The GMC

and

Dr Jane Barton

Opening

INTRODUCTION

1. This case concerns the treatment provided to twelve patients at the Gosport War Memorial Hospital all of whom were in-patients there between 1996 and 1999. Dr Barton was employed during the period as a clinical assistant which meant that she had day-to-day care of the patients on the two relevant wards which were Daedalus and Dryad.

2. The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth Area. The Queen Alexandra Hospital which has a number of sites clustered around the top of Portsmouth; St Mary's Hospital which is in Portsmouth itself; the Royal Haslar Hospital which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th Century; and finally the Gosport War Memorial Hospital (GWMH).

3. The GWMH was opened in 1923. Since then it has occasionally been extended. At the relevant time that you will be asked to consider, the

GWMH was effectively a cottage hospital which would receive patients who required longer term or rehabilitative care. Prior to the period we are considering the GWMH had been spread around a number of sites, but by the relevant time period it was centred in a single building.

4. It was a community hospital and did not have an acute ward nor any emergency facilities. Originally palliative care patients or those terminally ill were cared for in part of the Gosport War Memorial Hospital (GWMH) called the Redcliffe Annex which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own, it was closed in 1995 and all of their patients were sent to Dryad Ward which was one of three wards at the GWMH. The other two elderly care wards being called Daedalus and Sultan Ward.

5. Emergencies arising on the wards of the Gosport War Memorial Hospital would have to be transferred by ambulance to one of the local hospitals where emergency treatment could be provided.

6. Dr Barton was a local GP practising in Gosport in Hampshire. She qualified at Oxford University in 1972 as a Bachelor of Medicine and a Bachelor of Chemistry. She became a GP, initially as an assistant and then as a partner. In 1980 she was appointed to the General Practitioner medical staff at the GWMH (see - Samuel) and in 1988 she applied for and was appointed to the post of Clinical Assistant at the Gosport War Memorial Hospital. The period of her employment there upon which this case will focus was between 1996 and 1999.

7. During her period at the hospital she continued in her full time post as a GP doing morning surgeries every day and evening surgeries on a rota basis with her other GP partners. She was also doing one night a fortnight on call and one weekend on call in four (police statement of Dr Barton re: Gladys Richards).

8. Dr Barton had not specialised in either Geriatric or Palliative medicine and had no specific training of which we are aware other than her experience over the years. Dr Barton's main job was as a GP in a local Gosport practice. She would conduct ward rounds at GWMH as a general rule between 7.30 and 8 a.m. Monday to Friday on a daily basis (Barrett). She would also, according to the witness Philip Beed and according to the statement Dr Barton made subsequently to the police, attend at midday to clerk any new admissions. She would be fairly reliant on nursing staff to flag up any problems and would not necessarily see every patient every day (Beed, Interview 7/25).

9. There are two wards at the GWMH to which all of the twelve patients upon whom we are focussing were admitted.

10. Dryad Ward which was an elderly care ward consisted of 20 beds.

11. Daedalus Ward was a 24 bed ward. 8 of those beds were for slow stream stroke patients and the remaining beds were for the continuing care of elderly patients. Many of the patients admitted to these wards were expected to be rehabilitated sufficiently so that they could either return home or to care homes. This was not a hospice although of course some patients were very ill and inevitably were not going to leave hospital.

12. Additionally GWMH had an old age psychiatric ward by the name of Mulberry.

13. Dr Barton appears to have developed a practice on the two wards Dryad and Daedalus, of prescribing large quantities of opiates on an 'in-case' or, as she called it, an 'anticipatory' basis. 'In case' the patient found themselves to be in pain or 'in case' the patient's pain was uncontrolled by the opiates already given, or in case Dr Barton was away or it was a weekend. Many of the patients you are going to hear about were opiate naïve, in other words, until they set foot inside the GWMH, they had never been given opiates as a form of pain relief. In the view of the GMC expert Professor Ford none of the patients, about whom you are going to hear, were properly and appropriately prescribed opiates by Dr Barton.

14. There was a series of failures which led to patients being over medicated and unnecessarily anaesthetised. The failures included a lack of proper assessment before opiates were prescribed and a wholly irresponsible method of prescribing opiates. There was an almost universal failure by Dr Barton to make proper notes either of assessment of the patients if such assessments were taking place or to justify her actions in prescribing opiates. Frequently opiate medication was increased with no explanation noted.

15. The favoured method of prescribing to these patients was to provide for a variable dose of the drugs Diamorphine and Midazolam which were to be administered by way of syringe driver. The dose range prescribed by Dr Barton was, in each case that you are going to consider, far too wide and breached acceptable medical practice.

16. Prior to the syringe driver being administered many of the patients were unnecessarily prescribed oral morphine in the form of liquid morphine called 'Oramorph' or slow release Morphine tablets (MSTs).

17. Philip Beed one of the nurses and Clinical Manager of Daedalus Ward puts it in this way (police interview p.28/37) – "it's the nursing staff who really have the full picture of how a patient has been and then we would discuss and talk about how we would do it with the medical staff making decisions about care. We would call a doctor if we needed to, but we would have discussed the patient's ongoing care and prognosis on each occasion we saw the doctor so we are empowered to initiate a syringe driver. The syringe driver would be written up and the instruction would be 'if this patient's condition worsens you can utilise the syringe driver to keep that patient pain free'". There appears therefore to have been considerable discretion left with the nursing staff as to commencement of the syringe drivers and the quantity of opiate to administer.

18. When the patients became agitated they were then administered increasing quantities of Diamorphine and Midazolam by the nurses under Dr Barton's prescriptions, until they were agitated no more. Many of the patients who are described in the nursing notes as 'calm and peaceful' were, in fact, according to Professor Ford, in 'drug induced comas'.

19. Professor Ford is the Professor of Pharmacology of old Age at the University of Newcastle upon Tyne and practices as a consultant Physician in clinical Pharmacology at the Freeman Hospital. He is the co-editor of Drugs and the Older Population published in July 2000.

20. He has examined each of the cases which we have placed before you and he is highly critical of Dr Barton's practice in terms of her prescribing, her lack of assessment of patients and her failure to make relevant and necessary notes.

21. Dr Barton may claim that she was entitled to rely on the experience of the nurses when prescribing the huge quantities of Diamorphine and Midazolam which she did. She may say that she was entitled to rely on the nurses not to provide the medication which she was prescribing unless it was necessary. However, there was a lack of a proper system to ensure that patients were not overmedicated and in the view of Professor Ford, over-medication was a frequent and recurring problem. Dr Barton effectively delegated responsibility for her patients in relation to the administration of opiates to the care of the nurses and there were frequent occasions when the nurses went on to use those prescriptions inappropriately.

22. As she said in her police statement – "on a day to day basis mine was the only medical input".

CONSULTANTS

23. There were three consultants who had duties in relation to these two wards. The wards were visited on a weekly basis by one consultant or the other. However in general they were reliant upon what they were told about the patient by Dr Barton.

24. The consultants were Dr Tandy, Dr Reid and Dr Lord. None of them saw the patients more than once a week on the wards and the day to day control was left to Dr Barton and her nursing staff. Dr Tandy was away on maternity leave from April 1998 until February 1999 and her post was not filled by a locum.

25. **Dr Jane Tandy** was a Consultant Geriatrician at the Queen Alexandra Hospital Portsmouth who was ostensibly responsible for Dryad Ward at GWMH as consultant from 1994. She was away on sick leave for a month from 11 July to 12 August 1996 and again from 16 September to 22 November. From the 23 November 1996 to 1 September 1997 she went on maternity leave. When she was there she carried out a ward round once every two weeks on Wednesdays. She was only there during the period when patients A and B were on the ward and would have left by the time patient C arrived.

26. She describes Dr Barton as more experienced than her in long term and palliative care.

27. **Dr Reid** was based at the Queen Alexandra Hospital in Portsmouth. He was a consultant Geriatrician. He carried out one session a week at the Dolphin Day Hospital and from February 1999 was the consultant in

charge of Dryad Ward. He was in post at the times that Patient I, J and K were admitted to Dryad Ward.

28. He would carry out a ward round on Monday afternoon. On alternate weeks Dr Barton would accompany him. He would therefore only see her once a fortnight. He was not aware that Dr Barton was writing up prescriptions for patients with a variable dose in advance of them complaining of pain. He spoke to her on one occasion about a variable dose he saw and appears to have accepted her explanation.

29. He was aware that Dr Barton was working very hard and believed that without her GWMH would not have been able to function.

30. **Dr Lord** would carry out a consultant ward-round once a week alternating between Dryad and Daedalus (Beed).

31. She is in New Zealand and careful consideration has been given as to whether she should be called as a witness. A review of the notes of the twelve patients with whom you are specifically concerned reveals that although she provided medical services to a number of them prior to their transfer to the GWMH her input post transfer was very limited indeed. She had no role in the prescribing treatment at GWMH for Patients A, B, E, F, H, I, J, K or L.

32. Her role in relation to patients C, D, G was very limited as you will hear and is in any event revealed by the notes. In the circumstances it has been decided that she will not be called by the GMC.

33. Dr Barton may say she was overworked and under pressure and if that is shown to be true, that may be some mitigation for what occurred, but it

does not provide a defence for some of the practices which built up and which were directly contrary to Good Medical Practice.

34. In due course Dr Barton did resign apparently because of the pressures of work but there was unfortunately quite clearly a period of time under her management when her patients were receiving very substandard care.

