FFW/105/06.

General Medical Council

– and –

Dr Barton

FTPH Transcripts

General Medical Council

- and -

Dr Bolton

32 — 38

FTPH Transcripts

File 5

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 27 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-TWO)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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A

JANE ANN BARTON, Recalled

THE CHAIRMAN: Good morning. Welcome back. I trust everybody had a refreshing weekend. We are ready for another week of action.

Mr Kark.

Further cross-examined by MR KARK

B

MR KARK: Dr Barton, I do not have very many questions for you arising out of the Panel questions, but I do have a few. When you were asked questions by Ms Julien, you were asked, effectively: when do you now feel you should have formalised any complaint or when should you have formally voiced your concerns? You said you should have written to the Trust formally in 1998-1999 when Dr Reid took over. Do you remember that?

A Yes.

C

Q Because that was a year, up to that year, when you had not had proper medical cover. I just want to understand: why do you feel that you should have done that only when Dr Reid took over? Why have you pinpointed that timeframe?

A I think that we all felt, doctors and nurses alike, that, although the situation was becoming gradually more difficult, we were just containing it and we were just able to manage the rate of admissions and the level of dependence of the patients we were getting.

D

I think we all perhaps hoped, when the new clinical director was appointed and when it became apparent that he would also be looking after Gosport, that there would be a proper look at how we were able to look after our patients and the resources we were given to do that. Although he was appointed in 1998, he did not start working on the ward until 1999, and those informal discussions I had with him made it apparent to me that there were not going to be more resources and there was not going to be any change – in fact, there was going to be an acceleration of the rate at which we were getting very dependent, very ill

E

patients – and then was the time to start thinking about saying, "I can't do this any longer."

Q Dr Barton, up to that time when you described yourself as holding your head above water, what change did you make to your practice or the practice on the ward to ensure that your patients' safety was kept at the right level?

A Just worked harder.

F

Q Yes.

A Because that is what you did in those days. Went in more often. Came back more evenings. Gave up more time. Which I did not resent. I did not mind doing it because I felt the patients and the staff deserved it, but it did become more and more intrusive into free time and private life.

Q But this comes to an issue, I think, that Mrs Mansell asked you about, which was who

G

was there to challenge your practice? Who guards the guard?

A That is a philosophy that did not really exist in those days. We did not do clinical audit meetings; we did not look over our shoulders at each other all the time; we were so busy getting on with doing the job and doing it well.

Q You also told the Panel that you regarded Gosport War Memorial Hospital as a community hospital. Yes?

H

A Yes.

Q In what way did that affect the level of care that you provided?
A It made it better because I was looking after my own patients and my own patients' relatives. Money was raised within the town to look after that hospital to supply it with equipment we needed and there was a force multiplier of affection for the town's own hospital and the people who worked in it.

Q Did that lead to a reluctance to return patients to the acute hospital?
A Not at all.

Q You were asked by Mr Payne about your anticipatory prescriptions. He used these words to you, I think, that it looks as if it was "one-size-fits-all". You said in respect of these patients – and I am sorry I do not have the transcript in front of me – that it was obvious they were not going to be rehabilitated and that at some stage they would need terminal care.
A Yes.

Q Is that in relation to all those patients for whom you wrote out these wide doses of opiates?
A I thought that what Mr Payne was perhaps suggesting was that it was something that I wrote up almost on arrival in case the patient was to go down that line. I tried to explain to him that you are looking at a very tiny, tiny minority of the patients who went through our wards who were chosen by the police because they were particularly different and difficult to look after, so that my what you chose to call normal range of anticipatory prescribing was something that I would consider and use when I thought the time was right for that particular patient. That is why you have seen it in several of these case and you have also seen that it was not always 20-200 mg, it was a range which I felt, in my clinical judgment at that patient's bedside, was going to be appropriate for that patient's symptoms.

Q Dr Barton, you are not saying, are you, that it was only in respect of these 12 patients that this Panel are looking at that you wrote out these very wide prescriptions?
A I am not saying that at all, but I am saying that in a number of patients whom you have not been looking at the syringe driver was probably never even given.

Q Yes, that may well be right but ----
A Because they got better, not worse.

Q But I just want to have it clear, when you talk about these 12 cases and the police picking them out especially – and this is not a police prosecution, this is a GMC prosecution, you understand – you are not saying that they were exceptional because they were the only ones for whom you wrote out these prescriptions.
A I am not, no.

Q Right. What was it that you are saying which was exceptional about these 12 cases? Can we look at them for a moment? I am just going to take the first five or six. Patient A was very depressed and had an ulcerated left buttock and hip. Patient B had had a stroke and a fall. She was diabetic and incontinent. Patient C had carcinoma of the bronchus and was depressed. Patient D had a resolved UTI and dementia. Patient E had a fractured right neck of femur and dementia. Patient F, just by way of example, had a left fractured neck of femur. We know about the circumstances of all the patients in this case. What are you saying is exceptional about any of these cases?

A A I am saying that all the patients I looked after through that 12 years were exceptional in their own way. They are not bundles. They are not letters 'A' to 'F'. They were real people and they had real and difficult problems of management of their symptoms at the end of their lives.

Q That I entirely understand but you are not saying, are you, that these 12 patients were any more difficult or worse than any of the hundreds of patients that you dealt with? You B dealt with a range, did you not?
A I did.

Q And these 12 people were within that range, were they not?
A Yes. But they stuck out for some reason. They were focused on originally by the police investigation for some particular reason.

C Q I understand that but that reason revolved, I suggest, around your treatment of the patients themselves.
A My treatment of them depended on the problems that the patients in front of me had.

Q You were also asked, I think by Mr Payne, about the position of making the decision about returning any of these to the acute hospitals.
A Yes.

D

Q I just want to ask you this in relation to any of these 12 patients. Before deciding that any of those patients were too ill to transfer, except of course for Mrs Richards, did you make a call to the hospital to find out if they could take them?
A No. I was a practising GP at the same time in the town. I was on call for my own patients most days. I was well aware what the bed state was. We did not get emails in those days, we got pieces of paper down from the Trust saying "We have a bed crisis." "We are E not able to admit cold surgical patients." "Please do not admit patients unless it is absolutely necessary." I was not working in the vacuum of a cottage hospital; I was working in the community with the Trust all the time.

Q Yes, and that pertains, does it, for the entire period 1996, 1997, 1998 and 1999?
A It was beginning to ramp up in 1996 because continuing care was beginning to fade out even in the Portsmouth district and the bed crisis was beginning to start. It was not as F acute as it was in 1998-99 but it was there.

Q Because of that, you never felt it appropriate to call the acute hospital to say, "Have you a bed for one of my patients? I need to return them."
A I did not feel it was appropriate to call the hospital and ask them for a bed because I did not feel that a bed would be appropriate for any of those patients.

G Q You also spoke to Mrs Mansell about the over-optimistic view by the previous hospital. We have heard a lot of evidence about that. When you first assess these patients after transfer, you accept that they are likely to be or sometimes at least they will be in a less good condition than they will be pre-transfer.
A Yes.

Q If you decide their path then and there, do you agree that there is a considerable H danger of setting them on too pessimistic a route?

A A Yes. That is why I said on a number of occasions that we did not write out a formal plan at the 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.

Q And yet you were writing out these large variable doses.
A Because clinically, at the bedside, these patients were very ill.

B

Q You were also asked by Mrs Mansell: does it matter if there is an overdose in a patient who is dying?
A I have thought about that question all weekend.

Q Yes, I expect you have. And you answered: "That is a very good question …" Do you think it is acceptable to overdose someone who you believe is obviously dying?
C A I think that it goes back to "do no harm" and I think that if I was accused of over analgesia or sedation rather than under analgesia or sedation, I know which direction I would wish to err. I would wish in an ideal world always to get it absolutely right for that patient, so that they were comfortable, at peace, and not over-sedated, but it is a very difficult clinical balance.

Q In your mind does there come a point when, because the patient is so close to death, it
D effectively does not matter if you overdose them?
A No, I have never felt that. It always matters. The patient is always your prime concern right up until the moment of death.

Q In that light, do you accept that some of these patients were, by reference to any national standard, given excessive opiates?
A I do not, because you are talking again about a national standard as applied to
E palliative care not terminal care. As you said to me, you have seen no literature on the management of terminal care, I suspect there is not any. I do not think you can do clinical trials and crossover studies and blind trials on people who are in the hours and days of death.

Q You were asked by Dr Smith about why not use an intramuscular dose when a patient had breakthrough pain and you spoke about the importance of avoiding intrusion and peaks and troughs.
F A I did.

Q You said – and again I am sorry that I do not have the transcript in front of me – that these were patients who were going down hill and who are put on the syringe driver because they are dying.
A Yes. And therefore you could be giving a dose of analgesia and anxiety relieving
G drug that would give you a level of comfort that you could not achieve by assessing a patient every hour, every four hours, and giving them injections to control their symptoms.

Q It follows from that, does it not, that you must have made the decision in relation to those patients that they were by then on a terminal pathway.
A I had.

Q You were asked specifically about Mr Cunningham and Mr Farthing and about your
H words "I would find it abhorrent to pull back because withdrawal would be very unpleasant."

A You said, "We were only able to control him just and otherwise he would have been in agony."
A Yes. This was the gentleman ----

Q Again ----
A Carry on, sorry.

B Q Are you saying that you now remember him?
A I have been living with these bundles, these cases, for all these years, and going back and back over them, but this man I do remember. I knew by then that his lungs were filling up with pus. He had a post-mortem subsequently which showed that he had lungs full of pus. Had we reduced his analgesia and his hyoscine and his midazolam, there is no certainty that he would have woken up but my goodness he would have been in agony.

C Q You were asked about Elsie Devine. You were asked: why give her fentanyl and not chlorpromazine? Before putting Elsie Devine on to fentanyl, did you consider making more urgent efforts to get her into Mulberry Ward that day?
A Mulberry Ward from my knowledge of it was not an appropriate ward for her to end her days on. Mr Pittock came down to us from Mulberry Ward to receive medical and terminal care. It would have been quite inappropriate to transfer her upstairs to a different team of people whose focus would not have been on ensuring that her death was dignified
D and pain free.

Q I think it was in relation to Elsie Devine that the consultant indicated they were going to try to find a bed on Mulberry Ward.
A Yes.

Q You disagree with that, do you?
E A Yes – as it turns out from the change in her clinical state from the morning that she started the fentanyl patch and for the remaining three full days of her life, it would not have been appropriate to move her up on to a psychogeriatric ward.

Q You were asked by the Chairman about Professor Ford's evidence about titrating the dose. Yes?
A Yes.
F

Q You said Professor Ford was talking about titrating the dose and having one-to-one patient nursing care: "We gave patients comfort and dignity." First of all, let us deal with titrating the dose. Titrating the dose is not a specialist field, is it?
A No, but it is a very intensive field. You need two trained staff and you need somebody with the patient virtually 24/7 to assess their condition, assess their needs. Even to draw up the doses and bring them to the patient's bedside and give them, we simply did not
G have the level of staffing to do that on a ward of 24 people.

Q I want to ask you about the level of staffing that you had in 1996, 1997 and 1998. On average, how many nurses were there on Daedalus Ward and Dryad Ward during the day?
A I would think that there were sometimes two trained staff and four untrained staff.

Q To cover how many wards?
H A Each ward. They did not, in the day time, move between the wards: they stayed on

A their own ward.

Q We have heard repeatedly from nurses about the general excellence of nursing care.
A They were superb.

Q Yes. Patients did not suffer from a lack of nurses, did they?
A No, but, my goodness, they would have if two trained staff had been tied up titrating
B and drawing up and giving injections of diamorphine, even every four hours, let alone every hour.

Q Titrating doses is a basic standard medical principle, is it not?
A It is.

Q And you are saying that under your watch that simply was not being done throughout
C these three years?
A I am saying that. I was not taught it. I was not familiar with using it. I was a community doctor and a GP and it was not practical, either in general practice or even in the best nursing homes or in the continuing care, palliative care, wards where I worked. It just was not feasible.

Q And what you said about that was that when you saw how much these patients
D needed, in other words the quantity of opiates that they needed, it would have taken a long time to find out what your steady state was? Yes?
A Yes, it would have taken 24 hours.

Q That of course is based on the assumption that you got their eventual dose right at the beginning?
A Yes.

E

Q Finally, I think it was the Chair asked you again about Elsie Devine and you explained why you had replaced the fentanyl with diamorphine.
A Yes.

Q But the fentanyl was applied because of this particularly acute and difficult episode?
A No. The fentanyl had been on for 24 hours when she had the particularly acute,
F difficult episode.

Q Well, there were two, were there not?
A Her behaviour was deteriorating markedly. I did not know what her creatinine was on the Thursday morning but I knew that her general condition was deteriorating markedly and I was minded to give her something – it was not an injection, it was not tablets because she was spitting them out – to control her general agitation, distress and the beginning of the
G terminal phase. The episode you are talking about is when the fentanyl had reached his steady state and I was then minded that I needed to give an anxiolytic: I needed to give the midazolam. As the Chairman asked me, I could have continued with the patch, left that on and put up a syringe driver with the midazolam in it, but I thought it was a preferable option to change over to the syringe driver and put both in.

Q Are you saying that when you started the fentanyl, it was recognised at the time that
H the patient was not necessarily in pain at all but was simply agitated?

A A And entering the terminal phase and, as I remember, Professor Ford had no difficulty with the use of that medication in that particular indication in that patient.

Q The episode that I was referring to was on 18 November when she is described as deteriorating and becoming more restless and aggressive again and refusing medication.
A Yes.

B Q And that was when the fentanyl was first put on?
A That is the Thursday, yes.

Q Was that effectively as an emergency measure?
A No; you would not use a fentanyl patch as an emergency measure but she was not sufficiently bad that she needed an intramuscular injection of anything, and she was fine during that day. When the family visited that afternoon and when the psychogeriatricians
C visited that afternoon, she was happy and waiting for her daughter.

Q You see, the following day when you started the syringe driver, which Professor Ford, you will remember, described as extremely excessive, you added 40 mg of diamorphine to it.
A I did.

Q Together with the midazolam?
D A Yes.

Q If you were simply trying to control agitation at that stage, why did you need to add diamorphine at all?
A Because I would not have taken away the comfort that the opiate was giving her in her terminal stage; I would not have just withdrawn the fentanyl patch and not given diamorphine to replace it and just put her on midazolam to replace the intramuscular injection
E chlorpromazine.

Q I am sorry; why not? What would the midazolam do to her?
A It gave her sedation.

Q Yes. It helps her with her agitation, does it not?
A But it does not help her with her terminal distress that she was obviously suffering
F from as she approach death and the reason for the fentanyl patch in the first place

Q Dr Barton, the midazolam would have cured her agitation?
A But midazolam is not a euphoric drug, it is not a comfort drug. Again, was it Professor Ford who said that even he felt that there was a place for diamorphine in terminal care for relief of other symptoms than pure physical pain. This lady was suffering mental pain and agitation and distress.
G

Q So your reasons for adding diamorphine to this mix was to give her a sense of euphoria as well?
A Yes.

Q Did you consider how sedated this lady was going to become if you added diamorphine and midazolam together?
H A I did.

Further re-examined by MR LANGDALE

Q I just want to ask you something about the last matter you were asked about by Mr Kark and you were also asked questions by the Panel about the same patient with regard to Elsie Devine. What sense did it make to you, or what sense does the suggestion make to you of a patient who is on fentanyl – and Professor Ford did not criticise that – when the fentanyl is removed, not replacing some other kind of morphine? What sense is there in that?
A There would be two very major problems with that: one, she would get a withdrawal; and, secondly, she would become very uncomfortable and agitated and distressed again. It would have been cruel to remove the opiate, having once started on that path.

Q Because the suggestion is being made, as I understand it, by Mr Kark, that when the fentanyl was stopped, you should only have put her on midazolam?
A Yes.

Q Titration: you have said you were not taught it. I would just like you to enlarge on that. What do you mean by that? You have explained why it was not really practical, in terms of what was involved and what was required so far as resources were concerned, but you said you were not taught it. What does that refer to?
A I suppose I mean that any postgraduate teaching courses or any refresher courses that I attended during the time that I was doing palliative care in those days was very focused on what you did in the community. It was not appropriate to teach us how it could be done in a tertiary centre of excellence or in a hospice environment where you had the staff and the resources to administer your opiates in a different way. So the teaching I was given was always aimed towards how to manage these people in the community and of course when the syringe driver came on to the scene, it made life extraordinarily easier, both for us and for the district nurses working for us, because we could offer analgesia and sedation and whatever else, throughout the 24-hour period.

Q In relation to that, going back to 1991, before the hospital development took place in '93, we have been looking at that period of time and what Dr Logan had to say to nursing staff and others in relation to concerns that were being voiced then; was titration being practised then under Dr Logan, do you remember?
A Before the 1991 meeting?

Q In 1991?
A We were using syringe drivers. We were titrating with the syringe drivers. Before I took over that job, I would imagine that the GP responsible for each of those patients in that unit would have to come in and write up four-hourly, intramuscular diamorphine to be administered by the nursing staff until his or her next visit the following day. I cannot remember back that far but I imagine that is how we had to do it until we had a delivery system that allowed us to take out the peaks and troughs and assess the situation throughout a 24 hours.

Q Did Dr Logan ever say to your suggest to you that instead of administering subcutaneous analgesia by means of the syringe driver with a dose range that you should be titrating out for a period of time?
A No, absolutely not.

Q You have answered questions about these particular 12 cases and I am not going to go back over the general remarks that you made in response to questions, but you were making the point that apart from these 12 patients which this Panel is considering, there were a number of other patients who you would have written out an anticipatory prescription for.
A Certainly.

Q In terms of numbers generally, what are we talking about? Is it possible to give us any idea? Are we talking about tens of patients or hundreds?
A I would think approaching hundreds over the 12 years that I was doing the job.

Q You indicated that was important to bear in mind that in a number of those cases the anticipatory prescription was never used.
A Certainly,

Q In what circumstances did that happen?
A The patient became peaceful and died without the need of any medication at all. Professor Ford suggested that on an acute ward only between 30 and 50 per cent of patients needed terminal sedation or analgesia, and I would imagine that those figures would very much be mirrored on our continuing care wards.

Q Taking up from that particular matter with regard to anticipatory prescriptions and anticipatory prescribing generally, you have been asked questions framed in a way that there is a decision made by you that a patient is on a terminal path, and so on. You said in answer to one of the members of the Panel that it is not a case of you, the doctor, putting the patient on the death pathway or the terminal pathway; you are on it because the patient is dying. I would just like you to explain that. What do you say to any description given in terms of your decision as to putting somebody on a terminal pathway?
A We did not do that. Patients were dying. We were aware from 24/7 observation by very experienced nurses that these patients were reaching the end of their life, either very quickly or very slowly. They had reached the point when they were dying, and that was at the point at which you would then consider using the anticipatory prescribing.

Q Actually using it?
A Actually using it, yes.

Q Because obviously everybody at some stage enters a terminal pathway of some kind in their lives. What was it you were endeavouring to do when patient had in your view reached that stage when you saw to it that these drugs were administered?
A We were endeavouring to make that period of passing, however short or long it was, as comfortable and dignified and peaceful as we possibly could.

Q Questions have also been asked of you in relation to overdose of a patient. Did you ever consciously or deliberately overdose, that is the word that is being used, a patient?
A Never.

Q How would you recognise or determine when a patient was on subcutaneous analgesia if a patient was receiving too much in the sense of there being an overdose? How would you recognise that at the bedside?
A I suppose it is a very difficult picture. When somebody is dying anyway and all their organs are shutting down and they are drifting in and out of consciousness, are they

A over-sedated? I suppose if they were deeply unconscious, you might say "we are giving too much of the sedative or too much of the opiate; we will reduce the dosage" but the process of dying is so closely mirroring the bad effects and the good effects of the opiates and the anxiolytics are so close to what you are trying to achieve that it would be difficult to be absolutely sure.

Q It has been clear on all sides, including Professor Ford, that the administration of
B subcutaneous analgesia in the form of diamorphine and midazolam in appropriate case carries with it a side effect or the risk of a side effect.
A Yes.

Q And Professor Ford has made it clear, as indeed have others in this case, that in a patient who is dying, they are on the terminal pathway, the effect or the risk of side effects is something that is looked at rather differently because they are dying. Is that your view?
C A Yes. It is otherwise known as the double effect. You accept that the patient's life may be shortened by the drugs you are using but you are prepared to accept that for the benefits that that is bringing the patient.

Q Because if you do not ?
A Because they will take a few hours or days longer to die but it will be in agony.

D Q Then the question please about which you were asked some questions with regard to anybody challenging --- I appreciate you said it was not a case of challenge, it was a case of discussions about decisions, but let us keep with the expression challenging. Who would challenge your decisions? First of all, there is you as a GP. Are you making significant decisions with regard to patients in your ordinary professional life as a GP?
A Every day.

E Q Is there anybody there who is required to or you feel is necessary to challenge your decisions, the important decisions you are making about patients?
A We are required to challenge ourselves. We are required when we meet as a partnership or as a professional body to talk about critical incidents and significant events and bring them to each other and talk about how a situation was managed and whether the result was appropriate. At that time, I do not remember there being any similar set-up within the hospital, and not in general practice either. It is really a more recent phenomenon – audit
F and significant events and critical incidents.

Q At that period of time, this is in the 1990s, the time that we are talking about, in terms of patients who were not in hospital and who were receiving syringe drivers to supply medication, did you prescribe patients in that situation?
A I did.

G Q Was that involving prescribing subcutaneous medication?
A I was.

Q Would that also involve the administration subcutaneously do diamorphine?
A It did.

H

A Q When you made your decision as a GP that one of our patients ought to be receiving diamorphine by means of a syringe driver at home for example, what was the process there, because obviously it is a pretty important decision?
A It is a very important decision, so it was a decision that was made with the patient, the patient's family and the district nurses, because they were the people who were going to be setting it up and charging it and renewing it every 24 hours. So it was a decision made, if you like, at the patient's bedside, in the same way that it was done in the hospital.

B Q I would like you to enlarge on that in terms of this issue of whether anybody should have been available to challenge your decisions. What actually happened when you were treating a patient of yours, as a GP, who in your view required diamorphine administered by a syringe driver without them coming into hospital; what is the process?
A You would have your district nursing service already visiting that patient regularly; they would be helping the family with nursing procedures. They would be assessing the
C patient, in the same way that my nurses at the hospital were assessing patients; they would be assessing the patients in their own home but obviously not 24/7. There would then be a meeting, a discussion, between all the people involved that the method of analgesia now needed to be a syringe driver and it would be set up by the community nurses.

Q So once that had happened would you be prescribing a range of diamorphine to be ---
A Yes, we had a green card and a white card that stayed at the patient's home so
D although I was writing an ordinary FP10 prescription for the family or the district nurses to get hold of the drugs, they were written up and they were prescribed on the equivalent of a drug chart in the patient's home with a range on it, nought(?) to 20mg to 200mg.

Q So who would be deciding in an instance like that when and by how much the dose should be increased since there was a range on the prescription?
A The district nurse charging the syringe driver the next time would do it in consultation
E with me.

Q Did the patient have any input as to the increase?
A Yes. You are still talking here about palliative care. You are not talking about terminal care. At a point when the patient became terminal then quite probably they were not able to make the decision themselves and then the decision would be handed over to the nurse and the family.
F

Q So the patient in such circumstances would be indicating – just to take an example – that their pain was still not controlled ---
A Yes, absolutely.

Q --- there would be, as you would expect, some discussion between the patient and nurse ---
G A Yes.

Q --- and there would be some sort of increase?
A Yes.

Q Was that something you would become aware of after the event in such circumstances?
H

A I would quite probably become aware of after the event, if I was not available at that particular time then the district nurse had the ability and the right to increase the dose if she felt it appropriate.

Q Leaving aside that particular question and turning back to patients at Gosport War Memorial Hospital, in terms of your decisions as to what was appropriate in terms of, focusing on subcutaneous analgesia, would it be the consultants to whom you would look for supervision in terms of whether your decisions were right wrong?
A What consultant?

Q Was there anybody else to challenge your decisions, apart from the consultants?
A No, only the family.

Q You were asked a question about end-stage dementia, and you were asked to indicate what it was, in effect. Professor Ford gave evidence about this at Day 23/7 when he was asked about it in relation to the patient, Patient E, Gladys Richards, because we may be able to remember – I am not asking for people to turn it up – that Dr Banks described her at some stage, before she ever got to Gosport War Memorial Hospital, being end-stage dementia.
A Yes.

Q Professor Ford was asked about that in his evidence, end-stage illness with severe dementia, and he said:

> "A I think to most geriatricians" – describing end-stage dementia – "that would be describing someone who has severe dementia, and in the latter stages one sees increasing frailty, less activity, less food intake, often the patient develops further wasting and becomes more withdrawn, and one is anticipating they will die within a relatively short period of, say, weeks from usually bronchopneumonia or other complications."

Is that a picture you would agree with or not?
A Both for Mr Pittock and Gladys Richards, yes.

Q That general description?
A That general description. It is almost like a slow inexorable process of the actual dying process that you see more quickly in other conditions, but it happens over a period of weeks and months rather than hours and days.

Q So that is frailty, less activity, less food intake, developing further wasting and becoming more withdrawn?
A All of those.

Q All those signs?
A And then superimposed on top of those sometimes very bizarre behaviour patterns, like the screaming and the hanging on to the bars and those sorts of things. Presumably, again, control mechanisms in the brain have shut down.

Q You were asked a question about Mr Packman, and I just want to deal with the situation in terms of when you saw him because I think you said in your evidence that when you first saw Mr Packman you thought he was probably dying, is that right?

A A Yes.

Q Perhaps we can just register the fact, as the patient history shows, perhaps if you just get the patient history for Mr Packman, please, so we can deal with it. I am focusing on when it was you first saw him: if we look at page 10 of the patient history for Mr Packman do we see there the date of his admission to Dryad?
A Yes.

B

Q He was admitted on 23 August, as we will remember it was Dr Ravindrane who dealt with the admission, that is his review note there.
A Yes.

Q In terms of your seeing him I think we go on to 26th, is that right, on page 13?
A Yes.

C

Q We can see there that you reviewed him – we have been through this more than once – is that the time you are referring to, the note on page 13 says:

"Seen by Dr Barton this afternoon; await results of haemoglobin. Further deterioration etc. Verbal order from Dr Barton ..."

D An instant dose of diamorphine was given at 6 o'clock that evening: is that the time you are referring to?
A Yes.

Q We can see over the page, on page 14, the note of your review that day:

"Called to see male; clammy; unwell, etc."

E

Yes?
A Yes.

Q That is the occasion you are talking about?
A Yes.

F Q Lastly this, in terms of transfer back, an issue which has been raised with you more than once, when you got a patient who was ill, and it is being suggested that you should have transferred the patient back to the referring hospital or maybe to another acute ward on another hospital, what comes first, calling up to see if there is a bed available or deciding whether the patient should go back?
A The latter.

G Q Would there be in any sense, in your view, of calling up the hospital concerned before making that decision, to see whether they had a bed available?
A None, at all.

Q If, in your view, a patient should be transferred back what would you do in terms of seeing to it that they were?
A I would do exactly as I did in the case of Gladys Richards, I would write a letter to the consultant who had seen her; I would contact either him or his registrar and I would say "This

H

patient needs to come back to you". I would make it so but I would know that it was going to be difficult, but it would not stop me doing it if it was appropriate for that particular patient, as it was for Gladys Richards that day.

MR LANGDALE: Thank you Dr Barton, that is all I ask you. Sir, those all the questions I have.

THE CHAIRMAN: Thank you very much Mr Langdale. I do not know if you want to take a break now. It is a little early but it would probably be a convenient time.

MR LANGDALE: Mr Jenkins is going to be dealing with forthcoming witnesses today, and certainly tomorrow. I think he is indicating that a break now might be sensible.

THE CHAIRMAN: Very well. We will take 15 minutes now, please, ladies and gentlemen.

(Short adjournment)

THE CHAIRMAN: Welcome back everyone. Mr Jenkins.

MR JENKINS: I will call Isabel Evans, please. The Panel will recall the name if they go back to folder 1/tab 6, the name is there a few times.

ISABEL EVANS, Affirmed
Examined by MR JENKINS

Q (After introductions by the Chairman) Would you tell the Panel your full name?
A Isabel Evans.

Q Is it Mrs Evans?
A It is, indeed.

Q I think you qualified in nursing as long ago as 1961?
A I did indeed.

Q I think you went through a number of changes in your jobs over the years, but you retired in 1996, is that correct?
A That is correct.

Q I think in 1966 you started work at the Gosport War Memorial Hospital as a staff nurse in what was then an accident and emergency department?
A Minor injuries, yes.

Q I think you later, towards the end of the 1970s, became ward sister in the female ward at the Gosport War Memorial Hospital?
A That is correct.

Q And subsequently, in 1988, you became matron?
A Yes.

Q You eventually became Patient Care Manager, is that right?

A A Yes.

Q Which was the role you fulfilled until you retired in 1996?
A By the time I retired in 1996 I was actually the Hospital Manager.

Q Can you tell us, when you were Patient Care Manager what was the extent of your responsibility?
B A In that role I was responsible for all nursing, catering and domestic services within the hospital.

