

(17/7/09)

# Hearing told nurses made drug choices

Prescriptions were pre-signed by doctor

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## HEARING FACTS

THE General Medical Council hearing into Dr Jane Barton fitness to practice comes after an inquest jury at Portsmouth Coroner's Court in April heard that the deaths of five patients at the Gosport War Memorial Hospital were 'more than minimally' contributed to by the medication given.

In three cases they found the use of painkillers was inappropriate for their condition or symptoms.

But they also ruled that the medication had been administered for therapeutic reasons in all five cases and that medication had not contributed to a further five deaths.

NURSES could decide when to give potentially lethal drugs to patients at the Gosport War Memorial Hospital, a panel heard.

Consultant Althea Lord said Dr Jane Barton - at the centre of elderly deaths at the hospital - used to pre-write prescriptions.

This meant nurses could choose when to give some patients powerful painkillers and sedatives.

Speaking via videolink from New Zealand on day 31 of a General Medical Council hearing, Dr Lord said nurses started some patients on syringe drivers - automatic pumps for administering drugs - signifying they were nearing the end of their lives.

When asked by GMC counsel Tom Kark if there were occasions when nurses activated syringe drivers when they had a pre-written prescription, Dr Lord said: 'Yes. With the prescription there the nurses could start it but by and large they would discuss it with the doctor on call.'

Mr Kark added: 'And the syringe driver was the start of a palliative care, end of life route?'

Dr Lord replied: 'Yes it was.'

The consultant - who worked with Dr Barton at the hospital - also noticed the GP's poor notekeeping and wide dose ranges she prescribed - but took no action.

Mr Kark said: 'So you noticed the lack of notes and you noticed the wide prescriptions and you did nothing about either

problem, is that right?'

Dr Lord replied: 'Yes, that's right.'

She said: 'Dr Barton was on the ward every day - certainly at least once or twice a day, so I don't feel that the patients were let down, but the record should have been there.'

Dr Barton's conduct is being examined in relation to the care, treatment and subsequent deaths of 12 patients who died on the now defunct Dryad and Daedalus wards at the hospital where she was clinical assistant between 1995 and 1999.

Dr Barton has already admitted poor notekeeping, that dose ranges were too wide, and could have led to patients being given too many drugs.

But Dr Barton denies serious professional misconduct.



HEARING Jane Barton

(Proceeding)