Dr Barton

Speech

INTRODUCTION

1. At this stage your function is to decide whether any of the remaining allegations which have not already been admitted have been proved so that you are sure. The issues have become crystallised over the course of the case and some of those issues which took up many hours of evidence are now so clear that they hardly bear mention.

2. I am not going to even attempt to deal with all of the evidence that you have heard and there will no doubt be witnesses to whom I make no reference at all. I have to try to focus on that evidence which will most assist you and it is the evidence which goes directly to the heads of charge which will do that.

THE CHARGES

3. You have heard a great deal of evidence in the case some of which might now appear somewhat extraneous. It is worth therefore reflecting upon the charges before turning to the evidence and the nature of the allegations fall broadly into the following categories:

i) *That the lowest doses of Diamorphine (D) and Midazolam (M) as prescribed by Dr Barton for the specific patient were too high;* The GMC case has not set out to prove that such large prescriptions were written with the specific purpose of hastening death although on some occasions they may have had that effect. This is not a case in which we say the patients entering GWMH were fit as

fiddles, and some, it has to be recognised were likely to die there. However in respect of those patients who were likely to die at the GWMH it is still alleged that the prescriptions weer in general inappropriately high and wide.

ii) *That the dose ranges of Diamorphine (D) and Midazolam (M) as prescribed for Dr Barton for the specific patient were too wide;* This Head has largely been admitted although not in respect of Patient A and K who we will look at in due course.

iii) *That doses were administered which were excessive the particular patient's needs;* it is not a complete answer to this charge for DB to say – well I was the one standing next to the patient and therefore I am the only one who can say what the patient needed. You have to look at what reasonable competent medical practice dictates in any given situation. She was tackled about this by the Chairman, and asked why they could not take the titration approach to find the appropriate level of opiate (D31/17) so that when one does move to the SD one has the dose right she answered – ' when you saw the sort of doses that some of these patients needed, you would need to escalate the injections quite quickly or you would take a long time to find out what your steady state was going to be'. The difficulty with that answer is the assumption that DB got the amount of opiates right and that the patient needed these very large amounts and they were not over sedated. Without an element of titration or a similar approach there was no way of knowing. She also said this about titration – D32/6 – (TK after Panel Questions) Q are you saying that under your watch titration was simply not being done throughout these 3 years – A. I am saying that. I was not taught it, I was not familiar with using it. It was not practical. For any medical practitioner who was regularly prescribing opiates that is a surprising and worrying admission.

iv) *That the total amount of drugs prescribed were excessive to the patients needs;* Again you will have to consider each individual patient and you will have to take into account not only what is written in the notes at GWMH, but what was recorded in the notes before the patient arrived there, as well as the evidence of patient relatives. DB said this to the Chair – D31/18 – If you start

from the initial premise that these patients are dying and that was the process that was going on, then it was perfectly acceptable to give sufficient doses of the drugs to control their distressing symptoms and accept that controlling those symptoms might in some way shorten their life. That approach raises 2 issues – 1, were all the patients who DB thought were dying, actually dying? 2 - What effect did that approach have on the patient's overall care and treatment? And 3, that approach allows for much greater doses to be given than were necessary to govern the patient's pain, even applying liberal standards of prescribing. It is a fundamental issue in this case that every time a patient was put onto a SD that was for DB, for the staff and for the patient the Terminal Care Pathway starting. When that battery got inserted into the machine and the needle inserted into the patient that was the beginning of the beginning of that patient's final journey. Hydration was not going to happen and that patient was going to deteriorate and die and everyone knew that. If DB's attitude can be summed up in those words - 'If you start from the initial premise that these patients are dying' then it says a great deal about what was happening on Dryad and Daedalus Wards under her management.

v) *That both prescriptions and administration of drugs was inappropriate for the particular patient and not in that patient's best interests;* on occasion we submit that you do not have to look much further than the quantities of drugs prescribed and administered for these elderly and generally frail patients. For others you will want to examine the claims made that the patient must have been in considerable pain. This is a problem for DB – she made such poor notes that there is nothing to support her assertions that patients were in great pain or agony as she sometimes liked to describe it. If a patient is in agony then surely that is something that would be noted by someone at least. DB's position now is – well if I look at these Pxs now, the only reason I would have allowed them to be administered was if the patient was in great pain. But that ignores the fundamental charge behind the GMC case which is that here is a practitioner who just did use excessive quantities of opiates either deliberately or through a lack of understanding.

vi) In looking at whether the prescriptions were or were not in the patient's best interest is not the same as looking into DB's mind to see what she thought the best interests of the patient were. The fact that there is has been a lot of evidence directed to establishing that DB always had her patients' best interests at heart does not answer the question of whether or not the prescriptions she wrote out in this style were or were not in fact in the patient's best interests.

vii) *That in the particular case of Patient H she failed to recognise the importance of the previous alcoholism and consequent liver disease when prescribing her standard 'one size fits all dose's.* The evidence which was read to you from Gill Hamblin will bear special attention in this regard because you may think it becomes clear from her evidence that she had no understanding of the effects of liver disease upon the proper dosage of opiates. In Pt H's case that is an added feature which you will want to consider, whether any account whatever was taken of his alcoholism when DB wrote out her standard Px.

viii) *That on occasions DB failed to perform and adequate examination either when the patient's condition changed or an adequate examination prior to prescribing opiates*. You may think there is good evidence that in many cases there was little or no effort made to diagnose properly what was causing the patient's pain, if they were in pain at all. That the easiest option was, on occasion taken, and that was the option of providing large amounts of prescribed opiates. If you find there is force in that suggestion then you may think that DB's protestations that she always examined the patient fully may sound rather weak. One also has to bear in mind what DB's approach to many of these patients was. She confessed that she had a very pessimistic view of most of these patient's chances of survival.. Very often it was much more pessimistic that those of her consultants or those treating the patients at the previous hospital. That will undoubtedly have effected her management of each Pt and the quality of her assessment.

ix) *That on occasions she failed to provide an adequate plan of treatment.* There were occasions you may feel when there was no real attempt or effort to

achieve any form of rehabilitation for some of these patients at all. The effect of her approach to some of these patients can be summed up in her own words – 'to sort out analgesia'.

x) *Finally there is criticism (14 iv) that DB did not sufficiently record the drug regime* – you may think that although DB wrote out her prescriptions sometimes with dates and sometimes without, what she never did was to make any sufficient note as to the circumstances in which those drugs were going to be administered. There is never any note we have seen which sets out the drugs are only to be used if the patient has been in considerable pain and oral analgesia medication has been tried first. Or, that the SD is only to be used for certain patients when they become unable to swallow. Or after full discussion with the patient and or their relatives. Or the size of the increments that are allowed and of which drugs. Or the circumstances in which both D and M are to be used together instead of one or the other. None of these things were recorded and it can not be said that they did not need to be because of the great depth of knowledge of the nurses – because we've heard from a number of the nurses and although they were no doubt very well meaning and caring some of them did not have the foggiest idea about conversion rates or the like.

4. In respect of all of these charges you will have to consider whether there is evidence that there were certain practices taking place at the GWMH which in reality had little to do with the individual needs of the patient but in the words of Mr Payne may have been a 'one size fits all' approach. If you find that that was the true position having considered all of the evidence then that may take you a long way towards finding that drugs were prescribed which were inappropriate.

