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**HEALTH:** Claim made that failure to rehydrate was 'regular practice'

# Hospital patients were 'left to die', hearing is told

By Clare Semke  
Health reporter

ELDERLY patients were left to die without fluids because medical staff did not want them to recover, a panel heard.

Philip Beed told a General Medical Council hearing it was 'usual procedure' for patients receiving end-of-life care at Gosport War Memorial Hospital not to be rehydrated.

Speaking at a hearing into the fitness to practise of Gosport GP Jane Barton - formerly clinical assistant there - he admitted administering high doses of powerful painkillers and sedatives to patients on now defunct Daedalus ward.

Mr Beed, a former senior ward manager at the hospital, gave evidence to a five-strong panel examining Dr Barton's conduct relating to 12 elderly patient deaths there between 1996 and 1999.

He told the hearing at Regent's Place, Euston Road, London: 'In 1998 the usual

## CONDUCT INVESTIGATED

■ The panel is examining Dr Jane Barton's conduct in relation to the deaths of Geoffrey Packman - known as Mick - Ruby Lake, 84, Robert Wilson, 74, Elsie Devine, 88, Leslie

Pittock, 82, Elsie Lavender, 88, Arthur Cunningham, 79 - known as Brian, Enid Spurgeon, 92, Alice Wilkie, Jean Stevens, 73, Eva Page and Gladys Richards, 91.



**Dr Jane Barton denies serious professional misconduct**

procedure for patients receiving palliative care wasn't to rehydrate them [when using a syringe driver.]

'There was evidence that it wasn't of benefit to them.'

When asked by General

Medical Council counsel Tom Kark if it would lead to the deterioration of a patient, he replied: 'It could do if it was a patient we weren't wanting to make a recovery, yes.'

Mr Beed admitted administering high doses of powerful painkiller diamorphine - a form of heroin - to Gladys Richards on Daedalus ward after the 91-year-old was re-admitted on August 17 1998.

The cocktail Mrs Richards - who was initially admitted six days earlier following a hip operation - was given also included anti-psychotics and a sedative.

Mr Beed said the drugs were 'pre-prescribed' by Dr Jane Barton.

He started Mrs Richards on the daily cocktail including 40mg diamorphine three days

before her death.

However, the panel heard the normal conversion rate for a patient being switched from oral morphine to a syringe driver - an automatic pump for administering drugs - as in Mrs Richards' case meant she should have had a maximum 10mg. Mrs Richards died on August 21, 1998.

Dr Barton admits her prescriptions were 'potentially hazardous', and that she failed to keep adequate notes.

Dr Barton agreed her actions relating to notekeeping were 'inappropriate' and not in Mrs Richards' 'best interests'.

She denies serious professional misconduct.

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