THE DRUGS + PROTOCOLS

35. Of the drugs that you will be hearing about there are four which are central to this case: Oramorph, Diamorphine, Midazolam and Hyoscine.

36. Oramorph is an oral solution of Morphine. It is suitable to be given as an opiate where the patient is able to swallow. It has the effect of depressing respiration and causing hypotension. It should be avoided for acute alcoholics.

37. Diamorphine, as you will know, is what drugs users call 'Heroin'. It is a powerful opioid analgesic and is given via syringe. Apart from removing the sensation of pain it has a depressive effect on the vital functions and frequently causes nausea and vomiting. Its use should be avoided in the case of acute alcoholism. Great care has to be taken when exchanging oral morphine for subcutaneously delivered Diamorphine. The dosage delivered subcutaneously should, according to the BNF, be one third to one half of the oral dose of Morphine. So an oral dose of 30 mgs Morphine over 24 hours should be replaced by a dose of 10-15 mgs as a subcutaneous infusion over 24 hours (Ford).

38. Midazolam is a sedative and anti-epileptic and said to be suitable for the very restless patient. It can be mixed in a syringe driver with Diamorphine. Midazolam can cause respiratory and cardiovascular depression, hypotension and ultimately death.

39. Hyoscine has the effect of reducing salivary and respiratory excretions. In the elderly particularly it can cause drowsiness.

40. Specific advice is given in the BNF (File 1 Tab 3 page 7) that dosages for elderly patients should generally be substantially lower than for younger patients. Doses should generally start with 50% less than the normal adult dose.

41. Drugs may be prescribed 'PRN' (pro re nata) or 'as the occasion arises' or 'as required'. This can be appropriate and is often used but it is important to provide clear instructions as to what event will trigger the use of the drug.

42. The 'analgesic ladder' is a phrase which will crop up in the course of this hearing. It describes the simple concept which you are entreated to apply at the sanction stage of a FTP case. In other words you should consider the lowest sanction first. The analgesic ladder provides, in a similar way, that drugs are classified into three groups depending on the severity of the pain that they are intended to meet. The starting point is non-opioid analgesics such as aspirin, paracetemol and Ibuprofen. Next there are more potent anti-inflammatory drugs such as Diclofenac and Codeine. Except in an emergency, which did not arise in any of the cases you will consider, it is only for patients for whom those first two stages have

proved ineffective to control their pain that Morphine and Diamorphine are recommended. The lowest starting dose should be used at the commencement of pain relief and increased if necessary by 50% on subsequent occasions.

43. You will hear reference to a document called the 'Wessex Protocol'. This is also known as the Palliative Care Handbook (File 1 Tab 4). This sets out guidance as to best practice when applying a palliative care regime. That means a medical regime to ensure that the patient is comfortable and pain free when their illness is no longer responsive to potentially curative treatment. In other words, when it is recognised that the patient is dying and can not or should not be saved by medical intervention.

44. One of the issues in the case is whether the nurses were in fact following the guidance given and whether in respect of certain patients the decision was taken inappropriately to treat patients under a palliative regime as opposed to a curative regime.

NURSES

45. The GMC proposes to call a number of the nurses who cared for the patients and who administered doses of Diamorphine and Midazolam of which criticism is on occasion made. Many of the nurses who worked on the relevant wards can remember nothing beyond the notes that they made and it has not been thought necessary or relevant to parade those nurses before you. Some of the nurses do have recollection of the patients or the practices at the hospital and will be called by the GMC. Many are likely to

be highly supportive of Dr Barton with whom they worked over many years.

46. The Panel will have to be alert when listening to the evidence of those nurse witnesses to guard against biased or self serving evidence.

47. Lynne Barrett by way of example was a senior and experienced nurse who worked at GWMH from the late 1980s. She had no concerns about the use of syringe drivers nor the quantities of drugs that were being prescribed by Dr Barton. She takes the view that as a result of the issues raised at GWMH, patients will not now get the pain relief that they need. She feels that Dr Barton is being used as a scapegoat. You will need to assess that evidence, but it is called so as to provide you with as complete a picture as possible. Some nurses we are not calling if in the GMC's view they are so biased as to be not capable of belief. If the defence wish to call them then that is a matter for them.

48. Sister Hamblin was the clinical manager and Ward sister and it is clear from a substantial body of evidence that she was a formidable person who effectively ran the wards in Dr Barton's absence. She is too unwell to be called to give evidence and the GMC have taken the view that it would not be appropriate to rely upon her evidence in statement form.

49. Freda Shaw takes the simple line that 'syringe drivers were always used correctly and only when necessary'.

50. Other nurses have expressed concern about the extent to which both Diamorphine and syringe drivers were used on the wards. Some nurses speak about the use of Diamorphine without adopting the analgesic ladder

first. They speak of the considerable trust that Dr Barton appears to have placed in Gill Hamblin (see Carol Ball) and concerns appear to have been raised back in the early 1990s.

51. For a period Dr Barton had worked on the Redcliffe Annex prior to the transfer. Nurse Tubritt remembers that once she started the ward was better organised and syringe drivers were introduced at around that time. It was prior to the transfer to Dryad and Daedalus that nurse Tubritt remembers concerns being raised in the early 1990s about the use of Syringe Drivers and the quantity of Diamorphine being used.

52. Meetings were held between nurses and management and Dr Barton attended at least one of those meetings. Unfortunately although there were calls for a formal written policy on the use of Diamorphine and Syringe drivers no such policy appears ever to have been produced (See Exhibits to Turnbull's GMC statement in Bundle 1 Tab 6).

53. Nurse Turnbull was similarly concerned and certainly initially she was worried that the analgesic ladder was not being used appropriately. However her view once the ward was moved to become Dryad Ward, was that the culture did change and that syringe drivers were only used when needed.

54. Nurse Turnbull does however reflect in her evidence that the regime allowed the Nurse in Charge to increase the dosage of drugs at their discretion provided it was kept within the parameters set by Dr Barton. Those parameters were however set very wide indeed.

55. Meetings were held and fears apparently therefore were allayed. It will be a matter for the Panel to consider whether the concerns should in fact have continued and whether or not they had been addressed by a real change of culture.

56. Phillip Beed was the manager of Daedalus Ward from 1998. He describes how Dr Barton would attend the ward at 9 am every morning and carry out a review of the patients. He is very supportive of Dr Barton and had no concerns about her. It was a very busy ward according to Mr Beed.

57. Nurse Giffin remembers concerns about syringe drivers being raised in the early 1990s and there were meetings with Dr Barton and hospital management about their excessive use. Nurse Giffin appears eventually to have stopped complaining about what was going on and continued working with the others although in her view things did not in fact improve.

58. Ms Shirley Hallman was a senior nurse and only one grade lower than Gill Hamblin. She did not start work at the GWMH until 1998. She was new to palliative care and had a difficult working relationship with Ms Hamblin. She ran the ward when Nurse Hamblin was on leave or away. She describes Nurse Hamblin as an excellent nurse but 'her word was law'.

59. She did not feel that the analgesic ladder was appropriately adhered to. She describes how on Dryad it had become standard practice to double the dosage if it was deemed that the patient needed a higher dosage of opiates.

60. She was troubled by the fact that it appeared that Dr Barton would prescribe opiates and then hand the responsibility over to the nurses.

61. The GMC will call a number of nurses and you will have to analyse their evidence carefully. Some of the evidence may be founded on self protection or even upon a misguided loyalty. What may matter to your inquiry however is the evidence which actually supports the administration of opiates or in many cases, the lack of evidence as to why opiates were in fact administered or increased.

NOTE KEEPING

62. One of the allegations which is made in respect of every patient relates to the very poor quality of the notes kept by Dr Barton. In the cases you will be looking at there was a lack of a proper note of the first assessment by Dr Barton and a lack of reassessment notes or a proper diagnosis or treatment plan. The administration of Opiates was regularly increased with only a nurse's note to show it.

63. Dr Barton's explanation to the police was, in short, that she was too busy to make a note and that she had to decide whether to look after the patients or make notes about it.

64. She said this in one of her statements – "I was left with the choice of attending my patients and making notes as best I could or making more detailed notes about those I did see but potentially neglecting other patients" (see for example Dr Barton's generic statement and her statement re: Arthur Cunningham). The GMC does not accept that to be a

legitimate approach. Unless a proper note is made assessing the patient on admission and when there are significant changes in their state of health, then it is very likely that the treatment of that patient will be adversely effected.

65. There will be no baseline or benchmark from which to work. Other medical staff will not know what the finding and diagnosis was. The treating doctor may not remember what the state of health of the patient was when first assessed. Nursing staff will not be able to track the patient's progress nor will they know the appropriateness or not of administering analgesia. Nursing staff may not appreciate when a patient is opiate naïve nor might they understand the significance of that in setting the first dose.

66. Good notes are a critical element in the patient's care and in this case the notes were terribly inadequate and that may have led in some cases to failures in patient care.

BUNDLES AND PAPERS

67. Before turning to the individual patients let me introduce some of the paperwork you will be receiving. There are individual files for each of the twelve patients. We have put into each file only those documents which we think are immediately relevant to your consideration but we have all of the patient notes available should more documents become relevant. These are working files. We have retained the original pagination but at the front of each file you will find a chronology prepared by Mr Fitzgerald

which relates to the most important features of that patient's care and which follows the care afforded to each patient as shown in the notes. The original records are much larger and we have made efforts to restrict the amount of documentation that you need to see. If at any stage you feel the need to see more, or if either side wish to add to the material, then that can be done during the course of the hearing.