CHARACTER

5. On that issue of the generic evidence you have heard a great deal of good said about Dr Barton from many sources. The GMC does not allege that she treated every patient who came under her care in this way. You know that she is of good character in the sense that there has been no evidence of any previous findings against her in any disciplinary tribunal. That helps her but it does not mean she can not have acted in the way now alleged. She may have treated many other patients very well but that can not allow her to escape the consequences of serious malpractice in relation to these patients if you find evidence that there was such malpractice.

6. Many people have told you many good things about DB, Dr Brigg, Margaret Couchman, Philip Beeed, Lynne Barrett, Dr Banks – all said good things about her practice and about her as a caring person. But all of that evidence can not overcome the plain fact of these prescriptions, of the lack of notes, the lack of assessments as patients deteriorated unexpectedly, the huge starting doses. Because however caring and compassionate DB undoubtedly could be it is clear that there are also elements to her character which make her a very practical and down to earth person. A person who called a spade a spade and who could be pretty blunt according to many. You may have formed the view, having seen her give evidence over a lengthy period of time, that she is the sort of person whose mind once made up, is not going to be easily changed. In this case with these patients that may have proved to be a serious failing.

THEMES IN THE CASE

7. There are certain themes in this case, I will not spend very long at all on each. There are however some central issues which will require closer scrutiny.

8. The work or over burdening of Dr Barton and the the change in the nature of the patients during the course of the 1990s.

9. The issues which were raised in 1991 and what relevance they have to the charges which DB now faces.

10. The acceptability generally of anticipatory prescribing and the necessity of providing a dose range and the acceptability of the ranges prescribed by DB.

11. The autonomy of the nurses and whether or not they were able to start and increase doses by syringe drivers.

12. The use or lack thereof of re-hydration.

13. All of these issues will need to be examined by you. Some will take you less time than others.

14. But you have to bear in mind at all times that the most important document you have in the case is the heads of charge. That is the cornerstone of the case and you will need now to revert to it repeatedly.

HYDRATION

15. I will deal with very quickly now – there wasn't any for any of these 12 patients once the SD had been started. They were on the terminal pathway. Had there been any hydration by way of SC infusion it would have been written up. There is no note of that happening. Without hydration the patients are inevitably going to deteriorate, lose consciousness and die. That is all I need to say perhaps about that issue.

POOR NOTE MAKING

16. DB accepted D29-1 that there were significant failings in her note making. But she says that none of her patients suffered as a result. Indeed she says that they would have suffered had she made proper notes because then she would not have been able to devote her time to them. The GMC does not accept that proposition.

17. She accepted in evidence the importance of making a note of assessment and the diagnosis and the plan of treatment.

18. DB told you however that she attended at lunchtime specifically in order to clerk new patients in. If that is right then it is surprising that she claims not to have had time to make notes, which would have taken her just a few minutes to write up.

19. Her explanation for the lack of notes on first assessment came rather late in the day when she was being asked questions by me after the Panel Qs. D32-4 – "we did not write out a formal plan at time of arrival, because we needed a few days to get to know the patient, for the patient to get to know us, and particularly for us to meet the relatives and find out what their expectations and aspirations were". If that answer were true, in explaining why the initial plans of treatment were poor or non-existent which I suggest it was not, then its surprising that DB felt the need to have a few days before writing up a plan but did not need a few days to get to know the patients before writing up these enormous variable doses of opiates.

20. As significant, are the times when Dr B made changes in the patient's drug regime but there is nothing in the notes to demonstrate why that took place.

21. Also terribly significant were those occasions when DB set the patient off on what we have decided to call in this case the terminal pathway, and still made no note about it.

22. Prof Ford said this about the note keeping – MAGIC P.37.

23. She accepted how important it would be to make a note if she was deciding that the patient was entering the palliative care pathway D29/3. But she has accepted repeatedly that no such not was made by her. The only notes we see from Dr Barton to give us a clue as to what is to happen to the patient are phrases such as – 'please make comfortable', or – 'sort out analgesia', or 'happy for nursing staff to confirm death'.

24. Finally I ought to say something about the nurse's notes and suggest that caution is needed. I am not going to suggest that nurses have not written down what they believed or that notes have been deliberately falsified to assert that pain was present when it was not. However there are a number of occasions when a note is made that the patient is agitated and that has been interpreted as meaning that the

patient is in pain. One has to be cautious about that. Agitation mkay be caused by a number of things. In Gladys Richards case it may be because she needed to go to the lavatory, in Elsie Devine's case it may have been caused by dementia rather than pain. So where a nurse has interpreted a note to mean the patient was in pain, unless it specifically says so you may want to exercise caution before automatically accepting that agitation by way of example was caused by pain.

THE CHANGE IN THE NATURE OF THE PATIENTS DURING THE COURSE OF THE 1990S.

25. It is well established by evidence that there was a change in the nature of the patients this hospital received in the mid to late 1990s. This hospital was apparently not unique in that happening. How much does it actually matter, what difference does that or should that make?

26. The question is whether the change in fact affected the patient's standard of care and did it effect how DB approached her patients? The answer to that last question is revealed by her own answers to you -

27. If Dr Barton was so overburdened by work in the late 1990s that she could not properly care for her patients then it was her duty to bring that formally to the notice of the Trust. But that is not her case. She has not said to you at any stage either that she could not perform her duties properly or that the patients were suffering a result. She does not say that her defence to any of the charges that she faces is – I was forced into this position because of the burden upon me. That is not and has never been her case. Her case is – there was nothing wrong with anything that I did.

28. DB was asked about this during the course of Panel Qs by Ms Julien – D31/2 – in retrospect – would you now do anything differently in the case of those 12 patients? 'In the days and hours of their dying, I would have done nothing differently'.

29. Q – you would not have adjusted any Px or referred a patient or asked for a 2nd opinion – 'No', Q In none of these 12 cases? No.

30. Q. putting Prof Ford aside, is there anything – going over these 12 cases where you think, Oh well, maybe I should not have done it quite like that? A. Nothing at all.

31. Those answers reveal a woman of absolute conviction. Not a woman borne down by the pressures of her job or the exigencies of the situation in which she found herself. She is certain in her decisions. The letter which she wrote to Dr Reid which you have as Ex D6 and thereafter was not written until January 2000 when a police investigation into attempted murder had already been launched. This may look as if DB is trying to shut the stable door after the horse has bolted.

32. Why were there no letters like this prior to 1999? Why did it take a police investigation to bring about this moment of soul searching and formal concern. When issues were raised by nurses about practices at the GWMH in 1991 they were met not with any soul searching but with a brick wall.

33. You will also have to consider this issue of whether other hospital were transferring patients before the patient was ready. Rear Admiral Farquarson Roberts.. denied it on behalf of the RHH but said that might be happening at the QAH. But if a patient was too ill for rehabilitation, and they needed palliative care, why not say so? This is a point Mrs Mansell picked up with DB.

34. Sister Joines was asked extensively about the change in the nature of the patients received by GWMH and the increased workload that that entailed but she insisted – I must point out I had an excellent team of nurses. .. I never found that the extra workload affected my nurses' care in any way at all – D33/26.

35. In any event as Professor Sikora told you D34/22, – the changes made in the 1990s were not unique to Gosport. They were happening up and down the country and clinical assistants in DB's role were having to deal with these problems across the UK.

36. D28-64 Q What you are telling the Panel is this, that although the amount of work you had to do with the patients was greater than it had been before the actual management of the patients did not suffer? A. I hope not. Would more time have affected your decisions in relation to these patients? A. No.

37. Q. are you saying that in relation to any of our 12 patients that you started them on opiates or you prescribed opiates earlier because of inadequate staffing? A. No. D28-83.

