Form MG15(T)

RESTRICTED

RECORD OF INTERVIEW

Number: Y20E

Enter type: ROTI
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Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD OFFICE NETLEY

Date of interview: 03/03/2005

Time commenced: 0915 Time concluded: 0940

Duration of interview: 25 MINS Tape reference nos. (→)

Interviewer(s): DC Code A YATES & DC Code A

Other persons present: MR BARKER SOLICITOR

Police Exhibit No: CSY/JAB/4A Number of Pages: 22

Signature of interviewer producing exhibit

Person speaking	Text
DC YATES	This interview is being tape recorded I am DC Code A Chris YATES, my colleague is -
DC Code A	DC Code A.
DC YATES	I'm interviewing Doctor Jane BARTON, Doctor can you please give your full name and your date date of birth.
BARTON	Doctor Jane Anne BARTON 19/10/48 (19/10/1948).
DC YATES	Also present is Mr BARKER who is Doctor BARTON'S Solicitor. Can you please give your full name.

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SOLICITOR — Yes certainly it's Ian Stephen Petrie BARKER.

DC YATES — If you have a role about your, or if you have sorry a statement about your role here today maybe now.

SOLICITOR — No I'm just Doctor BARTON'S Solicitor.

DC YATES — Okay. This interview is being conducted in an office within the Fraud Squad at Netley Support Headquarters in Hampshire . The time is 09:15 hours and the date is the 3rd of March 2005 (03/03/2005). At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes. I must remind you Doctor that you are entitled to free legal advice, you have Mr BARKER with you, have you had enough time to speak to him before this interview started.

BARTON — Yes thank you.

DC YATES — Okay. If at any time you want to speak to Mr BARKER then just say and we'll stop the interview so that you can consult in private. I must also tell you that you've attended voluntarily, you are not under arrest, you have come here of your own freewill, therefore if at any time you wish to leave then your completely free to do so. You do not have to say anything but it may harm your defence if you do not mention when questioned something, which you later rely on in Court. Anything you do say maybe given in evidence. That's what's called the Caution Doctor, do you understand that Caution.

BARTON — I do.

DC YATES — Could you just for our peace of mind explain what you think that Caution means.

SOLICITOR — Well Officer again perhaps you could explain that so that Doctor BARTON'S absolutely clear sometimes it's rather difficult for people in this situation to put it across.

DC YATES — The Caution comes in, in three parts really. The first part is your right in law you don't have to say anything and the last bit is quite obvious, and anything you do say maybe given in evidence it's being tape recorded and should this matter ever go to Court the tapes can be played or a transcript could be read. It's the, the bit in the middle where it says it may harm your defence if you do not mention when questioned something, which you later rely on in Court. In a nutshell if you don't say something now but you later give a reason or an answer if this matter goes to Court then the Court may and it is only a may put an inference on that and wonder why you didn't say that earlier. Do you understand what I'm saying.

BARTON — I do.

DC YATES — Does that sound a reasonable explanation Mr BARKER.

SOLICITOR — I think we can have small trite arguments but the essense of what you've said.

DC YATES — Okay. Alright. This interview is not being monitored today so nobody else is listening, listending in if it was being monitored there would a red light situated somewhere which would, which would illuminate. Now during the interview I'll probably ask most of the questions but my colleague DC Code A will be making notes, don't let that worry you it's just so that we've got a reference straight away of what's been said. Mr BARKER can I just cover something with you. I believe you've been given some advance disclosure on the 4th of November which is the last time that we met.

SOLICITOR — Yes that's right.

DC YATES — And the disclosure consisted of a set of medical notes pertaining to Mr Code A and a summary is that correct.

SOLICITOR — That's correct yes.

DC YATES — Excellent. This investigation as you're no doubt already aware is being conducted by the Hampshire Constabulary it started in September 2002, I accept that it's over two years now but the investigation will probably continue for some considerable time still. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. No decision has been made as to whether an offence or any offences have been committed but it's important to be aware that the offence range being investigated runs from an assault all the way up to murder and part of the ongoing enquiries to interview witnesses who were involved in the

care and treatment of the patients during that period. You were a Clinical Assistant at the Gosport War Memorial Hospital at the time of the these deaths, so your knowledge of the working and of the hospital and the care and treatment of the patients is very central to this enquiry. The interview today will be concentrating on Code A Code A who was an 82 year old man and he died on Dryad Ward on the 24th of January 1996 (24/01/1996). Now I've done most of the speaking now but perhaps in your own words Doctor you can tell me your recollection of Code A and the care and treatment.