Q We know that some clinicians had responsibilities across not just one but several hospitals: did you have responsibilities outside the Gosport War Memorial Hospital or were you just confined to that hospital?
A Just to that hospital and obviously the annexes that were attached to it.
C

Q At that time, 1990-1991, what was the extent of the Gosport War Memorial Hospital and any annexes? Were there several wards?
A Yes, you will have to forgive me because at that time we were doing a rebuild of the hospital but if my memory serves me correctly we still had the two wards, the male ward and the female ward.

D Q Was there still a minor injuries unit at that point?
A There was still a minor injuries and an outpatient department.

Q Was there an operating theatre back then?
A Yes, there was. I confess I cannot remember what date the operating theatre closed but I think it was possibly still open at that time.

E Q We have heard that there was at least one annexe and one of them was known as Redclyffe?
A Yes, we had two annexes, one was Redclyffe and one Northcote Annexe.

Q Was that an annexe on the same site or was it on a different site?
A No, a different site.

F Q Can you tell us when you took control as Patient Care Manager of the Gosport War Memorial Hospital as a whole and the Redclyffe Annexe, how were things going on the nursing side at Redclyffe?
A At first all appeared to be well but at that time the only problem we were probably experiencing was getting staff. But it was very difficult at the general at that time; a lot of the nursing staff were going into nursing home because, quite frankly, the pay was better.

G Q I understand.
A Which was reflecting on us, particularly the annexes, because they were small units. They were not attractive to nurses who were looking to progress in their careers.

Q We know that the War Memorial Hospital was not a teaching hospital, in the sense that doctors would not be trained there. Would nurses be trained there?
A No.
H

Q What would you say about the morale or the nursing practices and treatment of patients that was evident at the Redclyffe Annex when you were there at the beginning of the 1990s?
A Shortly after I took over the unit problems did start to arise. I would say that the morale down there was very low. I had several complaints from members of staff on different issues relating to patient care.

Q Were these complaints that affected other members of staff?
A Yes.

Q I wonder if you can help us with some examples, but without giving us names necessarily.
A Yes. Those complainants were nursing auxiliaries, untrained nurses. One complaint was that patients were being force-fed and basically not given the choice in what they did or did not do.

Q Yes.
A And that they were not always treated with the greatest of respect.

Q Right. We know that towards the end of the 1980s Sister Gillian Hamblin arrived at Redclyffe.
A Yes.

Q She took over Redclyffe and, subsequently, after the reorganisation of the hospital, she became nursing sister on Dryad Ward.
A That is correct.

Q I think Dryad Ward and Daedalus Ward came into being at about 1993.
A That is right.

Q Does that sound right?
A Yes.

Q I wonder if I could ask you about Sister Hamblin's arrival towards the end of the 1980s and whether that brought about any changes or whether there were any tensions after she arrived on Redclyffe.
A She initially came, if my memory serves me correctly, from St Christopher's Hospital, which was another long-stay unit, as the senior staff nurse to the then sister, shortly after which the sister went on long-term sickness; so she in fact ran the department.

Q She was acting up.
A Yes, for at least six months prior to her being made up as the sister of the unit. During that time she did introduce many improvements into the general nursing care that was being given to the patients.

Q Yes.
A And obviously seemed to have a great knowledge of elderly care and a great empathy with the patients.

Q Clearly you remained at the War Memorial Hospital for a number of years after Dryad Ward came into being.
A Yes.

Q You will have seen Sister Hamblin working at Gosport over a period of about eight years or so from when she arrived.
A Yes, it would have been about that.

Q Again, just looking as a totality at Sister Hamblin's care for patients, what would you say about her abilities and skills as a nurse?
A I never found any reason to criticise them at all, and I was always more than happy with her care that she gave to the patients.

Q If she was instituting changes when she was acting up as senior staff nurse and then once she was appointed sister on Redclyffe Annex, were those always welcomed by perhaps nurses who had been there for a longer period of time?
A No. Change was not always welcomed by all the staff.

Q I understand. We know that Dr Barton was appointed as the clinical assistant in 1988 and she started at the Redclyffe Annex and obviously provided care for patients on the two wards, Dryad and Daedalus, once those came into being in the 1990s.
A Yes.

Q What was the provision of medical care for patients before Dr Barton arrived as the clinical assistant?
A Before she came there would be a designated practice within the town that provided care for the elderly care patients, and it was very much on an ad hoc basis: if we had a problem, we called in a doctor, but if we did not have a problem, we did not see one.

Q Right.
A Other than on the consultant's round, which was once a week.

Q Yes. Once Dr Barton did arrive as the clinical assistant, how did things progress?
A We had daily visits from Dr Barton.

Q Was that a good thing?
A Very much so, yes.

Q The Panel has heard that Dr Barton would be in every weekday morning to see patients.
A Yes.

Q And, as required, later in the day.
A Yes.

Q Either to admit new patients.
A Yes.

Q Or to review patients or see relatives.
A Yes.

Q Perhaps it is obvious, but did that make things easier so far as caring for patients was concerned, and also speaking with relatives, compared with the provision that had been there before.
A Yes. She obviously was aware of the patients, as we were, and knew them and knew their problems and she would come and inquire, if the patient had a problem the previous day, as to how they had progressed or otherwise.

Q You have suggested that there was some resistance to changes brought in at the end of the 1980s/early1990s. Can you tell us when the use of syringe drivers was started, roughly, at the Redclyffe Annex?
A I think it was in 1991, at the time that we had the problem.

Q Had those been available for a long time or were they relatively recent, once they arrived at the War Memorial Hospital?
A They were relatively recent. If my memory serves me correctly, we had a patient on the female ward who was on a syringe driver at home and had to be admitted into the hospital. I believe it was the Macmillan Nurses who were looking after her at home. They reluctantly let her keep the syringe driver while she was an inpatient, rather than remove it from her. We found it very beneficial – the nurses liked it – and we decided we would try and get some for the hospital, so that this problem would not arise again; so that if we had patients brought in who had been on a syringe driver we would have some of our own.

Q We have been told that they were very expensive.
A Yes, they were quite expensive. If my memory serves me right, round about the region of £100 each, but I would not like to be quoted on that.

Q We have heard much greater figures put to us – more like £1,000.
A Not each. Not each.

Q Fair enough. How did the staff react or respond to the introduction of syringe drivers? Clearly some were in favour.
A Yes. We bought five for the hospital. They were on an "as need" basis throughout. I think what seemed to upset some nurses was the fact that you obviously put a whole day's dose within the syringe at one time, so the figures looked a lot larger than they were used to giving.

Q I understand. How did the day staff react to the use of syringe drivers?
A I would say on the whole they welcomed them.

Q We know that nurses come with different levels of experience and qualifications. We know that a sister or a matron would normally be a G grade nurse.
A Yes.

Q A senior staff nurse, just one rung below, would be an F grade.
A Yes.

Q There might be staff nurses as well, who would be an E grade.
A That is correct.

Q Were there nurses below them?
A Not there, because one of the criteria for being an E grade nurse on grading, which was shortly before then, was that if you spent a certain amount of your time on duty in charge of the unit then you qualified for the E grade; so they all qualified under that criterion.

Q Right. What about the night staff? We will talk about one or two specific individuals soon, but would the night staff typically be at the same level of qualification and grading?
A They were at the same grade, yes.

Q Does that mean that they had the same training or just that they had spent a time being in charge of the ward and therefore got bumped up a grade?
A It was irrelevant, to be honest, to how much training they had had; it was purely because when they were on nights they were there in charge.

Q Right.
A There was normally just one trained nurse.

Q Does it follow from what you have said that you may have a nurse who has a grading to suggest she is able to be in charge but who does not have much training?
A At that time, yes.

Q Can I ask about the night staff and any concerns that some members of night staff might have expressed about the use of syringe drivers?
A It was not just purely on syringe drivers; it was purely on the fact of giving diamorphine on a regular basis that they objected to, but it arose at the time of introducing a syringe driver because obviously you cannot help but give that over the 24-hour period.

Q I understand. From your position, did you have a role in dealing with any concerns that were expressed?
A Yes. When staff raised concerns over the use of diamorphine I spoke to them and we held a meeting so that everyone could express any views, fears, worries that they had.

Q We have some documentation – and the Panel have seen it over the last seven weeks; we may turn to it in a minute – but could I ask you, as an overview, what your view was as to where these concerns came from. You have told us that the day staff welcomed syringe drivers.
A Yes.

Q What was the view of the medical staff about the use of syringe drivers?
A No-one had raised any objections from the medical staff about the use of them.

Q What about the more qualified members of the nursing staff, the sisters, the senior staff nurses?
A Again they welcomed them for the patients that required constant analgesia.

Q What was your view of why it should be that some few members of night staff should be expressing concerns about them?
A One member particularly seemed to be under the impression that you should only ever give opiates on an "as need" basis; that is, you waited for the patient to be in pain and then you gave it. If they were not in pain, they did not get it. It arose because one of the patients

A we had was experiencing a lot of pain in the mornings. During the day she would be given her opiates regularly. But at the end of the day she would be comfortable and she would be asleep. Because she was asleep, the night staff would then not give her anything form ten o'clock until she woke in the morning, at which point she woke in pain and it would then take several doses before the day nurses could get the patient comfortable again.

Q Would the night staff have seen that patient in pain?
B A No, because she had been having opiates all day and she was pain-free by the time the night staff came. She would have a dose to settle her for the night while she was still pain-free, but going from ten o'clock until six or eight o'clock in the morning the pain would return.

Q Were there discussions between day staff and night staff, so far as you were aware, about that sort of situation and the desirability of allowing it to continue?
C A We started arranging meetings between the day and night staff because there did seem to be very much a divide between night and day staff at that time – it was evident – and these sorts of issues were talked about.

Q I am going to take you to the documentation. If you turn to your left, you should find folder 1. Would you open that folder, please, to tab 6. The first page is meaningless. It refers to something that does not follow, so people can put a line through that if they wish.
D Page 2, I hope, is a summary of a meeting held at the Redclyffe Annex in July 1991 at which you were present.
A Yes.

Q Would that be right?
A That is correct.
Q If we go to page 4, we see your initials in the bottom left-hand corner.
E A Yes.

Q Which might mean – tell me if I am right – that this is your note.
A That is correct.

Q Your summary of the meeting.
A Yes.
F

Q If we go back to the start of the document, this was:

"A meeting arranged for the trained staff at Redclyffe Annex following concern expressed by some staff at the prescribed treatment for 'Terminal Patients'."
A Yes.

G Q Those present are listed.
A Correct.

Q We see you as the first person there named.
A Yes.

Q We see various other names that the Panel have become very familiar with: Sister
H Hamblin, Staff Nurse Giffin.

A A Yes.

Q Staff Nurse Barrett.
A Yes.

Q Staff Nurse Anita Tubbritt.
A Yes.

B

Q And Enrolled Nurse Turnbull at the end.
A That is correct, yes.

Q Just remind us, is enrolled nurse at a lower level than a staff nurse.
A Yes.

C Q Was it then?
A It was then.

Q It reads:

"The main area for concern was the use of diamorphine on patients. All present appeared to accept its use for patients with severe pain, but the majority had some
D reservations that it was always used appropriately...

The following concerns were expressed and discussed:

1. Not all patients given diamorphine have pain.

2. No other forms of analgesia are considered."

E

I know the Panel have read this many times. I can read it again, but are you familiar with it?
A I am very familiar with it.

Q Sir, unless I am asked to, I will not go through it point by point. At the bottom of that page, after the ten numbered points, I think you indicate that you acknowledged that staff concern on this subject was emotive but important.
F A Yes.

Q You say that both Dr Logan and Dr Barton would consider staff views so long as they were based on proven facts rather than unqualified statements.
A Yes.

Q You pointed out that you were not an expert in this field and were therefore not
G qualified to condemn or condone the statements, but you did ask them to consider certain points. Again there are a number, which I will not go through, but could
I point you to number 6. Should that read:

"That treatment sometimes needed regularising as patients condition changed – were staff attributing" –

H rather than "contributing"?

A Yes.

Q "... attributing signs of patient deterioration to effects of drugs?
A Yes.

Q "Few patients remained aware until the moment of death."
B A That is correct.

Q Can I break off at that point and ask you to give us your experience of patients approaching death, patients in the days or hours before their death. Was that your experience, that few patients remained aware?
A Yes.

C Q What do you mean by that?
A Well, as their condition deteriorated, then obviously their awareness did as well.

Q By awareness, do you mean consciousness?
A Yes, responsiveness, if you like.

Q For that last sentence "Few patients remained aware until the moment of death", are
D you saying that dying patients may drift in and out of consciousness?
A Yes.

Q Does that cover patients who are on medical treatment and those who are not?
A Yes.

Q At the bottom of that page you say again,
E

> "It was evident that no one present had sufficient knowledge to answer these questions with authority; it was therefore decided that before any criticism was made.... we needed to be able to answer the following questions."

You list a number, one of which, the penultimate entry on the page, is:

F

> "Is it appropriate to give Diamorphine in fact due to other distressing symptoms other than pain."

Was that an issue with the concerns that were raised?
A Yes. On several occasions the statement was made to me that the patient was on diamorphine but they did not have cancer. There were certain members of staff who seemed to think that only cancer patients should be given diamorphine or palliative care in this
G manner.

MR JENKINS: I wonder, unless there is any objection, whether you would not mind identifying those members of staff. We have heard from a couple. We have heard a statement read from Sylvia Giffin.

MR KARK: Please do not lead.
H

MR JENKINS: I was told not to lead, which is me asking questions suggesting the answer. If you want to see these individuals who were present again, you can turn back to the start of this document. One nurse, you told us, suggested that only those with cancer should have diamorphine?
A Yes. Certainly Staff Nurse Giffin was one of them. In fact, I think she was probably the strongest vocal-wise on that subject.

Q I understand. If I take you through the documents that follow, I do not think you can deal with page 6 because that was not a meeting that you were involved in, or a visit.
A No.

Q But we see the names of several nurses there, including the one you have just given us. If we turn to page 11 – Sir, I turn to 11 because it is the same as page 10 and I have just put a line through one of them – this is a letter to you from a member of the Royal College of Nursing?
A Yes.

Q Referring to concerns that had been expressed by staff earlier that year and other discussions that had taken place. The letter reads in the second paragraph:

> "It had been understood that the concerns raised would be addressed and the RCN had anticipated that clear guidance/policy would be promulgated as a result of the very serious professional concerns Nursing Staff were expressing."

The letter reads on:

> "It is now a matter of serious concern that these complaints were not acted upon...."

At the bottom of the paragraph the writer says,

> "We now expect a clear policy to be agreed as a matter of urgency."

If we go on, I do not think you can deal with page 13 because again it is not a piece of correspondence with which you had any involvement. If we go on to page 14, again correspondence with which you were not involved but it may be that you saw it. I do to know if you recall?
A I cannot remember seeing it at that time.

Q There is reference in, and it a letter dated December 1991, in the second paragraph which says:

> "I was contacted by a staff nurse who is currently employed on night duty in Redclyffe Annexe...."

and it sets out the concern. It then deals with correspondence with you in April 1991; it refers to a meeting that took place in July 1991 and says in the fourth paragraph:

> "Following the aforesaid meeting two study days on 'Pain Control' were arranged, as you will see from the minutes relating to the meeting...."

A It says,

> "These study days did temporarily alleviate the worries of the staff."

Would you have had any role in arranging study days for members of staff after concerns had initially been expressed?
A Yes, I contacted the nurse specialist in pain control who arranged and came to the unit B to give the staff the study days, and obviously gave them then the opportunity to ask any questions.

Q Are you able to help us with the identity of who came to give talks and assist the staff?
A I cannot honestly remember at that point in time. It was arranged through --- his name escapes me at the moment. C

Q Are you thinking of an individual or of a unit?
A He was a nurse within the elderly care.

Q We might come on to his name very soon. If we go over the page, there is reference at the top of the page:

> "After receiving this report Isobel responded by sending a 'memo' (copy enclosed) to the trained staff at Redclyffe." D

I think we will see in a moment there is reference to the author of this letter in the second paragraph on page 15 saying,

> "I have been told that it is only a small group of night staff who are 'making waves'...." E

Page 16, this is a letter to staff Nurse Tubbritt from you, I think?
A Yes.

Q Thanking her for her letter to you telling you of the meeting that had taken place in October. You say: F

> "I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion as I feel the only alternative is disruptive criticism which achieves nothing positive and leaves staff feeling frustrated."

A Yes.

Q Over the page, is this the memo that we saw referred to two pages ago? It is G distributed, as we see from the bottom, to every trained member of staff at Redclyffe Annex, the night sister, the two doctors and a Mr Hooper.
A Yes.

Q Can you remind us who Mr Hooper was?
A Mr Hooper was the --- I am just trying to think what role he would have had at that time. He was possibly the hospital manager, or he might have become the Gosport Care H Manager.

A

Q Was that Bill Hooper?
A Bill Hooper, that is right.

Q We have heard his name before. In your memo you say:

"It has been brought to my attention that some members of the staff still have
B concerns over the appropriateness of the prescribing of Diamorphine...."

A Yes.

Q Can I break off – "still have concerns" meaning after the training?
A Yes.

C Q "I have discussed this matter with Dr Logan and Dr Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings.

I am therefore writing to all the trained staff asking for the names of any patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately."

D

You say you would appreciate a reply from everyone, even if it is purely to state that they have no concerns.
A That is correct.

Q You say:

E "I am relying on y our full co-operational and hope on this occasion everyone will be open and honest over this issue..."

A Yes.

Q You say that you want to resolve this issue in a constructive and professional manner.
A Yes.

F

Q Was that right? Was that the approach that you were taking?
A Yes.

Q There is then a letter at page 18 in which I do not think you were involved and a letter at page 19, a copy of which I think you will have received. In which Mr Murray says:

G "As far as I am aware it is not the use of syringe drivers that is the cause of concern..."

A That is correct.

Q Then we go to page 21, please. This is the second memo from you, I think, in which you refer to the one that we have just read.
H A That is correct.

A

Q Again, it is a memo, as we see from the top on the right-hand side, to "All trained staff at Redclyffe" and the various other individuals to whom the first memo was sent.
A Correct.

Q You say:

B "Due to the lack of response to my memo of the 7th November Dr Logan will be unable to comment on specific cases. However we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on Tuesday 17th December at 2 p.m. to discuss the subject in general terms.

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have so I hope everyone will take the
C opportunity to attend and help resolve this issue."

Can I just go back a bit? Were nurses at Redclyffe perhaps dealing with syringe drivers on the ward before they had ever had any training in their use?
A No. The company that supplied the syringe drivers actually sent a trained nurse to the unit and went to visit each department and showed them the use of the syringe driver.

D Q Graseby is the name that we have seen. Is that the company?
A That sounds familiar.

Q Do you know if the Graseby representative was able to see the night staff as well as the day staff?
A She visited each unit several times, so, yes, they would have had the opportunity.

E Q Can I take you to page 23, which I think is the note of the meeting in December 1991. Again, if we go to the last page, the third page of it, on page 25 I think we see your initials?
A That is correct.

Q Suggesting it was your note of the meeting?
A It was my note of the meeting, yes.

F Q Again, going back to page 23, do you see your note of who was present at the meeting?
A Yes.

Q I think everyone turned up. Would that be right?
A Yes.

G Q You detail the history, including a staff meeting on 11 July 1991, a second meeting on 20 August where Steve King, nurse manager, and Dr Logan spoke to the staff?
A Yes.

Q You spoke a few minutes ago about someone in nursing who had spoken to the staff. Was it Steve King you were thinking about?
A It was, yes.

H

Q The aim of this meeting was to allay the staff's fears by explaining the reasons for prescribing.

"As no one challenged any statements at this meeting or raised any queries, it was assumed the problem had been resolved and no further action was planned."

A That is correct.

Q You go on with 3:

"Staff were invited to give details of cases they had been concerned over."

That was the first of your two memos that we have looked at, the one in November?
A Yes.

Q But no information was received. We see that in the second memo?
A Yes.

Q

"It was decided to talk to staff on the general issue of symptom control and all trained staff would be invited to attend."

You talk about:

"The issue had put a great deal of stress on everyone, particularly the medical staff."

The Panel will have seen before what this paragraph says. Was that from your own observation that some people felt under stress as a result of these concerns being raised?
A I found it rather confusing because, if you asked the staff if they were concerned that patients were being given two much diamorphine or it was in any way harming them, they would deny this. No, they did not have problems with that. It would just keep going back to the fact that it was patients who did not have cancer that it was being given to. It all seemed to be related to the fact that they were not sure that the type of patient that the diamorphine was given to was appropriate. There was no question at that time put to me that inappropriate amounts were being given.

Q If we turn over the page to page 24, the second page of your memo, you have listed a number of bullet points in which you stated the problems as you saw it?
A Yes.

Q You invited staff to indicate if they did not agree with your interpretation?
A I would say that it was my interpretation of what problems they had, not what problems I had.

Q Can we deal with the first of those.

"We have an increasing number of patients requiring terminal care."

A Yes.

Q Everyone agreed with that statement, we can see from the note after the five numbered points?
A Yes.

Q Can you expand on why it should be that there were an increasing number of patients requiring terminal care in 1991?
A Because of the ever increasing pressure on elderly care beds, the criteria for getting a place within what was then classed as long term care was being raised. This resulted in, whereas before patients were coming to us in a very stable albeit disabled state, we were now getting very ill patients coming into the terminal care that quite frequently were dying within a month of arriving in the unit.

Q So the mix of patients was changing?
A Yes.

Q That Redclyffe was dealing with?
A Yes. That type of patient required totally different care to a patient that came that you would anticipate would be staying there for a year or more, as had been the norm prior to this time.

Q The second numbered point I do not think I need deal with. The third point, again I do not think I need deal with. The fourth point is the particular concern, I think:

"What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain."

A Yes.

Q Again, you have dealt with the fifth point that:

"No one was questioning the amounts of diamorphine or suggesting that the doses given were inappropriate."

A No.

Q Is that your recollection?
A That was definitely my recollection.

Q We know that Dr Logan spoke to the staff at length. Is that your note of the points that he sought to make?
A Yes.

Q Again, the Panel are very familiar with these. But, can we deal with several of them.

"(d) The aim of opiate usage was to produce comfort and tranquillity at the smallest necessary dose – an unreceptive patient is not the prime objective."

A Correct.

Q

"(g) The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgment based on the knowledge of patients' condition to enable patient to be nursed comfortably."

A Yes.

Q

"(h) It was not acceptable for patients who are deteriorating and require 2 hrly turning to have pain or distress during this process. They require analgesia even if they are content between those times."

A Yes.

Q I am going to break off and go on several pages to page 26. You will see that these are notes that the prosecution in this case have placed before the Panel, notes produced by Dr Logan. If you go on to page 27, you will see a typed note from Dr Logan in which he is the first person. When he talks of "I", he obviously means himself, Dr Logan.
A Yes.

Q Also, we have a letter at page 29 written by Dr Logan which has been placed before the Panel the Panel may have seen but which we have not really been through. Since it is in front of the Panel and you are with us, can I ask you about that letter. It is dated July 1991 which was about the time of one of the meetings which had been arranged with the staff?
A Yes.

Q He writes:

"Dear Steve",

You and I have referred to Steve King as a nursing manager of the hospital?
A That is correct.

Q

"Thank you for agreeing to help regarding the use of opiates on poor prognosis longstay patients. Enclosed are the concerns which the staff hold. It seems to centre around the feeling that it is wrong to start subcutaneous diamorphine by pump for <u>any</u> patient who:

1. Has not tried 'lesser' analgesia first
2. Could take oral (or rectal) diamorphine
3. Does not have patient-voiced pain (even though they may be obviously restless and distressed)
4. Has not been discussed at full staff conference!"

A Yes.

Q Can we stop there. That is his view, as expressed in this letter, of what the concerns appeared to be. Does that reflect your own understanding of what the concerns were, that

people were being given diamorphine subcutaneously when the patient has not said, "I am in pain"?
A That is correct.

Q You smiled when I read point number 4, "Has not been discussed at a full staff conference!"
A It was one of the suggestions made by Staff Nurse Giffin that we would have weekly meetings at which point it would be decided whether a patient should start or not on an opiate, which would mean, of course, you would leave the patient in pain for a week until she decided that she could go on it or not.

Q You laugh. Again, is that appropriate or consistent with the care of patients?
A No.

Q Let us go on with page 30. Dr Logan writes:

"To me, the important points to make in answer to these questions would be.

1. Patients with distressing pain need adequate analgesia first – once pain is controlled reductions or changes in dosage can be made.

2. The subcutaneous route is more convenient for many patients and overcomes problems of vomiting back analgesics, variable absorption. The continuous infusion may allow lower total doses to be used."

A Yes.

Q

"3. Opiates are analgesic but also euphoriant and thus psychologically beneficial for many patients. Many distressed, uncomfortable, frail, elderly are unable to report their discomfort.

4. Prompt treatment is the best."

He writes:

"If you do not agree on any of this, please give me a buzz. Otherwise I think a 15-20 minute chat from you regarding the relief of symptoms and where opiates come in would be just the ticket.

I will try and tee up this for 2 pm on 20 August 1991 – maps, grid references etc provided anticipating the meeting."

A Yes.

Q Back to the four numbered points on page 30, from your perspective, as the Patient Care Manager, were the points that Dr Logan, as a consultant, was making valid?
A Yes, they were.

Q To the extent that some of the concerns expressed were along the lines of those set out on page 29, what did you consider to be the merit of the concerns that were being expressed?
A I always felt that to a certain degree the concerns raised were through a lack of knowledge or understanding on what was then classed to be the up to date thinking of pain control; ie to achieve a patient totally pain free on the lowest amount of opiates possible, was the prime example rather than give as and when needed, which often resulted in higher doses having to be given to get the patient pain free.

Q Do nurses have their own responsibility to keep up to date?
A Yes.

Q The Panel will know very well that doctors, and indeed all professionals, including lawyers, have to ensure nowadays that they undergo continuous professional development?
A Yes.

Q Do you know if nurses had similar obligations back at the time we are talking about, in the beginning of the 1990s?
A Not prior to 1998. When grading came in, this was the requirement that was brought in if my memory serves me correctly.

Q Let us come back to the note you made of the meeting. We left off at the bottom of page 24, which will take you to page 25. You just detailed the points Dr Logan had made and you say:

> "Following general discussion and answering of staff questions, Dr Logan stated he would be willing to speak to any member of staff who had concerns."

A Yes.

Q It is apparent that there was then a discussion because you say:

> "Comments raised during discussion were..."

and you made a number of points?
A Yes.

Q The first one is that:

> "All staff had a great respect for Dr Barton and did not question her professional judgment."

Is that right?
A Yes.

Q When you say "all staff", was that everyone who turned up?
A That was correct.

Q It says:

A "The night staff present did not feel that their opinions of patients condition were considered before prescribing of diamorphine."

A Yes.

Q Does that reflect what you have already told us as an example?
A Yes.

B

Q That night staff may not treat a patient if they appear to be comfortable?
A Yes. They still seemed to think they should have the say as to whether the patient required a dose at night.

Q Point (c) is obviously a concern expressed by the day staff:

C "That patients were not always comfortable during the day."

Only the day staff would know that?
A That was referring back to what I was saying earlier that, yes, they were finding that patients were sometimes in pain in the morning because they had not had anything during the night.

D Q There appeared to be a lack of communication causing some of the problem. Are you able to illustrate that – communication between whom, or a lack of it?
A There were definitely two separate teams within the unit at that time, the day staff and the night staff. Communicating skills were perhaps not very good on either side to be perfectly honest.

Q

E "Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms."

A I think this, again, goes back to the fact that the type of patient we were having in the unit was changing, so yes, therefore, the number of patients who required this treatment was increasing. It was because the type of patient was changing and this is what they could not always seem to grasp.

F

Q We go on in your note to say that you would be happy to talk to staff and you spoke to the staff ---
A Yes.

Q --- after some had left, and you asked if staff felt there was any need for a policy relating to nursing practice dealing with the concerns that had been expressed to you in correspondence and you were told that nobody felt it was appropriate?
G A I will say that we already went by the RCN drug policy which we were obliged to, as trained nurses, and the unit also had one so I could not see the point in producing another one because it would have to be identical to the ones we already had.

Q If we go back to page 27, we have looked at it noting that this is Dr Logan's note of that same meeting. Are you able to confirm, looking at the top of the second paragraph, that
H when invited to talk in general terms about the use of opiates on the long stay wards,

Dr Logan expressed the view that it was often very difficult to know what was best for the very frail, elderly patients who could not express their symptoms and that one could only do one's best in interpreting them. When there was any question that the patients had pain, they should be given the benefit of analgesia?
A Yes.

Q He talks about there being no useful middle range drugs between codeine, dihydrocodeine and diamorphine and there were useful psychological effects producing some psychological detachment and euphoria which can do much for the patient's tranquillity?
A A lot of these patients would not have been capable of taking tablets which narrowed down the choice.

Q We have seen some who could not swallow, we have seen some who refused to take oral medications?
A Yes.

Q It goes on, halfway down that paragraph, that:

> "...it was vital for us to make sure there not more simple reasons for the patient's pain or distress, such as a full bladder or faecal impaction that could be quite simply dealt with. Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

A Yes.