68. There are several further files. One is a file containing all of Professor Ford's reports. *[We are going to provide you with those in advance of his evidence and we would invite you to read his report in advance of hearing from the witnesses who we intend to call in relation to each patient. That will give you the context of the witnesses' evidence and highlight the issues which you may want to consider when you hear from the witnesses. It will mean that if anything occurs to you, to be of potential relevance during the course of the evidence of the witnesses themselves, you will be enabled to put the relevant question at the appropriate point in the evidence].*

69. A further file contains miscellaneous material which is called Panel Bundle 1.

70. A final file contains the statements produced by Dr Barton when questioned by the police. There have been a number of investigations into what went on at this hospital. There was a substantial police investigation as well as an investigation by the CHI. When Dr Barton was interviewed by the police she made no answer to the many hours of questions which were put to her about what had happened within these two wards. Instead, Dr Barton chose to draft a series of statements which she provided to the police in advance of her interviews. Those statements are self serving in

the sense that they are drafted by Dr Barton or by her lawyers and they were never tested under questioning by a police officer. Nevertheless, it is proposed that you should receive those statements as her account at the time of her actions. They must be regarded as self serving statements and we will have to wait and see whether or not Dr Barton chooses to give evidence so that she can be tested upon her account.

71. Most recently there was a coroner's inquest which looked into the deaths of a number of the patients. There was a degree of publicity about that inquiry and again if you heard anything about that through the press or internet you no doubt well understand that you should ignore anything you have previously heard. All that matters so far as your consideration of these charges is concerned is the evidence you now hear put before you by both sides. The findings of those other hearings and inquiries are at this stage irrelevant to your considerations except in so far as you may hear witnesses being cross-examined upon the evidence that they may have given previously in the course of other enquiries.

Patient A – Leslie Pittock (January 1996)

72. The first patient with whom you are concerned is patient A (Leslie Pittock). He was 82 years old when he was admitted on **5th January 1996** to the GWMH to Dryad Ward. He had previously been admitted to Mulberry Ward on the **13th December 1995** which was a psychiatric ward within the GWMH where he was under the care of Dr Banks. He suffered from depression and mobility problems.

73. He was verbally aggressive and was not mobilising well. Following his admission he developed a chest infection.

74. On the **3rd and 4th January** he had been assessed first by Dr Banks and then by Dr Lord who recorded that he was completely dependent upon nursing case, he had a urinary catheter in place, an ulceration on his left buttock and hip and low protein in his blood. Dr Lord indicated that she would transfer him to the GWMH to a long stay bed. It was thought to be unlikely that he would return to a residential care home. He was noted to be very depressed.

75. His daughter Lynda Wiles commented that she felt he had lost the will to live.

76. He was transferred on Friday **5th January 1996** to the GWMH to Dryad Ward where Dr Barton made a short entry – p.196. "Transfer to Dryad Ward from Mulberry. Present problems immobility, depression, broken sacrum small superficial areas on right buttock. Ankle dry lesion, both heels suspect. Catheterised. Transfers with hoist. May need help to feed himself long standing depression on lithium and sertraline".

77. On Tueday **9th** January Dr Barton noted that the patient's right hand was painful and he had increased anxiety and agitation.

78. Dr Tandy made an entry on **10th January** that the patient was for 'TLC' Tender Loving Care. She appears to have seen the patient prior to the administration of prescription of Oramorph later that day. That was during a ward round with Dr Barton and Nurse Hamblin.

79. At p.200 the drug chart indicates that Dr Barton prescribed Oramorph 5 mgs 5 times a day on **10th January**. There is also an undated prescription for between 40-80 mgs Diamorphine to be given over a 24 hr period subcutaneously. It is likely that that prescription was written out on the **10th** January at the same time as the Oramorph prescription because it appears to have been superseded the following day on the **11th January** when Dr Barton wrote another prescription for Diamorphine, but this time for a variable dose between 80-120 mgs to be delivered Sub-Cutaneously (SC) together with Midazolam 40-80 mgs. Dr Barton describes her first prescription for opiates by syringe driver as a 'proactive' one.

80. Two doses of oral morphine appear to have been administered on the day they were prescribed ie: the **10th** , and that became the regular prescription for the next five days.

81. Of the higher prescription on the 11th January Dr Barton says this – " I would have been concerned that although it was not necessary to administer the medication at that stage, (the patient's) pain anxiety and distress might develop significantly and that appropriate medication should be available".

82. According to Professor Ford the prescription on the **11th January** for a variable dose of Diamorphine of 80-120 mgs was poor practice and potentially hazardous and the lowest dose was still inappropriately high because it amounted to a four-fold increase on the opiate dose she was already receiving orally. His view is effectively the same so far as the Midazolam is concerned. The prescriptions ran a high risk of producing respiratory depression and potentially coma.

83. No Diamorphine was in fact administered until Monday the **15th January** when it was started at a rate of 80 mgs over a 24 hour period. Midazolam at 60 mgs over a 24 hour period was started at the same time. The only note that appears to give any justification for that medication was a nursing note that the patient 'appeared agitated'. That was a four-fold increase as compared to the oral dose which he had been receiving. Dr Barton claims she would have seen the patient on that Monday but made no note about it. She says – "I believe, I may have been told that his condition had deteriorated considerably over the weekend". "I believe my assessment of his condition at this time was that he was in terminal decline".

84. There is a note in the nursing record (p.208) for the **15th January** which simply states – 'S/B Dr Barton, has commenced syringe driver at 08.25'.

85. The dose of Midazolam, both that prescribed by Dr Barton and that administered by the nurses was excessively high. An appropriate starting dose for a frail older man, if an SC dose was justified at all would have been in the region of 10 mgs over a 24 hour period rather than a range of 40-80 as prescribed and 60 mgs as administered particularly in light of the fact that Diamorphine was started at the same time.

86. The lowest dose of Diamorphine prescribed and administered (which was unnecessary in the first place) was also far too high given that the patient had, until that point, been on only 30 mgs morphine orally per 24 hours on the **14th January**. The equivalent dose, even if necessary, should have been one of around 15-20 mgs going up to 30 mgs if the patient was sill in pain. The Midazolam was also according to Professor Ford excessively high. There was no explanation for it in the notes and no assessment to justify it.

87. On the **16th** Dr Barton added Haloperidol to the mix. A nursing note (p.26) records that the patient was agitated but that may have been a reaction to the Morphine he was being administered. There should at least have been a reassessment.

88. Apparently on the 18th but it may have in fact been on the **17th** Dr Barton again increased the dose of Diamorphine to 120 mgs and Midazolam to 80 mgs. Those doses were given from the 17th onwards. Dr Barton says that the increases were made on the 17th because the patient was tense and agitated. The nursing record for the 17th indicates (p.210) "S/B Dr Barton, medication increased as patient remains tense and agitated… remains distressed on turning".

89. Although the <u>oral</u> morphine prescribed by Dr Barton may have been justified by reason of the pressure sores from which the patient was suffering, there is nothing else in the notes to reflect why such a dramatic increase in the use of opiates was thought to be necessary by Dr Barton. The patient was not noted to be in any particular pain although he was agitated at times.

90. No clinical assessment seems to have been conducted before the prescriptions for the use of major opiates were issued. The high point so far as an assessment is concerned is that the nursing notes on **17.1.96** (p.210) indicate – 's/b Dr Barton, Medication reviewed and altered.'

91. On the **18th** January there is noted by Dr Barton –'further deterioration, sc analgesia continues, difficulty controlling symptoms, try Nozinan'.

92. On the **18th January** Dr Barton prescribed a new drug – Nozinan at 50 mgs. Nozinan is a sedating drug used to control terminal restlessness and agitation. A note the previous day on the 17th made prior to administration of that drug recorded that the patient appeared to be 'more peaceful' (p.210) and it is difficult to see what the justification was for adding another sedative to the potent mix that the patient was already receiving.

93. On Saturday **20th January** there is a medical note (p.198) that Dr Briggs was consulted (presumably because Dr Barton was not available over the weekend) and that the Nozinan was to be increased from 50 mgs to 100 mgs and Haloperidol was to be stopped on the verbal order of Dr Briggs. He did not attend the patient and this appears to have been done over the telephone. His reason for doing so was that Staff Nurse Douglas expressed a suspicion that the Haloperidol may be causing a side effect and he was concerned about the interaction of the drugs which the patient had been prescribed.

94. Between the 17th and 23rd January the daily syringe driver was filled with 120 mgs Diamorphine and 80 mgs Midazolam.

95. These drugs in conjunction with one another and with Haloperidol which the patient was also prescribed by Dr Barton, carried a high risk of producing coma and respiratory depression.

96. The patient died four days after the 20th on the **24th January 1996**.

97. Dr Barton may well claim that she was performing regular assessments but if that is so then she made no note of them and it is difficult to see how she could assess the needs of the patient on subsequent occasions when she had no assessment baseline from which to work. An assessment with no notes is clinically fairly pointless for the purposes of the future management of the patient.

98. Professor Ford is very critical of the note keeping in relation to the drug charts as well. At one stage there were three active prescriptions for Diamorphine which was extremely hazardous and in addition there were two actively running prescriptions for Haloperidol which put the patient at risk of coma had they been administered.

