoon was that she was not obviously in pain; but I knew perfectly well that she had just had a transfer from another hospital, she had not long had fairly major surgery and she was very frail anyway. She was going to be very uncomfortable for the first few days and I was minded to make available to the nurses

a small dose of oral opiate in order to make her comfortable during that time – not to be administered regularly but at their discretion if they felt she needed it.

Q You indicate a small dose. The dose range was 5 to 10 milligrams.
A Yes.

Q In a case like this, when 10 milligrams are administered by the nursing staff at quarter past two in the afternoon and indeed in the evening that would be within their discretion, as it were?
A Totally.

Q What sort of judgment would you be expecting the nursing staff to make as to how much of the Oramorph you prescribed should be administered? In other words, what is going to make them start at 10 as opposed to 5?
A The level of discomfort that they encountered when seeing to her, putting her on the commode, getting her back into bed, looking at her bottom, all of the general nursing duties that they would have had to do when she first arrived on the ward.

Q And the Oramorph would last for about four hours, I think you said.
A Four to six hours.

Q Something like that, so four hours after the administration at quarter past two takes us to quarter past six in the evening, and maybe a little bit later; and what would you expect to have happened in terms of the administration later on that evening? That she would have been monitored?
A She would have been very carefully monitored; she would have been given her supper, she would have been made ready for bed. Presumably at that time she was sufficiently comfortable that they did not feel they needed to give another dose of opiate but it was there available to them if they felt clinically it was needed.

Q I would like to ask you about the anticipatory part of the prescription, the diamorphine and midazolam in particular. Why write out that prescription on that day with this patient?
A Because I felt that this lady – her outlook on the background of her very severe dementia and this" –

I am sorry, the transcript says "and this fool" and I am afraid I do not know what that means, and when I marked the passage I did not know what it was –

> "and this [something] and the major surgery, that her general outlook was poor. She was quite possibly going to need end of life care sooner rather than later."

Now when one looks at that and looks at this patient, what is there that one can sensibly criticise with regard to what Dr Barton did? It cannot really be suggested that it has been proved that the prescription and administration of oramorph was not appropriate in this case. It may not be what Professor Ford would have done but it is certainly not something that no doctor would have done in the circumstances. One has seen other examples of where an oral opiate can be administered in circumstances such as this. Why is it done? Not to cause this lady to have some kind of side effect; it is to cause this lady to be free from pain and discomfort after the transfer to this hospital having had, pretty recently, an operation which

was bound to be something that caused pain, and in particular to a patient perhaps whose mental state was as it was with regard to Gladys Richards. Did they continue it? Was this a hospital needlessly administering opiates? No, they did not.

If you look over on page 7, dealing with Wednesday 12 August: "Haloperidol given as woke from sleep very agitated. Did not seem to be in pain."

B At 6 o'clock that evening, page 64 of the nursing notes, it is not on this but it is at page 64, the nursing notes show all medication including the oramorph and the haloperidol was stopped. Why? Because she was drowsy. So there are the staff at the Gosport War Memorial Hospital taking note of a patient being drowsy, taking into account the possibility that an opiate may be causing it, making an assessment about it, and obviously in this view concerned that it might be causing the drowsiness and therefore stopping it.

C That is hardly consistent with a picture of people simply putting people on opiates and not bothering about any possible consequences. It was a sensible judgment, the Panel may think, and a clear case of not giving oramorph for no reason. She had now settled in. Unfortunately the following day, the 13th, there was the accident which caused her to have some kind of problem which caused her to fall, she is found on the floor, and so on.

D No criticism made. Oramorph is administered because of the fall, page 8, no problem about that, that has not been criticised. She is reviewed by Dr Barton the following day, Dr Briggs having been contacted and advising an X-ray and analgesia. Dr Barton raises as an issue, considers it perfectly sensible: Is this lady well enough for another surgical procedure? And when she sees the X-ray she realises that obviously something needs to be done, over the page, page 9, "Hip X-ray - dislocated. Daughter seen by Dr Barton". Dr Barton having considered the matter makes a perfectly sensible and proper clinical decision for her to go back to Haslar, which she does. Oramorph administered again at GWMH before the transfer

E back, there is no difficulty about that at all, and she is treated back again in Haslar.