THE EFFECT OF TRANSFERS FROM OTHER HOSPITALS

38. We have heard much evidence about patients being described as being in one state at the RHH or at the QAA and a worse state on arrival at the GWMH.

39. Dr Brigg told you D9/47 – other hospitals would try to transfer patients as early as possible. There would be an expectation of rehabilitation which could not be fulfilled.

40. There were many other sources of that type of evidence. But at the end of the day you have to focus on these 12 patients and see if here there is evidence of that happening. If that did happen then what effect does it have in this case?

41. If the staff at GWMH find that the pre-transfer assessment was unrealistic then there must be a duty to re-evaluate and note it. It may be that that patient has simply been effected byt eh transfer itself and needs a day or two to recuperate. Dr Barton herself spoke about this and said that this was one of the reasons for not doing an assessment immediately. D32-4 – "we did not write out a formal plan at time of arrival, because we needed a few days to get to know the patient,

for the patient to get to know us, and particularly for us to meet the relatives and find out what their expectations and aspirations were".

42. But were patients being given the opportunity of demonstrating what their true condition was or were they in reality being pigeonholed as soon as they arrived. For each Pt for whom a SD was written up on arrival you may think that their initial assessment set the course for their treatment thereafter. Dr Banks told you D15/68 that one must build in a safety margin from the transfer in making an assessment. Whatever course of treatment must be well worked out.

1991

43. Whatever attack is levelled at the nurses who gave evidence about these issues and we will look at their evidence briefly in a moment. The fact remains that these issues set out at F1 T6 p.2 were raised 5 years before 1996 when the first of the patients you are considering were treated at the GWMH.

44. The reality is that there is no evidence from any source that practices actually changed. And whatever can legitimately be said to denigrate the evidence of nurses Hallman or Giffin, the fact is that they were raising concerns about very similar issues to those which you are now considering and, those concerns were never resolved because the practices continued. D29-5 DB – the practice did not change one jot did it? 'No'

45. That is important in two ways. i) to demonstrate that the practice adopted at the GWMH of anticipatory prescribing was unusual enough for nurses to be very concerned; ii) that the practices were recognised to be wrong at a relatively early stage; iii) that concerns were raised not just with management but with Dr Barton herself; iv) that the practices were so entrenched that despite them being challenged there was no internal review and no change.

46. Here was a perfect time to reflect upon the practices DB had adopted. A perfect opportunity to resolve to speak to someone and ask for advice. But the only people who received any extra training were the nurses themselves. DB herself did not receive any further training and no-one reviewed her practice.

47. When the defence put to nurse after nurse, you would not have administered these drugs unless content that they were appropriate, is to ignore the plain fact that when the practice was challenged it had no effect whatever and things went on as before. Drugs were administered in circumstances where all the guidelines in the BNF and Palliative Care Handbook were in fact being breached but no one from the consultants, to the pharmacist to the nurses did anything about it after 1991.

48. Whether or not the nurses retained their concerns or whether those concerns were resolved you may think matters very little.

49. Prof Ford said this D24 p.22 Magic p.32 -

50. In 1991 the practice was questioned and it came to nothing.

51. DB in her evidence explained it this way – D29-3 – 'I think the issues were quite different in 1991. The issues were difficulties between existing night staff and a new day sister and attitudes towards the care of patients towards the end of their lives'. The reality is however that the issues then were the same issues of i) patients being given D who were not in pain; ii) no other forms of analgesia being considered; iii) the sliding scale not be used appropriately or at all; iv) each patient's needs not being considered and drugs being used indiscriminately – how close to one size fits all was that? V) patient's deaths sometimes being hastened unnecessarily; vi) no titration or adjustment of doses to suit patients needs, and; vii) too high a degree of unresponsiveness sought from patients.

52. All of those issues were in reality mirror images of those which you are examining now. It really is an appalling indictment of the system that these specific worries having been raised in 1991 the practices which led to them were allowed to continue until 2000 when DB resigned following the complaints and the police investigation..

THE ACCEPTABILITY OF ANTICIPATORY PRESCRIBING.

53. No one challenges the pragmatism of anticipatory prescribing generally. It is widely practiced and a necessity in many parts of the NHS. What is attacked here is the method by which it was done at the GWMH and the doses themselves..

54. Magic P.21 Prof Ford

THE NECESSITY OF PROVIDING A DOSE RANGE AND THE ACCEPTABILITY OF THE RANGES PRESCRIBED BY DB.

55. GOTO MAGIC.

56. Mr Payne asked DB about this D31/4. – There were times when you wrote these Pxs out on the day of arrival – A. because it was obvious that they were not going to be rehabilitated, they were really very seriously ill when they arrived, and I was looking at them at some stage in the future needing palliative and terminal care.

57. DB claimed that these Pts were out of the ordinary 'out of the run of work we did on the ward' D31/4, – which is why she managed them in this way – but that is not true. 1st there was nothing which stands out with any of these patients who had a variety of ailments, some serious and some less so. She accepted when I re-examined her after Panel Qs that these were not the only occasions on which she had written out these types of Pxs. When you look at this broad range of Pts and then realise that DB wrote out very nearly the same anticipatory dose for each one – you quickly realise that this was a system which took little account of the individual needs of each patient. It was, although she denied, it 'a one size fits all' approach'.

58. Sister Joines told you that in her view SDs were never inappropriately prescribed nor was Diamorphine D33-19. you may think that there were a number of nurses who were extremely loyal to DB and who worked within the system of which they either whole heartedly approved or became inured to over time.

59. She also repeated the evidence that others had given which was that some of the other doctors were not prepared to prescribe stronger analgesics (D33-21) in the way that DB was willing to prescribe. Although later she told Mr Payne D33-34 that no doctor ever refused to come in and give what was necessary when it was necessary.

60. It is unfortunate perhaps that more heed was not paid to those other doctor's views who were unwilling to dole out heavy analgesics in the same manner. It seems therefore that DB felt it necessary to ensure that there could be circumvention, by the nurses, of the wishes of other doctors and to that end she handed control of the syringe and its contents to the nurses who she knew and trusted.

61. The evidence is also pretty clear that the use of the syringe driver meant that the death of the patient was forthcoming. Sister Joines – D33/23. We would never start a patient on a SD without the relative's consent – obviously the outcome inevitably was death. It was DB's assessment she said which always set the tone for the patient's treatment.

62. You may think it is very notable that whatever Professor Sicora was able to say on DB's behalf, the defence have not called before you any expert who has examined these notes and prescriptions and is able to say that in his or her view they represent acceptable medical practice. The reason for that you may think is that no self respecting expert could support these prescriptions.

63. Although he is an eminent cancer specialist he was not asked to look at the treatment meted out to these 12 patients. That was a deliberate decision no doubt, but it leaves DB bereft of any expert opinion which supports her management.

64. How safe was this policy in the hands of the nurses? That may depend on their attitude and what they felt was the purpose of their wards.

65. Lynne Barrett told you that they seemed to get the patients that no one else wanted. They would be in her words –dumped. D10/75-76. Anne Tubritt D15 – it felt that we were taking patients that other hospitals did not want. Some were in very poor condition when they arrived, some close to the end of their lives. Dt Tandy D18/30 Dryad ward was for patients too frail to go into nursing homes, patients who we would generally expect would not have a very long length of life.

66. What about the issue of nurses effectively being delegated the responsibility of starting a SD which in at least one case that of Mr Cunningham when it was started at 23.10.