99. The infusions of Diamorphine, Midazolam and Haloperidol and then Nozinan very likely led to respiratory depression and shortened Patient A's life although he was expected to die in the near future.

Patient B – Elsie Lavender (February 1996)

100. Patient B was born in Code A and was 83 years old when she was admitted to the Royal Hospital Haslar on **5th February 1996** following a fall at home where she lived alone. She was registered blind. She was X rayed and no bony injury was found but there was concern that she might have suffered a CVA (Cerebral Vascular Accident or stroke). She had pain in her left shoulder and abdominal pain.

101. According to her son Alan, she made very good progress at the Haslar and was, by the time she moved to the GWMH, talking coherently and understanding what was being said to her. She was also mobile with a stick.

102. Some weeks after her accident, on the **22nd February,** she was transferred to the GWMH Daedalus Ward for rehabilitation and hopefully for return to a rest home. She died two weeks later on the 6th March.

103. Upon transfer she was seen by Dr Barton (p.175) on the **22nd** who noted that the patient had leg ulcers, was incontinent of urine, and suffered from insulin dependent diabetes Mellitus. She prescribed Dihydrocodeine which is a powerful synthetic opioid pain-killer on the second level of the Analgesic ladder.

104. Professor Ford notes that there was no assessment of the patient's pain nor of her neurological function. There should have been a clinical review but there was not, or at least none that was properly noted. The patient's son Alan recalls Dr Barton telling him that his mother had come to the hospital to die. He was surprised as that had not been his understanding.

105. On the **24th** there is a nursing note that the patient's pain was not being controlled by DF118 (DHC) and she had a sacral sore. She was commenced by Dr Barton on Morphine 10 mgs twice daily (p.1021).

106. Two days later on the **26th** Dr Barton noted that the patient's bottom was very sore and needed a Pegasus mattress. 'Institute SC analgesia as necessary'. She wrote out prescriptions that day for Morphine MST (Morphine Sustained Release tablets) at 20 mgs twice daily, and Diamorphine at a variable dose as required of 80-160 mgs, 40 – 80 mgs Midazolam and 400-800 Mcgs Hyoscine. None of those medicines were in fact administered. In respect of those prescriptions however Professor Ford is very critical. He describes them as 'not justified, reckless and potentially highly dangerous' (para 11). Even the lowest dose of Diamorphine would have amounted to a four-fold increase in opiates.

107. Dr Barton's explanation in her police statement was that this was 'pro-active' prescribing for pain relief, in case the patient experienced uncontrolled pain. She claims that she would have seen the patient on the 28th, 29th February and 1st March but appears to have made no note about those assessments whatever. The 2nd and 3rd March was the weekend.

108. On Monday **4th March** the notes record that Dr Barton increased the MST prescription from 20 mgs twice daily to 30 mgs twice daily.

109. Dr Barton's next entry was on the **5th March** when she noted that the patient had deteriorated and was not eating or drinking (p.975). She noted that the patient was in 'some pain, therefore start SC analgesia'. A nursing note records that the patient's pain was uncontrolled and the patient was

distressed (p.1013, 1022). Nurse Couchman, whose note that was, explains that she would have been relying on the night staff in order to make that entry and the dose was authorised by Dr Barton.

110. The syringe driver was commenced by the nurses at 09:30 that day with Diamorphine at 100 mgs and Midazolam at 40 mgs over a 24 hour period (p.1022) which doses were allowed for by Dr Barton's prescription for Diamorphine of between 100-200 mgs over a 24 hour period. Her prescription of Midazolam was between 40-80 mgs over 24 hours. Dr Barton (police statement) says that that this was necessary to relieve the patient's pain and distress.

111. An equivalent dose to that which the patient was already receiving orally but to be given S/C would have been in the range of between 20-30 mgs per 24 hours. So, even though the nurses were in fact starting at the minimum dose prescribed by Dr Barton even that was over three times greater than her previous equivalent dose of opiates. If the intention was to control the patient's pain by increasing the dose then a 50% increase at most might have been appropriate. Professor Ford describes the prescribing by Dr Barton as 'reckless and dangerous' (para 13).

112. The following day **6th March** Dr Barton noted that the SC analgesia had commenced and the patient was now comfortable and peaceful, she also wrote: 'I am happy for nursing staff to confirm death'. A nursing note (p.1023) says that the patient was seen by Dr Barton that day and the medication other than through the Syringe Driver was discontinued as the patient was unrousable.

113. Professor Ford states that the description of the patient as being comfortable and peaceful was more likely to reflect the reality that the patient was by that stage in a drug induced coma (para 14).

114. At 9.28 pm that evening the patient died. In Professor Ford's view the administration of the sub-cut Diamorphine and Midazolam led to patient B's deterioration and contributed to her death.

115. In respect of each patient Dr Barton is charged with prescribing drugs in such a way as to create a situation whereby the patient could be administered drugs which were excessive to their needs and that such prescribing was inappropriate, potentially hazardous and not in the patient's best interests. It may be thought to be relevant specifically to those charges that there is evidence that in some of these cases excessive drugs were indeed administered and that the hazard did indeed arise.

116. Additionally in Professor Ford's view, when the patient's condition deteriorated there was a duty upon Dr Barton to consult with her consultant colleagues as to the best approach to future treatment.

Patient C – (Eva Page) (February 1998)

117. Patient C was 87 years old when she was admitted on **6th February 1998** to the Queen Alexandra hospital having experienced a general deterioration over a five day period and was complaining of nausea and a reduced appetite. A suspected malignant mass was seen in her chest and the notes recorded on 12th February that she should be managed with palliative care on Charles Ward to which she was transferred on the **19th February**.

118. On the 23rd February she was diagnosed as being depressed and suffering from possible carcinoma of the Bronchus, Ischeamic heart disease, and congestive heart failure. She was plainly not at all well but she does not appear to have been in any pain.

119. She was transferred to GWMH on 27th February 1998, according to Dr Barton's note 'for continuing care'. Her Barthel score was zero to 2 which meant she needed help with all of her basic bodily functions. The Barthel scoring system is a method of assessing a patients ability to cope with their daily living requirements (an example of which appears in Bundle 1 Tab). A Barthel score of 20 would indicate that the patient was fully competent in all daily living requirements, a score of 0 indicates that help is needed with all activities.

120. A note made by Dr Laing (the duty GP) on 28th February records that she was 'confused and felt lost' but was not in any pain. She was distressed however and she was given Thioridazine and a small dose of Oramorph (2.5mgs) to help her.

121. On 2nd March Dr Barton suggested the use of adequate Opioids to control fear and pain. A Fentanyl 25 microgram patch was started that day as well as a small amount of Diamorphine 5mgs given by injection. Fentanyl is a very powerful synthetic opioid which comes on a patch which can be applied to the skin. It is particularly useful in circumstances where it is difficult to inject the patient. By its nature its effect is less immediate but may be longer lasting and the effects remain long after the patch is removed.

122. That patch was the equivalent, according to Professor Ford, of a 90 mg oral dose. All of those drug prescriptions up to this point are approved of by Professor Ford who regards them to have been a reasonable response to the patient's anxiety despite the lack of pain although the Fentanyl patch is very likely to have caused the patient to become very drowsy.

123. On 3rd March a rapid deterioration in the patient's condition is recorded with her neck and both sides of her body rigid. That same day Dr Barton prescribed Diamorphine with a variable range from 20-200mgs daily and Midazolam at 20-80 mgs daily by syringe driver. There is no note that the Fentanyl patch was removed or directed to be removed at that time. That syringe driver was commenced at 10.50 hours with 20 mgs of each drug and 11 hours later at 9.30 pm she was pronounced dead.

124. Those prescriptions of Diamorphine and Midazolam were in Professor Ford's expert opinion not justified. Her deterioration on the 3rd could have been as a result either of a stroke or an adverse reaction to the Fentanyl patch. However there was no indication that the patient was at that stage in any pain. The drugs would be expected to result in depression of the

level of consciousness and respiratory depression. The prescriptions were not consistent with Good Medical Practice and the analgesic ladder was not followed.

Patient D - Alice Wilkie (August 1998)

125. Patient D was born in Code A and was 81 years old when she was admitted on **31st July 1998** from the Addenbrooke Rest Home to the Queen Alexandra Hospital Portsmouth Philip Ward which was within the department for elderly medicine. She had had a fall and was refusing fluids. She was severely dependent and had a 0 mental test score when she was transferred to GWMH Daedalus Ward on **6th August 1998**. The nursing notes reveal that she was for 'assessment and observation and then decide on placement'. A further note reveals – 'pain at times, unable to ascertain where'.

126. Dr Lord assessed the patient on **10th August 1998** – 'Barthel 2/20, eating and drinking better, confused and slow. Give up place at Addenbrookes. Review in one month. If no specialist medical or nursing problems discharge to a new home'. (Probably this would have meant a continuing care bed within the NHS).

127. An entry on **17th August** in the nursing notes records that there had been a deterioration over the weekend and the patient's daughter had agreed that active intervention was not appropriate'. 'To use syringe driver if patient is in pain'.

128. There is in the notes an undated prescription written by Dr Barton for a variable dose of between 20-200 mgs of Diamorphine and 20-80 mgs of Midazolam per 24 hours and by syringe driver. That prescription must have been written on or before the 20th when a syringe driver was started.