Q Nurse Giffin makes a point, and Dr Logan deals with it according to the body of his note. He said:

> "...it was not necessary for the patient who was tranquil and apparently asymptomatic. On occasions a patient would only become distressed when disturbed, for example when two-hourly turning was necessary. I explained that I felt in these circumstances the patient should have this pain dealt with, even if it was only transient and intermittent. I am not sure if she accepted this view or not."

He goes on to say:

> "... we were all agreed that when opiates were given there was no need for the patient to be rendered totally unconscious. Far from it, the aim was to keep the patient comfortable ..."

As we see from the end of the note,

> "The general concept that improved communications between day and night staff and between night staff and medical staff might help in the future was met with little apparent enthusiasm from Staff Nurse Giffin."

That is his comment. I do not know whether you agree with it.
A Verbally she was agreeing and had no objections, but her body language said differently.

Q Can you tell us what happened after these meetings in 1991. Was there further training given to staff?
A Yes. We had an ongoing policy of training the staff and identifying training needs and sending them off. We also arranged meetings once a week between the day and the night staff – which I believe Dr Barton initially joined us in – to allow everyone to just discuss care that was being given within the unit generally, not specifically on this topic.

Q We have heard of a consultant from the Countess Mountbatten, a hospice locally – Dr Bee Wee is the name we have heard being involved in giving further training, as one amongst others.
A The staff attended courses on terminal care outside of the hospital but I cannot remember ----

Q It is nearly 20 years ago, Ms Evans. No-one would criticise you. Are you able to tell us whether people were brought in to give further education to nursing staff.
A Yes. Staff did attend the department specifically on the giving of opiates in terminal care, but also the staff went out of the unit to attend courses.

Q You retired in 1996.
A That is correct.

Q Obviously nearly five years or so after these concerns had been raised and the meetings and training that we have talked about had taken place. From your perspective had the concerns been dealt with?
A Yes. And they certainly were not raised again from the December meeting until I left.

Q We have heard from some members of staff who had been on additional training outside the hospital or had undertaken their own training as to whether their concerns continued at all. I do not need to ask you any more about that. Can I turn to Dr Logan. He was the consultant in geriatric care ----
A At that time.

Q -- at that time. It is clear from what we have seen that he has been expressing his own view about how his patients should be treated.
A Yes.

Q From your understanding, was Dr Barton providing treatment in accordance with Dr Logan's wishes?
A Yes.

Q What can you tell us of Dr Barton's demeanour when dealing with the meeting or meetings that were held at that time? How did she deal with it?
A As always, she was very approachable towards the staff. I felt that, considering – particularly after the second time it was raised – she was very restrained. I think if anyone showed signs of any anger, it was Dr Logan. It was certainly not Dr Barton.

Q If he was showing signs of anger, why might that have been, from what you could see?
A Because he had taken the trouble to come over and talk to the staff and arranged for Stephen King to come over and they had all stated that they were quite happy with the

A explanations given to them, and then they went to the RCN, rather than come back to us, because they had further concerns. At the end of the day, the nurses were questioning medical treatment – or they appeared to be.

Q You have told us already, and we have seen from the documentation, that by 1991 you had an increasing number of patients requiring terminal care. We have seen that from your document.

B A Yes.

Q Did that position stay the same or did things change after 1991 until you retired in 1996?

A I would say it was still getting progressively worse.

Q Can I get you to tell us what you mean by that.

C A Insofar as the patients that were coming over, I would have found it difficult to class as long-stay patients. They were very close to being acutely ill patients ---

Q What about ----

A -- or rehab.

Q I am sorry, I interrupted you and I may have distorted the sense of what you were

D saying. The state of the patients coming over were worse and worse.

A Yes.

Q So they were not really long-stay patients.

A No.

Q Or rehab patients, you said.

E A Sometimes. Not as often. There would be the occasional rehab patient.

Q Right. Again this is in the period leading up to your retirement in 1996.

A Yes.

Q Why were patients coming in in a worse condition than they had been coming in earlier years?

F A Because of the pressure on the acute beds.

Q Acute beds being other hospitals?

A Yes. In Portsmouth, which is 20 miles plus away from Gosport, they did not have any beds. They had to free a bed, so they would send us, if you like, the least acute patient over. But as the pressure increased on them it also increased on us, because the patients were coming to us at an earlier and earlier time in their treatment or it was the type of patients they

G could no longer do anything for which they were sending to us. On one occasion I remember a patient died within 24 hours of getting to the unit, not because of anything she was given, she received no treatment, but she was just so ill. One had to ask was the 20 mile journey contributing to her death rather than anything else.

Q I was going to ask. In your experience, transferring patients, was that always something that resulted in improvement in the patient's condition or typically did it remain

H the same?

A A No. It was not the ideal scenario, particularly as some of the patients we were getting at that time were not even local patients. They were not even Gosport patients. They were being sent away from relatives at a time when they needed their relatives the most. Certainly I did raise concern on that issue at various meetings at that time.

Q Raised concerns with whom?
A Again, to think back, it would have been at meetings I had with management.

B

Q Did you have the power to change anything?
A No. No. In fact, we would not, because we were at the mercy of what the elderly unit sent to us – in fact the beds were their beds. We just staffed them, if you like.

Q On a question of geography, Gosport is just across the water from Portsmouth.
A If you can swim.

C

Q Or if you can get the ferry.
A Yes.

Q It is a peninsula, effectively.
A Yes, it is.

D Q It is a long way round by road.
A That is correct. I believe it is 22 miles from one hospital and 25 miles from the other.

Q The precise distances probably do not matter.
A I used to claim mileage for it!

Q All right. It is clear from what you have told me that the transfer of patients did not
E always result in their condition improving.
A No. No.

Q One patient, you have said, died the same day.
A Within 24 hours, yes.

Q Did anything happen as a result of that? You have said you spoke to people but did
F not yourself have the power to change things.
A No. Nothing happened that I can remember.

Q Would it have been raised if patients who are unstable, who are acutely ill, are being transferred to Gosport?
A I am sorry?

G Q It is an issue that has arisen before in the hearing about acutely ill or unstable patients being transferred to Gosport.
A Yes.

Q If that had happened, a decision had been made that the patient should be transferred to Gosport, and it is felt on arrival that this patient really should not have been brought or that their deterioration after arrival is due to the transfer, would anyone have complained?

H

A I certainly did not complain directly to the elderly unit. I certainly mentioned it to my immediate boss in the hope that they did. I did not attend meetings or anything that met with the elderly services, so my only route was to go up through my management.

Q I understand. But if you had complained, what do you anticipate would have happened as a result, given the situation that you were dealing with?
A We would have just probably got the same answer we normally did, that they did not have any option because of the pressure they were under.

Q I would like to ask you about Dr Barton herself and your opinion, as patient care manager, of her as a doctor.
A As a manager, I found her very good to work with. She was always willing to help in any way she could with any project that we had for the unit, whether it was on a professional level or anything to do with the patients or even down to the raising of funds for the unit. She would help us with that. As a doctor, I found her to be very professional, very caring, very dedicated to the patients she was looking after, and, above all, very compassionate to them.

MR JENKINS: Thank you. That is all I ask.

THE CHAIRMAN: Thank you, Mr Jenkins.

Mrs Evans, we will take a break now. You will be taken somewhere where hopefully you can get some refreshment and recover yourself a little before we come back and ask Mr Kark to begin with his questions.

Please do not discuss the case during your break, and if you have subsequent breaks that remains true.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone.

Cross-examined by MR KARK

Q Mrs Evans, you retired, I think, in 1996.
A That is correct.

Q You told us you were a matron at GWMH up until 1988.
A No, I was a ward sister until 1988.

Q Then what did you do after that?
A Then I took over the role – the title of matron was not given to me but it was the role that the old matron would have had; that is, just nursing.

Q Until when? You then became ---
A Patient care manager. I think after about a year I was given the responsibility for the domestics and the catering staff.

Q That would have been by 1990, would it, patient care manager?
A Yes.

A

Q Then hospital manager followed from that.
A Yes.

Q That is obviously between 1990 and 1996. Can you tell us when?
A I think about 1993.

B Q When you were dealing with the issues that arose in 1991, you would then be the patient care manager.
A That is correct.

Q As the patient care manager, can you help us with what medical role you would have?
A Purely just overseeing the nursing.

C Q How do you do that? Do you mean in terms of rotas and the like?
A No, that would be the duty of the ward sister to do rotas.

Q Right. How often would you go round the wards?
A Redclyffe Annex, because it was away from the hospital, very much depended on what was happening within. Several times a week I would be doing that.

D Q And the purpose of that would be what?
A Just to satisfy myself that things were all right down there and give them the opportunity to question me.

Q Them being the nurses.
A Yes.

E Q Right. When we come to the issues that arose in 1991, you seem to have had a fairly pivotal role.
A Yes.

Q Who had the nurses gone to in the first instance? Was it to you?
A Yes. I am not aware that they went to anyone other than me.

F Q If we turn page to page 2 in this document, this is the summary of the first meeting in July of 1991. Did you actually have this document typed up yourself?
A Yes.

Q We can see that it starts with the words

G "A meeting was arranged for the trained staff at Redclyffe Annex following concern expressed by some staff at the prescribed treatment for 'terminal patients'."
A Yes.

Q Was it specifically in relation to patients who were dying that these concerns were raised?
A It was the treatment of patient that were dying at that time, yes.

H Q We can see that there are I think it is 10 nurses who are named.

A A Yes.

Q Your understanding was that the majority of those nurses had some reservations. Yes?
A No. I would not say the majority.

Q I am sorry. Can we deal with the next paragraph:

B

"The main area for concern was the use of Diamorphine on patients, all present appeared to accept its use for patients with severe pain, but the majority had some reservations and it was always used appropriately at Redclyffe."

I took that to mean the majority of the nurses there.
A Certainly the way it is written.

C

Q I expect now it is rather difficult for you to remember precisely 18 years ago but it would appear from that, would it not, that the majority of those nurses who were present, who would include both night and day staff, had concerns?
A There were four nurses there that raised concerns of one form or another.

Q Who were they then?
D A Staff Nurse Giffin, Staff Nurse Rider, who was a relief nurse ---

Q She was a day nurse staff, was she not?
A Yes. She was not actually a member of the unit: Staff Nurse Tubritt and Enrolled Nurse Turnbull.

Q Tubritt and Turnbull were both nights, so who were the others who had concerns. Can you now remember?
E A I cannot remember any of the others raising any concerns at all.

Q And the concerns were in relation to the use not of syringe drivers specifically but diamorphine?
A Yes. Staff Nurse Rider's concern was specifically on syringe drivers but the others were generally on diamorphine.

F

Q Did you regard your role as reassuring the nurses about their use, about the use of diamorphine and the use of syringe drivers?
A To satisfy myself and them, yes, that it was being used appropriately.

Q Had you in your own practice when you had been a sister, matron and nurse, used syringe drivers with opiates yourself?
G A Not actually syringe drivers as they were only just being introduced at that item.

Q When you made a statement to the police, you said this: In regard to the amount of diamorphine used, some of the staff were under the perception that patients were getting more. This was because they were used to giving the patients for example 10 mg of diamorphine orally every four hours. Yes?
A Yes.

H

Q However, now with the use of syringe drivers, they were getting 60 mg at once but this was fed to them over a 24-hour period by the driver at a constant level. This obviously equated to six doses of 10 mg over 24 hours. Some of the staff originally could not comprehend this. Was that the kernel of the problem so far as you were concerned?
A It certainly was if my memory serves me correctly with Staff Nurse Rider. That is why I said her concerns were specific.

Q I just want to make sure that I follow what you said in that statement. The nurses were used to giving patients 10 mg of oral morphine every four hours ---
A Can I say that the figure of 10 I plucked out of the air. It was not an example of ---

Q It does not matter if it is 10 or 5 or anything else.
A It was just that it was an easy number to multiply.

Q Even on my maths we get 60 mg over the day. Then you say, using those same figures as I understand it: Now with the use of syringe drivers they were getting 60 mg at once, but this was fed to them over a 24-hour period.
A Yes.

Q Was that your understanding, that when you convert from oral to a syringe driver, you would be giving the same dose as it were, but over a longer period?
A If you were changing from oral to injection, no, you would normally reduce it from giving them 10 mg by injection.

Q Sorry, just repeat that, will you – from giving them 10 mg by injection you would do what?
A Normally if you are changing a patient over from oral to injection, then the dose is quite often adjusted because it has a different effect on the patient.

Q Quite. Can you remember now by how much it should be adjusted?
A No, off the top of my head.

Q At the end of all of these discussions, and we will look at them in a little more detail in a moment, although the gentleman, Keith Murray, the branch convenor who had been representing the nurses, had wanted a written policy drawn up, no such policy was drawn up, was it?
A It was not within my power to draw up – a policy on drugs.

Q But your view was that policies that you had in place already, by which I mean presumably the palliative care handbook and the like, were sufficient?
A We had the RCN.

Q The RCN what?
A The Royal College of Nursing leaflet on drugs, and we had a unit policy on drugs, if my memory serves me correctly.

Q Do you remember *this* coming into force, and I am holding up for the purpose of the note the Palliative Care Handbook? Do you ever remember that document?

A I cannot remember that one specifically but we had literature from when nurses had been to study days and sessions on palliative care and they had brought back literature from Countess Mountbatten and various places.

Q You also had no doubt, even in those days, the BNF?
A Yes, but that was for the use of the doctor not for prescribing. The nurses would refer to it if they had any doubts on the dosage.

Q Because the BNF would provide, as you said primarily to the doctors who are prescribing, a fairly good guideline for the prescription of drugs.
A Correct.

Q And in general terms you would expect that to be followed?
A Yes.

Q If we come back to this letter at page 2, paragraph 5, one of the concerns was that "The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients needs." Is that referring to titration?
A Sorry? We are referring to ---

Q Titration of doses.
A They were concerned that once it was set for the day it could not be adjusted until the following day.

Q Was it you understanding that before a syringe driver should be started, there should be at least a good idea of what the patient needed to control their pain from the previous doses of oral morphine?
A Yes. More often than not a patient would go from injection to the syringe driver rather than oral. Normally, if they were able to take oral medication, they would continue to do so.

Q One of the purposes of using an injection obviously is to relieve pain?
A Yes.

Q It is also to find out what level of pain relief the patient requires?
A Yes.

Q Before a syringe driver is started?
A Yes.

Q Do not agree with me if you have any doubt about that. Do you have any doubt?
A I cannot remember an example where the patient was started off, in my experience, straight on to a syringe driver, put it that way.

Q I have called it titration and perhaps that is not her right word, but the idea, the principle, was that you should try to identify what the patient's required level of opiates was before you start them on a syringe driver, for instance. That would not be a novel idea to you, would it?
A No, not really, but you would normally give them initially a larger dose in any case.

Q A bolus, you try and give a bolus dose?
A Yes.

Q I understand.
A It is quite often a little bit of trial and error; i.e. you give them a certain dose if ---

Q That would mean presumably that doses can go up, as they say, as well as down?
A That is correct.

Q You referred to the November meeting. As I understood it, what you were saying was that Dr Logan who attended on --- I am sorry, I think it was in fact in December. Dr Logan who had attended was slightly more irate, as it were, than Dr Barton herself. Is that right?
A When he was talking to me, he was the only one that expressed slight irritation, should I put it.

Q If we go to page 15 of this bundle, and it is the letter that you were asked about from Mr Murray to Chris West, it is not to you and I do not think you were copied in on it but you are asked to comment on it. If you look at the second paragraph down, Mr Murray writes:

> "I feel the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain amount of ostracization."

Is that right as far as you understood it, that there was at this time quite a difficult atmosphere in this hospital?
A I was not aware oaf any ostracization. As I say, I was aware that there certainly was a certain amount of antagonism between day and night staff but it was a problem that we were addressing during that time, and nobody had raised any issues.

Q No, but of course it would make it difficult, I expect you understand, or it might make it difficult for nurses to speak out at a meeting, particularly when there are two doctors present. Did you understand that or not?
A At the first meeting it was just myself and the nursing staff; there were no doctors present.

Q But if we go to page 23, and it is the meeting of 17 December, you were there as Patient Care Manager?
A Yes.

Q Dr Logan was there as the consultant geriatrician?
A Yes.

Q Dr Barton as there as the clinical assistant and then there was Sister Hamblin and there were various nurses.
A Yes.

Q Did you consider at any stage whether it might be difficult for any of those nurses to speak out at such a meeting?

A I could not see why. I had actually worked with all of these, done shifts with them, during this time between the two meetings, so they had plenty of opportunity to talk to me on a one-to-one basis had they wanted to and they did not.

Q You see, you describe Dr Barton as being very restrained, Dr Logan as quite angry?
A Not with the staff.

Q With whom?
A When I raised the subject with him, he showed some irritation because like myself he had been very open and patient with them at the beginning. The staff had appeared to be appeased; they all said that they were happy with the explanations given them, they were happy with the care they were providing. Then, without any warning to any of us, I get a letter from the RCN saying that they are taking out a grievance against us because we are ignoring their complaints.

Q That took you by surprise?
A It did, yes.

Q And you said this, and again this is possibly my rather poor note of it: At the end of the day the nurses were questioning medical treatment.
A Yes.

Q Can we take it you did not approve of that?
A No. I would support any nurse raising any concern over any issue but they seemed to think that it was a problem that I could solve, that I could snap my fingers or say to the doctors what they should or should not prescribe. They were asking me to do something that was not within my control. They seemed to fail to recognise that what they were saying was implying that the doctors were prescribing inappropriate drugs. When you said that to them it was shock horror – oh, no, we are not. So it was very difficult for myself to really know what they were expecting us to do or what they wanted from us.

Q That would be one of their functions, though, would it not? If they thought that inappropriate drugs were in fact being issued, they would be under a duty to raise that, would they not?
A They would. In fact, as a trained nurse, I would refuse to give inappropriate drugs.

Q I also just want to examine briefly with you this issue between the night staff and the day staff. What you said, as I understood it, was that the day staff would have an understanding of the patient's needs because they would be turning them and the like; the night staff would see them when they were asleep. Then the patient might wake up in the morning in pain because they had not received anything overnight.
A Yes.

Q And so there was this disparity between what the day staff were seeing and what the night staff were seeing. Is that right?
A That appeared to be the case, yes.

Q That could not be in relation to patients on syringe drivers, could it?
A No.

Q This is in relation to patients who have been given either oral morphine or four-hourly intramuscular doses?
A Yes, they were prescribed this on a regular basis.

Q What was the suggestion – that the night staff should wake the patient up during the night to give them an oral dose?
A No.

Q How was it going to work?
A It is very difficult when you are going back. I cannot remember specific patients that they talked about but obviously if a patient is awake, then you would give it. If not, it would be given in the morning at the prescribed time.

Q By the day staff?
A By the night staff.

Q By the night staff as they were going off shift?
A Yes.

Q That is not the syringe driver issue, is it?
A No, the syringe driver would have been an ongoing thing. I can say at this point we only had one syringe driver within the unit, and it was not in constant use all the time.

Q Later on, as you told us, you had five?
A No, no. We had five in the hospital, one of which was given to Redclyffe annex.

Q We know that changed ultimately, by the time you left in 1996?
A As far as I was aware, there were still only the five within the hospital.

Q You told us about Nurse Giffin verbally agreeing, but her body language said not. We all understand what you mean by that. Was that in relation to this meeting in December?
A Through both actually.

Q So it certainly appeared from her body language, if not at least verbally, that she remained concerned?
A That she did not accept our views, yes.

Q Was anything done about that?
A Not really. She concurred and did what we asked of her.

Q Finally, the result of all of this, essentially, was that, first, there was no written policy but you expect, presumably, the National Guidelines and the Local Guidelines to be followed?
A Yes.

Q Secondly, the nurses received further training in relation to the use of opiates and syringe drivers?
A Yes.

Q Dr Barton did not receive any further training, did she?

A A That, I honestly do not know. I cannot remember.

MR KARK: Thank you.

Re-examined by MR JENKINS

B MR JENKINS: Can I come back to a further couple of points arising out of that. You were taken back to your statement with the police in which you were dealing with the idea of a patient being given a quantity of medication something every four hours and the nursing staff then giving a much larger quantity, six times or so of that quantity, over 24 hours?
A Yes.

C Q You told us you know about conversion, although having retired in 1996, you do not recall the fractions of the conversion rate?
A No.

Q Was that part of the concern, that nurses were being asked to give a much higher dose via syringe driver than they had ever given before?
A They were perceiving it as a higher dose because you are normally giving a patient – I cannot remember what doses patients were on at that specific time – say, it was 10 mg, it D does not seem as much when you ask them to get hold of a syringe and draw up 60 mgs in one go – when you get them to stop and say you would be giving that to the patient over 24 every four hours.

Q You mentioned the RCN leaflet on drugs. You said there was also a unit policy on drugs and you were asked about the concept of the nurse stepping in and declining to give medication if they thought it was inappropriate to do so. Can you tell us whether the RCN E leaflet or the unit policy on drugs would have referred to that concept of a nurse as the patient's advocate?
A It is the UKCC leaflet.

Q It was then, but it has moved on. It is something different now?
A I think the last page specifically states that a nurse has a responsibility not to give anything that she feels will harm a patient, so yes, it is no defence to give something to a F patient and say, "That is what the doctor wrote up", if you are aware that it would harm them.

Q The last point I want to ask you about is a document we have looked at before. It is page 2, which is probably open in front of you – page 2 of tab 6. You were asked about point 5 on that page, that this is a concern which was expressed and discussed, a suggestion that:

> "The use of the syringe driver on commencing diamorphine prohibits trained staff G from adjusting the dose to suit the patient's needs."

We have heard on a number of occasions during the last seven weeks of cases where the contents of a syringe driver were discarded and a different dose was instituted?
A It can be, yes.

Q What comment do you make about that concern?
H

A It was just a comment that was made and I felt it important to put all comments made by all the staff in this so that we could address all the concerns. I did not want them to come back. That was just something that they saw as a problem, but you rightly say you can discontinue and start off a different dose.

Q Are they right to think that would be a problem, that you cannot adjust the dose?
A No.

B

MR JENKINS: Thank you very much. You may be asked more questions by the Panel.

Questioned by THE PANEL

THE CHAIRMAN: This is the time for the Panel to ask questions of you if they have any, and I will turn now to see if there are any questions. Mr William Payne is a lay member of the Panel.

C

MR PAYNE: A couple of questions with regard to the whole episode, the whole investigation or inquiry. Why did it become your role to do the investigation or inquiry, why was your input required?
A As the immediate in-line manager, they were raising their concerns with me, which was the right channel for them to go.

D

Q They also must have raised their concerns with their trade union, their union, the Royal College of Nursing?
A They did at a later date.

Q Is that because they were not satisfied with the way the inquiry was going?
A I believe that was the explanation they gave to the RCN.

E

Q On page 10 you received a copy of a letter that you received from Mr Steve Barnes. It is you, is it not?
A Yes.

Q On paragraph 2 it says:

F

"This office was aware of the concerns that had been expressed by staff earlier this year and other discussions that had taken place with yourself as the Manager. It had been understood that the concerns raised would be addressed and the RCN had anticipated that the guidance/policy..."

You have told us that it was not your position to write the guideline or a policy?
A No.

G

Q Whose was it?
A As a nurse you cannot override the policies that are laid down by the nursing body, i.e. what was then the UKCC. It would be, I think I am right in saying and someone will correct me, illegal to do so as a nurse.

Q I accept that as the role of the nurse, but surely Mr Barnes, as the officer for Wessex, would have known that, would he not?

H

A I would have thought so, yes. I must admit that, following these two letters which came out of the blue to me from Mr Barnes, I did write and explain that everything I had done prior to the meeting, and they seemed to be quite happy with that.

Q To carry on from there, it says:

"... as a result of the very serious professional concerns Nursing Staff were B expressing.

It is now a matter of serious concern that these complaints were not acted upon in a way that had been anticipated."

That is quite a serious letter concerning its concerns?
A Yes.

C

Q Afterwards you took to having another meeting with the nursing staff and with the doctors?
A Yes.

Q All in one room together?
A Yes.

D

Q Am I right in thinking that you had been down that road once before and, obviously, it had not quenched their fears?
A The first time I saw the nursing staff on my own, and then as a training exercise Dr Logan came over and saw them. On the second time I felt it was important that everybody should meet. As I had not received any information from the staff from the first meeting until I got this letter the RCN, I had no idea what their concerns were or what the E problems were.

Q Do you think that once you had received that, this should have been something that went much higher than your pay grade, for want of a better explanation?
A They also wrote to Chris West who was the chief executive so, obviously, they were aware of what was happening and were overseeing.

F Q There was no input from that gentleman at all?
A No.

Q None whatsoever?
A Not to my knowledge.

Q If you are in a situation where you have some people complaining and some people G trying to answer the complaint, but the complaints are about the people who are trying to answer those complaints, would it not have been prudent – and we are all talking with hindsight – to actually get an opinion from someone else outside of the whole unit?
A They had a nurse specialist in pain relief, I think her name was Linda Foster if my memory serves me correctly, who came over and talked to staff on this issue, so, yes, they had input and they were nothing to do with the unit whatsoever.

H Q That was an input from a nursing staff grade?

A A Yes, to answer nurses' queries.

Q It was not an input from someone on an equal to, say, Dr Logan, perhaps from another hospital?
A No, but these nurses were working with specialists for pain control and were very aware of the correct drugs and doses to be given.

B Q You talk about individual cases. It says, in your memorandum on page 17, that, "Dr Logan and Dr Barton are prepared to discuss..." – paragraph 2 – "...individual cases staff have". I do not think anyone came back, did they?
A No. After the first meeting Dr Logan had talked about, in general, the prescribing of drugs, who one would prescribe it for, for what reasons, how much etc.

Q Sorry, would you say that again, I missed what you said?
C A I said, Dr Logan, after the first meeting, spoke to the staff and went into detail as to what type of patients or for what reasons it would be, in his opinion, appropriate to prescribe opiates. Also, there was in existence at that time a sliding scale of pain relief that the doctors and nurses could refer to. All that was discussed, but after that they went to the RCN. They obviously still had concerns, so Dr Logan said what he wanted to do was to explain to staff fully why Patient X was given "y", for what reason, but they would not give us this. They would not tell us which patients they had concerns over or why they had concerns over a
D particular patient so we were not able to answer their concerns individually. Do you understand what I am trying to say?

Q Yes, I do understand?
A I felt they were trying to get us to solve the problem blind folded, ie they would not really tell us what the real issue was that they were raising the concerns over.

E Q You have no idea why that was?
A I have. Knowing the individuals concerned I have perhaps some conception of why, but that would only be my own personal view and that would not be based on fact.

Q No one said anything to you official?
A No.

F MR PAYNE: Thank you.

THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: At some point you described how it was that syringe drivers came to be introduced.
A Yes.
G

Q A patient came in with their own syringe driver. Can you remember who instituted the use of syringe drivers, whether that was Dr Logan or whether it was Dr Barton?
A It was myself.

Q You started it?

H

A Yes. On request from staff on what was then the female ward. We regularly had terminal patients in who the Macmillan nurses were looking after at home but suddenly would require hospital admission.

Q Can I go back to something Mr Kark explored with you and I think, in a way, Mr Payne did too. It is how nurses deal with problems with doctors, or with what doctors do in general. I wonder if you could help me understand how a nurse thinks, when confronted with the doctor in the room, about her position as a nurse when there is a doctor there, the relative position?

A I would say most nurses look at themselves as the patient advocate for the doctor and the treatment they are receiving. As a nurse you are with a patient 24 hours a day and, possibly, are more able to assess the patient's condition, ie whether a patient is improving or otherwise, than the doctor who is on a five minute visit. I think the doctors rely quite heavily on the nurse's assessment of that patient as to what treatment they require, particularly when you are talking of pain. You are with the patient 24 hours a day, or one of your colleagues are and you see how much pain the patient suffers. The doctor might come in the morning and in that five minutes the patient is pain free, but half an hour later the patient might be writhing in agony.

Q At the bedside it would not be difficult, to use the words, broadly challenge a doctor and say why.

A Yes.

Q But when it comes to a meeting, everybody marches into a meeting, the door is closed and there is an issue. As Mr Payne says, you have two sides of an argument there, and you have nurses, a consultant and a general practitioner?

A It was a very informal meeting. The doctors concerned were very approachable. I do not think anybody would feel threatened by Dr Logan or by Dr Barton who were the only two medical people there.

Q On a formal issue might they feel intimidated by a consultant being present, a consultant being, if you like, the opposite side of ---

A Not in the circumstances of that meeting, no, I would not accept that. There was nothing threatening about the meeting. If you like, I was voicing their concerns for them and I was not saying, "Nurse X said 'Y'." I was saying, "The nurses are raising", so they could not have – and, certainly, the individuals concerned were not, I think, the type of nurses to be intimidated.

Q This might sound impertinent and I hope it is not: do you think that your view of what happened then was because you were no longer a nurse but a manager?

A No.

Q Were you still being a nurse? I think you said something about doing shifts.

A Yes. I used to try to work in at least one department one day a week, just to keep my hand in and, if you like ----

Q Keep your feet on the ground.

A -- build up a rapport with the staff. Otherwise, you were just someone in the distance.