67. Prof Ford said this – Magic p.26-27

THE BNF AND THE WESSEX PROTOCOL

68. I am not going to insult your intelligence by taking you once again through the BNF and the Wessex Protocol. I did it when I opened the case, we have looked at it with many of the witnesses and we went through it with Professor Ford. Suffice to say we have not found a word of support for DB's practice and she has not been able to point out any single guideline ever written which supports her prescribing of opiates.

69. There are clear and specific guidance set out in relation to palliative care, the use of opiates generally, to the use of opiates in the elderly who are considered to be particularly sensitive to opiates, and there is specific comment in relation to the use of opiate with those with liver damage or renal impairment through alcoholism. You know what the guidelines say and they are there for your perusal when you retire to consider your decisions.

70. Magic P.20 for Prof Ford on BNF. + p.25 re: liver disease.

71. The reality is that whatever the guidelines say – was not going to effect DB's management of these patients or her prescribing policy. Despite the fact that she kept a copy in her pocket (D28-66) the reality is that DB despite her relative lack of training made a positive decision not to apply the guidelines contained therein to any one of these 12 patients.

72. With small fluctuations on occasion she gave pretty much the same to all. Whether you are old, younger, fat, thin, alcoholic these patients got opiates with a wide and dangerous range and with no special instruction to the nurses in any of the cases.

73. So forgive me if I do not now spend another 20 minutes going through the guidelines. I am going to take it that in general terms you know the principles well. For reference you will find the point t which I went through the guidance with DB at D28/71. She said this – My philosophy in those days working as GP and visiting the community hospital was that I would go in at a higher dosage ain order to give adequate pain control sooner and then reassess the dosage.

74. DB accepted that she was well aware of the guidance and accepted D28-73 that the danger was if you went outside the guidance that you would end up over sedating your patients. Importantly she was also aware apparently that mental confusion was a recognised adverse reaction to opiates – D28/78. That was also spoken about by Prof Ford – Magic p,23.

75. When I asked DB about the principle of reducing the dosage by 50% of the adult dose for elderly patients she gave quite a surprising answer – D28/79. Q Is that a principle you applied in your practice? A. No. I applied the principle of what I felt was an acceptable starting dose for the drugs I was familiar with in this very specialised corner of prescribing.

76. It is as if she felt that her particular corner of the Gosport Peninsular fell outside the run of the mill. That the guidelines did not apply to her because somehow either she or her patients were an exception.

THE ROLES OF THE CONSULTANTS

77. You heard from Dr Reid and Dr Lord. Both you may think must have known that there was anticipatory prescribing happening and both must take a degree of responsibility for failing to control it or put a stop to the very wide ranges.

78. Dr Reid it appears even had a hand in a protocol which looked at one time as if it was going to give DB carte blanche to write wide Pxs of the type we have seen. Dr Reid denied that ever came into existence in that form. Ex D5. Even that document headed proptocol speaks of a starting range of 10-40 mgs, not 20-200.

79. Barbara Robinson was plainly fairly sure that Dr Reid did know about the so called agreed protocol referred to in D4 which mentions the 20-200 ranges and it may well be safest for you to assume that he at least did.

80. The fact that he did not challenge what was plainly inappropriate does not make it appropriate.

81. That they were plainly inappropriate is clear because the Pxs are frankly dangerous.

82. Dr Reid should undoubtedly have said so. But it sounds as if the relationship was not the usual one between a consultant and a more junior doctor. As Reid readily conceded DB had greater experience in this field that he did.

83. Equally the Pharmacist who we are told looked at the Pxs but did nothing. It does not make the Pxs any better or safer. It simply demonstrates that there were failures across the board at this hospital. But, at the end of the day DB can no escape her own responsibility by pointing at the failures of others. They were her Px and as she told you this was her hospital, her wards, her nurses and her patients.

POLICE STATEMENTS

84. I have described these previously as self serving and carefully crafted.

85. What is the relevance of them now?

86. Dr Barton now seeks to justify her prescriptions by saying on a number of occasions that the patient concerned was in great pain. Before you accept that evidence you will have to consider what she told the police about what she could actually remember of those patients. When she was interviewed in 200 and 2004 she first chose to answer no questions and respond instead with carefully crafted statements. You will find her phrase 'I anticipate that' throughout those statements. What she means is of course – that because the prescriptions and administration of drugs was so great she would not have written them or ordered them to be administered unless the patient were in great pain. But the notes do not bear that suggestions out. Nor in many cases does the lead up to the administration of those drugs. Nor in many cases does the recollection of those nearest and dearest to those patients bear that out. And we would ask you to examine those claims now made by DB with great care before you accept them.

87. As she told you D29-7 – she would not and did not leave anything significant out of those statements which she could then remember.

EXPERT WITNESSES

88. Just before turning to the individual patients – a word or two about the two expert witnesses who were called. It may be suggested that Professor Ford approached these issues as an academic looking down upon these proceeding from some ivory tower. That is not the case because Professor Ford is a clinician with a current clinical practice – go to Ford's experience. MAGIC p.40

89. He had, before he gave evidence read all of the evidence, all of the relevant statements, read all of the patient notes and equipped himself with the material to give him a proper foundation form which he could give his expert opinion.

90. Professor Sikora who is extremely eminent in his field, which is as an oncolgical physician, did not have the advantage of having looked at the patient notes, or reading the relative's statements or hearing or reading their evidence. He was not asked to comment on each individual case and you the reason he was not asked to do so you may think is because there isn't a reputable doctor in the UK who can sit in front of you and defend these prescriptions and DB's practice in relation to each of these 12 patients.

91. Professor Sikora gave general evidence which I will examine briefly now. Professor Ford gave specific opinion evidence which I will deal with when we take a brief look at each patient.

92. Prof Sikora gave evidence on D34. It quickly became apparent that his opinion was based on a wholesale acceptance of the material put forward in Dr Barton's police statements as if they were fact. He was not, but you need to be cautious about that.

93. He was asked by TL to describe how it is possible to judge accurately what a patient's analgesic needs are. The purpose of the question was to elicit from him his evidence that you have to have the patient in front of you and no one other that the doctor looking after that patient is in a better position. But he started his answer in this way D34/6 – 'the only way is to be with the patient and see what happens after a given dose of an analgesic is given''.

94. That may well be right and if it is DB broke the first rule. She prescribed large doses in advance of a patient even needing analgesia. She did so because she thought she could gaze into a crystal ball and assess what pain relief the patient would need in the future.

95. Prof Sikora confirmed the importance of making notes in relation to any major change in the management of a patient's condition and in the drug regime D34-23. Particularly important he agreed was the decision to enter into the non-curative palliative care pathway. He said when answering questions form Miss Julien that note making was an integral part of good medical practice. D34-40.

96. In his opinion a range of between 10-20 was reasonable provided the patient was already in pain or very soon to be visited by some serious pain D34-24. A one size fits all approach would he said be wholly inappropriate.

97. We also established with him the importance of the BNF and the Palliateive care handbook in the treatment of real patients – I put to him D34-25, you do not throw these out the window as soon as you are confronted with a patient – 'exactly'.

98. He was also an advocate of titration - - to use oral morphine or long acting morphine and work out over 2-3 days what the dose is and then use that in the SD - D34-27. Q Because unless you do that there is a serious danger that you are either going to start too low or too high with your SD– A. Exactly.

99. Titration does not mean having to have a nurse hovering over the Pt every minute, but checking every hour or so and making a note every four hours.