129. On **20th** the syringe driver was started with 30 mgs Diamorphine and 20 mgs of Midazolam. Prior to that point this patient had not been receiving any analgesic drugs but her daughter Marylyn Jackson who visited her that day did notice that she appeared to be in pain. In this case it is difficult to see how the analgesic ladder was being applied.

130. The next entry in the notes by a doctor is on the **21st August** by Dr Barton – 'marked deterioration over the last few days. SC analgesia commenced yesterday, Family aware and happy'. A nursing note of the same day records that the patient is 'comfortable and pain free'.

131. At 6.30 pm that day the patient's death was confirmed.

132. In Professor Ford's opinion there was nothing to justify the use of a syringe driver in this case, there being no record of specific pain. Even if there were such a record, milder analgesics could and should have been tried first. A medical assessment was required before prescribing those drugs when the deterioration was apparent.

133. The variable range prescribed by Dr Barton was poor practice, very hazardous and in Professor Ford's view unjustified.

134. So far as the notes are concerned in Professor Ford's view the only acceptable medical note was that made by Dr Lord on 10th August during the entirety of the patient's stay at the GWMH.

Patient E - Gladys Richards (August 1998)

135. Patient E was born in Code A and she was 91 years old when she was admitted as an emergency via the A&E department at Haslar Hospital on **29th July 1998**. She had fallen on her right hip which was then painful. She was found to have a fractured neck of femur. Surgery by way of hip replacement was performed on the **30th July**.

136. On 3rd August she was seen by Dr Reid. He found her to be confused but pleasant and cooperative. He took the view that despite her dementia she should be given the opportunity to be remobilised and with that in mind he organised her transfer to GWMH.

137. Between that assessment and transfer on the 11th she had an episode on the **8th August** when she was recorded as being agitated and she was calmed down with Haloperidol and Thioridazine.

138. Her daughter Lesley O'Brien remembers that she made a good recovery after the operation and was soon up on her feet and walking with the use of a Zimmer frame.

139. On **11th August** she was transferred to Daedalus Ward at the GWMH. By this stage she was fully weight bearing and walking with the assistance of two nurses and she was continent but needed total care with washing and dressing. The purpose of her admission appears to have been rehabilitation.

140. Dr Barton's note on admission was – 'Impression frail hemi-arthroplasty, not obviously in pain, please make comfortable. Transfers with hoist,

usually continent, needs help with ADL (Activities of Daily Living) Barthel 2, I am happy for nursing staff to confirm death'.

141. Professor Ford describes this note as revealing a much less proactive not to say pessimistic attitude towards this patient's rehabilitation. Dr Barton's failure to recognise the patient's rehabilitation needs may have led to subsequent sub-optimum care for this unfortunate patient. Philip Beed also says that she was, in his view, in pain from her hip but that was not recorded at the time and the notes on the 12th (p.50) specifically state that the patient did not seem to be in pain.

142. Dr Barton wrote a prescription that day (the **11th**), effectively upon the patient's admission for a variable dose of between 20-200 mgs of Diamorphine together with 20 – 80 mgs Midazolam to be administered via a syringe driver. Very fortunately none of that prescription was in fact administered at that time though the Midazolam was administered at a later stage when the patient was re-admitted to the hospital.

143. She also prescribed Oramorphine 10 mgs on the 11th which was administered on the morning of the patient's admission. That prescription Professor Ford regards as inappropriate in the circumstances and may in fact have precipitated what followed.

144. The following night on the **12th** the patient was very agitated possibly as a result of her new surroundings but potentially also as a result of the commencement of opiate analgesia and she had to be settled with a dose of haloperidol. Philip Beed describes the patient as agitated and he ascribes pain as being the cause of that agitation but he does not appear to have

made a note to that effect. The patient's daughter Lesley visited her mother on the day after her admission, ie: on the 12th and was very surprised to find that her mother was unrouseable. She remembered that up until her transfer to GWMH her mother had been enjoying three meals a day.

145. On the **13th** she was found on the floor having fallen from her chair. That fall may well have caused a dislocation of her repaired hip and it certainly appears to have caused the patient pain. Her daughter Lesley remembers this being obvious and that her mother was weeping and calling out. The staff at the GWMH at first instance seem to have thought that this was as a result of the patient's dementia.

146. The following day on the **14th** the patient was assessed by Dr Barton who noted that sedation and pain relief had been a problem and that the patient was very sensitive to Oramorph. The patient was referred to the surgeons at Haslar again having been given a small amount of Oramorph and a further operation was undertaken. Again she appears to have recovered well from that operation and to have been treated well at the Haslar (Lesley O'Brien).

147. On the **17th** August she returned to the GWMH and the transfer unfortunately appears to have been performed inappropriately. She was transferred without the use of a canvas sheet which once again may have put too much pressure on her hip causing it further damage. The decision appears to have been taken not to send her back to the Haslar Hospital again.

148. On that day Dr Barton wrote out a further prescription for a variable dose of 40-200 mgs of Diamorphine. The patient was then dosed with 40 mgs of Diamorphine but at that stage, given the patient's pain Professor Ford takes the view that although high, the dose was not unreasonable.

149. On the **18th** she was recorded by Dr Barton as being 'in great pain' and was put onto a syringe driver on the direction of Dr Barton. She was dosed with 40 mgs Diamorphine, 20 mgs Midazolam and 5 mgs Haloperidol. That dosage continued until her death.

150. The expert's view is that Midazolam which had in fact been prescribed 7 days earlier on the 11th should not have been added to the cocktail of drugs because the combination of drugs was likely to lead to respiratory depression and coma. Dr Barton's explanation in her police statement was that it was used as a muscle relaxant to assist her movement and to make her as comfortable as possible.

151. On the 21st she was recorded by Dr Barton as being 'I think more peaceful, needs Hyoscine for rattly chest' and she died later that day.

152. The focus of the charges in respect of this patient is upon the original prescription by Dr Barton back on the 11th August of Diamorphine and Midazolam before the patient had her second fall and dislocated her hip. That prescription was say the GMC unjustified and dangerous and allowed for the administration of Midazolam to the patient at the end of her life of which Professor Ford is also critical.

153. Professor Ford is most critical of that early prescription where there was little or no indication that the patient was in pain at all. In the last days of

her life there are certainly indications that the patient was in pain and did require pain relief by opiates but there is a total lack of any suggestion that the patient was in pain when she first arrived at the hospital.

154. Indeed Dr Barton, when she was interviewed by the police indicated that the patient did not appear to be in pain. Immediately prior to her arrival at GWMH the patient had not been on regular analgesics at all and had last taken two tablets of cocodamol.

155. The expert is of the opinion that it was simply inappropriate to start the patient on opiate medication before trying milder analgesics.

156. The decision immediately to prescribe subcutaneous Diamorphine, Haloperidol and Midazolam was inappropriate, reckless and placed the patient at serious risk of respiratory depression and coma if they had been administered. The administration of the Midazolam in the last days of the patient's life when added to the other drugs was unjustified and inappropriate. That administration would appear to have been upon Dr Barton's direction and it was her prescription.

Patient F - Ruby Lake (August 1998)

157. Patient F was born in Code A and was 84 when she was admitted to Royal Hospital Haslar on **5th August 1998** for treatment for a fractured neck of femur following a fall at home. She was operated upon the same day and was transferred to GWMH two weeks later on **18th August to Dryad Ward**. One of her daughters Pauline Robinson who saw her on the weekend of the **15th and 16th** describes her as being 'very lucid' and 'up-beat'. She was mobile with a Zimmer frame on transfer and could wash her top half independently but suffered from leg ulcers, angina and breathlessness. She died three days after her admission on the **21st**.

158. Her Barthel score (p.373) was 9 and so she was able to wash and feed herself but needed help getting dressed and some help with walking.

159. Dr Barton's note on admission (p.78) recorded the history of the fall and her Barthel score of 6. Her note then reads 'gentle rehabilitation. I am happy for nursing staff to confirm death'. Nurse Hallman for one was surprised when she saw that annotation in this patient's notes. The patient was started on Oramorph and 5 mgs was given to her just after lunch at 14.15. The nursing notes record that the patient had two sacral pressure sores and ulcerated legs (Barrett xp.375).

160. That night the patient became anxious and distressed and wanted someone to sit with her – she was given 10 mgs of Oramorph instead. The following day on the **19th** at 11.50 Nurse Shaw describes how she administered the patient with Oramorph oral solution 10mgs in 5 mls.

That drug is of course a pain killer. The patient was complaining of chest pains which were not radiating down her arm.

161. In Nurse Shaw's words she was just continuing the prescription which had been started the night before, she was unable to comment on the pain that the patient was suffering. That may be an indication of the regime to which nurses had become used and which therefore they pursued without much thought.

162. In her police statement Dr Barton claims that she reviewed the patient on the morning of the 19th but made no note about it. She says that she was concerned that the patient was going to die shortly and wanted to be sure she had appropriate pain relief for the pain from her fractured hip and her sores and also from her anxiety and distress.

163. Either on the **18th** or more probably on the following morning **19th** , the day after Patient F's admission, Dr Barton prescribed her a variable dose of Diamorphine at a range of 20-200 mgs and Midazolam 20-80 mgs over a 24 hour period. The prescription is undated but we know was administered on the **19th** at 16:00 by Syringe Driver at 20 mgs together with Midazolam at 20 mgs. Nurse Hallman made an entry in the notes that the patient's pain was only being relieved for short periods and she was very anxious (xp.394).