On page 10, looking at the treatment at Haslar, she was given midazolam and was very slow to recover from it, all the notes show. She is transferred back to Daedalus at about lunchtime on Monday 17 August on page 10. Dr Barton not present at the time she is actually transferred back.

F The Panel will recall how the daughter describes coming back some time at lunch time, or shortly after, to find her mother, as it were, screaming in pain, and we know the reason why, the what I have described as ham fisted transfer back which caused her to be suffering in that way.

Dr Barton reviewed her later on. Readmission to Daedalus. Remained unresponsive for some hours. She has taken note of the fact that the intravenous sedation evoked that response

G in the patient.

> "Now appears peaceful. Plan: Continue haloperidol, only give oramorph if in severe pain. See daughter again."

Perfectly correct decision; no criticism there.

H

And then over the page one has the record made by nurses in terms of the problem when she arrived, Nurse Couchman, whose evidence was given about this, and recording that the daughter reports the surgeon to say she should not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray.

It is on that day that Lesley O'Brien claimed that Philip Beed had arrived when she was concerned about the pain and distress and given two injections directly into the thigh of her mother. Again, a classic head-on collision between two witness. Who is to be believed, or perhaps more sensibly, who is accurate? Lesley O'Brien, who says that is what he did, or the nurse who says: "No, I did not. That is wrong".

Philip Beed, you may feel, had he administered two injections directly into this lady's thigh, would have recorded that fact.

He did not and he says it did not happen. It is clear again, we suggest, there is an example of somebody getting it wrong, for whatever reason, and not giving an accurate account.

Philip Beed's evidence was that he had a lot of encounters and discussions with the daughters: they did not at any time complain to him about anything that was being done to treat their mother, and if we move on to page 12 of this history, Dr Barton reviewing the patient on Tuesday 18,

> "Still in great pain. Nursing a problem. I suggest [subcutaneous] diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable".

Beed's note:

> "7 am. Reviewed by Dr Barton. For Pain control on syringe driver. Beed: Later: Treatment discussed with both daughters. They agree to use of syringe driver to control pain and allow nursing care to be given".

Well, is that right, or is that wrong? The Panel perhaps in the circumstances may have little difficulty in reaching the conclusion that Philip Beed's note is accurate. It did happen. Eight o'clock in the evening, patient made peaceful and sleeping, reacted to pain when being moved. Lesley O'Brien does say that Philip Beed said that the analgesia was to be administered via syringe driver, so that part of it does not appear to be in contention. She agreed because she wanted her mother to be pain free (Day 3/57).

Dr Barton's evidence about the daughters was that when she and they met it was polite, they never criticised her. They were concerned about what drug management their mother should be given. She explained to them. They seemed content (Day 27/10).

Over the page one carries on still with the history on 18 August. Oramorph is administered and then diamorphine, the subcutaneous infusion commences with the consent of the daughters there, watching closely at what was happening, concerned about their mother. Perhaps this is a good instance of where one can say that if any relative had any justifiable concern about the subcutaneous analgesia being administered in this way, they would have been the first to complain. It is another sign, perhaps, albeit not from a professional medical source, that this was appropriate.

We can do all the calculations. By that morning she had had, once the oramorph was administered twice in the early hours, in the previous 24 hours she had had a total of 45. So if the total in 24 hours was 45 and it clearly was not enough to control pain, obviously an increase was justified. It is a question of how much should the increase be. There is Dr Barton making a judgment about it and reaching a clinical decision that that would be appropriate. Even on the calculations it really does not seem to be the case that the diamorphine was anything remotely approaching excessive.