100. He confirmed the great caution required when adding Midazolam to the mix D34-29. He also confirmed, and this is of particular importance to rebut one of the assertions made by DB that simply because a Pt is on the terminal pathway, in other words – dying, does not obviate the necessity for using the analgesic ladder and the guidelines.

101. So far as going outside the guidelines, Prof Sikora confirmed that he had done that himself – he said that in each case his patient had cancer and they were all

patients in really severe pain and in one case distress and agitation that was really distressing to the family, he was on the spot and he said it was very unusual.

102. The difference being that from what we have seen in these 12 cases it was not unusual at all for DB to ignore the guidelines.

103. Finally he spoke about the practice of titrating using a SD and how that required considerable monitoring because the plateau is reached after about 1o hours and if you have started with too high a dose it will only become apparent after that period of time. I asked him – does it follow form that that your responsibility for monitoring the patient is obviously much greater. A. It is - D34-54.

104. For a doctor in the position of DB without specialist training he agreed that guidelines took on a particular significance - D34-55.

Patient A

105. Run thru overview. And Magic overview.

106. The increase on the 15th when he was started on the SD was effectively and increase from 30 mgs orally to 80 mgs SC, so an equivalent increase of 8 fold onto which was added Midazolam at 60 mgs.

107. Then go to Ford in Magic

108. Dealing with her anticipatory dose for this patient it is worth reminding oneself of the justification for it according to DB - – D29-12-15.

109. DB accepted D29/10-11 that nowhere was there any literature to support what was in reality an increase of 4 times the previous dose – she said this – its not written in guidelines but you do it on the assessment of the patient. Not what you read in text books D29-11. And there lies the fundamental problem of DB's defence of these administrations. It is based on her own infallibility in guessing the right amount of drugs to use even though they are outside any guideline which anyone else might use. As Professor Sicora was later to accept, a person in her position should be guided by the principles set out in the the BNF and Palliatice care handbook.

110. The BNF and the Wessex protocols were not written by academics for academics. They were written to guide doctors dealing with real patients in significant pain. Indeed the Wessex Guidelines are specifically for palliative care patients. But DB did not think those applied in her practice, nor apparently did the BNF.

111. D29-11 D. At the time you wrote out this prescription you had never read anything hat could conceivably support it had you? A. No.

112. The doctor accepted in relation to this first patient that the guidelines in the BNF were so far as she was concerned irrelevant, the guidelines in the Wessex handbook were irrelevant and that she did not use at all the practice of titration.

113. Finally DB accepted D29-18 that the doses were dramatically over any form of guideline that she could have been relying on.

Patient B – Elsie Lavender

114. Run thru précis. Run thru Magic.

115. Then go to Ford

116. Prior to transfer the patient had been on co-proxamol and DHC.

117. DB's view was that an assessment of why this lady was in pain was pointless as it was not going to alter her management in any way D29/25. It does not appear that she agreed with the assessment of the consultants as to this lady's rehabilitation

118. DB's prescription for this patient for D and M if administered would have involved and eightfold increase in the MST which had been delivered the day before.

119. Again DB accepted that when she wrote out her px for this patient she would not have done so by reference either to the BNF or to the Palliative Care handbook. D29/26.

120. DB accepts that there is no note made of any re-evaluation of this patient and you have to ask were the re-evaluations taking place at all. Is the truth that once the anticipatory SD has been written out the patient's destiny has been decided. Is that in truth why there is a complete dearth of notes and a lack of assessment because such assessment would be pointless if the view has been taken that this patient is on the road to death.

121. She directed that the patient should receive on conversion three times what she had been previously receiving. There is not a book nor an expert which supports such an increase. She told you that she was aware when she wrote out that Px that it may have potentially fatal consequences for her patient. D29-28. That is all very well and may well be acceptable under the principle of double effect but the dose was outside of all medical learning and no-one has come along to say that was acceptable.

122. DB was relying on Nurse Coachman who was in turn relying on what she was told by the night staff.

123. From the moment this patient arrived in the hospital there was no plan of treatment – only palliation of her symptoms. It appears also that she did not agree with the assessments of either Dr Lord or Dr Tandy. Both of whom thought that this lady should have the chance of rehabilitation.

124. Yvonne Astridge was called by the defence D30 but could not in fact add to her notes and could not remember the Pt specifically. She was asked specifically about this patient moving to the terminal care route and what note is made when that happens – by Mrs Mansell D30/80. Sher could not point to any note of any assessment when that crucial decision was made for this patient.

125. She also told you that the nurses would always seek specific authority before starting a SD (D30/83) but unfortunately the reality is that that did sometimes happen and that illustrates the dangers of these Pxs.

126. Nurse Joines said in answer to Mrs Mansell about this patient Elsie Lavender that when the patient was crying out in pain she did not really concern herself with what was causing the pain but set out simply to relieve it. D33-36. She went on that in essence she would leave that sort of thing up to the doctor. But the doctor in this case had the same attitude – control the symptoms of the pain, not its causes.

Patient C – Eva Page

127. This patient was for palliative care having a cancer of the Bronchus. She was not generally complaining of pain but she was understandably frightened. She was opiate naïve before her arrival at the GWMH on 27.2.98 when DB wrote her up fpr Ormorph which in the particular circs of this case Prof Ford thought appropriate. Nor is there any complain in the charges about that Px.

128. Go thru Chrono.

129. Go to Magic. To Ford. Dr Lord appears to have approved of this patient having Fentanyl patch and Professor Ford was not critical of that management for this particular patient.

130. DB D29/33 – I would ensure the patch was taken off, otherwise the patient would receive a higher dose than you would want and that could lead to over sedation.

131. There is no note of that patch being removed prior to the SD being started. In the later case of Elsie Devine we know that it was normal to make such a note. Once the SD started there was a rapid change in the patient's condition.

132. In relation to patient C it is worth bearing in mind that the charges relate to the prescriptions for D and M and that they created a situation which allowed for drugs to b prescribed which were excessive to Eva Page's needs – that was inappropriate and not in her best interests – and that you may think is the case irrespective of the use of the Fentanyl Patch. But this case may be a good example of the failure to make a good or any note of the drug regime.

133. The failure to make any record here of the circumstances in which the D and M should be deployed and their administration apparently when a Fentanyl patch was still in place is a good example of the dangers inherent in DB's practice.

134. Only 2 charges remain in relation to this patient and that is that DB's wide prescription of D and M on 3.3.98, when the patient still at that time had the Fentanyl patch on her body were inappropriate and not in the patient's best interests. In fact the D and M were administered it would appear when the Fentanyl were still there and the patient died that same evening.

Patient D – Alice Wilkie

135. 81 years old, unresolved UTI. Opiate naïve prior to GWMH. DB says that this patient's care may have been effected by the rumpus made by relatives of Gladys Richards (D29/36). In examining that excuse it may be worth considering whether the care afforded to Alice Wilkie was in fact any different to that given to the other 11 patients or whether it was the standard prescription and the standard treatment.

136. Right up until the 20th, the day the SD wsa started apparently by Philip Beed, this Pt ws opiate naïve. Go to Chrono and Magic

137. DB admitted a complete failure to make any note of any assessment of this patient (D29/36). There was one note of pain on the 6th August on the day of transfer - chrono.

138. There is an undated Px which DB assumes was on the day that Mr Beed first administered it. There is no record made by DB of why her px was written nor the purposes for which it was written. DB agreed that even 20mgs her lowest dose was not a small amount but equated on her figures to 40 mgs of Oramorph daily. That of course does not take into account the fact that this was an elderly and frail Pt.