164. On the **20th** the Diamorphine was increased in the afternoon to 40 mgs. Nurse Turnbull notes that the patient was still suffering some distress when moved. Her daughter Dianne Mussell went to visit her on the 20th,

she had been a regular visitor up until that point. She noted a marked deterioration in her mother's response.

165. A day later on the **21st** those drugs were increased to 60 mgs each at 07:35. Although Dr Barton says that she may have been unaware of that increase she would in any event have approved it. The patients **death was recorded at 18.25**

166. Professor Ford is critical of all of Dr Barton's prescriptions. On the night of the 18th it is unfortunate that the response of the staff to the patient's agitation was to provide her with a dose of Morphine when she simply wanted someone to sit with her. In the alternative a dose of Temazepam would have calmed the patient.

167. The lack of clear instructions as to what the morphine was to be used for may explain why it was given for distress and anxiety when there was no indication of pain. It is not an appropriate first line treatment for stress or anxiety, indeed morphine can in fact promote or exacerbate exactly those symptoms.

168. There is no indication from Dr B why she thought it right to prescribe either the Diamorphine or the Midazolam and there appears to have been no adequate assessment of the patient. If there was an assessment there was no note made of it.

169. The patient deteriorated rapidly after the commencement of the syringe driver and there was no medical assessment as to why that was happening. It may well have been due to the sedative effects of the opiates that were

being automatically injected into her body. The reaction to the patient's deterioration was to increase the quantities of opiates she was receiving.

170. It is likely that this patient died as a result of the combined effect of the drugs in her system.

Patient G – Cunningham (September 1998)

171. Patient G was 79 years old when he was admitted to GWMH Dryad Ward on **21st September 1998** under the care of Dr Lord the Consultant to whom he was known.

172. He had been admitted to Mulberry Ward on 21st July 1998 when he was depressed and tearful, and since the 27th August he had been living in a local nursing home 'The Thalassa'.

173. He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell where he was found to be very frail with a large necrotic sacral sore, he was depressed suffering from dementia and was diabetic. Dr Lord admitted him for treatment of his sacral ulcer, a high protein diet and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least 3 weeks. His prognosis was described as being 'poor'.

174. Dr Barton saw him on the day of his admission on the **21st** and made the following note (p.647) – 'Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for Nursing staff to confirm death'.

175. It appears that she prescribed Diamorphine at a variable dose of 40-200 mgs and Midazolam between 20-200 mgs on that very day. The prescription is undated (p.758) but it has to be presumed to be the 21st because he was, on the day of his admission, put onto a syringe driver delivering those opiates to him automatically. Dr Barton's explanation for her prescription (in her police statement dated 21.4.05) was that she was

concerned that the Oramorph might become inadequate in terms of pain relief.

176. The patient's step-son Charles Stewart-Farthing went to see him that day and found him to be cheerful but complaining that 'his behind was a bit sore'. He was started at a rate of 20 mgs Diamorphine and 20 mgs Midazolam on the **21st**, and according to Nurse Lloyd's notes (p.754) the other drugs he had been on Coproxamol and Senna were not given because the patient was being or about to be sedated. P.867 reveals the patient remained agitated until approximately 20.30. The notes reveal that the patient had been behaving pretty offensively However, the driver was not commenced until 23.10 that night when the patient is described as 'peaceful'. It is hard to glean therefore from the notes what caused the commencement of the syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

177. On the **23rd** that medication was increased to 20 mgs Diamorphine and 60 mgs Midazolam. A note (p.868) by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight and so Hyoscine was added to the driver. His stepson was informed of a deterioration and asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage which he needed. Charles Stewart Farthing saw his step-father again that day and was shocked at the difference in his condition. He found his step-father to be unconscious. He was so concerned that he asked for the syringe driver to be stopped so that he could have a conversation with the patient but this was denied.

178. He insisted on a meeting with Dr Barton who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton claims that she reassessed the patient on a daily basis but failed to make any notes about it. She refers to the doses the patient received as 'small and necessary'.

179. On the **24th** the Midazolam was increased to 80mgs and on the **25th** the Diamorphine was increased to 60 mgs. That followed a further prescription from Dr Barton dated the **25th** for a variable dose between 40-200 mgs Diamorphine and 20-200 mgs of Midazolam. On each occasion that the dose was increased Dr Barton claims in her police statement that she 'anticipates' (as she puts it) 'that the patient's agitation might have been increasing'.

180. The following day the **26th** , the Diamorphine was delivered to the patient's body at a rate of 80 mgs and the Midazolam at a rate of 100 mgs. The patient died that day at 23:15 of broncho-pneumonia.

181. The first prescriptions on the day of his admission by Dr Barton are described by Professor Ford as 'highly inappropriate' and 'reckless' particularly in light of Dr Lord's assessment that he should be prescribed intermittent Oramorphine if in pain (PRN). There is no doubt that the patient would have been in pain from his sacral sore but there was no indication that the patient would not be able to take any medication for his pain orally if he needed to.

182. The prescription written by Dr Barton which allowed the nurses to administer the Diamorphine and Midazolam was undated but must have

been written on the day of admission and was for a dose range of between 20-200 mgs Diamorphine, and 20-80 Midazolam. It was poor management to prescribe those drugs to an elderly frail underweight patient and it created the hazard that the combination of drugs could result in profound respiratory depression

183. The increases on the **23rd** and thereafter are described as inappropriate and dangerous by Professor Ford who also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect which in this case would have been between 15 and 25 hours (para 3.11). The result of this would have been that they were increasing the doses before the earlier dose had a chance to be fully effective.

184. As his condition worsened, in all likelihood as a result of the drugs which were being administered to him, there was no reassessment to discover the cause.

185. The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton had created the situation where that had become possible.

186. The administration of 100 mgs Midazolam and 80 mgs Diamorphine would produce respiratory depression and severe depression of the consciousness level.

187. In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five

days later and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet.

188. The cause of death was bronchopneumonia which can occur as a secondary complication to opiate induced respiratory depression.

Patient H – Robert Wilson (October 1998)

189. Patient H was 75 years old when he was admitted to Queen Alexandra Hospital on **21st September 1998**. He had sustained a fracture of his humerus bone following a fall. Whilst at the QAH he was given relatively small doses of morphine for pain. On assessment his Barthel score was 5.

190. On **7th** October it was noted that he did not want to go into care but wanted to return home. He was seen by Dr Luznat who was a consultant in old age psychiatry and Code A Code A She thought he may have developed early dementia.

191. On **13th October** he was assessed by his consultant physician Dr Ravindrane who found that he needed both nursing and medical care and that a short spell in long-term NHS care would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient Frusemide which is a diuretic and Paracetamol for pain relief. The patient could, according to the doctor, have stabilised or alternatively died quite quickly.

192. The patient was visited that day by his son Iain (Wilson) who remembers him on the **13th** , the day before his transfer to GWMH, sitting up in bed and having a joke.

193. On his discharge from the QAH he was taking Paracetamol and Codeine as required for pain but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man weighing 93 Kilos.

194. On the **14th October** he was transferred to Dryad Ward for continuing care and Dr Barton noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with his wife. He was continent and the plan was for further mobilisation. She also noted that he had alcohol problems. He also had congestive cardiac failure.

195. Professor Ford has noted that there was no record of any symptomatic medical problem at that time (para 5.8 police report). His blood pressure was not taken nor was there any clinical examination. It is important to note that this patient was not admitted for palliative care but for rehabilitation.

196. His wife Gillian Kimbley saw him on the day of his transfer to GWMH and indeed travelled with him in a minibus which was used for the transfer. She remembers him being lucid that day and able to hold a conversation.

197. The nursing note at GWMH on the **14th** recorded that the patient had a long history of drinking and LVF (Left Ventrical failure) and chronic oedematous legs.

198. On the day of his admission into the GWMH (**14th**) Dr Barton prescribed him Oramorph 10 mgs in 5 mils, 2.5-5 mls 4 – hourly despite the fact that in the days leading up to his transfer he had only been on Codeine for pain relief.

199. That prescription for Oramorph was administered twice that day, once in the afternoon at 14.45 and again in the evening at 22.45.

200. The following day **15th** he was administered 10 mgs in 5mls every four hours. That was given according to the nursing notes because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by Codeine and Professor Ford regards that very first prescription of morphine to have been inappropriate. His son Iain saw him that day and describes how his father was in 'an almost paralysed state'.

201. On the **16th** he was seen by Dr Knapman who noted that the patient had deteriorated overnight and he was for active nursing care. His son Iain describes him as being almost in a coma and unable to speak.

202. Later on the **16th** it was noted by Nurse Hallman that his chest was very bubbly and a syringe driver was commenced with 20 mgs Diamorphine and 400 mcgs Hyoscine. That was on the basis of a prescription written by Dr Barton which may have been written, according to Dr Barton, on the day of admission for a variable dose of Diamorphine between 20 and 200 mgs over a 24 hour period by syringe driver. That was, according to her police statement, one of Dr Barton's 'proactive' prescriptions for pain relief.

203. There appears to have been no re-examination by Dr Barton prior to that prescription being administered by the nurses. Indeed from her police statement it appears that she was away that day. It is quite possible according to Professor Ford that the Morphine the patient had been receiving was the cause of his deterioration.