Professor Ford said the does was high in equivalent terms. He said the 40 mgs of diamorphine is high, but not unreasonable. He would not be overly critical. The haloperidol is appropriate. The midazolam, and quite often that is really the thrust of his concern about a number of these cases, is a high starting dose and likely to have adverse effects in combination. One has to bear in mind that the two mgs of midazolam administered intravenously at the hospital is not the same thing in terms of either its impact or the absorption by the body as subcutaneous midazolam.

Dr Lord indicated that - she was asked this by Mr Kark - for an elderly frail lady to be given 40 mgs of diamorphine and 20 of midazolam would be a very large amount. It is large but it is very difficult to comment because I did not see this lady - a classic example of the need to see the patient.

So far as Dr Barton is concerned, her evidence about the subcutaneous analgesia can be highlighted in this way, Day 27/12.

She was asked whether she thought it was excessive and she said:

> "A It seemed a very appropriate starting dose for her symptoms.
>
> Q If it had been appropriate to prescribe 20 as the starting dose, would there have been any difficulty or problem with your doing that if that was your view?
> A Not at all.
>
> Q Did you consider as to whether the administration of those two particular drugs – I am leaving out anything else for the purposes of these issues – did you consider that there was a risk with the administration of diamorphine and midazolam that there would be adverse effects which would outweigh the benefit to the patient of relieving her pain and her agitation?
> A I considered that there were potential hazards and side effects to it but my overriding priority was to make her as pain free as possible".

and she pointed out about the stage that on the Tuesday she had become very bubbly overnight and so on, and she was probably developing bronchopneumonia.

> "Q One appreciates that these are not absolutely hard and fast lines, the line between palliative care and end of life care, but that would be a significant development, in your view?
> A A significant downturn in her condition".

Then the issue is as to whether some examination should have been carried out on the hip and had some discussion with the orthopaedic team.

> "A She was not well enough to return to the acute orthopaedic ward. We knew she had a large haematoma, or bruise, around where the dislocation had been put back. I knew that nothing surgically could have been done for this condition and that it would just have to be allowed to heal in its own time, if her condition permitted and she remained well enough."

Again, when one looks at that history, when one hears the evidence from Dr Barton, it is very difficult to see how one could say to oneself, "Yes, I am sure. I am sure that what was done was inappropriate and not in the patient's best interests." There was a possibility that the drug level might have been lower. Who knows? Dr Barton remains confident that the decisions she made at the time were balanced and based on proper medical concerns.

Lastly this in relation to this patient, before I look at the charge. The evidence of Nurse Giffin, the one who was particularly concerned about syringe drivers and so on; her statement covered the question of Gladys Richards and her treatment. She was one of the nurses who looked after her. She was not concerned about the drugs this patient was being administered. She checked regularly on this patient and she appeared comfortable with regard to the 40 mg. I appreciate this is a nurse, not a doctor. "With regard to the 40 mg, that is a low dose given over 24 hours. It is not very dramatic at all. She did not show any signs of pain at the time I was on duty, so I would have thought that is the best level, and 20 mg of midazolam were what she [that is Nurse Giffin] would expect." She put it in this way: "There was nothing to make me say, 'Oh crumbs, this is too much'."

That is pretty important evidence from the nurse who was critical and very much had an eye to whether patients were properly being administered subcutaneous analgesia via a syringe driver. Does one simply forget about that evidence, or does one think, "Perhaps it is really worth taking into account as assisting me to decide whether in this case anything inappropriate was done, or whether this patient was treated in a way that she was improperly over-sedated or had her respiratory situation depressed?"

We suggest that a close look at all the evidence in that case in a fair and balanced way does not lead one to say – at the very least it does not lead one to say – "I can be satisfied that Dr Barton is, as it were, guilty as charged."

Looking then at the charge itself with regard to this patient, it is on page 6 of the document. It is charge 6. As my learned friend Mr Kark pointed out when he addressed you, the charge is quite briefly put, and therefore the issues that I need to speak about at this stage can be kept pretty short.