SOLICITOR — Officer can I say that Doctor BARTON has produced a pre prepared statement so that she can convey to you all the information that she thinks she can about Mr Code A and his case. I would invite if your content with this Doctor BARTON to read that out as her account responding to your invitation just now. I have to say for the reasons that I articulated on the previous occasion though my advice to Doctor BARTON is that she should then make no further comment to questions.

DC YATES — Right.

SOLICITOR — Put to her and hopefully this is a detailed pre prepared statement, which will take care of necessary information you seek.

DC YATES — As you mention that yes if you could read it Doctor BARTON but you you're indicating that once you've read the prepared statements your not going to answer any

further questions put to you about this matter. Is that correct.

BARTON — Correct.

DC YATES — Okay. If you, if you could it read then please Doctor.

SOLICITOR — It's simply the form as I do have a copy of the statement for you.

DC YATES — That would be ever so handy.

SOLICITOR — Of course no problem at all it will save you making notes.

DC YATES — Yeah. Thank you.

BARTON — I am Doctor Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire . As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mr Code A As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the Gosport War Memorial Hospital. I adopt that statement now in relation to general issues insofar as they relate to Code A

In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal bartel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients.

Whilst the demands on my time were probably slightly less in 1996 than the position which then pertained in 1998 and beyond, certainly even by 1996 there had been a significant increase in dependency, increase in bed occupancy, and consequent decrease in the ability to make notes of each and every assessment and review of a patient. These difficulties clearly applied both to me and the nursing staff at the time of our care of Mr Code A. Similarly I had by this stage felt obliged to adopt the policy of pro-active prescribing to which I have made reference in my previous statement to you, given the constraints and demands on time.

In any event, it is apparent from Mr Code A 'S medical records that he was 83 years of age and had been suffering from depression since his 50's. Mr Code A had been

living in a residential home, Hazeldene and also had been an in-patient at the Knowle Hospital where he had received Electro Convulsive Therapy as treatment for severe depression. Having returned to Hazeldene, early in 1995 it is recorded that by September that year Mr Code A had taken to his bed and was no longer eating and drinking properly. In view of his general condition and depression, he then appears to have been admitted to Mulberry Ward at the Gosport War Memorial Hospital having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

The note of the Community Psychiatric Nurse for the 1st September 1995 records that she had been asked to review Mr Code A 'S mood and behaviour. She said that he had lost 1 pound 1 stone 2 pounds in two months and appeared physically frailer, anxious and had fallen at times. She recorded the drug regime at that time, and her view that the best course of action was to arrange an admission to Mulberry Ward for assessment of the regime and to provide interim intensive support for Mr Code A.

From Mr Code A 'S records it appears then that he was admitted to Mulberry Ward on the 14th September 1995 (14/09/1995) under the care of Consultant in Old Age Psychiatry, Dr Vicki BANKS . Mulberry Ward is the long stay elderly mental health ward at the Gosport War Memorial Hospital. On admission it was recorded that there had been a deterioration of Mr Code A 'S mood and physical capabilities over recent months. Whilst on Mulberry Ward, Mr Code A 'S depression was treated

with Lithium, Sertraline, and he also received Diazepam and Thioridazine.

Mr Code A was then discharged from Gosport War Memorial Hospital on 24th October 95 (24/10/1995). The subsequent discharge letter to Mr Code A 'S GP from Dr Rosie BAYLY , Registrar to Dr BANKS, stated that Mr Code A had scored 8 out of 10 on a mental health score, and that he had been offered ECT for his depression but had turned it down as it had not been very effective previously. Dr BAYLY referred to his frail physical condition, but said that his mood had improved quite a bit during his admission and that he seemed to have more energy. He was apparently to be followed up as a day patient.

Mr Code A was then re admitted to Mulberry Ward from Hazeldene on 13th December 1995 (13/12/1995). The nursing staff at the residential home were said to have found it increasingly difficult to manage him as he had become both physically and verbally aggressive. On 20th December his physical condition was described as poor, and he later developed a chest infection and areas of pressure ulceration.