204. On the following day, the **17th**, his secretions had increased and so the Hyoscine was also increased (Florio). In the afternoon the dosage of Diamorphine was increased to 40 mgs and Midazolam was started at 20 mgs. The date of Dr Barton's prescription for Midazolam at a variable dose between 20-80 mgs is unclear but it must have been on or before the 17th being the date it was administered. Hyoscine which was the drug used to dry up secretions was also increased. There was no record made of the reason for starting the Midazolam and at the time the notes suggest that the patient was in fact comfortable. Professor Ford views the use of Midazolam in these circumstances to have been highly inappropriate (para 5.15).

205. No consideration appears to have been given by Dr Barton or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous Diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain free.

206. A particular issue with this patient was his previous chronic alcoholism which had been noted by staff and appears to have been known to Dr Barton. The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored and preferably not used unless required to deal with severe pain. If he was in pain then a low dose of morphine would have been a more appropriate response.

207. On the night of the **17th and into the morning of the 18th** that dosage was continued but in the afternoon of the **18th** it was increased again from 40 to 60 mgs Diamorphine and from 20 to 40 mgs of Midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain though there were many notes that the patient was deteriorating.

208. At 23:40 on the night of the **18th** the patient's death was recorded four days after he entered that ward at GWMH. It was recorded that he had died from congestive heart failure. Professor Ford is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and or bronchopneumonia.

Patient I – Enid Spurgin (March 1999)

209. Patient I was 92 when she was admitted to the Royal Haslar on **19th March** 1999 following a fall in which she had broken her hip. Prior to her fall she had been living at home and caring for herself. According to her medical notes she had been active and in good health. The fracture is described by an Orthopaedic surgeon Daniel Redfearn who has examined her notes, and was instructed by the police as an expert in her case, as a 'relatively complicated one'.

210. At the Haslar she had initially been given 3 doses of 5 mgs Morphine over the 20th and 21st March which had resulted in Hallucinations and so a note was made by the anaesthetist – nil further opiates. She was operated upon on the **20th** a right dynamic hip screw inserted. The only other analgesic prescribed for her was paracetamol (Redfearn).

211. She appears to have had post operative complications by way of bleeding, a haematoma developed and she had a painful hip.

212. Dr Reid reviewed her on the 23rd March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

213. She was transferred that day **26th March** to GWMH Dryad Ward. Prior to transfer she was mobile and walking short distances with a Zimmer Frame and two nurses. She was continent during the day but not at night and her only analgesia was paracetamol. [Her nephew Carl Jewell who visited her at the Haslar fully expected his Aunt to be discharged from the GWMH and returned to her home].

214. Dr Barton made a note on admission (p.27) of her transfer to Dryad Ward '…PMH nil of significance, Barthel, not weight bearing, tissue paper skin, not continent, plan sort out analgesia'.

215. Dr Barton prescribed her Oramorph on the day of her admission 10mgs in 5 mls 2.5 mgs 4 times a day. A note (p.106 and see Tubbritt) asserts that the patient had complained a lot of pain. Oral morphine was administered on the **26th, 27th and 28th March** and then discontinued because the patient was vomiting it. She was given codydromol as an alternative (Barrett and Lloyd).

216. On the 27th, although it was a Saturday, Dr Barton believes she reassessed the patient although if she did she made no note, and she increased the prescription for Oramorph to 10 mls 4 times a day with 20 mls at night.

217. The care plan records that the patient was experiencing pain on movement (p.84).

218. If pain was uncontrolled by less powerful analgesics then those prescriptions were appropriate, according to Professor Ford. However, there is no note from Dr Barton recording her assessment or her reasons for prescribing as she did. The patient should not have been in severe pain unless something had gone wrong with the hip repair which would have required re-assessment.

219. The fact that Dr Barton has recorded that the patient was not weight bearing is not consistent with the notes made at the Royal Haslar and is either inaccurate or indicates that there had been a change in the patient's mobility. That should have triggered a re-assessment which does not

appear to have taken place. A nursing note (p86) reveals that on the 4th April the wound was oozing serous fluid and blood and the wound was redressed.

220. On the 31st March Dr Barton has prescribed 10mgs of Morphine Sulphate to be given twice a day. There is no note of any review by her.

221. [The patient's nephew Carl remembers visiting her on about the 1st April when she was still talking about leaving the hospital. His impression was that she was very rarely seeing a doctor].

222. On the **6th April** Dr Reid suggested that there may have been a problem with the hip screw and requested that an X-ray be arranged. Unfortunately that was never actioned. That day, Dr Barton increased the dose of Morphine by slow release tablets to 20 mgs twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it.

223. A note by Nurse Shaw (p.106?) of that consultation with Dr Barton reveals that Enid has been incontinent a few times but was insistent about not going into a care home. There was in that note no mention of pain. Those doses were administered until the **11th** April.

224. By the **11th** April the patient was very drowsy but still in pain if moved.

225. On the **12th** April Dr Barton prescribed Diamorphine by syringe driver at a variable dose between 20-200 mgs over a 24 hour period as well as 20-80 mgs of Midazolam. There is no note of any further assessment by Dr Barton on the 12th.

226. Those prescriptions are described by Professor Ford as 'reckless and inappropriate'. The patient was already described as 'very drowsy' and any dose over about 30 mgs sub-cut would be highly likely to produce coma and respiratory depression.

227. In fact the dose administered by Nurse Shaw, apparently either on her own calculation or under Dr Barton's direction on **12th April,** was 80 mgs Diamorphine together with 30 mgs Midazolam. Those doses were well within the variable dose that Dr Barton had prescribed but in fact were much higher than the dose of Morphine that the patient was already receiving and extremely dangerous. Nurse Lynne Barrett could not explain why the patient was prescribed such a large dose and she in fact thought that the dose was only 60 mgs.

228. When Dr Reid noticed that the patient was receiving 80 mgs of Diamorphine he reduced it down to 40 mgs (p.108 and Barrett) however the patient died the following day. In Professor Ford's view the drugs she was being administered were a direct contributor to the patient's death.

229. Mr Redfearn the orthopaedic expert raises concerns in relation to the lack of response to the patient's pain which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms. This was never done.

230. The charges reflect on this occasion specifically the lack of assessment by Dr Barton given the patient's condition on entry onto the ward. Criticism is also made of the prescriptions written by Dr Barton on the 12th and the direction to administer such a high dose on the same day.

Patient J – Geoffrey Packman (August 1999)

231. Patient J was born in Code A and he was 67 years old when admitted to Dryad Ward on 23rd August 1999. He was suffering from bi-lateral leg oedema (swelling) and venous hypertension. He was very obese, suffered from atrial fibrillation and had poor mobility. He had a poor Barthel score. He was not a well man.

232. Some weeks earlier he had suffered an accident in his bathroom at home. He was admitted to A&E on the **6th** August to Anne Ward at the Queen Alexandra Hospital. On the 8th August it was noted that he had very severe sores on his sacral area. The annotation was made in his notes on two occasions – "not for 555" meaning that he was not to be given resuscitation in the event of a life threatening event.

233. Eventually, according to his wife Betty, he made a good recovery and looked better than he had for years.

234. He was, on the **23rd August, transferred to Dryad Ward** for recuperation and rehabilitation.

235. When he was assessed on Dryad Ward by Dr Ravindrane on the **23rd** the problems recorded were: obesity, arthritis in both knees, pressure sores. His mental test score was however good there being no significant cognitive impairment. His Barthel score had by now improved to 6. Nurse Hallman however remembers this patient as having the worst pressure sores she had ever seen.

236. Dr Barton believes, according to her police statement about this patient, that she must have reviewed him on the morning of the **24th** but made no

note about it. On the **24th** August a drug called Clexane was prescribed which he received to reduce the risk of a DVT as well as Temazepam

237. On the **25th** August he was vomiting and passing fresh blood. Again there is no note of any review by Dr Barton though she thinks she performed one. The notes reveal that when it was noted that the patient was passing fresh blood through his rectum Dr Beasley was contacted and directed that Clexane which was an anti-clotting agent should be stopped.

238. His wife Betty recalls visiting him with friends on around the 25th or 26th and meeting Dr Barton for the first time. Dr Barton took her into a room and told her bluntly that her husband was going to die and she should look after herself now. Betty was very shocked and surprised.

239. On **26th** August Dr Barton made this note – 'called to see. Pale clammy unwell. Suggests ?MI (Myocardial Infarction) treat stat Diamorph, and Oramorph overnight. Alternative possibility GI (gastrointestinal) bleed but no haematemesis (vomiting of blood). Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death.'

240. No note of pulse, blood pressure or any other indications of a clinical examination are present.

241. However on that day (Thursday **26th)** Dr Barton appears to have given a verbal order to give Diamorphine intra muscularly which was injected that day. She also prescribed Oramorph 10 mgs in 5 mls 4 times a day which was administered daily thereafter from the 27th August until the syringe driver was commenced on the 30th August. There is also an undated

prescription written by Dr Barton for a variable dose of Diamorphine of between 40-200 mgs and Midazolam of 20-80 mgs. Dr Barton says in her police statement that she wrote that prescription out on the **26th** and that may well be right. Dr Barton says however that she had no intention that it should be administered at that time.

