Patient E is Mum.

General Medical Council

Fitness to Practise Panel
Session beginning 8 June – 21 August 2009
Regent's Place, 350 Euston Road, London NW1 3JN

New case of serious professional misconduct.

This case is being considered by a Fitness to Practise Panel applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988

Dr Jane Ann BARTON

The Panel will inquire into the following allegation against Jane Ann Barton, BM BCh 1972 Oxford University:

"That being registered under the Medical Act 1983, as amended,

'1. At all material times you were a medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire;

'2. a. i. Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

ii. between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as Diamorphine with a dose range of 40 - 80 mg over a twentyfour hour period to be administered subcutaneously ("SC") on a continuing daily basis,

iii. on 11 January 1996 you prescribed Diamorphine with a dose range of 80 - 120 mg and Midazolam with a range of 40 - 80 mg to be administered SC over a twentyfour hour period,

iv. on 15 January 1996 a syringe driver was commenced at your direction containing 80 mg Diamorphine and 60 mg Midazolam as well as Hyoscine Hydrobromide,

v. on 17 January 1996 the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg,

vi. on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

b. 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,

c. The doses of Diamorphine administered to the patient on 15 and 17 January 1996 were excessive to the patient's needs,

d. Your prescription described at paragraphs 2.a.vi.in combination with the other drugs already prescribed were excessive to the patient's needs,

e. Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and vi. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient A;

'3. a. i. Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996,

ii. on 24 February 1996 you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day,

iii. on 26 February 1996 you increased the prescription for MST and prescribed Diamorphine with a dose range of 80 mg - 160 mgs and Midazolam with a dose range of 40 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

iv. on 5 March 1996 you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg - 80 mg over a twentyfour hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg,

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

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

ii. the dose range for Diamorphine and Midazolam on 26 February and on 5 March 1996 was too wide,

iii. the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs,

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

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient B,

d. In relation to your management of Patient B you,

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

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

iii. did not provide a plan of treatment,

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

e. Your actions and omissions in relation to your management of patient B were,

i. inadequate,

ii. not in the best interests of Patient B;

'4. a. i. on 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

ii. on 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twentyfour hour period on a continuing daily basis,

b. In relation to your prescription for drugs described in paragraph 4.a.ii.,

i. the dose range of Diamorphine and Midazolam was too wide,

ii. the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

c. Your actions in prescribing the drugs described in paragraph 4.a. ii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of your patient;

'5. a. i. on 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation,

ii. on or before 20 August 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20mg - 80mg to be administered SC over a twentyfour hour period on a continuing daily basis,

b. In relation to your prescription for drugs as described in paragraph 5.a. ii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

c. Your actions in prescribing the drugs as described in paragraph 5.a.ii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient D;

'6. a. i. Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

ii. on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required),

iii. on 11 August 1998 you also prescribed Diamorphine with a dose range of 20 mg - 200 mg and Midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

b. In relation to your prescription for drugs described in paragraph 6.a.iii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs,

c. Your actions in prescribing the drugs described in paragraph 6.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient E;

'7. a. i. Patient F was admitted to Dryad Ward at GWMH on 18 August 1998 for the purposes of rehabilitation following an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

ii. on 18 August 1998 you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required),

iii. between 18 and 19 August 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

b. In relation to your prescription for drugs described in paragraph 7.a.iii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs,

c. Your actions in prescribing the drugs described in paragraphs 7.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous,

not in the best interests of Patient F;

'8. a. i. Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions,

ii. on 21 September 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

iii. on 25 September 1998 you wrote a further prescription for Diamorphine with a dose range of 40 - 200mg and Midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

b. In relation to your prescriptions for drugs described in paragraphs 8.a.ii. and/or iii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs,

c. Your actions in prescribing the drugs described in paragraphs 8.a.ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient G,

d. You did not obtain the advice of a colleague when Patient G's condition deteriorated;