With his condition remaining poor, Dr BAYLY wrote a note on 2nd January 1996 (02/01/1996) requesting Dr Althea LORD, Consultant Geriatrician, to see Mr Code A In her note Dr BAYLY said that on admission Mr Code A 'S mobility had initially deteriorated rapidly and that he had developed a chest infection. She reported

that his chest was now clearing, but he remained bed bound, expressing the wish to die. The following day, Mr Code A was said to be deteriorating.

Dr LORD then undertook an assessment on 4th January. In Mr Code A 'S records she said that she would be happy to take Mr Code A to a long stay bed in the hospital. Recording the position at this time when then writing formally to Dr BANKS on 8th January, Dr LORD said she noted that he had suffered from a chronic resistant depression and long courses of ECT in the past had not been effective. He had recovered from a recent chest infection but was completely dependent with a Bartel score of zero, his urinary catheter was bypassing and he had ulceration of the left buttock and hip. He had hypoproteinaemia with an albumin of 27 and was eating very little although he would drink moderate amounts with encouragement. She felt that he would need high protein drinks as well as a bladder wash out but overall felt that his prognosis was poor and would be happy to arrange transfer to Dryad on 5th January. She gathered that Mrs Code A was also aware of his poor prognosis.

In noting that his prognosis was poor I believe that Dr LORD felt that Mr Code A was unlikely to get better and sadly he was not likely to live for a significant period.

Accordingly, Mr Code A was admitted to Dryad ward the following day, 5th January, though under the care of Consultant Geriatrician Dr Jane TANDY , and I undertook his assessment. Unfortunately, given the very considerable

interval of time I now have no real recollection of Mr Code A, but my admission note in his records reads as follows:

"5th January 96 Transfer to Dryad Ward from Mulberry
Present problem
Immobility depression
Broken sacrum. Small superficial areas
Ankle dry lesion Left ankle
Both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and Sertraline"

I also prescribed medication for Mr Code A, continuing the Sertraline, Lithium, Diazepam, and Thyroxine which had been given during his stay on Mulberry Ward, together with Daktacort cream for his pressure sores.

I believe that I would have seen Mr Code A each weekday when on duty at the hospital. 5th January 1996 (05/01/1996) being a Friday, I would have seen him again on 8th January and reviewed his condition. I have not made a note, but anticipate that his condition may have been essentially unchanged.

I saw Mr Code A again on Tuesday 9th January and made the following entry in his notes:

"9-1-96 Painful Right hand held in flexion
Try arthrotec
Also increasing anxiety and agitation
? sufficient diazepam
? needs opiates"

The nursing note for 9th January documents that Mr Code A had taken a small amount of diet. He was noted to be very sweaty that morning, but apyrexial. He stated that he had generalised pain and it was noted that he would be seen by me that morning.

The prescription chart shows that I prescribed Arthrotec, which would have been for the pain in Mr Code A 'S hand as recorded by me in the notes. The prescription is in fact dated for the previous day. I do not know now if the date is an error or if I had prescribed and seen him the previous day, and made a substantative note the following day, 9th January. In any event on 9th January I noted that Mr Code A had increased anxiety and agitation, and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. I would have been conscious that a ward round with Dr TANDY was to take place the following day, and that a change in medication could sensibly be considered then.

The notes show that Dr TANDY and I then saw Mr Code A the following day, 10th January. Dr TANDY

noted his dementia, that he was catheterised, had superficial ulcers, his Barthel score remained zero, and he would eat and drink. She wrote that Mr Code A was "for TLC" (Tender loving care). This indicated that Dr TANDY effectively agreed with Dr LORD'S assessment and felt Mr Code A was not appropriate for attempts at rehabilitation but was for all appropriate nursing care and treatment only. She noted that she had had discussion with Mr Code A 'S wife who had agreed that in view of his very poor condition this was appropriate.

The nursing note for the same day confirmed that we had seen Mr Code A and that his condition remained poor, with Mrs Code A being aware of this.

The prescription chart shows that I prescribed Oramorph for Mr Code A the same day, no doubt in consequence of liaison with Dr TANDY at the time of the ward round. This would have been for relief of pain, anxiety and distress. The dose is recorded at 2.5 mls in what is a 10mg/5ml ratio, 4 hourly. The regime was written up for doses at 6.00 a.m., 10.00 a.m., 2.00 p.m. (14:00) and 6.00 p.m. (18:00). It appears that I also proactively wrote up a prescription for diamorphine , in a dose range of 40-80mgs subcutaneously over 24 hours, together with 200-400mcgs of hyoscine and 20-40mgs of midazolam via the same route. I anticipate we were concerned that the Oramorph might be insufficient and that further medication should be available just in case he needed it.