Exactly the same arguments apply with regard to the allegations about dose range being too wide and the prescription creating a situation, and so on. It is worth noting that in relation to the allegation in respect of this patient, there is no head of charge relating to the administration of the drugs on the 18th. It does not form the subject of a charge. The dates concerned are 11 August, with regard to the Oramorph, and so on. It is difficult to see on any basis how the Oramorph could possibly be criticised. I have dealt with any other criticisms, I think, with regard to the diamorphine and the midazolam.

It might be appropriate if I deal with one more patient before proceedings conclude today, if that is sensible.

I will turn, then, if I may, to Patient F, Ruby Lake. This is the lady who had the history, as we have seen more than once: fractured left neck of femur and left ventricular failure. We have the history beginning in January of 1998, but we can take these early passages, I think, pretty quickly and perhaps move on to page 6. This is dealing with the situation when she is being seen in Haslar. Would you look at page 6? It covers the dates in early August, Sunday 9 August. "Reviewed by SHO" and so on.

You heard evidence from her daughter, whose first name, I am afraid, has deserted me but the lady whose surname was Robinson. She saw her mother. "She did not want to know me that day when we visited. She was not interested in anything. A very great deterioration after she had broken her hip."

The lady giving evidence about this was a medical secretary, and had worked with orthopaedic surgeons and anaesthetists. She was aware that in such cases, patients can go downhill pretty quickly.

I will move on, please, to page 9. Dr Lord had this patient referred to her, and on page 9 we can see, in relation to the referral:

> "Post-op recovery was slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work on her mobilisation. ... Physio has visited for past 6 weeks."

This is an 84-year old lady.

Over the page, there is a review by Dr Lord. She sets out the situation and, as you can see, towards the bottom of her review:

> "Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement."

Dr Lord in her evidence said she had a number of medical concerns about her.

At the bottom of the page, the physio records:

> "Unable to mobilise at present due to chest pain."

Obviously this patient, said Professor Ford, was still quite medically unstable. Then, over the page, we can see examples of a general up and down picture with regard to her. I am going to go on to page 12, because on Saturday, 15 August the lady, Mrs Robinson, the daughter, said she thought her mother was better that week-end. It appears in Haslar with complaints about pain, and so on. There does not appear to have been any medical assessment. It is worth bearing that in mind when this criticism is levelled at Dr Barton for not making medical assessments when pain was experienced by somebody. They do not appear to have investigated that at all, according to the records.

Then over to page 14, please, where she is reviewed by the SHO at Haslar, who says, on 18 August, Tuesday:

> "Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well → GWMH today."

In the afternoon:

> "Increased shortness of breath. Recommenced on oxygen therapy..." et cetera.

The surgeon, Rear Admiral Farquaharson-Roberts, when he looked at that note, his view was that Haslar did not transfer patients when they were not well enough to do so, although he seemed to think Queen Alexandra did. It is interesting to note that he said about this patient, "It looks like she was beginning to get ill." That was his evidence. I am looking at these notes. It rather looks as if he was right on that assumption.

Diane Mussell was the lady who gave evidence in relation to this patient as well, a relative. "It was clear that the operation had had quite an effect on her. She was really not very well. She was very slow – much slower than other people who have had broken hips. Her mood would go up and down." When she saw her at Gosport, she was realistic enough to know that the trauma of the fall and the surgery often took their toll on elderly ladies.

That does not mean to say you do not treat them. It does not mean to say that, as you were, you consign them instantly to a patient who does not need any care, but it is a factor which everybody sensibly has to have in mind as to what is sensible to aim at.

Then the transfer letter is set out:

> "Has had slow recovery, exacerbated by bouts of angina and breathlessness."

It is also the case, worth remembering perhaps with Diane Mussell, who was a community nursery nurse, she says that she raised concerns at Haslar, that her mother was not well enough to be transferred to Gosport, but she was assured that she was fit enough.

Over the page, page 15, Dr Barton reviews her.

> "Transfer to Dryad Ward continuing care."

Leaving out the things she noted, the problems:

> "Get to know. Gentle rehabilitation. Happy for nursing staff for confirm death."