139. This Px was started by Philip Beed, who could not remember this patient at all, apparently on the say so of Marylin Jackson who gave evidence about this –

140. She told Beed that her mother was flinching with pain. It appears to have been on that basis that he decided to commence the SD at 30 mgs. DB agreed (D29/40) that that was a large dose but insisted it was what the Pt needed. Howe does she know? Nothing else had been tried. There was no attempt to deal with the analgesic ladder whatever.

141. Alice's daughter found her unconscious later that evening and her mother never woke up again. According to her there had been no mention of an SD by Philip Beed or anyone else before it was started. DB agreed (D29-40) that if it had happened in that way it would be an extremely unsatisfactory state of affairs.

142. The Px is admitted to be too wide, it is admitted to be potentially hazardous – in this case we say it may well have hastened the patient's death, but, says DB it was appropriate.

143. It was only appropriate you may think if it was the lowest dose which would control this patient's pain and there is nothing to support that contention anywhere. Neither DB, nor Philip Beed nor Professor Sicora can possibly say so. The lack of notes about decision making in this case frankly are a scandal. This patient was transferred to Daedalus on 6th August from QAH, Dr X made an extremely brief note on clerking her in, 4 days later there is a clinical note by Dr Lord which says the Pt is eating and drinking better and the only clinical note made by DB records, on the 21st August that the day before the SD was started. That same evening this patient died

144. The allegations are restricted to the wide Px which was, for this Pt inappropriate and not in her best interests and was the standard 'one size fits all frail old ladies'. If one asks oneself – what was it about this lady's presentation or symptoms at the time that DB wrote that Px out which justified it, its impossible frankly to see any justification at all.

Patient E – Gladys Richards

145. The only issue in relation to the charges for this patient is whether the initial Pxs on 11.8.98 for Oramorph and the wide Px for D and M were either together or separately inappropriate and not in the Pts best interests.

146. At her pre transfer hospital she was described as fully weight bearing having had her hip fracture fixed on the 30th July. She was cared for at the Royal Hospital Haslar and you will remember the evidence of rear Admiral Farquharson Roberts called by the defence on D33/62 who dismissed the suggestion made by Yvonne Astridge D30/74 that his nurses were a bunch of beefy sailors who would not know the difference between a patient who was weight bearing and one who was not. On the day of her transfer she was opiate naïve.

147. Go to summary and go to Magic.

148. DB told you (D29-43) that the assessment at the previous hospital was not relevant to her assessment of the patient. You may find that a fairly surprising statement to make. If there was a significant difference between the 2 it ought to alert the doctor that something may have gone wrong since the previous assessment and that would entail a further examination and a plan of action – potentially involving a re-transfer. She did have severe dementia it would appear as was well known.

149. But the plan for this patient was said to be.. chrono p.5.

150. On 12th again – specific comment that this patient did not seem to be in pain.

151. This was another Pt who had to be regarded as opiate naïve. As soon as she was admitted DB treated her to the usual Px. DB agreed that this was not a dying or terminal care pathway patient. This lady had come to be remobilised. So what was DB doing when she wrote out this potentially dangerous Px? What DB said was this – (D29/44) "I anticipated with the severity of the dementia in this patient and the insult to her caused by the fractured neck of femur that she could, at some stage in the future become palliative and terminal".

152. She was immediately given Oramorph as well as Haloperidol and that night was so drowsy that all her other medication was stopped (notes p.64). That was on the very day of her admission and entirely down to the Oramorph and Haloperidol she was being given.

153. It is worth comparing that medication with the medication she was given at the RHH. She broke her hip on 29.7.98. A week later there was this note – 8.8.09 Chrono. A single dose of Haloperidol seems to have helped her but kept her alert and conscious and able to eat and drink.

154. About the return on the 17th - DB told us (D29-47) that she knew this Pt had been more effected than normal by the Midazolam she had been given preoperatively. That was something she may have wished to take into account and reviewed her previous prescription for between 20-80 Mgs.

155. On 17th DB sees her on her readmission and apparently she is peaceful, but that afternoon she is in pain again. An X ray is very properly ordered by DB and a haematoma is seen. The decision seems then to have been taken that this pt was on the terminal pathway. She was drugged so that she became unconscious and was rendered in that state so that it would not have been possible for her to reveal to anyone if the haematoma resolved itself. DB told you that had the Pt survived (D29/49) the body would have eventually resolved it and it would hopefully have drained away. The reality is that that opportunity was denied to this patient.

156. The Pt was given 40mgs Diamorphine which was high but given that this pt was now in pain not unreasonably so but Prof Ford found the Midazolam impossible to justify. That was administered solely on the basis of the original Px from the 11th August.

157. Thereafter Lesley O'Brien described her mother as not conscious and not moving or doing anything'.

Patient F – Ruby Lake

158. Again the charges are very limited and relate to the first Px for Oramorph on 18th August and the standard D and M Px of the same date the allegation being that for this Pt those Pxs were inappropriate and not in her best interests. As with all Pts there is the additional allegation at para 15 that DB failed properly to assess them before Prescribing opiates. The basis for that being that if Prof Ford is right in each case that these Pxs were wrong and inappropriate then it is difficult to escape the conclusion that the patient was not appropriately assessed.

159. FNOF Chrono p.2.

160. On 14th August she sees a physio and the next day she was given some Codeine because she was in pain after being manhandled.

161. On 17th August the day before her transfer she had a small spike of temperature but the next day her temp was normal and she was described as 'well comfortable and happy. This was a transfer from the RHH from which according to the Rear Admiral Surgeon in Orthopaedics the patient would not have been transferred unless stable and ready D33/52.

162. Go to chrono and Magic.

163. As DB accepted D29/54 this lady did not have a particularly gloomy outlook when she was transferred. DB wrote out a note but in relation to that it is worth remembering that DB in evidence told you that her comment about gentle rehab was 'slightly tongue in cheek' (D29/54) 'this was potentially a very ill elderly lady'.

164. Until her transfer her pain had been controlled by Paracetamol. She was totally opiate naïve. DB accepted that when she wrote out her px on admission she was ignoring both the palliative care handbook and the BNF (D29/55).

165. This was the patient who woke up on her 1st night at the GWMH and was confused and wanted someone to sit with her and at 12.15 she was given 10mgs of Oramorph. DB accepted (D29/56) that if the pt was confused Oramorph was not going to help them but it would help congestive heart failure if that was her

problem, which at 12.15 at night you may think it was not. She was anxious and distressed and in a new environment and she was given opiates.

166. of her px DB agreed – if nurses had given her even half of the full amount that might have killed her D29/57.

167. By 4pm the next day she is on the terminal pathway of the SD. On the equivalent of 60 mgs if given orally and mixed with Midazolam. No note is made as to why that was done which again DB accepted was unacceptable. D29/59.

Patient G – Arthur Cunningham

168. This Pt was admitted for treatment of his very bad sacral ulcer. Admitted from the Dolphin Day Hospital by Dr Lord who well knew the abilities at the GWMH and who can not be accused of an overoptimistic approach. He was also reviewed there by DB who viewed the sore according to her (D29/62).

169. Again the charges are very confined to the prescriptions and the lack of assessment before prescribing opiates but in this case there is the additional charge that DB did not obtain advice from a colleague as the Pt's condition deteriorated. That is a fact and in due course you will have to decide whether that contributes to the allegation of SPM.