Sister HAMBLIN recorded in the nursing notes the same day that Mrs Code A was seen and was aware of her husband's poor condition. He was to occupy a long-stay bed. It was clear that his condition was such that he would not recover and in essence all that could be given was palliative care, with his death expected shortly.

I anticipate that I would have seen Mr Code A again the following day. Although I did not make a clinical entry in Mr Code A S records, I wrote up a further prescription chart for the various medications Mr Code A was then receiving. In addition I increased the Oramorph available for Mr Code A 'S pain, anxiety and distress, by adding an evening dose of 5mls to the four daily dose doses, to tide Mr Code A overnight. I also provided a further prescription for hyoscine, diamorphine and midazolam, with the latter two drugs being at a slightly greater level than I had written the previous day, at 80-120 and 40-80mgs respectively. I would have been concerned that although it was not necessary to administer the medication at that stage, Mr Code A S pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. The Sertraline and lithium were discontinued from this point, given Mr Code A 'S poor condition.

I anticipate that I would then have seen Mr Code A on the Friday morning, but I would then have been away from the hospital over the weekend. I returned on the morning of Monday 15th January, and would have reviewed all of the patients on both Dryad and Daedalus wards in the usual

way, including Mr Code A. I believe I may have been told that his condition had deteriorated considerably over the weekend and he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress, through his mental and physical condition. Unfortunately, I did not have an opportunity to make a clinical entry in Mr Code A 'S notes, I anticipate due to lack of time, but the nursing note indicates that I saw Mr Code A and that 80mgs of diamorphine, 60 of midazolam, and 400mcgs of hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 (08:25) that morning.

The previous medication, including the Oramorph, was clearly insufficient in relieving Mr Code A 'S condition. He had been transferred to the ward in a poorly condition, and had been considered by consultants at about that time to be in terminal decline. Dr TANDY in particular had noticed noted that he should have "TLC" - in other words palliative care in circumstances in which he was clearly dying. Since then Mr Code A had deteriorated yet further. My concern therefore was to ensure that he did not suffer anxiety, pain and mental agitation as he died. I believe my assessment of Mr Code A 'S condition at this time was also that he was in terminal decline.

I tried to judge the medication, including the increase in the level of opiates to ensure that there was the appropriate and necessary relief of his condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe

driver. This had to take into account the fact that the lithium and Sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime.

Although the nursing notes suggest that Mr Code A continued to deteriorate, his pulse was noted to be stronger and regular, and he was said to be comfortable during the night.

The notes continue that the following day, 16th January, Mr Code A 'S condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the previous day had been largely successful in relieving Mr Code A 'S condition, but not entirely. At the same time, it would seem that Mr Code A 'S pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I had felt appropriate.

In view of the agitation I decided to add between 5-10mgs of haloperidol to the syringe driver, with 5mgs being given at that time. The fact that I saw Mr Code A and prescribed is recorded in the nursing notes, but again I anticipate my commitments in attending to patients at that time meant that I did not have an opportunity to make an entry in Mr Code A S notes.

Mr Code A 'S daughter apparently visited later that day and was said now to be aware of her father's poorly condition.

I believe I saw Mr Code A again the following morning, 17th January. It appears from the nursing notes that Mr Code A was tense and agitated and so I decided to increase the level of his medication. I wrote a further prescription for 120mgs of diamorphine, noted by me on the drug chart to have been at about 08.30 (08:30). This was with the specific aim of relieving the agitation, and from concern that as Mr Code A would be becoming inured to the medication and tolerant of it, so he might experience further agitation, and the pain and distress might return. I also increased the haloperidol to 10mgs and the hyoscine to 600mcgs, the latter to dry the secretions on his chest, suction being required that morning.

I returned to review Mr Code A in the early afternoon. The nursing note suggests that the medication was revised at that stage, and it is possible that the changes I had recorded earlier were instituted at about this time.

Unfortunately, Mr Code A appears to have deteriorated further that evening. He was however said by Sister HAMBLIN now to be settled and aware of when he was being attended to. My inference was that the increase in the medication had not seemingly caused Mr Code A to be excessively sedated.