A Q Okay. On this question of why night nurses might see things differently from day nurses, and why night nurses, I think you said, would not see the patient in the morning when they had their pain – or that was the suggestion – can you refresh my memory about the exact sequence of what happens in an elderly care ward. The night staff see the patients wake, do they not?
A Yes, normally. They are there until eight o'clock in the morning.

B Q What functions would they carry out with patients before they go off duty?
A They would normally give the patients drink. The vast majority of the patients would require changing. Those that did not would need to be toileted. None of the patients were able to get to the toilet on their own. And medication.

Q Some significant activities on the part of the patients.
A Yes.

C DR SMITH: That is all I wanted to ask you. Thank you.

THE CHAIRMAN: Thank you, doctor. Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Going back to a point where you were trying to establish the basis of the complaints raised by the nursing staff and you were talking about them not wanting to say
D that it was the level of drugs due, the prescription by the doctor, did you get to the bottom of why they did not see this around the prescribing levels?
A I am sorry.

Q You were saying that some of the complaints were about the amount of diamorphine that was being prescribed for individual patients.
A Yes.

E Q But then I understood you to say that, when you were trying to understand the basis of their complaints, they did not want to level a complaint against the doctors. They did not see it as a doctor problem.
A No. They -----

Q But they are the people who were doing the prescribing.
F A Yes.

Q Did you get to the bottom of that?
A They were adamant that they had no complaints about the amount of diamorphine being prescribed. It always came back to the fact that they did not always see the type of patient being prescribed the diamorphine.

G Q So it did come back to prescribing really.
A It came back to the prescribing, yes.

Q To clinical decisions.
A Yes.

H Q What do you think was going on that the nurses could not put those two facts together?

A I honestly could not explain it at the time and I cannot now. Other than, yes, we were, in line with guidelines, we were trying to get the nurses ... If it was recognised that a patient needed to go on these strong drugs then we were preferring that they had it on a regular basis, so that we could try to control the levels they had better.

Q Yes.
A Rather than, as had been the practice in the past, you just gave a single injection and then you waited for the patient to be in pain again and then gave them another one – injection or tablet or whatever. Some seemed to have a resistance around that issue. They could not see why. I think the whole thing was very complicated, because there were lots of different things going on at the same time, because they were getting a different type of patient in as well.

Q To me, you are raising questions around clinical judgments.
A That is correct, yes.

Q Around the treatment of the patients.
A Yes.

Q But the nursing staff could not articulate it in that way or would not articulate it in that way.
A No. On more than one occasion, it always came back to the fact that they have not got cancer. There was always the inference there from some of the members of the staff that if they did not have cancer they should not be given opiates.

Q Going back to questions that my colleagues have already questioned, my understanding of hospitals is that there is quite a hierarchical position between the different tiers, between different doctor tiers and nursing tiers. Tell me about that hierarchical position.
A We were a very small hospital – what was classed as a GP hospital. Certainly from when I started in 1961 until I left, the hierarchy thing had merged slightly in any case, but it was almost non-existent within the small hospital. We were a very friendly unit. I do not think the fact that staff felt intimidated in any shape or form was really an issue on any front.

Q Yet, on the other hand, you say that Dr Logan became irritated when the nurses raised questions again. That tends to suggest that there is a hierarchy there.
A No, it was more a frustration, I think, than anything. Certainly that is how I felt.

Q Right.
A Because you were trying to solve a problem without really knowing what the problem was.

Q Yes. Yet there was something, in a way, that was stopping the nurses being able to communicate that problem, so as you could understand it fully.
A Possibly.

Q Would you say that?
A Yes, I would accept that perhaps it was a failure on my part to fully understand them, but I do not know what else I could have done.

Q Okay. What we cannot grasp then is really the basis for that, what was behind that. That is what we are having difficulty grasping.
A What their fears were based on, then, no. Other than, as I say – but it is only supposition on my part – saying that.

MRS MANSELL: Thank you.

THE CHAIRMAN: Thank you, Mrs Mansell.

Ms Joy Julien is a lay member of the Panel.

MS JULIEN: I just want to clarify where you fitted in in the process regarding the complaint. You may have answered it and I may have missed it. At the point where the nurses took their complaint to the Royal College of Nursing, were you out of the picture by then or did it come back to you? I was not quite clear.
A After the initial meetings and the staff training, I was not aware there was a problem until I got a letter from the RCN stating staff grievances.

Q It was raised then. Did the RCN take it up specifically?
A Because the RCN obviously wrote to me saying the staff had concerns, I then went back to the staff.

Q Did the RCN fall out of the whole picture then, as it left you?
A They were quite satisfied with the response I gave them as to what I had done in relation to staff complaints.

Q When you mentioned a grievance, was that what you were talking about, the RCN?
A The RCN, yes.

Q So there was no outstanding grievance after that.
A No, no. It never reached that

Q Okay. You also mentioned the unit having a policy. Did you mean as a result of these issues from this meeting, or was that something that pre-existed?
A It pre-existed.

Q Did it address the issues?
A There were five small hospitals within the unit that were similar to ours, in so far as we did not have a resident doctor on call. This sometimes creates problems in relation to prescribing and giving drugs, so we felt it was necessary as a unit to have a policy which covered those issues that were not covered in the UKCC policy that we were bound to; that is, we had a policy on which drugs a nurse could give without a doctor prescribing – such things as Panadol if a patient had a headache – not relating to opiates, obviously.

Q Okay.
A That is the type of thing that was in our own unit.

Q As a result of this complaint and these meetings, was the policy amended?
A No, because there was nothing that was not already covered in the existing policy that would have changed the situation.

Q Should those nurses not have been aware of that?
A You cannot write a nursing policy stating what a doctor can prescribe for certain patients. It is not a nursing role. They were looking for me to include medical policies, if you like, within the nursing policy – which is not feasible. It just cannot be done.

Q This was just a nursing policy.
A Yes. I do not know honestly where they got the bit from saying that a policy was going to be made from.

Q As far as you know, was there ever a policy that addressed these issues?
A No, the policies that were already in existent were sufficient.

Q Then, as a result of the discussions and meetings, as far as you know there was no further policy development.
A Not in relation to the giving of the drugs, no.

THE CHAIRMAN: Finally, it is me. I am a lay member. You have told us that you started out as a nurse and you ended as a manager.
A Yes.

Q I take it that you would be in a perfect position to understand the extent of the chasm, be it big or small, that might exist between the two sides or two parties.
A Yes.

Q You have also told us today that in dealing with this or trying to solve this problem – a problem which you did not really know what it was but which you knew you had to solve – staff intimidation was not an issue.
A No, in my opinion not.

Q Yet when you wrote your memo on 5 December 1991 on page 21 of tab 6, you said,

"It is not our intention to make this meeting in any way threatening to staff."

A Yes.

Q Would that indicate that at that time you recognised that some staff might have that concern?
A Well, the fact that they had gone straight to the RCN and not come back to me made me wonder if they felt in any way intimidated or threatened, but no other reason did I have for concerns that they felt so.

Q In your meeting of 11 July 1991, you had had very specific issues and concerns raised, and you have very helpfully listed all of those. You are, I am sure, aware that similar concerns were raised again some six to eight years later.
A Only what I have read in the press.

Q It appears that the problem that you were seeking to understand and try to solve at that stage is one that apparently came back at a later stage. I would like to understand from you if you felt that there were any external circumstances that might have been leading to this

general disquiet among the nurses in 1991. You have told us that there was concern where the heavier medications, the opiates, were concerned. Am I right or not to get the impression that around this time there was a general up-scaling towards heavier medications in general hospital practice? Or have I misunderstood that

A No, I do not think so. Certainly we were looking at the way we were giving it. There were guidelines coming out from places such as Countess Mountbatten and others on prescribing and how it should be given, and we were doing our best to follow those guidelines.

Q You mentioned just now that at that time in 1991 the nurses were getting a different type of patient in.

A Yes.

Q I take it that you are referring to the less acute of the acute patients and those who were going to be more difficult for a variety of reasons to manage.

A Yes.

Q So that that problem was already manifesting itself in 1991.

A Yes.

Q Do you see any connection between that problem manifesting itself with more of those sorts of patients coming through onto the ward and the consequent increase on pressure on the nursing staff? Do you see any connection between that and their concern, which you had difficulty in really pinning down but which seemed to be about the prescribing of opiates and the care of those patients?

A Only in so far as obviously the higher number of patients you had in who required terminal care, then the higher the proportion/the number of patients you are going to have within a unit who require opiates. Whereas it had been a fairly rare event for a patient in that unit to be given diamorphine, it was becoming a more common thing because of the type of patient they were looking after.

Q Perhaps that is really the issue I am struggling to understand. Is it simply because there were more patients who were requiring opiates, or rather that the patients for whom opiates were seen as appropriate widened?

A Mainly the first. Possibly .....

Q Possibly the second also?

A Yes, as people's awareness, if you like, became ....

Q Would that explain concerns such as number 6:

"That too high a degree of unresponsiveness from patients was sought at times?"

A Again these points I will stress, were just comments that they made.

Q Yes.

A It was not the general opinion of that. As a nurse, I would say the last thing you would want to do is to increase the unresponsiveness of the patient because you are just making harder work for yourself. It is much easier to look after a patient who can wash, feed, dress themselves, than one you have to do all those things for. Obviously the higher the

degree of responsiveness you can leave a patient in, but at the same time have them pain free, then that would be your aim.

Q Would that be equally true of a very demanding patient who was constantly crying out and requiring a great deal of nursing time, where you have a one-on-one system, where a nurse has to sit with the patient for a period of time to calm them?
A Well, I do not think for that type of patient, if their only problem was disruptiveness, then I would think you would be looking at sedatives rather than opiates, but if the patient had multiple problems in amongst those problems with that, then, yes, it might be that that patient was given.

Q We have been told that the general profile was that it was multiple difficulties that tended to be presenting themselves rather than one individual one.
A Yes.

Q Similarly, you had the concern you noted also, number 4, that a patient's death is sometimes hastened unnecessarily. Is that again something that you would ascribe to the first issue or would that also perhaps be connected with the second issue, the fact that there was now increasing pressure on the wards, one, to receive inappropriate patients, but it appeared to be, from the descriptions we had had, an endless requirement. The acute wards were constantly seeking to move on. We have heard the phrase dumping patients on your wards.
A I think that comment – and again, it is very difficult for me in my mind having to go back so many years – was made in relation to patients being given opiates on a regular basis rather than a PRN basis or on an as-needs basis, that there may be an ulterior motive, but I would hasten to say there was never any proof to that.

THE CHAIRMAN: I was just trying to understand what you clearly had been trying to understand, what the real problem was. I am most grateful for your assistance in that regard. We have a little bit more for you. Mrs Mansell would like to come back swiftly.

MRS MANSELL: I am sorry about this. We were trying to get to grips earlier with the prescribing and whether it was actually about the different patients and the prescribing for those different patients. As the Chairman was asking you questions, it did seem to me: was it the diagnosis that someone was now into terminal care and so that the diamorphine was being given as part of the dying process?
A No, I am not suggesting that every patient once they were labelled as terminal was given diamorphine. The one case I can remember, and it is actually in here, was a patient that became very distressed every time she was turned or had to have treatment, and this was on a two-hourly basis. In my book to put a patient through agony every two hours when it can be alleviated is not on but some of the staff did not feel that that type of thing was enough of an excuse for a patient to be given an opiate.

Q We probably cannot go further than that.
A I find it difficult sometimes to express myself.

THE CHAIRMAN: Don't we all? Now we are at the stage where the barristers have the opportunity to ask any questions which have arisen out of the questions asked by the Panel.

Further cross-examined by MR KARK

Q I do not have very many questions. In light of the fact that the nurses did in fact end up going to the RCN and that apparently was a surprise to you, do you think you may have misunderstood the level of their concern?
A It might sound arrogant, but, no, I do not. In fact, the RCN representative said to me in private that he could not understand what the problem was either.

Q This is the same RCN representative who spoke about making a grievance?
A Yes. He had not realised the full extent of what I had done in answer to their complaints the first time.

Q So, despite everything that you had done, the nurses had still gone to the RCN?
A Yes.

Q When you received this letter saying it is now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated and they now expect a clear policy to be agreed as a matter of urgency, that came as a shock to you?
A Yes. I had no knowledge of the policy that they were expecting.

Q But you did not take it any higher than yourself, as it were?
A I obviously took the letter to my manager. What he did with it, you would have to ask him.

Q We do not see his input here, do we?
A No.

Q You were asked by Ms Julien about the policy that the nurses were working to. Again, I just want to understand what it was. Was this a nursing booklet?
A Guidelines issued by the UKCC.

Q And the guidelines covered what?
A They covered the administration of drugs by nurses.

Q You also spoke about the guidance given by the Countess Mountbatten House but you do not know this book?
A I cannot remember that specific book. I can remember we used to have a sheet with a sliding scale. I am not syiang I have not seen that; I just do not remember it.

Q The sliding scale we have all heard about; that is the sliding scale of analgesia.
A Yes.

Q Was it your understanding that that was used?
A Yes. It is not always appropriate for patients but where it was appropriate, then, yes.

Q You were asked by Mr Payne about whether anybody from outside, as it were, had come in to review your practice and policies. You mentioned a nurse specialist who came in.
A Yes.

Q It was never thought appropriate that a palliative care consultant should come in and review the practices either of Dr Barton or Dr Logan?
A No. The nurses continually said that they did not have a problem with the amounts that were being prescribed. Dr Logan was aware that I would have left that to him.

Q I just wanted finally to ask you this. You said that on a number of occasions and I understand that, but how does that square up with the complaint that patients' deaths are sometimes being hastened unnecessarily?
A That was a comment made by one nurse and that was one of her fears; i.e. the route being given.

Q That must relate to over-dosing, must it not?
A Not necessarily so, no.

Q How else would it be?
A I think I am right in saying --- Again, you are asking me and I am no expert but I think you will find that with anyone, particularly in a very ill condition who is regularly on opiates, you do run the risk of possibly shortening their life slightly. It is a choice between allowing them to be in pain for six days or to be pain-free for five and a half type of scenario.

Q The suggestion here is not simply that they were being hastened, and that would be a consequence of the double effect, but that they were being hastened unnecessarily.
A Yes, but I personally did not have any concerns on that issue.

Further re-examined by MR JENKINS

Q You introduced syringe drivers to the Redclyffe Annex?
A Yes.

Q And elsewhere in the Gosport War Memorial Hospital. You told us why you did so and you related it to the fact that there were other patients being treated by Macmillan Nurses or cared for by Macmillan Nurses?
A Yes, and in fact they wanted to take their syringe driver off the patient but we did not have one to replace it with, so they allowed us to keep it for that patient, and we endeavoured to get some for the hospital.

Q Clearly this was a relatively new development, the use of syringe drivers?
A Yes.

Q Certainly new to Gosport when you introduced it?
A It was new to Gosport and, as I say, there were a lot of people who advocated that it was the easiest and most economical way of giving the diamorphine.

Q The doctors and the senior nursing staff did not have any difficulties with it, indeed supported it is what you told us.
A Yes.

Q You have been asked questions along the lines of: the nurses expressed concerns and the Chairman used the idea that there was general disquiet amongst nurses. Did that reflect what was happening? You said there were four, and you identified them for us.

A A The four?

Q You said there were four nurses and we looked the second page; you identified them for us by name.
A Yes.

Q If we stay at page 2, the following concerns were expressed and discussed, and there
B are 10 points. Can you help us: were all four expressing those concerns?
A Not all 10 concerns. The 10 concerns were raised by all the staff generally.

Q If one person raised one concern, that would be written down?
A Yes. I tried to include everything. I did not want anything left out because I felt if we were going to go into the issue, then it was no good resolving one issue and then the following week going back and having to resolve another.

C

Q Again, just to understand the nature of the complaint, you were told, in correspondence with the RCN representative, that it was not the use of syringe drivers that was the cause of concern? That is page 19.
A By that time, no, but the initial concern was related to syringe drivers and then once we got into questioning staff, then all these other issues came. Obviously by the time they went to the RCN, they were quite happy with the syringe drivers but still had concerns.

D

Q So it was not the use of syringe drivers that was still a problem later on?
A No.

Q And you have told us again and again the amounts of diamorphine that were being given to patients; no one was questioning those – page 24, point number 5. You said on that page "What is questioned is the appropriateness of prescribing diamorphine for other
E symptoms or less obvious pain."
A Yes.

Q What we have heard from you is that there was one nurse who had a view about cancer and treating patients with diamorphine?
A There were several of them that mentioned that. I think I am correct in saying Nurse Turnbull and Nurse Giffen certainly raised the issue that ---

F

Q We have seen Dr Logan's letter right at the end of that tab talking about one of the concerns that appeared to be that there should be a full staff conference before anyone could be prescribed subcutaneous analgesia .
A I would say if you could wait that long, then the patient would not need it.

Q I understand but does that reflect the sort of concerns that were being raise – we
G should all be discussing it?
A Yes.

Q Dr Logan also deals on the same page, page 29, with the suggestion that it would be wrong to start subcutaneous diamorphine where there had not been a patient-voiced concern about pain?
A Yes.

H

Q Even though a patient may be distressed regularly?
A I find it very difficult the fact that you could have nurses that had worked in a long-stay, elderly care unit that did not recognise that sometimes within the elderly patients have pain but are not able to verbally express that.

Q You have told us of a patient being in agony every two hours if they were treated.
A Yes, but at other times quite a lot of these patients are very confused and they are unable to verbally put it to you but you recognise it by signs; the patient gets very agitated and fidgety. Each patient is different. You get to know the patient. You get to realise that they are in some discomfort, or at least distress.

MR JENKINS: You were asked questions from members of the Panel and others about what lay behind these concerns, given that the precise nature of the concerns was not clear to you and you said that knowing the individuals concerned you would have an idea what lay behind it. I am entitled to ask you what you mean by that.

MR KARK: Is that not speculative? You are not inviting the witness to speculate?

THE CHAIRMAN: That must be right, must it not, Mr Jenkins?

MR JENKINS: The question of what weight the Panel gives to the answer is a matter for them, but I think I am entitled to ask the question. I am prompted by one senior to me. The Panel have been asking that sort of question and I am keen that we grasp the nettle, as it were.

THE CHAIRMAN: I think that is a fair point. What is sauce for the goose should be for the gander.

MR JENKINS: I will ask the question again. You said "knowing the individuals concerned I would have an idea what lay behind their concerns". You also said they were not the type to be intimidated of the people you have named.
A Yes. I have got to say that the worst culprit had to be Staff Nurse Giffin, who was a very vocal lady and seemed to be of the opinion that if she was not trained to do anything in 1961, then she should not be expected to do it now. Any change she was resistant to and if she did not think it warranted change, then it should not be changed.

Q And yet there were changes by the nature of necessity in the patients?
A Yes, and she would go along with it, but she would let you know that she did not approve.

Q Do you want to say anything about the others?
A Enrolled Nurse Turnbull was a very caring nurse who was easily swayed and worked a lot with Staff Nurse Giffin, so I think once doubts were put into her mind, she rightfully wanted them answered.

Q Lynn Barratt has told us that she does not remember being at any meetings. She accepts that she was because she has seen the documentation but she cannot say now that she had any concerns then, so I do not need to ask you about Lynn Barratt.
A She never raised any concerns but did not always help the situation with the barrier between the night and the day staff. She was not always terribly diplomatic with what she should say.

Q I understand. What about Anita Tubritt?
A Anita Tubritt in my view was a good nurse, had the patient's interests at heart, but over this particular issue I was a little disappointed, because I thought that we built up quite a good rapport, that she felt she could not come to me when she felt she had further concerns. I could not fault her as a nurse. Saying that, as she worked on night duty, I did not have a great deal to do with her.

Q Concerns were raised initially. We have heard that Steve King was involved. You told us Linda Foster was involved and she was independent of the hospital.
A Yes.

Q A nursing care specialist?
A Yes. I cannot remember whether she was a Macmillan Nurse or not but she certainly was involved within the terminal care and pain relief.

Q Steve King was on the nursing side. Did he have a specialty at all?
A He was branching out into being a tutor and as a nursing officer had been for many years within the elderly service and was very highly trained. If you like, you could say he was the specialist within elderly care.

Q Notwithstanding that training or that talking to nurses, these complaints re-surfaced?
A Yes.

Q We have seen the letter from the RCN, at page 10. You have told us what Gerrie Whitney told you confidentially. You told us you wrote back.
A Not Gerrie Whitney.

Q Keith Murray?
A Keith Murray.

Q You have another letter, you told us, in which these complaints resurfaced. You told us you wrote back, I think you said a long letter?
A If my memory serves me correctly, and I do not have it on record, Staff Nurse Tubritt wrote me a little note and just said that she had been to Gerrie Whitney to discuss this issue with her, and that was my response to that note.

Q You wrote back to the RCN?
A I wrote back to the RCN, gave them a minute of the meeting, which they already had in any case, but then went through the training sessions that I had arranged and the meeting that they had with Dr Logan and the fact that we had staff meetings etc.

Q You told us that you thought that was an end of it when you wrote back?
A Yes.

Q You answered a question from Ms Julien saying that it was not a grievance, it was not taken that far?
A No, it did not come to the grievance.

Q So far as policy was concerned, we know from page 25 of this bundle, from your note, that at the meeting in December 1991 you asked staff if they felt there was any need for a policy relating to nursing practice and no one thought it was appropriate?
A That is correct.

Q Was there further training organised after this meeting?
A Not specifically ongoing from this but, yes, we had a regular programme of identifying as part of staff appraisal, staff training needs and arranging the appropriate training.

MR JENKINS: Thank you very much.

THE CHAIRMAN: That concludes your testimony. We are most grateful to you for coming and assisting us. When a Panel has, as this one does, from such a great distance in time enquire into circumstances and events, it really assists us enormously when witnesses such as yourself are prepared to come forward in person and share your memory and understanding with us. We are most grateful for that and you leave with our thanks. You are now free to go.

(The witness withdrew)

MR JENKINS: You will want to take a break as a Panel?

THE CHAIRMAN: Your perspicacity never ceases to amaze me, I was just contemplating the amount.

MR JENKINS: I was rising because I knew you were going to deal with that. I have two witnesses to call. One is Barbara Robinson and the nurse, Patricia Wilkins, who deals with a couple of patients. I was not proposing to take her at great length through the treatment she gives the patients, Lavender and Stevens, B and L, but I know she has to finish today. She is not available tomorrow and I was proposing to call them in that order, Barbara Robinson first and then Patricia Wilkins. It may be that the Panel would find favour in having a slightly abridged lunch period today.

THE CHAIRMAN: You are not making yourself as popular as Mr Kark did on Friday! We will try and accommodate you. Let us say we will come back at half past two.

(Luncheon adjournment)

Barton32e1ln

2.30

THE CHAIRMAN: Yes, Mr Jenkins.

MR JENKINS: Sir, I am going to call Barbara Robinson, please. The Panel will recall her name and if they look at D4 they will see a document she had a hand in writing.

BARBARA FRANCES ROBINSON, Sworn
Examined by MR JENKINS

Q (After introductions by the Chairman) What is your full name?
A Barbara Frances Robinson.

Q I think it is Mrs Robinson.
A Mrs Robinson.

Q I think you qualified a long time ago as a nurse?
A I did, in 1967.

Q I think you then qualified as a district nurse in 1971.
A That is correct.

Q You then worked in various settings in nursing until your retirement in 2004?
A That is correct, yes.

Q I think you worked as a district nurse with the practice where Dr Barton was a GP in the 1980s, between 1982 and 1987.
A That is correct.

Q I think you were subsequently appointed to the position of Services Manager for the Community Hospitals and Elderly Mental Services in Fareham and Gosport?
A That is correct.

Q From 1996 to 2000 you were responsible for nursing, administrative and catering staff at the Gosport War Memorial Hospital?
A I was, yes, as part of my larger role.

Q The last witness we heard from, Isabel Evans, was responsible for nursing and other matters at the Gosport War Memorial Hospital, was she your immediate predecessor?
A She was, yes, but it was a different role that I took over.

Q But she was responsible for nursing, as were you once you took over your position at Gosport?
A That is right, yes.

Q I think after 2000 you went to the Queen Alexandra Hospital as chief nurse for older people's services?
A That is right, it was elderly medicine at Queen Alexandra's and St Mary's and elderly mental health services at St James' Hospital in Portsmouth.

Q Can I come back to the time when you were a district nurse.
A Yes.

Q And working for patients for whom Dr Barton was their GP?
A Yes.

Q Would you have had a fair exchange of information and contact with the GPs whose patients you were looking after?
A Yes. It was an excellent GP practice and we met every day at coffee time to discuss patients with the doctors, and at other times during the day if we needed to.

Q What sort of patient group would you be dealing with as a district nurse in the 1980s?
A Certainly terminal care, leg ulcers, any post-surgical wounds that needed dressing.

Q As a district nurse would you be seeing some patients in their homes?
A Every patient in their home.

Q What about patients who might be treated on a GP ward in a hospital? We have heard of Sultan Ward at the Gosport War Memorial Hospital, you would not be there?
A No, no, the district nurse's role was purely in people's homes.

Q So it was community based?
A Community based, yes.

Q The War Memorial for GP beds would have had their own resident staff?
A That is correct.

Q So you would be dealing with patients who had leg ulcers and other conditions which needed to be treated at home, including patients who might be approaching the end of their lives?
A Yes.

Q How did you find the care that Dr Barton was providing for that class of patients?
A Dr Barton's care was excellent. She really cared about the patients. She cared about the carers. She always had time to listen, discuss treatment regimes. She always had time for the district nurses and Dr Barton always treated the patients in a way that would give them the best quality of life until they died.

Q You have been in nursing for 40 years or so ...
A That is right.

Q You will have seen many, many doctors ---
A Certainly, yes.

Q --- over that period of time?
A Yes, I have.

Q What proportion of those doctors would you say were excellent? I am inviting you to put Dr Barton on a scale?
A Maybe 75 per cent.

Q You said she would listen to nursing staff as well.
A Yes. I mean, Dr Barton always made time. If you went and knocked on her surgery door during surgery she would always see you after the patient she had with her had gone. She always made time.

Q Would you be able to say the same of all the doctors that you have worked with?
A No.

Q When you moved to the Gosport War Memorial Hospital, what we know is that patients were being treated with Dr Barton as the clinical assistant, in two wards, Dryad and Daedalus ward.
A That is right, yes.

Q You were based at the hospital.
A I was based there, yes.

Q How much contact would you have had over the course of a working week with Dr Barton or the nurse managers, sister or nurse manager, on those two wards?
A I would see the wards most days. Every day I was in the hospital I would always walk round the wards. I did not see Dr Barton a huge amount, but if I needed to see Dr Barton I always knew where to find her and what time of day to find her.

Q I understand. What would you say of the level of medical care that was being provided via Dr Barton to those patients on Dryad and Daedalus Ward?
A It seemed to be very good, and I would know that from the sisters, the nursing staff, so if they had been unhappy with the medical care then they would have certainly complained.

Q Would it follow that you would have had regular discussions with the nurse managers on both those wards?
A Yes.

Q Would you have had discussions with the nursing staff as well?
A Quite often, yes. I was a person who walked the wards.

Q We know that there might be a sister, say Sister Hamblin, on Dryad Ward, but on occasions when she was not on shift there might be another senior staff nurse who would be in charge of the ward.
A That is right, yes.

Q Would you have regular feed back from that individual over time?
A I would, yes. If the sister was off duty, yes.

Q Again, what would you say about Dr Barton's care of the patients as far as you were able to judge it, both from your own observations and the feedback that you were getting?
A I had no reason ever to be worried about the care that was being given to the patients, as far as I could see it was excellent and relatives were pleased. I would often talk to relatives about the care because in those days it was the beginning of real quality and trying to get patient and relative feedback, and that was always good.

Q If you were talking to relatives what would you be talking to them about? Would you be discussing clinical matters concerning the patient they were a relative of?
A I would be asking them if they were satisfied with the care that their relative was being given at the time, and that could be anything. That could be the food, but nobody ever complained about Dr Barton's care to me.

Q As time went on, whilst you were at the Gosport War Memorial Hospital, again between 1996 and 2000, what can you tell us about the type of patient that was being admitted to Dryad and Daedalus Ward?
A It was the beginning of a time of change really because more and more patients were going into nursing homes more quickly – iller patients were going into nursing homes so that the Gosport War Memorial beds could be cleared for iller patients from the acute unit to come to Gosport War Memorial so care was changing and patients had very complex needs and the number of those patients during that period increased from the days maybe where it was more convalescent, but a slower pace.

Q The acute wards, are we talking about the two surgical units locally?
A No, I am talking about the Department of Elderly Medicine at QA and may be some of the medical wards at QA and Haslar Hospital medical wards.

Q So patients were frailer than they had been at an earlier time?
A Definitely.

Q And their medical needs were more complex?
A They were. They were definitely multi-pathology. They had a lot of needs. In the end, most of the patients on the wards needed feeding, it was very time-consuming.

Q Was there any change to the resources that the wards had over this period of time, change dealing with the nursing complement and the number of nurses that were there or the skills of the nurses or the medical complement?
A There were a few more nurses employed for the stroke unit, which started on Daedalus Ward at that time, otherwise there were not any more nursing staff. There were certainly no more medical staff. There was no more help for Dr Barton during that time, except the two consultants did start visiting weekly rather than fortnightly. At first one used to visit one week and then the other the other week.