242. The following day, on Friday **27th** , the patient is noted to be in discomfort particularly when his dressings were changed. Dr Barton claims she would have reviewed him but made no note of it.

243. The syringe driver was commenced on Monday the **30th** August which was a Bank Holiday, with Diamorphine at a rate of 40mgs and Midazolam at 20 mgs. There is no note from Dr Barton about that and she is not sure if she would have gone in on a bank Holiday. It seems therefore that the syringe driver was started at the discretion of the nurses as was the amount of opiate to be administered within the range set by Dr Barton and at the lowest dose. Dr Barton believes the nurses would have spoken to her but there is no note of that recorded.

244. Those same doses were administered on the **31st August** when it was also noted that he had passed a large amount of black faeces which was an indication of a significant gastro-intestinal bleed.

245. On the **1st September** the Diamorphine was increased to 60 mgs and the Midazolam to 40 and then 60 mgs on the same day and then the following day they were increased again.

246. On the 1st Betty visited him and he did not wake up throughout the visit. His daughter Victoria remembers that her Dad deteriorated once he was in

the GWMH and that he appeared to be 'spaced out'. She describes the change as 'dramatic'.

247. On the **2nd September** the Diamorphine was increased to 90 mgs and the Midazolam was increased to 80 mgs in a 24 hour period. Jeanette Florio (nurse) says that she could not imagine such an increase taking place without the authority of a doctor. Dr Barton says that she would have reviewed the patient but made no note of it. She says this – "I anticipate again that (the patient) would have been experiencing pain and distress". If that is so it is very surprising that no note has been made about it.

248. The patient's daughter Victoria sat with him throughout the 2nd. He was unconscious throughout the day.

249. The patient **died on the 3rd September** at 13.50.

250. In Professor Ford's opinion the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed on the 24th August although it was stopped the following day, and possibly by the opiate induced respiratory depression. He was not dying nor expected to die prior to his deterioration on Dryad Ward on the 26th August. He had pressure sores but those were treatable. He had been transferred for recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Dr Barton did on the 26th, she should have had further discussion with a senior consultant colleague.

251. Her assessment of the patient was inadequate and her verbal order to administer Diamorphine was inappropriate.

252. There is no proper explanation for the doses of subcutaneous Diamorphine or Midazolam that she prescribed and no explanation for the dramatic increase in quantities of those drugs being administered.

253. The dose ranges were inappropriate and hazardous and unjustified by an assessment of the patient's condition.

Patient K – Elsie Devine (October 1999)

254. Patient K was an 88 year old lady when she was admitted on 9th October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter at xp.29 and 30 by Dr Taylor a clinical assistant in old age psychiatry.

255. She was confused, disorientated and sometimes aggressive. She had a medical history of treated hypothyroidism and chronic renal failure. She was independent and able to wash but tended to get herself lost.

256. She was transferred to GWMH on the **21st October 1999**. The referral letter (p.21) written by Dr Jay a consultant geriatrician who saw her on the 19th stated – that she was alert and could stand but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

257. Dr Barton's note on admission on the **21st** stated that she was for continuing care. That she needed help with all her daily living needs and she had a Barthel score of 8. 'Plan get to know. Assess rehab potential probably for rest home in due course'.

258. On the **25th October** and **1st November** there are entries by Dr Reid indicating that the patient was continent but mildly confused and wandering during the day, she was suffering from renal failure, but was physically independent although she needed help with bathing.

259. Two weeks later on Monday the **15th** November there is a note that she had been aggressive at times and needed Thioridazine to calm her down. Lynne Barrett was one of the nurses who helped to look after her and she

recalls a specific aggressive incident when the patient grabbed a nurse and would not let go and kicked out at Ms Barrett.

260. Dr Reid saw her on his ward round that day but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal. Her legs were however badly swollen. He wanted the patient to be seen by Dr Luznat the psychiatrist and made a note to that effect.

261. On the **18th** the patient was seen by Dr Taylor one of Dr Luznat's team (Consultant Old age Psychiatry) and arrangements were being made to transfer her to an old age psychiatry ward for assessment and management.

262. However, that same day she was confused and aggressive (18th) and Dr Barton prescribed a Fentanyl patch for the patient. Fentanyl is an opiate which is applied to the skin on a patch. There was no indication in the notes as to why Dr Barton thought it appropriate to start the patient on opiates and there is no reference anywhere in the notes to this patient being in pain. Dr Barton in her statement to the police about this patient stated that the patch was 'an attempt to calm her, to make her more comfortable and to enable nursing care'. The patch was applied at 09:15 on the 18th and can take up to 24 hours before it becomes fully effective (Reid) and remains in the system for between 12 and 24 hours after the patch itself is removed (Reid).

263. A note made by Dr Barton on the **19th** indicates that there had been a marked deterioration overnight.

264. Dr Barton wrote on the **19th** – 'today further deterioration in general condition. Needs SC analgesia with Midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death'. Dr Barton prescribed that day Diamorphine 40-80 mgs and Midazolam 40-80 mgs.

265. In addition at 08:30 the patient was given an injection of Chlorpromazine 50 mgs prescribed by Dr Barton following an incident in which the patient is suggested to have been aggressive with nurses. This is a tranquiliser and 50 mgs is according to Dr Reid at the upper end of the normal range of dosage. An hour later a syringe driver was started by the nurses that day (**19th**) at 09:25 containing 40 mgs of Diamorphine and 40 mgs of Midazolam. The Fentanyl patch was not removed until 3 hours later at 12:30 according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage therefore on this Friday morning this patient had in her system, Fentanyl, Chlorpromazine, Diamorphine and Midazolam.

266. It is very difficult to understand why anyone would have thought it appropriate to start this patient on anything less that the minimum dose of 20 mgs Midazolam even if the patient was complaining of pain, which she wasn't.

267. The syringe driver was kept replenished for the next two days at those dosages. Dr Barton wrote in her police statement – 'this medication (Diamorphine and Midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving (the patient's) significant distress, anxiety and agitation which were clearly very upsetting for her'.

268. Dr Barton again says that she had been making daily weekday reviews of this patient but accepts that she failed to make a note of any of them and that she 'relied greatly on daily reports from the nurse in charge and their nursing note entries'.

269. The patient **died** two days later on the **21st November.**

270. Dealing with the Diamorphine and Midazolam prescription on the 19th Professor Ford can not see the justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20 mgs if the patient was in pain but not double that and not when coupled with Midazolam.

271. Neither in Professor Ford's view was the Fentanyl justified. This regime of opiate medication has every appearance of being given to keep the patient quiet which would not be an appropriate use of opiates in this setting.

272. The drugs administered are very likely to have led to respiratory depression and coma.

Patient L – Jean Stevens (May 1999)

273. Patient L was 73 years old when admitted to Royal Haslar Hospital on 26th April 1999 after experiencing chest pains and collapsing.

274. She was found to have suffered a stroke as a result of a cerebral infarction in the right parietal lobe. She was looked after for several weeks and made a substantial recovery. [She was seen on the 19th May by her daughter June Bailey and was in good spirits, laughing and joking].

275. On 20th May she was transferred to Daedalus Ward but she was according to records in a very poorly condition and died two days later.

276. The criticism by the GMC of Dr Barton's care of this patient hinges around her immediate prescription upon entry onto the ward on the **20th** of Oramorphine, Diamorphine, and Midazolam in the usual very large variable ranges. This is not a case where this unfortunate patient was likely to recover or leave the hospital.

277. The only note by Dr Barton was on (Vol 3, p.20). The 2nd note was by nurse Tubritt recording death on the 22nd. According to her husband (Mr Stevens), Dr Barton did not in fact see her at all during her short stay at GWMH.

278. A nursing note on the **21st** recorded a conversation with her husband indicating that he was anxious that medications should not be given which might shorten her life.

279. The syringe driver was started on **21st** with 20 mgs Diamorphine and 20 mgs Midazolam.

280. Dr Barton's entry makes no mention of the patient being in any pain and contains no record of any physical examination of the patient. In Professor Ford's expert opinion there is no evidence that Dr Barton undertook a clinical assessment of this patient. Although the patient had previously complained of chronic abdominal pain, treatment with opiates would not have been appropriate.

281. In addition the dose ranges were far too wide and the dose of Midazolam excessively high.

CONCLUSION

282. As already indicated, Professor Ford is very critical of the quality of Dr Barton's note making. She failed to note assessments of the patients' condition if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few if any notes about why she regularly increased the dosages of her prescriptions.

283. Failing to make appropriate notes in relation to assessments in admission to the hospital is particularly serious because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission and it left her with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened.

284. In view of the complete lack of note making it has to be inferred that no assessments were being performed properly before opiates were prescribed. The prescription of very large doses of opiates appears to have become a matter of course in the GWMH and the patient's best interests were not served as a result.

285. The prescribing by Dr Barton was, on occasion, dangerous and inappropriate and left far too much to the discretion of the nurses.

286. Patients were overdosed with opiates so much so as to become unresponsive.

BURDEN AND STANDARD OF PROOF

287. The burden of proving the charges is upon the GMC and the standard of proof in this case which is heard under the old rules is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted, proved, the Panel would have to be sure that Dr Barton had acted in the way alleged.

A) WITNESS SCHEDULE AND EXPLANATION

B) PATIENT NOTES AND CHONOLOGIES

C) PROFESSOR FORD'S REPORTS

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4th June 2009