I believe I saw Mr Code A again the following morning, Thursday 18th January. The nursing note indicates that his poorly condition continued to deteriorate. I made an entry in his records on this occasion, as follows:

"18th January 96 Further deterioration
subcutaneous analgesia continues
difficulty controlling symptoms
try nozinan".

I believe from my note that Mr Code A 'S agitation had returned and we were having difficulty controlling his symptoms. I therefore increased the Haloperidol to 20mgs and decided to add 50mgs of nozinan to the syringe driver to run over 24 hours, nozinan being an antipsychotic, used also in palliative care for pain and severe restlessness.

The nursing note states that he appeared comfortable in between attentions, from which I would infer that he had adequate relief from symptoms, but he would experience pain, distress and agitation when receiving care, such as being turned, that being necessary to prevent the further development of bed sores.

Later that day a marked deterioration in Mr Code A 'S condition was noted by the nurses. Clearly Mr conditions Mr Code A 'S condition continued to deteriorate given the fact that he was in the process of dying. His breathing was noted to be intermittent and his colour poor.

I would not have been on duty over the weekend, and it appears that one of my GP partners, Dr Michael BRIGG , was available. The records show that on Saturday 20th January, he was consulted about Mr Michael Mr Code A, and he advised that the nozinan should be increased to 100mgs and the haloperidol discontinued. My expectation is that Dr BRIGG would have been advised of Mr Code A 'S condition and the drug regime. The only modification being in the antipsychotic medication, it would seem that Dr BRIGG did not consider the general regime to be inappropriate in view of Mr Code A 'S condition.

Dr BRIGG sufficient specifically recorded in the notes that Mr Code A had been unsettled on haloperidol, that it should be discontinued and changed to a higher dose of nozinan.

It seems that Dr BRIGG then saw Mr Code A the following day. He has made a record in the notes for 21st January, in addition to the entry for the verbal advice given the previous day. Dr BRIGG noted that Mr Code A was much more settled, with quiet breathing and a respiratory rate of 6 breaths per minute. Dr BRIGG said that he was not distressed, and stated "continue". Again, it would seem that Dr BRIGG did not disagreed with the overall medication which was being administered in view of Mr Code A 'S condition.

I would have seen Mr Code A again on the Monday morning, 22nd January. I have not made a note, but the

nursing records indicate that Mr Code A was poorly but peaceful.

I would have seen Mr Code A again on 23rd January, when again it was said by the nurses that his poorly condition remained unchanged and that he remained peaceful. In view of the fact that the medication was apparently relieving his symptoms, it was not necessary to alter either the nature or the amounts being given.

Sadly, in the early hours of 24th January, Mr Code A deteriorated suddenly, and he died at 01:45 (01:45).

DC YATES Thank you Doctor again that's very full, very informative. Can I just ask you is this statement made by you Doctor. This prepared statement. Can I ask you if you could sign it and endorse it with the fact that you've handed it to me, possibly sign that one and time and date it please.

BARTON This one.

DC YATES Yeah the one you read from would be the best one.

BARTON On, on the back page or on the front.

DC YATES Is there room on the last page, yeah just put it on the last page please.

BARTON Is today's date the 3rd.

DC YATES — Yes. And if you could just put on there handed to DC YATES, it's Y A T E S. Lovely thank you. Would you consider countersigning Mr BARKER, you did the other one.

SOLICITOR — Yes no problem.

DC YATES — Right for the purpose of the tape I'm going to give this prepared statement an Identification Reference and I'm going to call it JB/PS/3 that's by Doctor Jane BARTON, Prepared Statement and that's the third one we've had from you. Right I intend to call a halt to the interview pretty much now so that we can go away and consider all this information that you've told us. Before is there anything you want to ask Geoff.

Code A — No there isn't.

DC YATES — No okay. Well we'll going to go away and have a read through. Before we turn the tapes off Doctor is there anything you wish to say, anything you wish to clarify.

BARTON — Nothing.

DC YATES — Mr BARKER.

SOLICITOR — No thank you.

DC YATES — Okay well we'll give you a notice explaining the tape recording procedure, feel free to use the canteen and if you

want get a breath of fresh air and we'll come back. The time is 09:40 and we'll turn the recorder off.