Q What would you say about the workload for the nursing staff and also for Dr Barton as time went on?
A As time went on the nurses were more and more stretched because of the complex needs of the patients, and also we had to start sending them to the QA to the acute elderly medicine wards to try and give them more training in more acute needs of patients, so that was time-consuming in itself.

Q Can I just go over that: you would send nurses over to the Queen Alexandra Hospital so that they could get more training?
A Yes. It was a bit of a deal because QA at the time were really stretched. They were imploding. They had so few staff on their wards in elderly medicine, but from Gosport we, for maybe a period of a month or so, we would send somebody over to help them out but also at the same time to gain more acute skills to bring back to Gosport War Memorial Hospital.

Q So the nursing staff were stretched over this time?
A They were, yes, yes.

Q What about Dr Barton?

A Well Dr Barton was also more stretched because of the frailer patients, more people inevitably were dying; they had more complex needs so ward rounds would take longer and the through-put of patients, the number of new patients being admitted was ever increasing, so, yes, Dr Barton's workload increased hugely I would say.

Q How was she coping with that?
A As far as I know extremely well, probably by doing more hours. I am not sure how many more hours but, I mean, she never let us down, she always attended, every morning, returned later in the day if needed. There was never any suggestion that she was not actually covering her workload but it must have been at her expense.

Q Can I ask about transferring iller patients to the War Memorial: when patients came in what sort of reasons were given to the relatives (or the patients) as to why they were coming?
A We did have a problem because more and more relatives were being told they were coming to Gosport for rehabilitation. I think this sometimes was to appease the carers who did not maybe want them to move and when they arrived at Gosport they were quite clearly were not for rehabilitation, they were very ill people who were in end-stage illness.

Q Would you pause there? You said the relatives were being told this.
A Yes.

Q Who was telling them that?
A The managers, particularly from Haslar. Haslar Hospital was a particular problem.

Q The Panel has heard evidence to the effect that there were real difficulties at other hospital concerning beds ...
A Yes.

Q The availability of beds and the scope for those hospitals to keep doing routine or emergency operations.
A Yes.

Q Are you able to tell us why it was that patients were coming to you when the relatives (perhaps the patient) had been told something that was not actually right?
A When we spoke to the managers it really was because they had to clear the beds because of the next lot of people who needed acute beds because there was a shortage of acute accommodation, acute beds. They had to keep the through-put going and ... Yes.

Q How did patients who were frail and perhaps being transferred early, how did they respond to being transferred out of an acute unit into the War Memorial Hospital?
A I can only tell you from what the ward managers reported back to me because I did not necessarily see them arrive. The ward managers were concerned that the patients were really quite worn out when they arrived and, because of their frail condition, a journey did not do them any good at all.

Q We have heard that a patient should be stable when they are transferred from one unit to another. What would you say about the stability of patients who were being transferred to Gosport during the time with which we are concerned?
A I do not think I can really comment on that.

Q You told us that you contacted others in relation to ---
A I spoke to the managers of Haslar and the managers at Queen Alexandra's.

Q What prompted you to speak to them?
A The ward managers from Gosport had come to me and said how worried they were about the expectations of relatives. This was causing real problems on the wards where relatives were getting quite cross with ward staff because their relative was not having the rehabilitation and not getting better and their expectations were not being upheld.

Q The response from the Haslar, or the units that you were speaking to, was that they had to transfer the patients out?
A Yes, they had no option.

Q Was Dryad Ward or Daedalus Ward set up to provide rehabilitation?
A Daedalus Ward at that time had just started to have some rehabilitation beds and some stroke unit beds. Dryad Ward was not for rehabilitation, that was a continuing care ward.

Q It follows that if patients or their relatives were being told that the patient was being transferred for rehabilitation, that was not going to be provided on Dryad Ward at least?
A No. They did their best if that was possible, but usually they were not medically in a fit state to be rehabilitated.

Q Did that cause difficulties with relatives or patients themselves discovering that what they thought was going to happen, or should happen, was not going to happen?
A It was causing difficulties and I was called to the ward on one occasion to meet a relative who was very angry that his mother, who he thought had come from Haslar for rehabilitation, in actual fact was in severe pain and was deteriorating quite rapidly and had been put on medication and the relative was quite angry about it.

Q I think you wrote a memorandum that we have. I am going to ask you to look at a copy. I think you know it well. It is a document we have marked D4, if we look at that document, I think you are the author of this memorandum?
A I am, yes.

Q You say:

"Learning points and the ..."

then you give a name "Complaint".
A Yes.

Q The name is the surname of the son?
A That is correct.

Q His mother was the patient?
A Yes.

Q Had a different surname?
A She did, and I cannot recall it.

Q Her initials, I think, were ES?
A I cannot remember her name.

Q It is not one of the patients with which – it is EP, I beg your pardon?
A "Purnell" it might have been.

Q Yes. That is my fault entirely, but this is not one of the twelve patients with which this Panel is concerned, but the son, and again you name him, complained?
A He did, yes.

Q Is this the person who you say was angry?
A He was extremely angry.

Q The reason for his anger was what?
A Because his mother was not being rehabilitated and she was deteriorating and that she had started having diamorphine.

Q Was this a case where it had been suggested at an earlier time that his mother could undergo rehabilitation?
A It was, it was from Haslar Hospital, yes.

Q It is apparent from your memorandum that you considered the complaint?
A We did, yes.

Q In your consideration of the complaint, was the view taken that this lady realistically could have been rehabilitated?
A No, it was not the view. She could not be rehabilitated.

Q But he had been told that she was going to receive treatment for rehabilitation?
A By Haslar Hospital, but when she got to Gosport War Memorial she was told by Ian Reid, the Medical Director who covered there, that his mother was dying.

Q He did not react well to it, plainly?
A No, she was in severe pain and she was adamant he did not want her to have pain killers, but she was in severe pain and needed pain relief.

Q Before I come to how this complaint was dealt with, that is one case where you dealt with a complaint and you were involved in dealing with it?
A Yes.

Q From your understanding, was that an issue that was repeated in other cases where relatives had been led to understand that a course of rehabilitation could be provided, that Gosport would get them back on their feet in a couple of weeks, that sort of thing?
A Yes. A complaint was put in later from somebody else which is part of this.

Q How were the staff able to deal with relatives who may have been given unrealistic expectations?
A It was extremely hard on the staff because they were the in between people and relatives would get angry with them when it was entirely not their fault at all. They did try very hard. Sister Hamblin was marvellous at talking to relatives and trying to explain things

A to them in the best possible way. She is/was then a very, very caring ward manager who is very hands-on with nursing care.

Q Let us come back to this particular case. Coming back to the document we have marked D4, you are writing to Max Millett, who I think was the Chief Executive at the time?
A He was, yes, of the Trust.

B Q Had you undertaken some investigation and asked for a Dr Turner to look at the concerns about this case?
A That is right, yes.

Q You have detailed a number of points arising, it would seem, from Dr Turner's letter?
A We had a meeting and Dr Turner wrote afterwards, yes.

C Q You deal at point 3(d) with "Good practice in writing up medication".
A That is right.

Q You say:

D "It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

A That is correct.

E Q What you told us is that, with this patient, diamorphine had been prescribed and administered?
A Yes.

Q Was the prescribing and administration of diamorphine part of the issue that Dr Turner was asked to look at?
A It was, yes.

F Q Can you tell us why you say, "It is an agreed protocol that Dr Barton writes up doses ranging between 20 and 200 mgs a day"?
A I was confirming to Max Millett, the Chief Executive, that this was indeed the case.

Q Would it be fair to say that Dr Turner had raised an issue that that would not be usual?
A I cannot honestly remember if he did or did not. I believe he just asked what the
G protocol was.

Q Where did you get the information to say that it was an agreed protocol that Dr Barton should write up diamorphine?
A From Dr Ian Reid and it was confirmed by the ward managers.

H Q The ward managers we know about were Sister Hamblin on Dryad, and in the year 2000 it was Philip Beed on Daedalus Ward?

A That is right.

Q You spoke to both of them.
A Yes.

Q Dr Ian Reid was one of the consultants and also the Clinical Director?
A He was the Medical Director for the Trust.

B

Q We know that there was another consultant, Anthea Lord, who was dealing with patients on one of the wards at that time. Did you speak to her as well?
A I cannot remember. I probably did – I could not say for sure I did or I did not – but I used to meet with the consultants together about every three months and we would raise things like that.

C Q The rest of that paragraph and the information in it:

> "The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

D Where did you get that information from?
A From the wards, yes.

Q When you were investigating that issue, was there any suggestion that nurses had not been following such an agreed protocol?
A No, there was no suggestion.

E Q From your position as someone investigating that, how did it seem – that that practice was being followed, that it was working or that there were problems with it?
A It seemed to work very well because, apart from the few hours Dr Barton was in the hospital, there was no doctor in that hospital all day and when another doctor, a deputising doctor, might be called out, say in the night, they did not always come very quickly because they would think, "This is a hospital", and would put it as low priority for visiting, so there was a misunderstanding with the deputising service. We had to keep reminding them that
F there was no resident medical officer in the hospital.

Q Staying with that bottom paragraph, you say:

> "Ian may wish to raise this at the Medicine and Prescribing Committee."

Which Ian was that?
G A That was Dr Ian Reid, the Medical Director.

Q Who were the Medicine and Prescribing Committee?
A It was a Trust group and it was the Medical Director of Portsmouth Hospitals, Dr Ian Reid, senior consultant, geriatricians, senior pharmacists. There was a group of people who agreed protocols for medication across the two Trusts.

H

A Q When you were dealing with this issue and the practice of prescribing in that way, did you have more than 30 years' experience of nursing – I think you qualified in 1967?
A Yes.

Q Had much of your nursing been dealing with elderly patients?
A A good deal of it, yes, probably the majority.

B Q Would you have had many years of experience in prescribing and administration of medicine to elderly patients and palliative care situations?
A Yes.

Q Did you consider that you were in a position to understand the issues that were being raised by this?
A Certainly

C Q Had you had specific training in palliative care and syringe drivers?
A Yes. During my time when I was a district nurse with Dr Barton at the Crossways Practice, I went for a two-week residential course at the hospice in Midhurst looking at pain control and various palliative care treatments. I practice as a district nurse using those treatments.

D Q I understand. Would you have been very familiar with syringe drivers?
A Before I left being a district nurse they had just come in, and so I did use them quite a bit. I looked after two terminally ill people at home, one being my mother and one being an aunt, and they both had syringe drivers, so I became very used to them.

MR JENKINS: Again, in investigating this concern and knowing of the agreed protocol, what was your view as to whether there were any reason concerns about the use of
E diamorphine on these wards?

MR KARK: I am sorry, I just want to understand where this is going. Is this witness being treated as an expert witness and being asked to give her opinion on the appropriateness of this prescription? It sounds very much as if she is. I do not, with respect, think this Committee can be asked that sort of question. She is a nurse and a very experienced nurse but I do raise the propriety of treating her as an expert witness on prescribing, which she seems to be asked
F about.

MR JENKINS: Mr Kark throughout the case has asked a lot of the nurses, and indeed Dr Reid, one of the doctors whom he has called, about the appropriateness of care that was given to various patients. He has asked that question of the care that was provided by that individual and he has also asked them to comment on the care that might have been provided by others. The Panel have very frequently throughout the case asked witnesses – usually
G prosecution witnesses, but very regularly – "What would you think of this?" and "What would you think of that?" together with, "What comment do you now make about the care that you yourself provided to that patient?" I am not treating this witness as an expert witness, but it would be unrealistic to think that her experience is of no value when she comes to give evidence. If she were to be called as an expert witness, she would be wholly independent. She is not. She has been involved in this case in a role at the War Memorial Hospital. I am sure I am entitled to ask her whether at that time she had concerns. She had
H the picture of someone in a management position. She was investigating concerns that were

then being raised. For it to be said that she is not allowed to express a view is being wholly unrealistic, I would suggest. It comes back to sauce and goose and gander, I think.

THE CHAIRMAN: Indeed I am very conscious of the sauce, and I think it is absolutely right, Mr Kark, that numerous nursing witnesses have been asked about their views about prescribing. Indeed, one of the central issues has been the duty of a nurse to challenge prescribing if they felt that it was incorrect.

MR KARK: That is right. This witness was not acting in that capacity in relation to any of these patients we are dealing with. That is the difficulty. She is being asked in a general way. As I have understood it, the witness was led with the question: Did you have considerable experience of syringe drivers? and her answer was: Well, yes, I had particular personal experience of two. That does not provide, with respect, the expertise that may be thought necessary. I understand this has been a topic that has been dealt with with nurses, but nurses who were dealing with our patients.

THE CHAIRMAN: Yes, I understand the distinction, but I think that the Panel is capable of giving such weight to the evidence of the witness in terms of her expertise or lack of it. But the fact remains that she was a nurse at the time that syringe drivers were in use, and, indeed, for what it may or may not be worth, she has direct personal experience herself of their use.

MR KARK: You obviously want to hear it. I will not try to stop you further from hearing it, but I may address you about the weight of the answers you are about to receive.

THE CHAIRMAN: Yes. I look forward to hearing from you on weight. It is not that I think we particularly wish to hear it or otherwise, but Mr Jenkins clearly wishes us to hear it and provided we are appropriately addressed on the weight to attach, I do not think that any great harm will come if we do hear it.

LEGAL ASSESSOR: May I add something.

THE CHAIRMAN: Yes, indeed.

LEGAL ASSESSOR: I do not advise against the course which the Panel wishes to take, but, given that it seems to be accepted that this lady is not somebody who, as it were, is actively concerned in the administration or anything like that of syringe drivers, it would be my advice to the Panel that if she is to be asked this kind of question it needs to be very firmly established, first, what personal knowledge she has of what went on. It is not going to be sufficient to ask in a general sense whether she approved of procedures. The Panel will need to know exactly what her involvement was and whether she received any complaints and so on. Also, if it were to be her view that her procedures were acceptable, the Panel needs to know by what criteria she is coming to that kind of judgment.

THE CHAIRMAN: Mr Jenkins, you have heard that put very clearly by our Legal Assessor. Please ensure that you do "perspectivise" this for us appropriately and we will hear in due course from Mr Kark on the weight to attach.

MR JENKINS: Thank you.

(To the witness): Coming back to training, you had been on a two-week course in Midhurst.

A A Yes.

Q That was roughly when?
A 1985.

Q Had you had any other training on palliative care or syringe drivers?
A Odd days, and the hospices came and trained us on how to use syringe drivers before
B we started using them.

Q Anything in the 1990s or anything whilst you were at Gosport?
A No.

Q All right. But you have been involved in the field, if I might put it that way, of elderly medicine.
C A Yes.

Q And palliative care.
A Yes.

Q For many years. You were dealing with a specific complaint.
A Yes.
D

Q And we have the son's surname and you have given us the patient's name. You will have looked into what happened in that case.
A That is right, yes.

Q We have been told that a pharmacist used to go round to the wards.
A That is correct. A pharmacist used to go in, I do not know if it was two or three times
E a week, and she was extremely thorough. She would be like a dog with a bone, so if there was anything she was not quite happy with ever, she would see the ward sisters or see myself and tell us about it. I never had any complaints from the pharmacist about the amount of diamorphine that was being prescribed.

Q The name we have is Jean ----
A Jean Dalton.
F

Q Jean Dalton.
A That is right.

Q At the time you were making this memorandum, would you have known all about Jean Dalton's role?
A Yes.
G

Q And the visits that she made to the wards?
A Yes. Yes.

Q Over what period of time, if you are able to tell us, was Jean Dalton making visits to the wards?
A Certainly during the time from 1996 to 2000 that I was there.
H

A Q So at least three years ----
A Yes.

Q -- by the time this memorandum was written.
A Yes.

Q Would you have known throughout that time that there were no concerns expressed
B by her about what she was seeing on the wards?
A Yes, definitely. She would have definitely come to me or written to me if there had been a problem.

Q What, so far as you understood, was she looking at when she was on the wards?
A She looked at the diagnosis of the patient and she would compare that with the treatment they were being given. She would look to see that things were written up
C correctly on the prescription chart. She would cross-reference the controlled drugs: what had been given, how many were left in the cupboard, had they been written up correctly in the controlled book. She was very, very thorough in cross-referencing controlled drugs.

Q What about if there was any possibility of drug interactions.
A She would look at that as well. That was part of her role.

D Q If there had been inappropriate prescribing for a patient's condition, would you have expected her to be aware of it?
A Most certainly. That was her role.

MR KARK: This is all leading. I have warned Mr Jenkins that I would raise my voice eventually and it really is quite important that this sort of evidence is not just led and the witness is allowed to give her answers freely.

E

LEGAL ASSESSOR: It is perhaps doing a disservice to Dr Barton sometimes for leading questions to be asked, because it is a matter entirely for the Panel to decide what weight it gives to the evidence and if the question being put to a witness by Mr Jenkins contains the seeds of a reply then it may be that the Panel will give that reply less weight than it otherwise would – and the Panel may take the view that that is not being fair to Dr Barton.

F MR JENKINS: I am reproached, but I will keep going, if I may.

THE CHAIRMAN: As long as it is not in the same vein. I think that the reproach must stand. First of all, it was you who reminded Mr Kark of the rules of leading early on in this case, and, secondly, there has been considerable discussion about the value to the Panel of hearing leading questions. What we are interested in is what is the view of the witness. When they are merely agreeing with something that is said, it may very well have less weight
G than when we hear their own words expressing their own view. As the Legal Assessor has pointed out, at the end of the day, if we do not get that, it is your own client who will be prejudiced, and we need to make sure that that does not happen.

MR JENKINS: Sir, I remember very well when you made observations. I accepted the reproach. If I have worded it to suggest I did not accept it, then I apologise.

H THE CHAIRMAN: Thank you very much.

MR JENKINS (To the witness): Was there anything else that the pharmacist would have picked up and notified you about beyond what you have mentioned?
A I cannot think of anything else.

Q Who did the pharmacist report to, if she had any concerns?
A She would report to the consultants or Dr Barton or to the ward manager, depending on what it was that she had found.

Q What would you have known about the sort of conditions that patients were being admitted to the wards for, Dryad and Daedalus?
A I would know the criteria of the patients that we should accept. I would not necessarily have known individual patients.

Q No. I think you had no role in the clinical treatment of patients.
A No, I did not.

Q When you came to look at this particular case and looked at the agreed protocol for Dr Barton to write up a syringe driver in an anticipatory way, what would you have known about other patients who might have been written up in a similar way? Would you have known of conditions of patients?
A I would know of conditions of patients, but I would not necessarily have looked at conditions of patients myself and then say to the staff: "And how are they being treated?"

Q I understand. We know that there were patients, some of whom had quite severe bed sores.
A Yes, they did.

Q Do you know if any of those were treated and prescribed in this sort of way?
A I do not know of individual patients who were, but it did sometimes happen. If bed sores were very deep and very painful, that would be the sort of medication that they might be prescribed.

Q Right. When you have said that it was an agreed protocol that patients could be written up with a range of doses for diamorphine in a syringe driver.
A Yes.

Q What sort of patients did you understand were being prescribed for in that way?
A The terminally ill. Patients who were receiving palliative care or patients with end-stage illness.

Q Using the experience that you had which you have talked about, did you have a view as to whether it was appropriate or inappropriate to prescribe in that way in that situation, only one doctor there for a relatively short period of every day, using a syringe driver and diamorphine?
A I thought it was a very reasonable thing to do for patients, to give them a good quality of care and to be as pain free as possible.

A Q Thank you. You have raised the matter with Dr Ian Reid and the idea that he should raise the fact of the agreed protocol with the Medicine and Prescribing Committee. Were concerns being expressed by any medical staff about that agreed protocol?
A No, they were not, it was just the fact that having had a complaint I always felt it was wise then, if a particular issue had been raised, to make sure that what you are doing is the correct thing to do.

B Q Staying with the memorandum, there is reference above what we have been looking at before to nursing care plans. You say,

> "This has been picked up as part of the Clinical Governance Action Plan for Community Hospitals."

You refer to a workshop for clinical managers and clinical practice development facilitators.
C You say,

> "This action plan was evaluated on 20 October 1999 and showed that work with Nursing Care Plans has taken place across all areas in the community hospitals."

That is a bit opaque for us. I wonder if you can tell us why you were writing to the Chief Executive about nursing care plans in the context of this complain.
D A Because, if I remember correctly, this was one of Mr Wilson's complaints. The first thing he did every day when he came to the ward was read the nursing notes, and he put in as part of his complaint that the nursing care plans were not always clear and had not been written up properly. So as that was part of his complaint.

Q You have told us that nursing staff became more busy and more stretched.
A Yes.
E
Q Over the time that you were at Gosport.
A They did, yes.

Q In what ways, if at all, did that increased workload reflect itself if we were to look at the paperwork?
F A Unfortunately it is the paperwork that always ... Well, not necessarily unfortunately, but paperwork does tend to get behind or not done at all because the patients and their care had to come first. But what we were trying to teach the nurses is that it is really important to write up the treatments they have had, so it is continuity of care, and it could be detrimental to patients' care if care plans were not continually being written up properly.

Q I am going to ask you about one other aspect of this bundle of material. Do you have D2 in front of you or do you just have the page marked D4? (D2 handed to witness) We
G have heard, and the Panel have it as D1, that a senior staff nurse Shirley Hallman made a complaint. She complained about harassment by Gill Hamblin and she said that she was receiving similar overtures from Dr Barton. I take that from her letter of complaint, which the Panel have as D1. It appears from document D2 that there was a meeting held between various individuals. You will see that from the top of the page. If you go to the fourth paragraph down in the body of the letter, you will see reference to you. I am not terribly interested in the complaint itself from Shirley Hallman and I do not know that you have seen
H this document before.

A A I have seen it briefly.

Q If we look two-thirds of the way down the page, we see that Shirley Hallman had applied for a G grade post at Queen Alexandra's Hospital.
A Yes.

Q It is said in the bottom paragraph that she was interviewed for the G grade post but
B was not successful. She received interview feedback from Barbara Robinson who had previously always been very supportive but Shirley Hallman was surprised at some of the content. She was told that she had a reputation for having an attitude problem and that Dr Barton found her challenging to work with. I raise that because the Panel have to consider what Shirley Hallman said. They have this document in front of them and they will already have read this. I just want your take on this. I raise it in case there is any objection to this question being asked.
C A From me or from somebody else?

MR KARK: I am afraid it is always from the lawyers. If this witness had any direct involvement herself in this meeting or was asked to comment shortly afterwards, then she can comment but if she knows nothing about this meeting or this note, I would have thought it is difficult for her to comment.

D MR JENKINS: I raise it because there is a comment attributed to this witness, Barbara Robinson, that Shirley Hallman had an attitude problem and that she was challenging to work with. I think it is an issue that the Panel have to grapple with, Shirley Hallman, and the evidence that she has given. I have previously been told in relation to another potential witness that it is a settled issue in a particular respect but the Panel have already read this and it seems to me fair that the Panel should allow itself to receive further information about Shirley Hallman. I raise it for your consideration.

E

THE CHAIRMAN: Is your question designed to elicit information as to what was said during the meeting or is it merely to deal with the attribution that is stated in the final paragraph on the page in that Barbara Robinson is, within that paragraph, we are told saying particular things to Shirley.

MR JENKINS: I do not think Mrs Robinson was at the meeting. She was not involved in
F this.
A I interviewed Shirley Hallman for the post and I gave her feedback afterwards. I did say to her ---

Q Pause for a moment. Can I just ask: would you have had a view about whether she was easy to work with and if yes or no why that was?
A Shirley Hall was quite ---

G

Q I am not asking you to answer the question because it may be that an objection is maintained. Would you have had a view about whether Shirley Hallman was easy or not to work with?
A Yes.

Q You would. Did you ever express that view to Shirley Hallman?

H

A I did in the debriefing after the interview. May I say that I did not say anything about Dr Barton, though.

Q That may be so. What other experience would you have had outside Gosport of Shirley Hallman and what she was like as a nurse or what she was like for people to work alongside? Do not give us a view. Just deal with: did you know of her working in other situations?

B A She took up a post at Jubilee House, which is part of the Elderly Medicine Department at Portsmouth.

Q After you left Gosport in 2000, you went to the Queen Alexandra Hospital.
A Yes.

Q With elderly medicine?

C A Yes.

Q And did Jubilee House fall under your remit then?
A It did, yes.

Q Would you have had a managerial role dealing with Shirley Hallman when she was at Jubilee House?

D A I had a managerial role for the sister --- No, I did not even directly have it for that. My Deputy managed the sister at Jubilee House.

MR JENKINS: Before I ask any questions about your view of Shirley Hallman, because objection may be maintained ---

MR KARK: I just wonder how much of this I suspect character assassination is going to help

E the Panel. If we can hear from one witness about what they think about another witness, we are going to be here for a never-ending process.

THE CHAIRMAN: I have to say, in the light of the reference to determination and the matter of settled issue, it is a very narrow area but I had hoped that it was clear within the determination that the Panel were indicating that it had had clear evidence from elsewhere that the individual concerned had raised specific concerns. Whether they were raised at a

F subsequent letter with a nursing support officer does not actually impact on that at all. In answer to Mr Kark's question as to therefore what value it will be to the Panel if this is put, I imagine the answer is "negligible". I would also perhaps observe, Mr Jenkins, to use a phrase that you employed a few days ago: you have shown us the bag. We have your point and perhaps not a great deal is going to be served by labouring that point.

MR JENKINS: The Betty Woodland point is a discrete one and that is rather separate, and

G I had not invited you to review your ruling at all. We have obviously adhered to it. So far as asking one witness to comment on what they think of another, that has happened throughout this case. Mr Kark is engaged on it on a regular basis. He has invited people to give an indication as to what they thought of other nursing staff, of what they thought of the qualities of Sister Hamblin as one. Why it should be said now that it cannot happen in relation to one particular witness when it has happened in relation to others has not been explained to you. As to the third matter that you raise, I may have shown you the bag but you have not heard

H

A the evidence. You may say "we think we know what the evidence would be" but it is a matter for the Panel to decide whether they properly should hear the evidence or not.

THE CHAIRMAN: There was a point within that which was that if we rightly predict what the evidence is going to be, the question is whether it is really going to be of any assistance to us, which was the point raised by Mr Kark. I cannot see that it would be, but if you feel that it is something you really wish us to hear, then by all means elicit the information.

B

MR JENKINS: Then I will. Was Shirley Hallman someone who did have a reputation of having an attitude problem?
A Yes, she was. She was always very critical of people and this was not popular with the nurses she worked with. She was always criticising Sister Hamblin and when she went to Jubilee House, she criticised the ward manager there and also took out a complaint about a night nurse, which was fully investigated and nothing was found.

C

Cross-examined by MR KARK

Q Can you go back to the document you were looking at, D4. I want to understand from you, please, who you say agreed to such a protocol?
A It was an agreement with Dr Ian Reid and Dr Althea Lord and Jane Barton as an agreed practice within the hospital.

D

Q But do you have a recollection of that because Dr Lord told us this: I have not quite registered that the dose range was that wide and I am not too sure why that was. I knew we were writing up. For me the fact that it was written up in advance is sometimes necessary but with hindsight maybe the 20 to 200 was probably too wide a dose range. That was her evidence before this Panel. Do you say that Dr Lord agreed to that protocol at the time?
A As I said before when I was actually asked, I asked Dr Reid and Dr Barton but I was not sure if I had asked Dr Lord or not.

E

Q Dr Reid told us as far as he was concerned, he was not aware of this.
A I find that very surprising.

Q But you have a recollection, do you, of speaking to him?
A Most certainly, yes, and, as I said in my memo, Dr Reid should take that to the Medicines and Prescribing Group to clarify that that was still all right for that hospital.

F

Q When you talk about a protocol in medical or nursing terms, what do you mean?
A I mean an agreement in this case of dosage.

Q Which people are meant to follow is the meaning of protocol, is it not? It is not merely guidance but a protocol; it is something medical staff are meant to follow. Is that right?
A Yes.

G

Q Do you mean that? In this case it was a protocol that Jane Barton would write up diamorphine doses between 20 and 200. That was her normal protocol, was it?
A I do not know if that was her normal protocol.

H

A Q What does this mean? It is an agreed protocol. Agreed with whom and in what circumstances?
A It was agreed with Dr Reid, Dr Barton and Jane Dalton, the pharmacist, who was very well aware, as she looked at these treatment prescription charts two or three times a week, that this was the practice.

Q Was this the practice in relation to those who were on a terminal care path?
B A Yes, that is right.

Q So if we see a prescription following this protocol between 20 and 200 mg, we can take it that that patient is on a terminal care path, as far as you are concerned?
A Usually, yes; it could have been somebody who was in very severe pain from a very deep wound but, yes, generally if I saw that, I would think it was for a terminally ill patient.

C Q You told us about the pharmacist who you said would be like a dog with a bone and she had no complaints that you became aware of?
A No.

Q And she reviewed the prescriptions regularly, did she?
A Yes.

D Q Would you like to take up one of the bundles to your left, patient bundle A, the very first one we have, just by way of example. Please turn to page 200. You are used to prescriptions. Look at that prescription for our first patient for diamorphine and for hyoscine and for midazolam.
A Yes.

Q Do you see that it has no date on it?
E A (Pause) Yes.

Q Sorry?
A No, there is not a date.