'9. a. i. Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions,

ii. on 14 October 1998 you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

iii. on or before 16 October 1998 you prescribed Diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twentyfour hour period on a continuing daily basis,

iv. on or before 17 October 1998 you prescribed Midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis,

b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was,

i inappropriate,

ii. potentially hazardous,

iii. likely to lead to serious and harmful consequences for Patient H,

iv. not in the best interests of Patient H,

c. In relation to your prescription described in paragraph 9.a. iii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs,

d. Your actions in prescribing the drugs described in paragraphs 9.a. ii., iii. and/or iv. were,

i. inappropriate,

ii. potentially hazardous,

not in the best interests of Patient H.,

e. You did not obtain the advice of a colleague when Patient H's condition deteriorated;

'10. a. i. Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii. on 12 April 1999 you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis,

iii. on 12 April 1999 a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Reid,

b. You did not properly assess Patient I upon admission. This was,

i. inadequate,

ii. not in the best interests of Patient I,

c. In relation to your prescription for drugs described in paragraph 10.a.ii.,

i. the dose range was too wide,

ii. the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs,

d. Your actions in prescribing the drugs described in paragraph 10.a. ii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I,

e. The dosage you authorised/directed described in paragraph 10.a. iii. was excessive to Patient I's needs. This was,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I;

'11. a. i. Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home,

ii. on 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J,

iii. you saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

iv. you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

v. on 26 August 1999 you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

vi. on 26 August 1999 you also prescribed Oramorphine 20 mg at night'

b. In relation to your prescription for drugs described in paragraph 11.a.v.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high,

ii. the dose range was too wide,

iii. the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs,

c. Your actions in prescribing the drugs described in paragraphs 11.a. ii. and/or v. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient J,

d. Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11.a. iv. was,

i. inappropriate,

ii. not in the best interests of Patient J;

'12. a. i. Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital She was reported to be suffering from chronic renal failure and multi infarct dementia,

ii. on admission you prescribed Morphine solution 10mg in 5 ml as required,

iii. on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch,

iv. on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

b. The prescription on admission described in paragraph 12.a.ii. was not justified by the patient's presenting symptoms,

c. In relation to your prescription for drugs described in paragraph 12.a.iv.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high,

ii. the dose range was too wide,

iii. the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

d. Your actions in prescribing the drugs described in paragraphs 12.a. ii., iii. and/or iv. were,

i inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient K,

e. You did not obtain the advice of a colleague when Patient K's condition deteriorated;

'13. a. i. Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke,

ii. on 20 May 1999 you prescribed,

a. Oramorphine 10 mgs in 5 mls 2.5-5mls,

b. Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

c. Midazolam with a dose range of 20 to 80 mgs to be administered SC,

iii. you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999,

iv. doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999,

b. In relation to your prescription for drugs described in paragraph 13.a.ii. and/or iii.,

i. there was insufficient clinical justification for such prescriptions,

ii. the dose range of Diamorphine and Midazolam was too wide,

iii. the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs,

iv. your actions in prescribing the drugs described in paragraph 13.a. ii. and or iii. were,

a. Inappropriate,

b. Potentially hazardous,

c. Not in the best interests of patient L,

c. You did not obtain the advice of a colleague when Patient L's condition deteriorated;

'14. a. You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

i. the findings upon each examination,

ii. an assessment of the patient's condition,

iii. the decisions made as a result of examination,

iv. the drug regime,

v. the reason for the drug regime prescribed by you,

vi. the reason for the changes in the drug regime prescribed and/or directed by you,

b. Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

i. inappropriate,

ii. not in the best interests of your patients;

'15. a. In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L,

b. Your failure to assess the patients in paragraph a. appropriately before prescribing opiates was not in their best interests."

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

The Panel will be Mr Andrew Reid, LLB JP.

19/6/09 - P Beed.

23/6/09 - nurse (nunor) Sylvia ?Goikin on duty pm 21..8 98.

29/6/09 - Dr Reid

Expert 1-7 July 2009 - possibly 2/7/09 will confirm

7/7/09 - Dr Barton's evidence