She did obviously properly assess the patient. It cannot be suggested that she did not. One can see what is recorded below that in relation to the notes by Barratt.

> "Pain: Yes."

It is worth noting that, if criticism is made about Oramorph being given. One can see the note of Oramorph being given at quarter past midnight with little effect.

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

Remember, Nurse Collins gave evidence about that. Professor Ford agreed that this lady had had a very variable medical course and, looking back on it, he thought she was not really fit for transfer.

In relation to what Professor Ford had to say about this, he said he criticised the administration of the Oramorph. A nurse should have sat with the patient. If that did not work after twenty minutes, give maybe temazepam or haloperidol. Nurse Collins said that somebody did sit with her for a while.

Dr Barton's evidence: this lady was entitled to be considered for rehabilitation, but I was not enthusiastic about her prospects. How long before she reached a terminal care route, she could not say. Potentially a very ill, elderly lady. She was aware of the problems with operations on femurs, and so on.

Over the page we can see the prescription by Dr Barton. Professor Ford said he could not find in the notes the rationale for that. It depended on what was being treated as to what was appropriate. He seemed to think that it would either be paracetamol or codeine of some sort, and he would not write up morphine for somebody with acute heart problems. She said: "It seems the administration was for anxiety and not pain, but his view it was not an appropriate use of morphine. There is solid, reliable evidence that it is." So we would suggest, if only on that basis alone, the prescription and the administration of the Oramorph was entirely justified in this case.

The anticipatory prescription, as we can see at the bottom of page 16, was dealt with by Dr Barton – Day 27/17-19. That also includes the administration of the Oramorph. She indicated that she was not medically stable. This was potentially and quite quickly a very unwell lady. That was borne out in the message in Dr Lord's transfer letter. Although she had not had a temperature since the night before, she had not actually gone into congestive cardiac failure the night before she arrived, she was quite likely to be doing so fairly shortly. The real problem as she saw it was not the repair to her hip, but her incipient congestive cardiac failure and the likelihood that she would go downhill very quickly, again following a transfer on top of major surgery. She dealt with what it was she had said when she was asked about the Oramorph. She said:

> "A Again like the previous patient, likely to be in some considerable pain when seen to by the nurses, so it was written up "prn" for their use if they felt that she was uncomfortable and distressed and they wanted to give her something for pain relief."

With regard to that with the heart problems, she said it was –

> "A Likely to be of benefit rather than detriment to somebody with incipient congestive cardiac failure.
>
> Q Why not send her back or contact the hospital, Haslar, and say, "This lady should not be here; she should not have been transferred"? I would like you to deal with that suggestion if it is being made.
> A It was not my place to turn down acceptance of a patient who had been accepted by my consultant into one of my beds. I was responsible for the day to day

care of these patients but I was not responsible for the politics behind why they came to me."

In terms of transferring her back when she was not medically stable, she also said:

"A I understood from the assessment that Dr Lord had made of her, albeit several days earlier, and how frail she was when she arrived with me that it would not have been appropriate to put her through a journey again. And, to be honest, what further could they have done for this lady other than made her comfortable?

Q ...
A There is not a further problem with her surgical procedure; that seems to have been relatively successful. Her problem is that she is at the end of her life due to her cardiac problems.

Q ...
A ... that she is likely to be on the terminal care route before too long."

She indicated herself that she thought in her note she was probably being slightly over-optimistic, "tongue in cheek", as she indicated.

"Q In terms of the nursing staff seeing that, would they understand that nonetheless, of course, if it was possible that gentle rehabilitation could take place then they should pursue it?
A Yes."

She also thought if three was a problem with the heart to give her temazepam in fact would not have been appropriate or likely to make matters worse.

I move over to page 17 where one can see what it was that Nurse Hallmann recorded on Wednesday, 19 August.

"... C/o [complaint about] chest pain ... grey around mouth. Oramorph .. given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20 mg midazolam 20 commenced in syringe driver."