Q Is that a lawful prescription, in your view?
A It should be dated.
F

Q Is that a lawful prescription, in your view?
A Not without a date.

Q Is that the sort of prescription that this pharmacist who is like a dog with a bone should have picked up?
A She should have done, yes.
G

Q Can you remember her picking up any prescriptions of Dr Barton?
A No. I would not have necessarily been the one she came to.

Q Ms Dalton, had she signed up to this 20 to 200 protocol?
A As far as I was aware.

H

Q If you had seen the administration of drugs, not just the prescription but the administration of drugs four, six or eight times outside the recommended guidelines in the BNF, is that something that you think you might have picked up on?
A I would not personally, no.

Q It is something you would think the pharmacist ought to pick up on?
A Yes.

Re-examined by MR JENKINS

Q Was the pharmacist seeing anything in addition to the drugs sheets? Were they seeing records for the patients?
A She was looking at the patients' records because they look at the diagnosis of the patient and also at the controlled drug book.

Q Of course. Staying with page 200, is there a box for the date to be put in on the diamorphine prescription?
A No, there is not.

Q I think if you turn over the page, you see a prescription for diamorphine which does bear a date in the relevant box?
A Yes.

Questioned by THE PANEL

THE CHAIRMAN: This is the time for questions from the Panel, if there are to be any. My colleagues do not have any questions for you. I have a little and I am a lay member of the Panel. You said just a few moments ago to Mr Kark that if the pharmacist had picked up any discrepancies or concerns she would not necessarily have brought them to you?
A No.

Q But a few minutes before, if my note is approximately correct, you said something along the lines of: she would have come to or written to me if she had seen a problem.
A If she had had a problem she had not been able to resolve by seeing the clinical staff. It might be a problem of getting drugs to the hospital. It would be more of a management type problem than a clinical problem.

Q My note simply was if she had seen a problem, but my notes are notoriously inaccurate, so I will wait to see precisely what the transcript says on that front. So far as the document D4 is concerned, Mr Kark has already asked you a little about that. You have indicated that the person whom you first consulted and who told you about this protocol, if I recollect correctly, was Dr Reid.
A Who first told me about it?

Q Who first told you about this protocol? I think that is what you said earlier in evidence today.
A After the complaint, I then asked Dr Reid and Dr Barton what the protocol was for the prescribing of diamorphine.

Q This is important then. After the compliant, you spoke to Dr Reid and Dr Barton?

A A Yes.

Q Did you speak to them together or separately?
A Separately I think.

Q And you are sure that you spoke to both Dr Barton and Dr Reid?
A Yes.

B

Q And they told you what exactly?
A They told me that it was their agreed protocol that Dr Barton could write up 20 to 200 mg of diamorphine on a gradually increased scale according to the patient's need.

Q Is there any possibility that you are mistaken on this recollection?
A No, I do not believe so.

C

Q I am not a medic, but my understanding of a protocol is that it is, by definition, agreed because it is an agreement so, technically, there would be no such thing as an agreed protocol, but a protocol is normally in writing, is it or not?
A Normally, yes.

Q Were you then shown a document headed "Protocol"?
D A No, I was not.

Q You were simply told about it?
A Yes.

Q Two particularly important elements you say were within that protocol: one, that Dr Barton was within the agreement able to write up in this manner; and, two, specific doses
E were mentioned. Mr Kark has already told you that when we heard evidence from Dr Reid, he denied all knowledge of such a protocol. In fact, when I asked him again later in Panel questions about the agreed protocol, he said, "I was not aware of any protocol". I then went on to ask him about the issue of the dosage range and he says that he was not aware of that and, indeed, he told us that it was only when it was pointed out to him some years later, that he was even aware of there having been such doses. He said, I put to him, "You had no recollection of ever having seen doses of that large a range?", and he replied, "Yes, that is
F correct"?
A Dr Reid was doing a ward round every week, so I do not understand why he would not have seen that written up.

Q We have had his evidence, we have had your evidence. You are clear that you are not mistaken. It cannot be a simple matter of mis-reference?
A I am very clear because I would not have written to our Chief Executive without
G finding out my facts first.

THE CHAIRMAN: You cannot be clearer than that. I am grateful for that, thank you. That concludes questions from the Panel. We now go back to ask the barristers if they have questions arising out of the questions from the Panel. Mr Kark?

MR KARK: No, thank you.

H

THE CHAIRMAN: Mr Jenkins?

Further re-examined Mr Jenkins

MR JENKINS: Just one arising out of that. You are talking about Ian Reid in that document?
A Yes.

Q He is the Medical Director at the time?
A Yes.

Q You are writing a memo to the Chief Executive of the hospital?
A Yes – of the Trust, Portsmouth Health Care Trust as it was then.

MR JENKINS: Thank you.

THE CHAIRMAN: Thank you. That concludes your testimony. We are most grateful to you for coming to assist us today. It is only by hearing live evidence from witnesses such as yourself that this Panel can begin to put together in a forensic manner some understanding of what happened all that time ago. We are most grateful to you for your assistance. You are now free to go.

(The witness withdrew)

THE CHAIRMAN: I know you are anxious to move on to your next witness. Shall we take a break now and then launch into that?

MR JENKINS: Shall I tell you what I am proposing. I have told you that she was a nurse on Daedalus Ward. Her name is Patricia Wilkins. She deals with two patients, Elsie Lavender and Jean Stevens. I was not proposing to ask her anything about her treatment of those patients. I was going to confine myself to general patients. I am told that she could be back first thing Friday morning. I do not know how long questions may be from others. I will be about 15 minutes. Mr Kark does not believe me, I see the eyebrows go very high, but I hope to be about 15 minutes. I raise it now because the Panel will know whether they are still interested in general issues, I suspect they will be.

THE CHAIRMAN: We are always interested in general issues. Whether there will be any that arise from this witness only time will tell. We will take a break now for 15 minutes, returning at ten past four and see where we get to.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: Patricia Wilkins. I am told this witness could be back Friday morning if matters do not conclude.

PATRICIA ELIZABETH WILKINS, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q Would you give us your full name, please?
A Patricia Elizabeth Wilkins.

Q I think it is Mrs Wilkins?
A It is.

Q You are a nurse?
A I am, yes.

Q When did you qualify in nursing?
A I did my training in the navy in 1969 as an enrolled nurse. I then went on to do my conversion course to RGN in 1991, I think it was.

Q Did you work at the War Memorial Hospital in the 1980s in Gosport?
A Yes, I did.

Q Were you working at the Redclyffe annex?
A Yes, I worked at the Redclyffe annex. That was for long stay patients. We had eleven patients at that time.

Q We know that in about 1993 the hospital was reorganised and that two new wards were created, one was Dryad Ward and one was Daedalus Ward.
A That is correct.

Q I think you moved to one of those?
A I did, I moved to Daedalus Ward.

Q I think you stayed on Daedalus Ward for a number of years?
A For ten years.

Q Daedalus was brought into being in 1993, so you would have been there ---
A I was, yes.

Q --- from 1996 to 1999 and the years each side of that?
A That is right.

Q I think when you first went to Daedalus Ward you were a staff nurse and later you were appointed as senior staff nurse?
A That is correct.

Q Are you able to tell us roughly when you became a senior staff nurse?
A I think it was 1998.

Q That is an F-grade, just one below the rank of Sister or Ward Manager?
A That is right.

Q I am going to ask you about patients that you will have dealt with over that period of time, first, when you were at the Redclyffe annex and on Daedalus Ward, towards the end of the 1990s?
A Yes. The patients actually at Redclyffe, and I also worked on the male ward, they were the continuing care patients. They are the type of patients that you would actually find in residential homes, but of course because long stay – we stopped doing long stay patients, we then came up to Daedalus Ward where we had slow stream stroke rehab patients and we also had continuing care patients.

Q Where those the same or were they different, and if they different in what way?
A They were different. The continuing care patients were always in a stable condition and they were sending over the slow stream stroke patients who were acutely unwell, so there was an awful lot of difference in them.

Q Did it mean that nurses had to be more heavily involved?
A Certainly. You would find the nurses would probably have to do everything for the patients, certainly their care, sort of feeding them, washing them, dressing them. They were really very dependent upon the nursing staff.

Q We know all about Barthel scores here because we have been dealing with it for weeks. If it is helpful for you to describe patients as having a particular Barthel score, feel free to do so.
A The Barthel in the majority of patients were zero, I would have to say, very few actually got more than about 5 or 6, so a Barthel of 20 is going to be somebody who is going to be totally independent, so they were very dependent.

Q As time went on, did it stay the same or did things change?
A I think the patients that we were getting over actually were more acutely unwell. They had a lot of underlying medical conditions as well as the stroke, they had a lot more underlying medical problems that needed a lot more care.

Q Where were the patients coming from?
A Mainly from Haslar Hospital and QA Hospital.

Q Why were you getting patients that were more acutely unwell?
A I think there was a pressure on the beds at the other hospitals to move the patients to us.

Q Why were they not staying where they were?
A Because they were being told to relatives that they were going to Daedalus Ward for rehabilitation and that they would be up and walking around, which was not the case.

Q Were you able to get people up and walking around on Daedalus?
A No, very, very few did.

Q We know that Daedalus dealt with stroke patients amongst others?
A Yes.

Q Do the very frail and unwell patients include some stroke patients or were they separate?

A No, we had some – I think the majority of the patients we had that did come over were the stroke patients.

Q Patients or their relatives were being told that the patient was being transferred for rehabilitation?
A For rehabilitation, yes.

B Q What would your comment be on some or many of the cases that were being referred over in that way?
A One patient's relative said to me that, "We were told that she was coming here to be rehabilitated", and that we were going to get her up and walking. This patient was totally dependent, so it was very easy to see that we were not going to be able to get this patient rehabilitated. Looking at the past medical history on some of the patients, they were not very mobile before they had actually had their strokes, so it was an uphill struggle. The patients'
C relatives had this preconceived idea what we were going to be able to do for them, so we were also, with this as well, with the patient's relatives, we had to try and balance what we were trying to do really.

Q Would you have conversations with relatives?
A Yes, we would.

D Q About what could realistically be achieved?
A Yes, and also the physiotherapists did as well. It was like goal setting really where you would be able to say the goal set would be to get the patient to sit up on their own and then go from there. I think there was a lot of pressure on patients themselves by relatives to say, "What have you done, how many times have you seen the physiotherapist today?" and their idea of rehabilitation, I think, is that the physio would be seeing them most of the day and they would be doing physio, but they were very frail so it was very difficult, really, to do
E physio with them.

Q What were the resources for physiotherapy on Daedalus Ward?
A I think the physiotherapist would perhaps spend a couple of hours if that.

Q With each patient or on the ward?
A No, no, on the ward. It may not be as much as that, I honestly cannot remember.
F

Q A couple of hours, was that over the week, each day or what?
A I think it really depends actually on the staffing levels of the physios.

Q If a patient needed help with moving, perhaps getting up and walking or recovering after a stroke, who would be doing that. Would it be the nurses or the physiotherapist or whom?
G A The physiotherapist would assess them, the handling side of things to make sure that we were able to carry on that treatment as well so, initially, the physios would assess the patient and then they would hand that over to us so we were obviously making sure that we were handling the patient correctly as well.

Q But with those patients where the relatives had been told they are coming for rehabilitation, and that was not realistic, would it be nursing staff saying to the relatives that
H that is not realistic or would someone else have those conversations?

A A We would have the conversations with the relatives. The relatives would ask for a progress report on their relatives and we would often ask Dr Barton to speak to them, we would speak to them and also the physiotherapists would speak to them and see them as well.

Q If you were involved either in having that conversation with relatives or witnessing someone else having such a conversation with the relatives to tell them that rehabilitation was not very likely, what would you say about how easy those conversations were to have?
B A Again, I think they have had these preconceived ideas from the other hospitals that we were going to be able to do it and of course we are the ones that are having to say realistically we are not going to be able to rehabilitate them, so there were some relatives who were not happy with that. It was a real uphill struggle.

Q When you were saying in any given case that rehabilitation was unrealistic was anything said about the health of the patient or the general health or what the prognosis might
C be?
A I think a lot of the time, yes, we did. We would ask Dr Barton to talk to the relatives about the prognosis and also the consultants would also see relatives as well, so the consultants would be there.

Q If a given patient was not likely to be rehabilitated, what was the reason for that?
A The reasons that they would not be rehabilitated?
D
Q Yes.
A Because they were just too poorly and also they had had a very dense stroke so we were not going to be able to do it.

Q Can I ask about this changing workload. If frailer and more ill patients were being transferred to you, were the management providing more nursing staff to deal with patients in
E that condition as time went on?
A No.

Q What about more physiotherapy?
A No, not at all.

Q We know that Dr Barton was the clinical assistant on Daedalus Ward during the
F 1990s. Was there any other medical input?
A Just a geriatrician who used to come round once a week but there was no other medical input at all.

Q How were the nursing staff coping with the increased workload?
A It was very difficult because if somebody went off sick then we very rarely got cover for that, so it was a struggle. I have to say it was very hard work.
G
Q How was Dr Barton coping so far as you could tell?
A Because of the condition of the patients we were having to phone Dr Barton throughout the day for some advice and she would come back. In the morning Dr Barton would come round and do a ward round. If we had any concerns then we would actually phone and speak to Dr Barton, she would come back at lunchtime to review that patient and also to see relatives or to clerk in patients in the afternoon.
H

Q I am going to lead on the next bit and if there is any objection I am sure I will be told. Dr Barton would attend Daedalus Ward in the morning.
A Yes.

Q There would be a discussion about all the patients on the ward.
A Yes.

Q If there were concerns about particular patients Dr Barton would go and see those patients.
A Yes.

Q Would she see other patients as well?
A Yes, we would go round the ward and see all of them but those that we were a bit concerned about had priority.

Q If there were investigations or tests or results in respect of given patients are you able to tell us when Dr Barton would see those?
A In the morning. If we wanted anything writing up like bloods or antibiotics, anything that we needed, then Dr Barton would write that up in the morning and tests again would be seen from the previous day on the next morning.

Q You have told us that if it was needed you could get hold of Dr Barton during the day.
A Yes.

Q We know that she was a general practitioner. Would you also have access not just to the surgery number when you could phone her during the day but to any other phone number for her?
A Yes, Dr Barton left us her home phone number so that we could contact her at weekends if we had any concerns about the patients. It was obviously something that we did not abuse but if we had any problems then we would contact her at home.

Q You will have seen Dr Barton over a number of years, both on Redclyffe and also Daedalus Ward.
A Yes.

Q How did you find her as a doctor?
A I found her to be a very dedicated, committed and caring doctor whose care of patients was paramount.

Q What would you say on the question of how busy she was when she was there?
A There were 24 patients to review and there were tests to be seen. We asked her to write up any medications that we might have needed like antibiotics. Yes, she was a busy doctor.

Q We know that when Dr Barton attended in the morning there would be a discussion about each of the patients on the ward.
A Yes.

Q We know that if concerns were raised about a patient during the day it would be nursing staff that would contact Dr Barton and ask her to deal with it in some way.

A A Yes.

Q What would you say about how approachable Dr Barton was?
A Very approachable. She was always more than happy to give us advice and to come in and see the patients that we had asked her to see. She was very, very approachable.

Q If you had concerns about a particular patient and whether what was being provided
B for them was appropriate or not, would you have felt able to raise those with her?
A Certainly, yes.

Q How would Dr Barton know how any given patient was getting on with the treatment that was being provided for them?
A We would discuss it with her on perhaps the next day that she came into the ward.

C Q Would you be there for handover in the morning?
A Yes.

Q Would handover involve the night staff giving information about each patient?
A Yes, they would give a report on each patient, how they had been through the night, if there had been any concerns with them.

D Q We know that Dr Barton would also be doing a ward round on Dryad Ward as well and that she saw one ward after the other. Was Daedalus the second ward that she saw or the first one?
A As far as I can remember I think Daedalus was the second ward that she came to.

Q When she arrived in the morning had handover already taken place?
A Yes, it had.
E
Q Or would she be there when it was taking place?
A To the best of my knowledge it was almost always over by the time Dr Barton came.

Q Who would go through the patients with Dr Barton?
A It was the nurse in charge that particular day.

F Q We know that Sister Sheila Joines was sister on Daedalus for many years.
A Yes, she was.

Q After that time the ward manager was Philip Beed.
A Yes, that is right.

Q If those were the nurse in charge of the ward would Dr Barton go through patients
G with them in the morning?
A Yes.

Q When you were senior staff nurse you were second in command to Philip.
A Yes.

Q Would there be occasions when you would go round the ward with Dr Barton when
H Philip was not there?

A A That is right.

Q You have told us about unrealistic expectations that there may have been in some cases. Did you see Dr Barton dealing with patients or dealing with relatives in cases of that type?
A Could you repeat that, please?

B Q In cases where patients were transferred, perhaps where unrealistic expectations for what could be provided or achieved were present, did you see Dr Barton dealing with the relatives or with the patients in that type of case?
A Dr Barton would actually come and clerk the patient in. She would also see relatives as well and explain to them the diagnosis and prognosis.

Q Would you be present for some of those discussions with relatives?
C A Yes, most definitely.

Q What would you say of Dr Barton's approach and manner in dealing with relatives?
A Dr Barton was very kind to them. She actually told them the prognosis of the patient and was very, very kind and went through the process of what they would like to be done.

Q From the way in which I framed the question these may be patients where the
D relatives had an expectation which was not likely to be realised. Does it follow that Dr Barton may sometimes be giving them uncomfortable information?
A Yes, but it was honest opinions and truth really. When the patients were in the other hospitals, certainly the relatives had been given expected outcomes really.

Q You have said that when patients were admitted Dr Barton would clerk them in.
A Yes.
E

Q Would you have been present when that was done?
A Yes, I would have been.

Q What happened when Dr Barton clerked in a patient?
A It was an examination of the chest normally and also then wrote down in the medical notes what was actually wrong with the patient, past medical history as far as I can recollect.
F

Q Would a nursing assessment by that stage have been undertaken of the patient or would that follow at a later stage?
A If a patient came in at lunchtime and Dr Barton happened to come in at the same time the nursing assessment would probably be taken after.

Q You have been in nursing for many years, I think?
G A Yes.

Q You will have seen many doctors clerking in patients in this setting and in others?
A Mostly this setting.

Q How would you compare Dr Barton's examination and clerking in of a patient compared with that of other doctors that you may have seen?
H A Fine. I had no problems or concerns about it.

Q We know that Dr Barton made notes following an admission of a patient.
A Yes.

Q We know that Dr Barton made notes when she was clerking in a patient and you have told us that you will have seen other doctors clerking in patients in the past. What would you say about the volume of notes that were made by the doctor?
A Dr Barton wrote quite precise notes and also we actually had a handover, so what was gleaned as well from the examination as well as what was written in the notes is what we would actually handover to the staff as well, so we had precise notes and a verbal handover that we used to give to the staff.

Q We know that on occasions there might be a prescription written up for a syringe driver.
A Yes.

Q We have called that anticipatory prescribing with a prescription being written up for diamorphine on a syringe driver at a time when the patient did not need to have that at that time. What was your understanding of why that might occur if it did?
A Looking at the past medical history of a patient and that they were perhaps on analgesia it meant that if a patient became unable to take medication orally that we could start a syringe driver at a time when it was relevant for the patient to have it without waiting for ages for a doctor to come in and to write up a driver.

Q Without waiting for ages for a doctor to come in and write them up?
A Yes. Certainly in my experience this has happened at weekends when it is an out of hours service doctor and they are based in Cosham, which is quite a way from Gosport hospitals and it seems that because we are a hospital we do not necessarily take priority for a doctor to come out so it could be hours before a doctor comes to see a patient.

Q If that were to happen that a prescription would be written out in that form and in advance of it being required, who else would have been aware of it?
A All the nursing staff would have been aware.

Q You say all the nursing staff. Does that include Sister Joines or the ward manager, Philip Beed?
A Yes, because it was actually written up on the drug chart that was kept for each patient.

Q What about the consultants?
A Presumably they looked at the chart.

Q Were you there for a ward round if one took place?
A I cannot remember, I am afraid.

Q You have made an inference but people will bear that in mind. So far as actually administering medication is concerned, would you have been involved in that as well?
A At times, yes.

Q We know that your signature appears in respect of a couple of the patients that the Panel are concerned with. I am not going to take you to those now – others may wish to do so – but can I ask you if you had had concerns about medication for a patient would you have raised any concern about that?
A Yes, I would have done. I would have challenged it.

Q As a nurse what would be your duty, if any, in relation to medication if you thought it was inappropriately suggested for a patient?
A I would challenge it and ask why because it may not be for the benefit of the patient.

Q You know that this is a case that concerns medication provided for patients.
A Yes.

Q Did you have any concerns about care given to patients on Daedalus Ward during the period that we are concerned with?
A No, not at all.

MR JENKINS: Thank you.

Cross-examined by MR KARK

Q On that last issue that you were being asked about that you would challenge medication if you thought it was wrong, did you actually ever do that?
A No.

Q What would be your reference point? What would you be checking the prescription against?
A It depends on each patient, does it not, because they are all individuals, so it would be very difficult for me to comment on anything on that at the moment because (a) I am not sure what patient you are saying ---

Q No, but if you are simply looking at a prescription, sometimes the notes were not perhaps as good as they should be, what would you be checking the prescription against, would you look at the BNF would you look at the Wessex Protocol?
A We would actually be looking at what they had before. I mean, if they have had something orally, oral medication and then you would ...

Q You would what?
A The oral medication and then they would go on to the driver.

Q Do you know what the guidance was about the transfer from oral to the driver?
A I cannot remember it I am afraid.

Q You cannot remember it?
A No.

Q So far as clerking in is concerned, you told us a bit about that: my note is – your voice is quite soft and I want to make sure I got the right word, did you say she made concise or precise notes?
A Concise.

Q Sorry?
A Concise notes.

Q Did you feel that the clerkings in that you saw were rushed?
A No, not at all.

Q I mean, Dr Barton had appropriate time, so far as you were concerned, to do a proper clerking in?
A Well, again, Dr Barton would come in at the lunchtime after surgery to clerk patients, and sometimes again in the afternoon.

Q Yes, but you did not feel any of these clerkings in were particularly rushed?
A No.

Q So far as the type of patients that you were getting in, would it be fair to put it like this, sometimes, particularly, what, in the latter half of the 1990s you were getting patients who had been given an over-optimistic prognosis, is that fair?
A Definitely, yes.

Q That obviously does not apply to all the patients: as you have said yourself, all the patients were individual but some had over-optimistic prognoses, yes?
A Uh-huh.

Q And on occasion you would have to let the relatives down ---
A Yes.

Q --- and, indeed, the patient down, yes?
A Yes.

Q It is important in those circumstances, I presume, to make a careful assessment of the patient, yes?
A Yes.

Q Because sometimes when the patient first arrives with you they may have been knocked back a little by the journey, is that fair?
A Yes, uh-huh.

Q So a proper and full assessment of that patient would be particularly important?
A Yes.

Q And a note of such an assessment would be important?
A Uh-huh, but this is actually ... We are talking about patients that had actually been on the ward for days, I would say perhaps a week, but relatives were still thinking that they were here for rehabilitation so, you know, they were not sort of admitted one day, assessed, and then we were sort of telling relatives that, you know, the prognosis was not going to be any good.

Q So some were, in your view, not really able to be rehabilitated.
A No.

Q But you did have some physio and rehabilitation services?
A Yes.

Q Did you say you had a physio spending a couple of three hours on the ward?
A No, it may be sort of like perhaps an hour and half on the ward really, realistically.

Q Per day?
A Yes, per day.

Q And this was on Daedalus Ward?
A Yes.

Q Which was supposedly the rehabilitation ward?
A Yes.

Q Presumably the physio would not have to deal with every patient on the ward because some patients plainly would not be fit for physio at all?
A No.

Q And some of these elderly patients would be doing very small amounts of exercise, such as turning their neck or lifting their arm, that sort of thing?
A Possibly or sort of trying to get the trunk control because some people that do have strokes they lose control of their trunks so it is basically perhaps the first step would be to sit the patient up and getting the sitting position sorted out first of all before you would actually go on to do anything else.

Q Also, presumably, to demonstrate on occasion to nurses how to get a particular type of patient out of bed and that sort of thing?
A Yes. With a patient with a Barthel of zero we would have hoisted them out of bed. We would not have actually got them to stand or anything.

Q I understand that. Finally this, in relation to the anticipatory prescribing, you obviously became quite used to that, did you not?
A Yes, uh-huh.

Q That was something that was done on a regular basis by Dr Barton?
A Yes.

Q I think you said it was particular relevant at weekends.
A I certainly think that was when we had the problems trying to get anybody in to see patients, if they had not been written up for any medication at all.

Q Would that mean that at weekends you as nurses could start those patients on a syringe driver without reference to a doctor?
A No, these are patients who have not been written up for any analgesia, that we ---

Q I understand that, I am sorry, but when you have a patient who has been written up for one of these anticipatory prescriptions, come the weekend if you the nurses take the view that

A that patient, for whatever reason, needs a syringe driver can you institute that of your own volition?
A Yes, if the patients were unable to swallow any medication and their condition had deteriorated and they were in a lot of pain we would start the driver on the lower dose of the analgesia.

Q You would not necessarily need to go back to the doctor at the time?
B A No.

MR KARK: Thank you.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: I have no re-examination, thank you.

C

THE CHAIRMAN: We now come to the point when members of the Panel, if they have any questions of you, have the opportunity to put them. (None)

Questioned by THE PANEL

D THE CHAIRMAN: Again it appears the only potential question is going to come from myself: I am a lay member, and it is a very brief point, and you will correct me immediately if my note is wrong but I think you were telling us that in relation to dealings with relatives, you were telling us how kind to the relatives Dr Barton would be; she told them what the prognosis was and went through the process of what they would like to be done.
A Sorry, I should have been a bit more clear on that really. It was basically, certainly if they were on medication for any pain relief, because the majority of them were on some sort of Oramorph or something, and then it would be really the next stage to that, on how we
E would actually be able to administer pain relief to them, and I on many occasions have actually gone through a syringe driver with the relatives and actually shown them what they are and they have been really happy with that, that the pain relief would be given via a driver so that they would have pain relief 24 hours a day instead of intramuscular injections which they used to give prior to the syringe drivers, which are very painful, and obviously you get your lows and troughs with an intramuscular injection but with a syringe driver it was 24 hours pain relief. As I say, the relatives were more than happy with that. They did not
F actually say that they did not want it or they were unhappy with that at all.

Q But in terms specifically of your experience of seeing and hearing the way in which Dr Barton dealt with those relatives, on a scale of one to 10, say, how receptive would you say she was to the views of the relatives on matters of the trade-off, say, between amount of pain and amount of consciousness, if you heard such a thing?
A Could you repeat that again?

G

Q Yes. We have heard a lot about there being a trade-off between the amount of sedation that you receive and the extent to which you will be alert and the extent to which you will be pain-free: did you hear of any occasions when patient's relatives, who had a particular view one way or the other about the trade-off, whether there should be more alertness or more pain treatment, and if so how receptive was the doctor to the views of those relatives?

H

A I think most of the relatives just wanted their loved ones kept comfortable, pain-free, so I cannot honestly recall them asking about that really, about whether or not they would be more conscious or pain-free. As I say, the majority of relatives wanted their loved ones kept comfortable.

Q So in general terms, in terms of responsiveness to the concerns of the relatives how open was the doctor to taking on board the wishes and desires of the relatives?

B A Dr Barton was very sensitive to that and obviously took on board what the relatives were saying; and hopefully that that was the case – that they wanted them either kept pain free, which was what most of the relatives wanted for them.

THE CHAIRMAN: That was all I had. The very final bit is that I have to ask the barristers whether they have any questions arising out of those. Mr Kark.

C MR KARK: No, sir.

THE CHAIRMAN: Mr Jenkins.

MR JENKINS: No, sir.

D THE CHAIRMAN: Then that completes your testimony. Thank you very much indeed for coming. It follows that you will not need to come back on Friday. We are most grateful to you for your assistance. We do rely on the help of parties such as yourself to help us in our inquiries and you leave with our thanks.

THE WITNESS: Thank you very much.

(The witness withdrew)

E

THE CHAIRMAN: We will be starting at 11.30 tomorrow. If there is nothing else we will adjourn now and meet again at 11.30 tomorrow. Thank you very much, ladies and gentlemen.

(The Panel adjourned until Tuesday 28 July 2009 at 11.30 a.m.)

F

G

H

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 28 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-THREE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Read & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning everybody. Welcome back. Mr Jenkins?

MR JENKINS: I am going to call Sheila Joines, who was a sister on Daedalus Ward. The Panel will only need one bundle of medical notes; that is, Patient B.

SHEILA ANN JOINES, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to start off giving your full name, please.
A Sheila Ann Jenkins.

Q I think you qualified as a nurse many years ago.
A Yes, 1958.

Q You qualified as a midwife as well, I believe, and state registered nurse.
A Yes, I did, in 1960.

Q In the 1960s I think you started working at the Gosport War Memorial Hospital.
A I did, yes.

Q You had children; you followed your husband's career for a period of time and came back to Gosport war Memorial.
A Yes.

Q You had worked in the interim in South Africa in a hospital, had you?
A Yes, I did. I worked in two clinics in South Africa.