170. Go to Chrono and Magic.

171. In fact as soon as that patient was wheeled from one ward to another he was almost literally on the terminal pathway because that is how this doctor approached his treatment (D29/62). In her view it was not even practical to try to give him the high protein diet directed by Dr Lord. Whatever the nurses were going to try to do DB agreed with me that she would have spoken to the nurses and given her opinion that the best that could be done for this Pt was to make him comfortable D29/64.

172. On the night of the 21st September he has a period of very serious agitation and behaving badly. Oramorph is given at 8.20 pm and 10 mins later he is no longer agitated. 2 ½ hours later the night staff appear to have thought it right to put this man on the SD prescribed for him by DB. No one seems to know who made the request mentioned.

173. It is difficult to see why SC drugs were needed given that that night it appears that he had been able to drink 2 glasses of milk.

174. The Midazolam then gets tripled. Chrono.

175. DB agreed that he was clearly a caring and loving relative, but she described as inhumane and abhorrent the suggestion that his infusion could be stopped or

reduced D29-69, D31/11. This pt 2 days earlier had been sitting up in bed and asking for chocolate.

176. I would have done little harm to reduce the dose sufficiently to be able to speak to the patient even if it was for the final time. DB said this (D29/72) 'your idea of withholding analgesia from somebody who was dying was just abhorrent to me'.

Patient H – Robert Wilson

177. This patient's Code A liver disease well known to DB and features as a significant factor in the charges which she faces. It is the GMC case that DB took no account of it whatever and it is clear that it made no difference whatever to her standard medication which was wholly inappropriate for this patient.

178. This patient had a Fractured humerus which he did not want to have fixed. Chrono p.17 – chatty and funny. On transfer he had a Barthel of 7. 9 days before transfer he knocks his arm and was given morphine. Prior to his arrival at the GWMH that was the last time he had been given it but he had thereafter been on codeine. Px -

179. DB agreed in evidence (D29/74) that the lowest dose of D she prescribed would have represented a massive increase in anything he'd had previously.

180. Go to chrono. And Magic

181. I put to DB this D29/74-75 – do you accept that the Px that you wrote out on the day of his admission appeared to be flying in the face of his management by other doctors at this stage – A. they appeared to be flying in the face, because they are more realistic that the previous pxs that were written. A. I did not reduce the doses because he had Code A and liver damage – I kept the doses exactly the same and took no account of it (D29-75).

182. Those realistic pxs had this effect – on the day of his admission he was able to stand to relieve himself at a urinal. He was given that day 20 mgs of Oramorph. The next day he went up to 50 mgs. This was a man whose pain had hitherto been mostly controlled by Codeine.

183. His deterioration mirrors the increase in his opiate dosage. His deterioration did not cause DB to consult with any senior colleagues and again you are invited to factor that in to the issue of SPM if you feel it appropriate to do so.

184. Dr Knapman saw him on his 2nd day and DB appeared at one stage to suggest that it must have been Dr Knapman who authorised the SD. But Dr Knapman saw the

Pt in the morning and increased his Frusemide saying nothing about a srynge Driver. It was not until that afternoon that the SD was started.

185. By the 16th he could not even speak. He had told Ian Wilson his son that the staff were killing him. That was no doubt the unintended consequence of their actions but it was one of the consequences nevertheless.

Patient I – Enid Spurgin

186. 92 year old lady pulled over by her dog breaking her hip. A potentially terminal event for any old person.

187. The charges in relation to this patient do need more careful consideration. The assessment on admission is criticised. The usual dose range is criticised as being inappropriate and not in the patient's best interests. Additionally the admnsitration of of the syringe driver at the dose of 80 mgs D with 20 mgs Midazolam which dr Reid later ordered to be reduced is also specifically attacked as being inappropriate and potentially hazardous and not in the patient's best interests – none of those allegations have been admitted.

188. At the time that this patient was Transferred to Dryad on 26th March she had last had any morphine 5 days earlier at 5mgs ic.

189. When you compare the sort of doses any one of these pts had received previously, even those having just been operated upon one does not find any sort of comparator with the doses that were administered at the GWMH under DB's authority.

190. On the day of her arrival she was given 25 mgs of Morphine. Up until then she had been on a regular dose of 1 gramme of Paracetamol daily. That's 2 standard 500 mg chemist bought pills a day. The analgesic ladder again has been thrown out of the window and for no clear reason.

191. Go to chrono and Magic

192. According to Prof Ford this Pt should not still have been in pain from her operation by 3rd April and it was an indicator of something wrong. When I asked DB what her plan was – D29/83 she said – 'to sort out her analgesia' Q. Did that plan change at any stage? A. No.

193. The Pt reacted badly to the Oramorph throwing it up and they tried co-dydramol instead. That was acceptable as was the later Oramorph according to Prof Ford if the Pt was still in pain. There was no exploration however by DB as to why this

patient was in pain so long after her operation. She appears to have been leaving it up to the physiotherapist to report if there was anything wrong.

194. On Thursday 1st April the wound is oozing but DB does not ask for it to be swabbed until the following week on Tuesday – DB had no explanation for that delay.

195. It is left to Dr Reid on the next week to perform an examination and found that one leg was 2" shorter than the other. Why that was not discovered by DB can either be regarded as a mystery or a revelation about the worth of the evidence that she would have been examining these patients regularly. She plainly had not examined this patient very recently.

196. Dr Reid ordered an X ray about which DB told you (D29/89) I would not have looked at the X ray because it would not have altered my management.

197. By the weekend she has deteriorated very markedly and she was given MST. On the Monday morning DB starts the patient on 80 mgs if Diamorphine. A massive jump form 45 mgs orally to the equivalent of 240 mgs orally in a day.

198. The day before that SD was started she had been described as very drowsy and unrousable at times. DB readily accepted that she had not been consulting the guidelines when she administered that dose – D29/91.

199. Even Dr Reid who you may think was not very quick to take any supervisory role thought that was too high and halved it.

200. A nurse deliberately or otherwise then doubled the dose of Midazolam – which Dr Reid thought was an astonishing thing to do in light of his reduction.

201. The cause of death given in this case by DB was CVA for which you may think there was precious little basis

Patient J – Geoffrey Packman

202. Patient J was 68 when he was admitted to GWMH.. He was extremely obese and had a very bad pressure sore. Eventually he suffered from a GI bleed which was left untreated and he was administered pain killers under a palliative regime.

203. He had been on Clexane, had signs of a bleed and as a result the Clexane was stopped. Once he gets to GWMH there are clear signs there that he has a GI bleed and DB decides not to attempt to treat it but to provide palliative terminal care instead.

204. The charges focus on the usual Px, on 26th August and on the administration of 10 mgs D administered on 26th August. As well as DB's failure to obtain advice as the patient's condition worsened as a result of the GI bleed.

205. The purpose of his admission was to try to sort out his pressure sores and get him out of bed, he needed a high protein diet. Until his admission he had been on Paracetemol but it is fair to point out that there is a note that he did not think very much of them.

206. Go to Chrono p.10 and then Magic.

207. In light of Ford's concession the criticism of the 10 mgs Diamorphine falls away.

208. Dr Ravindrane examined him and you have the one and only example of a proper note of an examination in this entire case at p. of the notes.

209. A blood test was taken and the lab made attempts to phone the results though unsuccessfully. The results would have demonstrated a significant drop in the patient's Haemoglobin. DB told you this – (D30/4) 'My impression was following the conversation between Sister Hamblin and Dr Ravi that he was not for resuscitation and in my mind that equated completely with not fit for transfer up to an acute unit'. That was a new slant on what not for rescuss meant and one which you may think DB made up on the spot. She certainly had not ever mentioned that previously in any of her numerous police statements.