Nurse Hallmann is a person who would have been concerned if she had thought this was inappropriate or too high, because it is an issue that she had, which she has spoken about. She thinks she would have got permission from Dr Barton and she thought it was right. She also said, obviously, 20 mg Oramorph was not enough. This patient was still in pain so an increase was indicated. She again said in her evidence she would have said something if she thought it was wrong.

Professor Ford criticises this as being inappropriate, there being no diagnosis being made. There should have been a chest X-ray obtained and so on. The dose of diamorphine was excessive. With respect, when we look at it, it does not seem to be excessive in fact, and it is worth bearing in mind in terms of the history that this did not result in this lady suddenly going into some kind of over-sedated or respiratorily depressed condition because on the night of the 19th, in terms of the nursing notes, that night, at page 388 of the records, she is shown as not being unconscious, but rousable and sipping fluid. That is in contrast to the

evidence of the daughter, Mrs Robinson, who visited on Thursday and said that she was unconscious: "She did not know we were there." She assumed she was on a syringe driver. She assumed it was diamorphine.

When one looks at the notes in relation to the Thursday, the condition appears to have deteriorated overnight. Driver recharged. "General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when moved". So she was not in an unconscious state. Dr Barton's evidence was that this was not the consequences of the syringe driver causing the patient to lose consciousness. She was not unconscious. It was the consequence of her congested cardiac failure causing her to retain secretions, both in the lungs and in the upper respiratory tract – Day 29/59. One has to pose this question: who is to say, on the evidence in this case, that Dr Barton is not absolutely right? How could anybody sensibly say, in these conditions, bearing in mind Dr Barton's evidence and the sort of doctor she is, "I am sure that it was not her condition that caused this deterioration"?

With all due respect to all the evidence and all the criticism made by Professor Ford, it is pure speculation to say that the administration of these drugs caused that deterioration. If one is in that position, it is very difficult to say that one can be sure that what Dr Barton did with regard to subcutaneous analgesia, either anticipatorily or in any other way, can be regarded as inappropriate and not in the patient's best interests.

I move on to the increase in dose that occurred. Professor Ford criticises this. One has to bear in mind of course that the diamorphine goes up in this case in stages of 20 to 40, to 60. It is not a tripling of the dose as was initially being suggested, and we can see that on page 18. Professor Ford said he wanted to see a rationale for those increases. Well, one has heard what that was; because of the position with regard to the patient and her being distressed on the Thursday. On the Friday the diamorphine and so on is administered in the morning. Her condition continued to deteriorate slowly. All care continued. Family present all afternoon.

Diane Mussell, who was there on each day, the Tuesday through to the Friday, said,

> "There was nothing that struck us as out of the ordinary with regards to her care".

Professor Ford is of the view that the doses very likely contributed to her death, but he cannot conclude that the drugs were the cause of her death bearing in mind her other conditions. We suggest that looking at this, standing back and looking at the evidence in relation to this case, this charge also is not made out because the evidential situation taken at its height against Dr Barton is not enough to establish so that one could be sure – I look at the allegations in the charge – that these prescriptions were inappropriate or not in the best interests of Patient F. It is quite clear in any event, on any basis, that the diamorphine allegation has not been made out.

I think in the circumstances I have got six more patients to go, but rather than beginning another patient or endeavouring to conclude it, which would not be appropriate, I can perhaps stop now. This is punishing stuff for anybody. It is always difficult, as the Panel know, having to listen to one person's voice. It is like going to one of those ghastly conferences and instead of the speaker being different on each new occasion, it is the same speaker, which encourages the seats to empty pretty quickly, but in this case there is nothing else for it, I am afraid.

Perhaps I can deal with the next six patients tomorrow. I will not do it in an hour, but I hope to conclude comparatively rapidly.

THE CHAIRMAN: Very well. Thank you, Mr Langdale. We will rise now and reconvene tomorrow morning at 9.30.

(The Panel adjourned until 9.30 am on Thursday 6 August 2009)