Q When we get to the 1970s you were working again at the Gosport War Memorial Hospital and between 1979 to 1997 you worked on the male ward at Gosport as sister on the ward.
A I did.

Q You dealt with various types of patient, all sorts of conditions. Can you help us with what sort of patients you were dealing with during the 1980s?
A Basically on the male ward we had a mixture of surgical patients. They were more or less lumps and bumps. We had medical patients and we also had palliative care, and towards the end we also had long-stay patients who were transferred up from Northcott Annex to the male ward. So it was quite a mixture.

Q We know about the Redclyffe Annex, we have heard quite a lot about that. Tell us about the Northcott Annex.
A Northcott Annex was a 12-bedded unit, six men and six women long stay. It was attached to Northcott House but I believe the NHS rented it from them and they were just the long-stay patients – what we used to refer to as geriatrics years ago.

Q I understand. We know that the War Memorial had two wards created and that people took up residence in about 1993 – Dryad Ward and Daedalus Ward.
A Yes.

Q I think you were sister on Daedalus.
A I was sister on Daedalus Ward, yes, stroke rehab and long-stay patients. We had eight stroke rehab beds and 14 long-stay beds.

Q When did you stop working on Daedalus Ward as sister?
A In 1997 when I retired for the first time.

Q Retired for the first time. I think you went on to be night nurse co-ordinator somewhere else.
A I did work for another eight years. I was asked to leave at 69 because I was too old.

Q Where did you go to after that?
A I have not. I have stayed retired.

Q But you were night nurse co-ordinator; whereabouts was that?
A It started off at St Christopher's. I just did Portsmouth and Havant & Petersfield and then the PCTs all separated into their own little units and I was asked if I would stay with East Hants and Petersfield so I worked from Waterlooville Health Centre and then we moved into Havant Civic Offices. Then because of the journey and the wear and tear on the car I heard that a post was coming up covering Fareham & Gosport, so I applied for the post but because East Hants did not want to lose me, I then ran East Hants, Petersfield, Fareham & Gosport until I was 69, when it was considered it was about time I left.

Q We have heard of St Christopher's Hospital before in the context of one of the patients that the Panel have been dealing with. That was Patient K, Elsie Devine, who was mentioned, I think. What is St Christopher's?
A St Christopher's, as far as I can remember, just dealt with long-stay patients. That is all they dealt with.

Q Let me take you back to Daedalus Ward. You were there, obviously, from 1993 once the ward came into existence, until 1997 when you retired.
A Yes.

Q Can you tell us what sort of patients you were receiving at Daedalus Ward?
A They were stroke rehabilitation patients, following strokes, and also long-stay patients.

Q Where were the long-stay patients coming from?
A Usually from the district more than anything else. Occasionally we got them transferred from other hospitals but usually it was from the local district, if I remember rightly.

Q At the time that you were there, did the nature of the patients stay the same?
A No, I think not so much for the long stay, but for the stroke rehab we certainly got the quota; the workload did definitely increase quite quickly actually from when the ward opened.

Q When you say the workload increased, do you mean the number of patients or do you means something else?

A A The number of patients, but also the type of patients we were getting too.

Q In what way did they change, the type of patients you were getting?
A We were a stroke rehab ward but to be quite honest the patients we were getting, I was under the impression they were blocking acute beds in St Mary's Queen Alexandra and also the Royal Naval Hospital, Haslar, and the fact that they were given to us because they were blocking beds, and basically mainly because of the density of their strokes and, more
B important, other underlying medical problems. So although we were stroke rehab, I am afraid a lot of them were not fit to be rehabilitated.

Q What, for that type of patient, would have been written down as the reason for their admission?
A For rehabilitation.

C Q For rehabilitation?
A Yes.

Q But a lot of them were not fit for rehabilitation.
A I do not think so, no, and I think that was the general opinion, not just my personal one.

D Q Are you able to help us with what the patient or their relatives might have been led to understand was the reason for their admission?
A One of the problems we did have, shall we say with the relatives, was the fact that they had high expectations. They had been told their loved ones were coming over for rehabilitation when, quite honestly, that was not the case. So we were trying then to adjust to telling the patients that unfortunately they were not fit for rehabilitation, whereas they would have been told that they were coming over for rehabilitation.

E Q If you had that sort of conversation with patients or relatives, were those easy conversations to have?
A Not always, no. Some were but the majority were not.

Q The reason may be obvious, but tell us why.
F A It is very difficult, when you have got a patient whose relatives come in fully expecting us to get them better to either go home again or go to a nursing/rest home, and the next minute you are saying they are not fit for rehabilitation. Eventually you have to turn round and say, "I am sorry, they are here and they will die eventually". That can be very difficult, and was very difficult.

Q Who was telling the relatives that the patient was going to be rehabilitated when in fact that was not possible?
G A Basically the hospitals they were being transferred from.

Q Where they had been bed blocking?
A Yes.

Q How was it to work in those conditions, as a nurse?
A It could be quite difficult at times. A lot of the patient's relatives were very
H understanding, but a lot of them were not and it must have been very difficult for them to

A come to terms with the fact that their relative was supposed to be rehabilitated and they were just not fit for rehabilitation.

Q If you say a patient was not fit for rehabilitation, what are you saying, if anything, about the prognosis or life expectancy?
A It was very poor. A lot of the patients that we had on the ward while I was on there, I think maybe we might have got one or two home, but if they were not fit they would B sometimes be seen by Dr Lord and they would go into a long-stay bed, or inevitably they were there till they died.

Q If we were to take that sort of patient, one where they had been bed blocking at an acute unit; they had been transferred on the paperwork for rehabilitation but they were not suitable for rehabilitation; if we were to look at the documentation, where would we see an accurate assessment of what was realistic for that patient?
C A They would have been assessed on admission but then it all depended on whether the condition deteriorated. That may be not immediately apparent, but as time went on you would see the gradual deterioration and then it would have been noted.

Q So if one was to look at the documentation from the discharging hospital, suggesting that the patient was fit for rehabilitation, that would not be right but one might think it was.
A Yes.
D

Q We know that Dr Barton performed the role of clinical assistant for patients on Daedalus Ward, and that she had been providing the role of clinical assistant since 1988 until she resigned, several years after you retired from the War Memorial.
A Yes.

Q We have heard that there was a consultant who would undertake weekly ward rounds E on Daedalus Ward.
A Yes.

Q Can you remind us of the name of the consultant?
A Yes, Althea Lord.

Q Just remind us, how frequently would you see her on the ward?
F A I think it was every fortnight. She would come on the Monday.

Q She was not based at Gosport. She was based elsewhere, was she not?
A Yes.

Q So how regularly would patients on Daedalus Ward see a doctor?
A Dr Barton on a daily basis and Dr Lord fortnightly on a consultant basis.
G

Q You have told us that you were dealing with patients for some of whom the prognosis was poor.
A Yes.

Q How were the medical staff – Dr Lord and Dr Barton – coping with an increasing number of poor patients?
H A I think under the circumstances they coped very well, Dr Barton especially.

Q Was there any change in the amount of time that doctors were allocated to spend on the ward over the time that you were sister of Daedalus Ward?
A There was no increase in time.

Q What about increase in other resources – nursing time?
A No.

Q Physiotherapy?
A Physiotherapy, I am afraid, it was not up to the acute wards like over at St Mary's, because I went over there to work on one of the wards. But it was a case of if we wanted physio, if they were available we would have physio, but maybe we could have had more physio input and OT input than we did.

Q What would you say about how the ward was set up to provide rehabilitation?
A In what way, Mr Jenkins, sorry?

Q Were the resources there to give rehabilitation to patients?
A Yes.

Q Does that include physiotherapy?
A Yes, physio was there, yes.

Q Can I ask about patients and when they might be admitted to the ward? How would that happen and what would happen once they were admitted?
A We would usually get a phone call – I am trying to think now. I think it was we used to get a phone call to say that a patient was going to be transferred, and then obviously we would be given times of expectation. Once they had arrived we would inform Dr Barton's surgery that the patient had arrived and she would come in and clerk the patient in.

Q We will come back to Dr Barton coming in in the mornings, but if Dr Barton arrived during the day to clerk a patient in, what sort of time typically – if there was a typical time – would that be?
A Late morning or lunchtime if the patients had been admitted in the morning, or if I was concerned about a patient, and sometimes, if the patients were admitted late morning, early afternoon, Dr Barton would come in late afternoon.

Q We have seen documentation to show that there would be a nursing assessment on admission.
A Yes.

Q And that nursing care plans would be drawn up.
A Yes.

Q In respect of the particular patients.
A Yes.

Q Are you able to help us, would there be any particular sequence in which that happened? Would you wait until the doctor had assessed the patient and clerked them in or might the nurses get on with their assessment?

A A Basically I think the nurses would have been first to assess them.

Q When Dr Barton came to clerk the patient in, would you or one of the senior nurses be present?
A Yes.

Q What would happen when Dr Barton first met the patient?
B A Obviously she would introduce herself.

Q Yes.
A Then having read, if we had the notes or transfer letter sent with the patient, having read them, she would then go through the assessment with the patient.
patient.

C Q Were the notes always there?
A Most of the time, but there was the odd time, no, they were not.

Q If the notes were not there, what would there be, if any documentation, relating to the patient?
A There could be a transfer letter. As I say, it did not happen very often. I could not say how many times it did happen.

D

Q I understand. When Dr Barton undertook an assessment, you have said she read the notes.
A Yes.

Q What would she do by way of an assessment?
A Well, obviously, examine the patient, speak to the patient if they were able to reply to
E questions, document it, and write up the medications and things like that.

Q What are you able to tell us about the examination, so far as you recall?
A I always thought it was a pretty thorough examination.

Q Right.
A In my opinion, anyway.
F

Q We have seen notes made by Dr Barton on occasions when she may have seen a patient for the first time. Would you have seen her make notes?
A Yes.

Q Would you have used the doctor's notes, the clinical notes, as part of her documentation about a patient? Would other nurses have looked at them?
G A Yes, we used to have discussions about patients.

Q Once Dr Barton had carried out an assessment of the patient, had clerked them in, would there be discussion with nursing staff?
A Yes. Yes, definitely. Either in handover or, like, if Dr Barton had done the ward round in the morning, we would sit down and go through the morning's work and then discuss the patients and the treatment and whatever instructions Dr Barton had given us. It
H would have been in the patients' notes and also in the nursing notes as well.

Q We have heard that Dr Barton would come in every weekday morning, Monday to Friday.
A Yes.

Q That she would be seeing patients on another ward, Dryad Ward, in the same hospital, and that she would come then to Daedalus Ward.
A Yes.

Q There would have been a nursing handover on Daedalus Ward between the night staff and the day staff.
A Yes.

Q Was Dr Barton there for that?
A Sometimes. She might come in sometimes, but obviously if she did come in we would stop the handover until after she had gone.

Q When Dr Barton arrived, we have heard there would be a discussion between Dr Barton and certainly the senior nurse.
A Yes.

Q Usually yourself.
A Yes.

Q Which patients, of those on the ward that there were, would be discussed?
A Stroke rehab patients.

Q Right.
A Basically.

Q Stroke rehab. There were eight beds, I think you have told us, on Daedalus.
A Yes. Eight, and 14 long-stay.

Q Would there be a discussion about the other 14 patients?
A Yes.

Q If a patient's condition had changed overnight or since Dr Barton had last seen them, would anything happen with regard to that patient?
A Well, it would have been either myself or one of my other senior staff would discuss it with Dr Barton and decide what future treatment was necessary.

Q Would Dr Barton see any or some of the patients on the ward in the morning?
A Yes, if we were rather concerned about them in any way.

Q Would she see particular patients or all of the patients? Which would she see?
A Usually particular patients.

Q She would be guided by you.
A Yes.

Q If she saw the patients, again would you be present while that happened?
A Most of the time, yes.

Q We have heard that for some cases there may be pathology reports or biochemistry reports or investigations to be ordered about various patients.
A Yes.

Q Are you able to tell us when in her working day Dr Barton would deal with those ----
A In the writing up of them?

Q Yes.
A Usually after the morning round. Or if during the morning I was concerned about any patients at all, I would ring the surgery and either speak to Dr Barton or leave a message and then she would return to do any of the necessary requests.

Q The picture we should have, is this right, is that Dr Barton would be in every weekday morning; she would do a ward round, having discussed the patients on the ward?
A Yes.

Q And any concerns that the nursing staff had.
A Yes.

Q And she would be updated on the progress of the patients.
A Yes.

Q You have said if there were any concerns later in the day you would contact her.
A Yes.

Q That would be at the surgery.
A Usually, yes.

Q Would you have any other contact numbers for her?
A I did not have, no.

Q You have told us about clerking in patients at lunchtime or at the end of the morning, but if Dr Barton was called back to see a patient during the day, were there typical times when she might come, like lunchtime or later in the day? Were there times that she would typically come to see a patient again?
A No, really she would come when we needed her.

Q You have told us about the patients' relatives and that there were conversations with relatives as well. Would Dr Barton have had conversations with relatives?
A Yes.

Q In what circumstances would that occur?
A Sometimes the relatives would be concerned about their progress or lack of progress. They would sort of question it with us and we would .... or they might even ask if they could speak to Dr Barton re the further treatment, and that is how it would come about.

Q I am assuming relatives would not often be there early in the morning.

A No, Dr Barton would perhaps say she would see a patient at two o'clock and then we would get back to the relatives and say, "Right, we've arranged a meeting," and that is how it would take place.

Q Would Dr Barton ever be there in the evening?
A Occasionally, yes.

B Q What impression did you have of how busy Dr Barton was in her work on Daedalus Ward at the Gosport War Memorial Hospital?
A Extremely busy.

Q Was that the case over all the time that you were there as sister: four years?
A I think so, yes.

C Q What would you say about her care for the patients and her concern to do what was best for them?
A I think it was beyond question. Her one aim was her patients' welfare.

Q How did she deal with relatives, in your experience?
A I think in a very caring and compassionate way. She was always very honest with them and, as I say, she always put the patients first. The relatives seemed to get on very well
D with Dr Barton. I have never heard anything said about her. She does not suffer fools gladly, but then she was always very polite and very compassionate.

Q It may sound a daft question, but you say she was always very honest with relatives.
A Yes.

Q Can you expand on that? Are there doctors who are dishonest with patients?
E A No. It is very difficult. What I am trying to say is: if the patient obviously was deteriorating and obviously the outcome was going to be death, Dr Barton would tell them but in the nicest way possible. I am not making very much sense, but that is the only way I can explain it.

Q Can I explore it? Might there be doctors who would not say that?
A No, but there are certain ways of putting it to patients' relatives – I think, anyway.
F

Q How was Dr Barton putting it?
A Very well. Yes.

Q If a patient was in need of medication, we know that Dr Barton on occasions would prescribe for patients and it would be written up on prescription sheets.
A Yes.
G

Q Where did Dr Barton get the information from about how a patient was getting on?
A Basically from the nursing staff and from observations of her own.

Q We know that nursing staff completed documentation in the ordinary course of nursing a patient.
A Yes.
H

Q Perhaps changing the bedclothes, changing dressings.
A Yes.

Q And matters of that nature.
A Yes.

Q What would happen to information about how a patient was getting on from, perhaps, the individual nurse who was looking after that patient? Would you know about it?
A Yes. Definitely.

Q Is that how Dr Barton would get the information?
A Yes.

Q Through various individuals on the ward.
A Yes. We always had a handover between night staff and day staff, and then, when the next shift came on at lunchtime, there would be another handover. Also, at the handover between day staff and night staff, any changes during the day or any changes in the patient's treatment was passed on so that everybody knew exactly what was going on.

Q If a patient's condition improved or deteriorated, would you know about that?
A Yes.

Q What about Dr Barton?
A Yes.

Q If a patient was in pain or distress at any time, again would that be information that you would know?
A Yes – or the rest of my senior staff, yes.

Q Can I ask about prescribing pain relief? We know that syringe drivers or a syringe driver was available.
A Yes.

Q Are you able to tell us how many syringe drivers were available on Daedalus Ward?
A I think I had about four. I think.

Q Again, no one expects you at this remove of time to get a precise number or proportion, but were they used regularly or occasionally?
A Regularly, I would say.

Q Right. For what sort of medications.
A Usually analgesia. Midazolam, if they were distressed, and hyoscine if hey had secretions.

Q We have seen prescriptions where a prescription for diamorphine and midazolam, and sometimes hyoscine as well, is written up in an anticipatory way.
A Yes.

Q That a prescription was written up, but that it was not administered in accordance with the prescription at that time.

A No.

Q You are clearly familiar with a prescription written in an anticipatory way.
A Yes.

Q What was your understanding of why that happened?
A I think, basically, if I remember rightly, there was a ward round with Dr Lord, Dr Barton and myself, and the only thing I can think of is that was brought up – the fact that a patient did not get analgesia when they really needed it – and I think it was a discussion between the three of us. I was asked if I approved, and the decision was that if they thought or anticipated that the patient might need stronger analgesia, it was written up beforehand. Because if we called in one of Dr Barton's partners or on-call doctors, they obviously did not know the patients and so, therefore, quite rightly, they were rather loathe to write up the stronger analgesia, and I think that is how it came about. But it was only in anticipation. It was not done on a regular basis.

Q Dr Lord was involved in the discussion about that.
A Yes.

Q You were asked if you approved.
A Yes. Was I happy with the decision, and I said, yes, I was.

Q What would happen over weekends? What doctor would be there or be able to come in to see the patients over the weekends?
A If it was not a weekend that Dr Barton was on call ... If she was on call, she would come in, otherwise we would have to get one of the duty doctors in.

Q How willing were they to come in?
A The partners in Dr Barton's firm, I never had any problems at all with them coming in to see the patients.

Q But you have said they would not know the patients.
A Some of them might, because some of them could have been their own GPs, but, basically, I think I am right in saying that a lot of them would not know the patients or their history.

Q What were the consequences if other doctors were reluctant to prescribe?
A The patients were left in pain, or discomfort.

Q What sort of levels of pain are we talking about?
A That is a bit difficult that, Mr Jenkins. I genuinely do not know how I could answer that one.

Q But you have told us there was a discussion with Dr Lord and Dr Barton ----
A Yes.

Q -- about prescribing in advance.
A Yes.

Q You were asked if you approved, and you did.

A A Yes.

Q If, let us say, a syringe driver was written up in an anticipatory way and the patient did not need it at that time, how might it come about that the syringe driver was started and the patient was administered medication in accordance with that prescription?
A Say, for instance, if it was the case that the night staff had reported a patient had had a very poor night and was complaining of pain and was distressed, I would obviously see
B Dr Barton in the morning and it would be discussed, and either the syringe driver would have been set up soon after, or, as it was written up, I could get a message through to the surgery and the surgery would let Dr Barton know and we would get verbal authorisation.

Q You say if a patient was in pain during the night you would discuss it with the night staff in the morning.
A Yes.
C
Q And the syringe driver would be set up soon after.
A Yes, after we had discussed it with Dr Barton.

Q Would Dr Barton always be involved in the decision to start the syringe driver?
A Yes.

D Q On Daedalus Ward?
A Yes. Definitely.

Q Forgive me, I have had raised eyebrows. That was the answer that the witness has just given. If nursing staff were to start a syringe driver on a range prescribed.
A Yes.

E Q At what level would the syringe driver be started?
A Always on the minimal dose.

Q How would the syringe driver be set up? Would it be set up by nursing staff?
A Yes, two trained staff always.

Q When you were asked whether you would approve of anticipatory prescribing, what
F was your view as to the competence of your nursing staff?
A I had an excellent nursing team – a very good nursing team.

Q If the patient's condition was such that their pain was not controlled or it was considered appropriate to increase the dose of medication within an anticipatory prescription or a range prescribed by Dr Barton, how would that occur if there was to be an increase in the medication?
G A Again, I would discuss it with Dr Barton, if necessary, on the morning round, and then maybe the syringe driver was not due until, say, mid-morning, but at the next time this syringe driver was set up with fresh medication we would increase the medication, or if we thought the medication needed to be increased I would phone the surgery and let Dr Barton know, or if we had to do it she always knew exactly what was going on with the increase in it.

H

Q Would there ever be an occasion when Dr Barton did not know that an increase was being ----
A No.

Q -- given to a patient?
A No, I do not think so. No. Even if it was just that we left a message, we always informed Dr Barton.

Q Yes. From your perspective as sister on the ward, how did that system work of administering medication by a syringe driver, sometimes with a doctor some miles away? How did it work?
A I thought it worked very well.

Q Did you have concerns about it, the way in which people were being treated?
A No.

Q You have told us that Dr Lord had been involved in the original discussion.
A Yes.

Q And that Dr Lord was there for ward rounds.
A Yes.

Q When she was there for a ward round, are you able to help us, roughly how long would that take?
A Anything from two to three hours.

Q How many of the patients on the ward would she see on a ward round?
A The majority of them actually.

Q What would Dr Lord know about the medication being given to her patients?
A The treatment charts were there for her to see and obviously we would report any change in medication at all.

Q Did Dr Lord express any concern about this system?
A No.

Q I want to ask you about a specific patient, Elsie Lavender.
A Yes.

Q The Panel I hope already have bundle B and I am going to ask you to reach in the bundles to your left, there should be one marked B.
A Yes.

Q I am going to ask you to turn towards the back of those pages to 1020. They have several paginations on those pages, but it is about 10 to 15 pages from the end and it should be a page which says "General information".
A Yes, I have it.

Q We have the patient's details written on this, yes.

A We have her details, the details of her next of kin, Alan Lavender, we have the hospital information. Yvonne Astridge is shown as the named nurse.
A Yes, she was my senior staff nurse.

Q An indication of the ward, the fact that it is Dr Lord the consultant and that you, Sister Joines, are the ward manager.
A Yes.

B

Q If we go over the page, this is part of the summary which indicates that this lady was seen on 22 February 1996, which we know was the day when she was admitted to Daedalus Ward.
A Yes.

Q There is an indication in the entry at the top of this lady's age and her medical
C conditions and the diagnosis that it was probably a brain stem cerebrovascular accident that she had had on 5 February 1996. There is a record that she was seen by Dr Barton, there are further entries down the page, some of which are made by you.
A Yes.

Q The first entry by you, I think, is made the following day. Just underneath where it is recorded "Seen by Dr Barton" on the 23rd.
D A Yes.

Q You have written, I think,

"Pathology phoned. Platelets 36, query too small sample. To be repeated Monday."

A I think, working it out, that must have been a Friday and obviously they wanted a
E repeat blood taken on Monday.

Q This was an investigation that would have been ordered at the hospital by Dr Barton.
A Yes.

Q You have written "Dr Barton informed", meaning about the small sample.
A Yes.

F

Q "Will review mane."
A Yes.

Q You have signed it "Sheila Joines".
A Yes.

G Q The next entry is the next day, "Pain not controlled properly by DF118" – that is dihydrocodeine.
A Yes.

Q "Seen by Dr Barton. Boarded" – that means written up for.
A Yes.

H Q Morphine sulphate tablets, 10 mg bd, twice a day.

A A Yes.

Q I think if we go over the page we are moving on, plainly, in the chronology. The following day now, 25 February, I wonder if I could ask you to read it to us.

A "Appears to be in more pain. Screaming 'my back' when moved but uncomplaining when not. Son would like to see Dr Barton."

B

Q Have you recorded the following day that the patient was seen by Dr Barton?

A Yes.

Q MST you have put arrowed, 20 mg bd.

A Increased to 20 mg bd.

C Q "She will see Mr Lavender at 2.00 pm this afternoon. I did phone him". Is that right?

A Yes.

Q "Blood sugars 20" and then an arrow.

A Yes.

Q What does that mean?

D A That her blood sugars were up. She was a very unstable diabetic I believe.

Q "She will see Mr Lavender at 2.00 pm this afternoon."

A Yes.

Q How was that set up because it reads like an appointment.

A It was, yes. Mr Lavender had asked me if he could speak to Dr Barton, I have relayed

E that to Dr Barton, she said to me that she would see him at two o'clock and then I would have phoned Mr Lavender and told him that Dr Barton was quite happy to see him. As I say, I can remember nothing about this patient but, having read this, both his wife and he were seen by Dr Barton and I was present at the time.

Q You have looked at the entry for 14.30 I think.

A Yes.

F

Q After the time that she was due to see him.

A Yes.

Q Are you able to help us? Were you present for the talk, does your note help you?

A I was there, yes.

G Q You have written:

"Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained."

A Yes.

H

Q Who would have explained that?
A If Dr Barton had seen him, Dr Barton. When it was a case that the patient was going – that we were thinking of putting a patient on a syringe driver because their condition had deteriorated, Dr Barton or myself or one of my senior trained staff would see the relatives, we would explain why we were putting them on a syringe driver, we would explain what was going into the syringe driver and what the effects of that were, like diamorphine for pain, midazolam to calm them down, and then inevitably they were told that it would lead to a peaceful, dignified, pain-free death. Then and only if the relatives had agreed to this would we go ahead; we never ever put a syringe driver up without the relatives consenting to it.

Q I understand. We have heard that from other nurses on Daedalus Ward. If we go on we see that at 14.40 hours you have made another entry.
A Yes.

Q Is it "Air mattress needed changing"?
A Yes, Pegasus mattress for relief of pressure areas, pressure sores.

Q "MST 10 mg given" is it "prior to moving onto Pegasus mattress"?
A Yes, prior to that. Obviously she was complaining of pain on being moved so we would have given her morphine before moving her to try and make it a little bit more comfortable for her.

Q I do not think there are any other entries by you on that page lower down.
A No.

Q But there are entries to suggest that as the days went on Mrs Lavender's pain was not controlled and she was still complaining of pain and having extra analgesia. Doses were increased and on 5 March her pain was uncontrolled, she had a very poor night.
A Yes.

Q And the syringe driver was commenced on 5 March 1996. If you had been working during that period of tine and not on holiday would you have been aware of the change in condition of this patient?
A If I had been working yes of course, because by looking at this if the syringe driver was commenced at 9.30 Dr Barton would have informed, when she came round first thing in the morning, and the agreement would have been that the syringe driver could be set up, but we would also have told the relatives which I think Margaret says she did.

Q We heard from Mr Lavender the son; we did not hear from him directly but we heard a statement from him read and we heard his evidence at the inquest summarised.
A Yes.

Q The evidence that he gave was to the effect that he had several conversations with Dr Barton; we only see one of them referred to in the nursing summary that you and I have just gone through.
A Yes.

Q Are you able to tell us, would the nurses aim to make a note of conversations that they may have with relatives?
A If they had had the conversations they would have been recorded.

Q Would the nurses aim to make a record if Dr Barton had had a conversation with the relatives?
A That would have also been recorded. about

Q If Mr Lavender is right there is not an indication that there were several conversations here; do you think it may be that things were not always recorded that could have been?
A I like to think that everything was recorded, Mr Jenkins, yes.

Q Mr Lavender's recollection of the conversations that he had with Dr Barton was that she told him, very bluntly, firstly "You will have to get rid of the cat". You do not remember this lady but we heard that she had a cat that she loved but no one else loved, it was a feral cat and used to attack other people.
A I believe so, yes.

Q Mrs Lavender was very concerned about it and attached to it. The other thing Mr Lavender recalls is Dr Barton saying rather bluntly that his mother had come here to die. You are shaking your head.
A I find that very difficult to believe. I have never ever heard Dr Barton talk to a patient's relatives in that way or in that sort of tone, I am sorry.

Q Thank you, I am not going to ask you any more about that patient but I would not put the file too far away because others may ask you about that. It follows from the documents that we have just looked at that nurses are making entries of patients' complaints of pain.
A Yes.

Q Or if they are distressed.
A Yes.

Q We know about diamorphine; in what circumstances was diamorphine or morphine administered to patients on Daedalus Ward?
A Do you mean in oral form or via a syringe driver?

Q We know it can be given in different forms – Oramorph, morphine sulphate tablets.
A Yes.

Q Dihydrocodeine is an opiate as well.
A Yes.

Q Or diamorphine via a syringe driver.
A Yes.

Q What was diamorphine in a syringe driver given for?
A To control pain.

Q Was it given in other circumstances, was it given for other sorts of condition?
A No, basically for pain relief.

Q I understand. Thank you very much, Sister Joines; would you wait there because you may be asked further questions.

THE CHAIRMAN: Mr Fitzgerald.

MR FITZGERALD: I do not know whether the Panel is considering giving the witness any break or whether to just get on.

THE CHAIRMAN: You have been giving evidence for just short of an hour.
A I did not realise.

Q It can sometimes seem to go very fast but we also are very aware that it can be very draining and debilitating, and our loose rule of thumb is that at around about the hour mark we would normally take a break. If you would like to take a break now you are absolutely entitled to have one; if you really feel that it has gone very fast and you are still tip-top fresh you might wish to continue. It is a matter for you.
A I am quite happy to carry on.

THE CHAIRMAN: Then we will carry on. We will not go beyond half an hour more or so in any event, we will take a break for lunch then.

Cross-examined by MR FITZGERALD

Q Mrs Joines, just to clarify a few things about your position, your role, you were the ward sister for Daedalus Ward for the period that we are concerned with in 1996.
A Yes.

Q You left in January 1997 having been at the hospital for almost 20 years.
A 24 years actually.

Q Was that effectively your last full-time position on a ward?
A Yes.

Q And as you explained you were 69 in 1997, is that right?
A No, I was 60.

