STATEMENT OF DR JANE BARTON - RE: Code A Code A

1. I am Dr 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 (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Leslie Pittock. 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 GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Code A.

3. 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.

4. 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.

5. 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 G W M H having been seen at Hazeldene by a Community Psychiatric Nurse in September 1995.

6. 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 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

7. From Mr Code A's records it appears then that he was admitted to Mulberry Ward on the 14th September 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.

8. Mr Code A was then discharged from GWMH on 24th October 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.

9. Mr Code A was then re admitted to Mulberry ward from Hazeldene on 13th December 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.

10. With his condition remaining poor, Dr Bayly wrote a note on 2nd January 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.

11. 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 at 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.

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

13. 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:

"5-1-96 Transfer to Dryad Ward from Mulberry

Present problem

Immobility depression

broken sacrum. Small superficial areas

ankle dry lesion L ankle
both heels suspect

Catheterised
transfers with hoist
may help to feed himself

Long standing depression on Lithium and
Sertraline"

14. 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.

15. I believe that I would have seen Mr Code A each weekday when on duty at the hospital. 5th January 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.

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

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

17. 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.

18. 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 in error or if I had prescribed and seen him the previous day, and made a substantive 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.

19. 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.

20. 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.

21. 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 as 2.5 mls in what is a 10mg/5ml ratio, 4 hourly. The regime was written up for doses at 6.00 am, 10.00 am, 2.00 pm and 6.00 pm. It appears that I also proactively wrote up a prescription for diamorphine, in a dose range of 40 - 80 mgs subcutaneously over 24 hours, together with 200 - 400 mcgs of Hyoscine and 20 - 40 mgs 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.

22. 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 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.

23. 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 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 mgs and 40 - 80 mgs 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.

24. I anticipate that I would have seen Mr Code A on the Friday morning, but 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, 60mgs of Midazolam, and 400mcgs of Hyoscine over 24 hours were commenced subcutaneously via syringe driver at 08.25 that morning.

25. 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 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.

26. 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.

27. 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.

28. 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.

29. 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.

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

31. 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. 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.

32. 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.

33. 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.

34. 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:

"18-1-96 Further deterioration
sc analgesia continues
difficulty controlling symptoms
try nozinan."

35. 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.

36. 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.

37. Later that day a marked deterioration in Mr Code A s condition was noted by the nurses. Clearly 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.

38. I would not have been on duty over the weekend, and it appears that one of my GP partners, Dr Michael Briggs, was available. The records show that on Saturday 20th January, he was consulted about Mr Code A, and he advised that the Nozinam should be increased to 100mgs and the Haloperidol discontinued. My expectation is that Dr Briggs 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

Briggs did not consider the general regime to be inappropriate in view of Mr Code A's condition.

39. Dr Briggs 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.

40. It seems that Dr Briggs 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 Briggs noted that Mr Code A was much more settled, with quiet breathing and a respiratory rate of 6 breaths per minute. Dr Briggs said that he was not distressed, and stated "continue". Again, it would seem that Dr Briggs did not disagree with the overall medication which was being administered in view of Mr Code A's condition.

41. 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.

42. 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.

43. Sadly, in the early hours of 24th January, Mr Code A deteriorated suddenly, and he died at 01.45.

Signed Code A

dated 3-3-05

Handed to Code A

Code A