210. Professor Ford told you that this man was not destined to die – he felt there should at least have been a discussion with the acute physician.

211. On the day of arrival Dr Barton prescribed her usual prescription of D and M. It is pertinent that although there came a point when this patient was plainly deteriorating rapidly she did not consult with any other colleagues, not even Dr Ravi who was in fact the consultant in charge of this patient. She chose on his behalf the terminal route instead. DB says she discussed that with his wife. Let

212. On 26.8.98 he is seen by DB. The note is made – keep comfortable. On that day she prescribed a higher version of the usual Px starting off at 40 mgs to take account of his weight apparently. That was as she agreed an anticipatory Px D30/11 for which At that stage there was no indication.

213. By the second day of his starting of opiates he was on 26th August on 60 mgs of Oramorph a day. Up until that stage the only reference to pain in the notes was that he had pain in his throat which DB took to be a Myocardial infarction.

214. On the 30th Sister Hamblin puts him onto an SD. On that same day he is said on the notes to be taking a little amount of food mainly puddings. DB suggested it may have been a duty doctor who authorised the SD but accepted if that were so it would be very surprising if the duty doctor had not made a note.

215. What is of note here is that when she first wrote up this prescription DB was apparently able to foresee not only that the patient would in due course need opiates but that he would need them at no less than 40 mgs.

216. The Midazolam was triples on the 1st September. Mrs Packman told us that he was on the 1st September unable to talk, he was unconscious.

Patient K – Elsie Devine

217. Nephrotic syndrome which meant that her kidneys were damaged. Transferred at the age of 88. She was medically stable. DB agreed that she was an appropriate transfer on 21.10.99 and she needed a safe and secure environment. She was not in any pain. D30/17. She did not have multiple Myeloma which had been investigated.

218. The charges relate to the first prescription for Oramorph, being not justified, and to the doses of D and M prescribed on the 19th including the allegation that the lowest does was too high – this of course was all in the knowledge that this patient already had had a Fentanyl patch applied to her skin and that it would be taking full effect on the 19th.

219. It is alleged that those doses were inappropriate, potentially hazardous and not in Elsie's best interests. Bearing in mind that at the time they were written the patient was already receiving the equivalent of around 90 mgs D via the Fentanyl patch those allegations are well justified.

220. Let us look at the circs briefly – chrono (Brief) and Magic Doc.

221. DBs reason for writing out a prescription for Morphine for this patient was she felt that the patient 'deserved it'. As DB herself said D30/18 there was no reason to think that this patient was going to have any pain at the stage of her admission when DB wrote out her Px for Oramorph.

222. On 10th November the patient has an episode of confusion. And she is said to be wondering around the wards and as result she is prescribed and given Thioridazine which is a major tranquiliser.

223. Chrono p.13 review by Dr Taylor. Arrangements were going to be made for the lady to be admitted to Mulberry Ward which was a secure ward where she could be treated. That day DB prescribes the patient Fentanyl, by patch.

224. DB was aware she told you D30-22 of the effects of Fentanyl and that it remains active long after the patch has been removed.

225. It is therefore essential to remove such a patch prior to starting any other form of Morphine.

226. She is confused and aggressive in the morning of the following day when she still undoubtedly has the patch on and it is still effective, indeed it will now be at its peak. DB told you that she arrived on the ward at 7.30 and found this incident ongoing D30/27. As a result she was fully aware of everything that from this moment on happened to this patient and her medication all of which was prescribed for her by DB.

227. Chlorpromazine was injected into the patient and that calmed her down so that the staff could get her into bed. That was at 8.30. That lasts according to DB for approximately 4 hours. 55 mins later however a SD is started with 40 mgs of D and 40 of M. DB said this – she needed sedation badly I was not going to allow her to rev up again D30/27. DB agreed that with the amount of drugs in her system there was a danger of oversedation. This was an opiate naïve patient and this was, together with the Fentanyl and the Chlorpromazine a chemical cosh.

228. Ths wsa according to Prof Ford 'extremely excessive' and he felt it demonstrated that DB simply misunderstood the uses of Midazolam.

229. When I asked her whether she now, with the benefit of hindsight had any concerns about the way she handled this situation sh said this – D30/30 'No, I am delighted that she is now comfortable and they have been able to get her into bed and nurse her properly. I gave her another opportunity – do you see nothing wrong with this situation? 'Nothing at all'

230. This is another patient who has got confused and aggressive and apparently as a direct consequence of their behaviour found themselves on a SD and on the Terminal Pathway.

Patient L – Jean Stevens

231. 26.4.99 Pt had collapsed at home with a right handed stroke.

232. In relation to this patient all of the opiate prescribing by Dr Barton is criticised including Oramorph and it is alleged that there was, even though the patient was ill and may not have recovered from her stroke, insufficient clinical justification for her Pxs.

233. During her admission at the RHH she had a problem with the nasogastric tube which may or may not have caused her later bronchopneumonia difficulties. She had occasionally been given Diamorphine, last on the 15thMay when she was given 5 mgs subcut.

234. Chrono p.15 liaison with GWMH. She was on regular co-dydramol whilst at the RHH. She had long term gastric pain following an operation many years before.

235. She was opiate naïve apart from Co-dydramol when she arrived and on her first day at GWMH under DB's management of her care she received 15 mgs and was written up for the usual range of D and M, it is extremely difficult to see what clinical basis there was for prescribing those drugs.

236. Magic -

237. Although it was Dr Beasley increased the Hyoscine DB was not suggesting that he ordered the SD. She accepted D30/40 that it looks as though the SD was started by the nurses because her own Px allowed that to happen.

238. The patient died the day after the SD had started. Prof Ford's views were effectively that this lady should not have been treated with opiates full stop.

Conclusion

239. You may think that one of the central problems here, is that no one from the outside medical world looked in and examined what customs and practices had built up at the GWMH. The consultants appear to have accepted what was happening even when they must have been reviewing Pxs way outside the norm.

240. One of the most startling pieces of evidence in the case was when DB told TL that the criticisms of Prof Ford did not give her cause to question her judgment. I asked her again about that D29/61 – I asked her – 'do you mean that? That they do not even give you pause for thought about your judgment?' A. – I do.

241. When you consider the evidence and consider whose evidence to accept and whose to reject it may be worth coming back to that reply because it reveals a doctor who brooks no argument, one who is absolutely convinced of the infallibility of her judgment and who will stand before you and justify the unjustifiable.

242. When DB was asked whether she felt it mattered whether or not a patient who was dying was overdosed her reply was revealing – D31/8 That is a very good question is it not? If you believe that and you think that is true then why am I here. She said that she thought that <u>probably</u> overdosing anyone with anything was wrong, incorrect and unprofessional. She also said later when I questioned her again D32/4 – if I was accused of over analgesia or sedation or under, I know which direction I would wish to err'.

243. This isn't a Tribunal of ethics or morals. We have rather simpler issues to deal with. We ask doctors to abide by good medical practice, to obey the Hippocratic oath, and to have regard to guidelines for those prescribing opiates.

244. But when Dr Barton says that she did ignore the BNF and the Wessex Protocols which she did time and time again, when that same doctor makes no note about what she is doing or why she is doing it, when she delegates responsibility to nurses for deciding how much to give and when to start the 'terminal path', then

you will have to consider whether those actions could ever be in the best interests of the patient.

245. In terms of ultimate responsibility this was in Dr Barton's words - Dr Barton's hospital. As she said D31/9 – these were my wards, my patients and my nurses (D31/9).

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3rd August 2009