Q I blame myself, I am sorry. You had worked with Dr Barton by that time for about ten years or so.
A Yes.

Q She was your GP.
A Yes, she still is.

Q She still is.
A Yes.

Q Is it fair to say that when the investigations started about what had happened on Daedalus Ward and Dryad Ward, particularly in relation to Dr Barton, you had a fairly clear view on that.
A I had actually left by then.

Q Yes, but when you were spoken to by the police about what had happened.

A A Yes, I beg your pardon, yes.

Q You told them clearly how you felt about that.
A Yes.

Q You said this in one of your police statements:

B "In my opinion, as a result of the current investigation, many people will not get the pain-free, dignified death they would otherwise have had."

A Yes.

Q Because your view was that the investigation itself and what was going on would cause people to be more reluctant to prescribe.
C A Yes, definitely.

Q Diamorphine in particular. Your position has always been, I think, that diamorphine and the syringe drivers were never inappropriately used in your experience.
A I do not think so, no.

Q That remains your position today.
D A Yes.

Q In fact the only patient of ours that we are dealing with who you dealt with was Mrs Lavender.
A Yes, that is correct.

Q And you have been referred to just a few notes today.
E A Yes.

Q In fact, is it right that you do not remember her?
A I do not remember. Even when I saw Mr Lavender at the coroner's court I just do not remember seeing him before.

Q You do not personally remember the conversations, as to what they were.
F A No, only from what I have written in the nursing notes.

Q Quite, you are reliant entirely on the notes.
A Yes.

Q Also in relation to her care your involvement – apart from of course the fact that you were the sister on the ward – seems to be limited to a few early notes.
G A Yes.

Q The last one, I think it is right, is in relation to the conversation about the syringe driver with Mr Lavender.
A Yes.

Q You probably know that it was not until a number of days later that the syringe driver
H is actually started.

A A Yes.

Q And you did not have any involvement in that.
A No.

Q We will come back to look at Mrs Lavender briefly, but that is, I am sure, a helpful overview.
B A Right.

Q You spoke a little bit about the syringe drivers and Dr Lord knowing that Dr Barton would prescribe syringe drivers in advance.
A Yes.

Q In an anticipatory way.
C A Yes.

Q That was not any sort of written policy or written protocol.
A No, it was not and I think it was just on Daedalus Ward – as far as I know it was never written down anywhere.

Q You described it as simply being on a ward round ---
D A After the ward round, yes, we used to sit and discuss the patients, various aspects, and that is when it came up.

Q And it was discussed that this was something that Dr Barton would do and it was something Dr Lord was comfortable with.
A Yes, she was fully in agreement with it.

E Q The question of the range of diamorphine that Dr Barton would prescribe on one of those prescriptions, was that discussed, or was it simply the principle at this time?
A I think it was just the principle; I do not remember dosages being discussed at all but then, as I say, I genuinely do not remember.

Q Very well. It may follow that you do not know the answer to this question but let me just ask it anyway. If Dr Lord's view was that she was not aware that Dr Barton would
F prescribe a range of, say, 20mg to 200 mg; that she was not aware of a range that broad, does that accord with your recollection, or can you simply not say at this stage?
A I genuinely do not think I can say. I do not think we ever discussed dosage or range at all.

Q Do you remember dose ranges of 20 to 200 mg of diamorphine being prescribed by Dr Barton?
G A I seem to remember, and I honestly cannot say this with all truthfulness, but I think that the range would vary from 80 to 200 mg of diamorphine, 40 to 80 mg of midazolam and the highest was 0.06, as far as I can remember. That was the basic and we always started off with the minimum dose.

Q When you say that was the basic, can you just explain what you mean? Do you mean that this was a standard form of prescription, a standard dose range that she would use?
H A To a certain extent, yes. I think I am right in saying that.

Q ... Again, please do say if you cannot be sure or be clear about it, but an 80 mg starting dose on a syringe driver, from one point of view, might seem quite high. Are you saying that that would be the minimum dose that would then be started for each of those patients?
A As far as I can remember.

Q At what point would that sort of standard prescription be written for a patient, in an anticipatory way? Are we talking about on admission or after that?
A I would say after, unless of course the patient – because some of the patients were admitted in quite poor condition, to be quite honest, and it would be discussed, but obviously if the patients started to deteriorate then it would be considered and the relatives would have been seen, because we did nothing without the relatives' agreement.

Q How far in advance, then, are we talking about for such an anticipatory prescription?
A I honestly do not think I could say off the top of my head, I really do not. It was not a matter of weeks or anything like that, but I genuinely could not answer that question.

Q What was the purpose of prescribing in an anticipatory way for a syringe driver like this?
A Basically, as I explained before, that Dr Barton was not always there and if you did call in one of the partners or an on-call doctor, they obviously did not know the patient's history and therefore were rather reluctant to prescribe stronger analgesia, and that was the way that we saw to it that the patient was not left in undue pain.

Q You have also, in your evidence, said that you would only set up a syringe driver or increase a dose having spoken to Dr Barton just before.
A Hopefully, yes.

Q Was not the purpose of the prescription to enable the nurses to set up the driver or increase the dose at their discretion when Dr Barton could not be contacted?
A We could but we always did try to let Dr Barton know what was going on and get her permission.

Q Yes, you always tried, but that would not always be possible.
A There were times when obviously we could not get hold of Dr Barton, so we would increase it a bit but we would always leave a message for her to let her know what was going on.

Q On a weekend, for example, if Dr Barton is not on duty, is it right that you would not be talking to her over that weekend.
A No, we would not.

Q It may well be that you would be reluctant to call an on-call doctor because they may not be able or willing to deal with the patient in a way that the nurses thought was appropriate.
A Do you know I cannot remember. I am ever so sorry, I honestly cannot remember.

Q Not at all. It is not a memory test and if there are things you do not remember, then of course you must just say. But you were explaining that one of the reasons why it was

necessary to have these sorts of prescription was because other doctors may not be willing to write the prescriptions that you thought were needed.
A Definitely, yes.

Q So this enabled the nurses to do what they thought was appropriate, having got the prescription from Dr Barton, without having to trouble another doctor.
A To a certain extent, yes, but it was always discussed among the trained staff. It was never a decision made by just one nurse.

Q No. Can you just help with the question of where the starting dose, how that would be decided? Was it always the minimum dose?
A Always the minimum dose, yes.

Q Why would that be important, please?
A We always used to start on the minimum dose because if that was sufficient we had no need to increase it at all.

Q Why start low rather than pick a higher dose?
A I do not think I can answer that question.

Q You may be able to answer the question, what are the dangers of choosing too high a dose of morphine?
A You could give the patient an overdose. I am sorry, I realise what you mean now.

Q You were always happy with the way that Dr Barton prescribed opiates, were you?
A Yes.

Q Did you believe that she was doing that prescribing by reference to any guidelines, professional guidelines that she had?
A I honestly do not know.

Q Were you aware of any guidelines for prescribing that existed?
A I knew of the Wessex Protocol, I think it was called, re analgesia. I had never actually seen it but I did know of its existence, yes.

Q What significance did you believe it had on the ward for the medical staff?
A I thought they would be guided by it.

Q Were you aware at the time about how one would convert from a person on oral morphine to diamorphine?
A In what way?

Q I am sorry, no doubt you had numerous occasions when a person who had been able to take oral medication and oral morphine became unable to.
A Yes.

Q So they had to be changed from oral morphine to syringe driver.
A Yes.

Q Were you aware at the time about what the conversion rate was between an oral dose to a dose on a syringe driver, or would that be a question for the medical staff?
A I would have thought that would be more for the medical staff, but I do know the conversion, yes.

Q You know the conversion anyway?
A Yes.

Q Again, I am sorry, it is not supposed to be a test but can you just help us with your understanding?
A If you were, say, giving 10 mg of morphine, that would convert to 20 mg of diamorphine. It was twice, I think.

Q It may be that you have just expressed yourself in the wrong way and I just want to make sure. Do you mean that if a person was on oral morphine, to get to diamorphine you would double it, or do you mean it is the other way round?
A It is the other way round. You have got me confused now, I am not quite sure.

Q I am sorry, it is difficult especially when you are on the spot, so to speak, so do not worry. Effectively your understanding was that it would be half to get to the diamorphine level.
A I think so.

Q Just to move on to the subject of conversations with family, you have mentioned already that you would never start a patient on a syringe driver without a relative's consent.
A No.

Q Why was that important?
A Obviously the outcome inevitably was going to be death. You would have to get the relatives to agree to this, otherwise what would be the point. They had to agree, and all the time I had dealings with syringe drivers, only one patient's relatives ever asked. It was a lady. I can remember her name, Mary. She was a bilateral CVA. They were a very devout Catholic family. She had a very bad chest infection. The relatives were seen by Dr Barton and they requested that she was treated with antibiotics, which she was, but inevitably she went on the syringe driver. So we would never ever put a syringe driver up without the permission of the relatives.

Q Was that a view that Dr Barton shared with you?
A I would like to think so.

Q In your dealings with her, how receptive would she be, how receptive was she to relatives potentially expressing a different view as to whether or not someone should go on a syringe driver?
A There were never any exceptions at all. She was always very easy to talk to from the nursing point of view and from the patient's relatives point of view.

Q What if a patient's relative said, "No, I do not want my relative to go on a syringe driver. I want you to do something else"?
A We would not have put them on a syringe driver. We would have gone along with them. Like I said with this Mary, they wanted antibiotics, so she was given a course of

antibiotics. We would never, unless the relatives wanted it, have put a syringe driver up. The relatives always knew.

Q When you were describing Dr Barton's manner, one of the things you said was that she did not suffer fools gladly.
A Yes.

Q Can you just explain what that meant, please?
A She was a very honest person. She expected people to be honest with her and she was honest with them. It is as simple as that.

Q When you say she did not suffer fools gladly, what do you mean in terms of her manner?
A It is rather difficult. I am trying to think of a for instance. It is so stupid, my mind has just gone a blank at the moment. She would be very open when she was discussing things with patients' relatives and if she thought there was something they should know, she would tell them, not to the point of being rude or anything like that, but all along the patient's relatives always knew exactly what was going on with their treatment, etc. Does that make sense?

Q Yes. No doubt there must have been relatives who did not like what they were being told sometimes.
A There were some because of the expectations they were given when the patient was admitted, but it never caused a problem, if you know what I mean.

Q Another witness has said that she was a woman who called a spade a spade. Do you think that is fair?
A Yes, I do.

Q Do you think she could ever have given the impression to relatives of being somewhat brusque?
A I do not think so, no. I never found that.

Q On the subject of patients being transferred to your ward, you were asked a number of questions about people who were coming there for rehabilitation, it would say on the notes.
A Yes.

Q You made clear that there were times when that may have been written but they simply were not fit for that.
A Yes.

Q Others, presumably, could be.
A Oh yes.

Q Or at least they had the chance of it.
A Yes.

Q Would it depend entirely on an individual assessment of that patient as to what their capabilities were?
A Yes, I think so.

Q For those who had the chance of rehabilitation, would you want to do your best for them?
A Yes, of course.

Q It might sound a stupid question, but please forgive me for asking it. You are obviously not saying that one could simply write off all the patients coming to your ward.
A Oh no.

Q It would be vital for each of them to be assessed individually to see what treatment was appropriate.
A Yes.

Q What rehabilitation could take place.
A Yes.

Q And to give them a chance if they needed it.
A Of course, yes.

Q Is it right that if a patient came to you and it was apparent to you that they were still in need of acute treatment, or they deteriorated from the transfer so that they needed acute medical treatment that you could not provide, they could go back to the acute hospital?
A I never heard of that happening.

Q Did you never hear of it happening because it was never necessary?
A I think basically the patients that we had in, the majority of them were really not fit for rehabilitation. I cannot say that any of them needed to go back for the acute. I think that is what I am trying to explain. They either progressed and we maybe did get them out, but the majority of them I am afraid either went into a long-stay bed or they actually died.

Q As we have discussed already, the individual assessment of the patient would be vital to determining that patient's progress, in a sense, to determine how they would be treated.
A Yes.

Q Which included how the nurses would deal with the patient in terms of what they would try in terms of rehabilitation.
A Yes.

Q And in terms of how pain relief would be approached.
A Yes.

Q Obviously there was a nursing assessment conducted as well as Dr Barton's medical assessment.
A Yes, there was.

Q But the nurses in terms of how they approached the patient would take their lead from the clinician, would they not?
A To a certain extent, yes.

Q Would Dr Barton's assessment set the tone of how the patient was to be treated?

A A Yes.

Q In terms of whether a patient was medically well enough for rehabilitation or the pain relief that would be required, are those medical, clinical matters?
A Yes.

Q You have already helped the Panel with the changing patients, the increased workload
B at the ward over the time you were there.
A Yes.

Q You said that under the circumstances Dr Barton and Dr Lord coped very well, you thought.
A Yes.

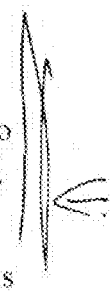
C Q Forgive me for a stupid question, but you are not saying that the treatment that was given by Dr Barton to any of your patients was ever inappropriate.
A I do not think so, no, definitely not.

Q You are not saying that she could not treat them appropriately?
A No.

D Q Was there anything that suffered, for example, in terms of note-keeping?
A I do not think so because Dr Barton's main aim was the patient's welfare. Obviously if we did a ward round with Dr Barton, whether it was myself or my senior trained staff, Dr Barton would have discussed it with us. It did not necessarily mean she would have put it in the medical notes, but the nurses would have put it in the nursing notes, so, although Dr Barton might not have recorded it, we were fully aware of what was going on because it had been discussed. And nine times out of ten it would have been written in the nursing
E notes.

Q In terms of Dr Barton's notes, for example, were they in any way, in your view, deficient?
A I do not think so, no, personally.

Q Did the nursing notes suffer in any way as a result of the increasing workload?
F A No. I must point out I had an excellent team of nurses. I am afraid I am a bit old school and I like to think my standards were quite high and my nursing staff knew of this, and if there had been any backlash from this, they would have either come to me or gone to management and it would have been discussed, but I never found that the extra workload affected my nurses' care in any way at all.



Q We have seen in this case, in relation to Elsie Lavender, that the conversation that is
G recorded with the son and Dr Barton is not recorded by her but is recorded by a nurse.
A By myself, yes.

Q In the nursing notes.
A Yes.

Q That is obviously an example, is it, of something where she has been heavily involved
H but there is no note by her personally.

A I did not see the note, so I can only go by what I have written. But I was there, so obviously I knew what was said.

Q Can we lastly and very briefly consider Elsie Lavender. You have already made clear you have no recollection of her.
A No, I honestly have not, no.

B Q We have a document which is a chronology which basically summarises the notes. It may be the simplest way of dealing with this. In the file marked "Chronologies" in tab B I hope you will find the chronology that is headed Elsie Lavender.
A Yes.

Q If you go to page 10, I hope you can see how the document works fairly quickly. There we are dealing with 26 February 1996.
C A Yes.

Q Which is the day of the note that you made.
A Yes.

Q About the conversation with Mrs Lavender's son. You can see that the first entry there is relating to review by Dr Barton. That is her note that has been written down.
D A Yes.

Q About the family being seen: "well aware of prognosis and treatment plan." In terms of what I said about the conversation with the son, I was not quite accurate in saying there is no note; there is a reference there. It may be that the nursing note is a bit more full in terms of what is described, but there is that note. Your note is the one just underneath it.
A Yes.
E

Q You have already been taken through that. Can you see on that same note is the fact that the patient was seen by Dr Barton and the MST – which is a slow release oral morphine pill – is increased to 20 mg twice a day.
A Yes.

Q At that point the prescription is for 40 mg of oral morphine a day.
F A Yes.

Q If you go over the page to page 11, we can see that the first entries on that page in colour relate to the drugs that were either prescribed or given that day.
A Yes.

Q Again please take as long as you need to read it and understand it. We can see that
G the first bullet point deals with that MST. We start off with a 10 mg dose being administered at six o'clock in the morning.
A Yes.

Q But then that is discontinued and, in accordance with the note that had been made, 20 mg twice a day was then started.
A Yes.
H

A Q That was first administered at ten o'clock in the evening. It is that same day, and obviously following on from the conversation with the son, that the syringe driver drugs are prescribed.
A Yes.

Q Those are diamorphine, midazolam and hyoscine. You can see, I think, that the diamorphine range that is prescribed is 80-160 mg.
B A Yes.

Q And the midazolam is 40-80 mg. On the basis of those prescriptions, the minimum dose of diamorphine that you could have given was 80 mg.
A Yes.

Q With midazolam a starting dose of 40 mg.
C A Yes.

Q On the conversion rate that you have spoken about with oral morphine to diamorphine, for a person who was on 40 mg of oral morphine that day, then the direct conversion would be 20 mg of diamorphine if one were going to do the same thing.
A This is where I am getting confused. I am sorry.

D Q I am sorry. It is very important that you are not, so let me take it slowly. She was prescribed this day 40 mg of oral morphine each day.
A Yes.

Q On the conversion rate we have spoken about, that would be equivalent to 20 mg of diamorphine.
A Yes. Yes, I think so, yes.
E

Q Right. Here, though, we have a minimum prescription for diamorphine of 80 mg. You have given evidence about always having been comfortable, happy, with the prescribing that Dr Barton carried out.
A Yes.

Q But given that conversion rate, does it in any way surprise you or strike you as in any
F way unusual with your experience on the ward?
A No, because I always thought Dr Barton obviously knew what she was writing up, and I have never had any question with the amount we have ever given.

Q On a day when the patient only needed 40 mg of oral morphine, how would it be possible to know that she would need a minimum dose of 80 mg of diamorphine? How could a doctor know that?
G A I am sorry, I do not think I can answer that question.

MR FITZGERALD: Very well. Those are all my questions. Thank you very much.

THE CHAIRMAN: Mr Jenkins, I anticipate that you will have some questions.

MR JENKINS: Indeed.
H

THE CHAIRMAN: In which case, I would suggest that you put them after the break.

MR JENKINS: I understand.

THE CHAIRMAN: We will take a break now for lunch. We will return at two o'clock. In that hour you are free to leave the building. Please do not discuss the case with anybody and please be back here for two o'clock.

(The luncheon adjournment)

THE CHAIRMAN: Welcome back everyone.

Mrs Joines, you are of course still on oath.
A Yes, of course.

Re-examined by MR JENKINS

MR JENKINS: Sister Joines, I am going to take you back to Elsie Lavender and the medical records. You have been shown a summary. I am going to take you to the documents themselves. Would you turn, please, to page 995 in bundle B? I hope you have a prescription sheet where, under the "As required prescription" the first drug that is written up is dihydrocodeine.
A Yes.

Q It is dated 22 February 1996.
A Yes.

Q And we can see that it is signed by Dr Barton just underneath the date. From the boxes to the right, we can see that it was given on a number of occasions. On 22 February, a couple of times. On 23 February, it would appear – the third row down on the left-hand side and the fourth row down on the left-hand side. Then to the right of that, at the top, on 23 February and again on 23 February. Do you have all that?
A Yes.

Q Are any of those signed by you?
A Yes. 23.2.96 at 1800 hours, two tablets.

Q Below those two entries there for 23 February, there is one entry for 24 February.
A Yes.

Q And then there is a jump, I think, to 3 March.
A Yes.

Q The 22 March is the day that drug is written up and it is the day when it was first given on a couple of occasions. Can I invite you to turn to page 975, Dr Barton's clerking in note.
A Yes.

Q For Mrs Lavender. "Transferred to Daedalus Ward GWMH." There is reference to the history. The Panel have had this read to them on a number of occasions. In the penultimate line: "Assess general mobility."
A Yes.

Q "Then:

"? Suitable rest home if home found for cat",

and she has written her initials after that. If we go back to page 995 and look at the page after, page 996, we can see that there is a whole series of further drugs written up as a regular prescription for Mrs Lavender and I think all of them on that page were written up on 22 February, the day of admission.
A Yes.

Q Digoxin. Co-amilofruse. Insulin for her diabetes. Thiosulphate. And there is another drug, which might be an inhaler, towards the bottom of the page.
A Yes.

Q If you go over to the next page, page 997, you can see another drug which may be an inhaler.
A Yes.

Q Salbutamol, also written up on 22 February.
A Yes.

Q That was the pain relief that was prescribed and administered for Mrs Lavender on the day that she was admitted.
A Yes.

Q Dihydrocodeine. We have seen already from page 995 that it was given again the next day, on 23 February.
A Yes.

Q On a number of occasions. If you are able to flick back to page 975, we can see that Dr Barton has made an entry for 23 February as well.
A Yes.

Q You will need several fingers. You and I have already looked at one of the pages further on. Page 1021 is the one we have looked at.
A Yes.

Q We have seen the entry for 22 February, we have already seen the entry for 23 February, and where it says "Seen by Dr Barton" on 23 February. .
A Yes.

Q We looked at your entries for 23 February and indeed your entry for 24 February.
A Yes.

Q We see:

"Pain not controlled properly by DF118" –

dihydrocodeine, we have said it was. "Seen by Dr Barton – boarded" – meaning written up – "for morphine sulphate tablets."

We know that that was written up, and we have that prescription written up at page 997.
A Yes.

Q It is in the middle of the page at page 997: "MST 10 mg". The date when it is written up is 24 February.
A Yes.

Q Again if we look just above the morphine sulphate tablets there, we can see trimethoprim which is a drug given for urinary tract infections.
A Yes.

Q Which Dr Barton has written up on 23 February.
A Yes.

Q When she saw Mrs Lavender then. We know that the pain was not well controlled because we have looked at other documentation. We have looked at page 1022.
A Yes.

Q "Appears to be in more pain." And "Son would like to see Dr Barton." We know that on 26 February Dr Barton did see the patient that day and the morphine sulphate tablet was increased.
A Yes.

Q Up to 20 mg twice a day.
A Yes.

Q We know that later that day, again from you entry at page 1022, you gave a PRN dose of morphine sulphate tablets.
A Yes.

Q In anticipation of moving Mrs Lavender ----
A Yes.

Q -- to the new mattress. That is 26 February and if we look for the prescriptions relating to 26 February, we can see at page 995 that Mrs Lavender was not getting dihydrocodeine then.
A No.

Q As we have agreed, it stopped on 24 February. We know that she had been receiving morphine sulphate tablets which had been started and then increased to 20 mg a day. On 26 February we can see Dr Barton writing up diamorphine via syringe driver.
A Yes.

Q As an anticipatory prescription.

A A Yes.

Q It was not needed at that point and it was not given at that point.
A No.

Q If you still have your finger in page 975, we have Dr Barton's entry for 26 February,

B "Not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress."

And that is something you had provided.
A Yes.

Q "Institute SC [subcutaneous] analgesia if necessary."
C A Yes.

Q What would you anticipate that would mean if subcutaneous analgesia was to be introduced? Would you anticipate that would be the same dose or an equivalent dose to what she was on?
A You mean in the syringe driver as compared to what she was taking orally?

D Q Yes. If subcutaneous analgesia is necessary, Dr Barton is suggesting it should be instituted by that note.
A Yes.

Q She was on, certainly, 20 mg of morphine sulphate tablets twice a day and PRN medication as well. If it became necessary to start the syringe driver would you anticipate that would be at an equivalent dose of what she was on or not?
E A I would have said slightly increased.

Q I understand. If we follow what actually happened with Mrs Lavender, we find that the medication was continued – she continued to get the morphine sulphate tablets for a number of days and we see that on page 997.
A Yes.

F Q There is morphine sulphate tablets 10 mg in the middle of the page.
A Yes.

Q That has gone on until the 26th in the morning, and then someone has put a line through the morphine sulphate 10 mg prescription.
A That was me.

G Q And there is a prescription for morphine sulphate tablets 20 mg and we see that that was given in the evening of the 26th.
A Yes.

Q Dr Barton has signed as the prescriber, and that continued to be given for a number of days until 3 March. If we go back to your notes we can see at page 1022 that by 4 March she is complaining of pain. She was having extra analgesia as required, including Oramorph, and
H the tablets were increased to 30 mg twice a day.

A A Yes.

Q We have got that at page 992 I think.
A Yes.

Q But the patient's pain was uncontrolled according to the nursing records – we have seen that at page 1022 – on the 5th, and I think it was at that time that the syringe driver was
B written up by Dr Barton. Can I take you back to the prescribing records and ask you to look at page 991.
A Yes.

Q The diamorphine was written up and it is dated 5 March 1996.
A Yes.

C Q And given. Are you able to help us whether you were involved in the administration of the syringe driver?
A No, my signatures are not there at all.

Q You were asked about the syringe driver being written up – what would you say about the history of Mrs Lavender's pain before any syringe driver was actually instituted?
A According to the notes it was obviously uncontrolled in spite of having the MST
D increased.

MR JENKINS: Thank you very much, that is all I ask.

THE CHAIRMAN: Mrs Joines, we have now reached the point when members of the Panel, if they have any questions of you, have the opportunity to put them. Do not look so alarmed; let me see first of all if they have any. Mr William Payne is a lay member of the Panel.

E

Questioned by THE PANEL

MR PAYNE: Good afternoon.
A Good afternoon Mr Payne.

Q I have one question for you. You have given us some background into the system for
F the instigation of the syringe driver and the anticipatory prescriptions.
A Yes.

Q You told us – correct me if I am wrong – that it was done predominantly with consultation with Dr Barton before you instigated the syringe driver.
A Yes.

G Q But on occasions you would contact her either by phone or in some form immediately after it had been started, am I right?
A Yes, sir.

Q But you would still contact her.
A Of course, yes.

H Q This was put in place in case the patient needed it to control the patient's pain.

A A Yes.

Q What happened with that anticipatory prescribing regime when the doctor was on annual leave, say she was away for a fortnight?
A We would obviously go to one of her partners preferably.

Q For what?
B A To ask permission again if we could give it. Although it was written up and we were – I have got to be careful how I say this. Although we could have given it we would still like a doctor's permission to have given it.

Q Yes.
A Obviously if the doctors had come in and read the notes they would have seen that Dr Barton had said that this could be written up and it could be given when it was necessary.
C

Q You had no problems with the doctors doing that.
A No.

Q The doctors never queried that or refused to do it.
A No, sir, never.

D Q So there was no difficulty with the other doctors then.
A No.

Q It is just that you said that it was done because some doctors were not happy about writing it up.
A I meant the initial writing up of it, not when it was already written up. Say, for instance, Mrs Lavender was on dihydrocodeine, if I had asked one of her partners or the duty
E doctor they would be a little bit reluctant to write them up, actually write on the prescription chart, whereas when Dr Barton had already written it up we were just getting their permission to go ahead with what Dr Barton had already written. Does that make sense?

Q Yes, it does and it does clear things for me; thank you very much indeed.
A Thank you.

F DR SMITH: You were asked earlier why you would ask the family before you started the syringe driver and you answered more or less this, "Obviously because the outcome was inevitably going to be death". Would you like to just explain what you meant by that?
A I am trying to think how to explain this. Obviously when Dr Barton had seen the relatives and explained and when you do put up a syringe driver of diamorphine et cetera inevitably the end result is a peaceful, dignified, pain-free death. We would always let the relatives know of this because sometimes the relatives have no idea that their patients have
G been admitted to my ward, they thought for rehabilitation, when actually the outcome could be death. Does that make sense?

Q Yes, but why inevitable?
A Because usually the patients are in such poor condition anyway. They are in a lot of pain, they are distressed, so you give them the appropriate medication. Diamorphine can suppress the respiratory system et cetera so inevitably it could end in death.
H

A Q So whenever a syringe driver was started the patient then died, is that what you are saying?
A A lot of the time, yes. I have known of cases, not personally, where patients have had syringe drivers put up on a temporary basis but as far as I was concerned on my ward when they did have syringe drivers put up it inevitably resulted in death.

Q Did you ever question that?
B A No, no, because of the patient's condition beforehand. To my way of thinking every patient is entitled to a dignified, pain-free, peaceful death and if that means putting up a syringe driver I agree with it. I have never had any reservations, and I have put up hundreds of syringe drivers over my 24 years at Gosport War Memorial and I have never once regretted any of it. It is so nice to see the relatives seeing the patients calm and peaceful; it relieves their state of mind as well and most importantly the patient.

C Q Some relatives have said that they asked for the syringe driver to be either reduced or stopped.
A Not on my ward, I am sorry, sir, they have not. I have never ever had a patient's relative query, never.

Q What would have been your response if they had?
A If they felt strongly enough of course we would have consulted Dr Barton and we
D would have stopped it. We never forced them to have a syringe driver put up on their relatives but I have never ever had anybody ask that of me and I have never had anybody query the treatment we gave the patients.

DR SMITH: Thank you.

MRS MANSELL: Going back to pain relief for patients, if we look at Elsie Lavender we
E have an assessment by Dr Tandy and an assessment by Dr Lord. Both of them are of the view that she should be given a chance for rehabilitation.
A Yes.

Q May not go back home, not to become independent with rehabilitation. Then when she arrives on the ward you are attending to the pain and giving analgesia, but then we see a reference on 25 February and "Appears to be in more pain, screaming 'My back' when
F moved." When would you think that there may be a cause for that pain that needed to be assessed?
A We would have realised it straightaway and that is why she was referred to Dr Barton, because she had the pain. Is that an answer?

Q What you are saying is that you would have been content to have moved down the route of analgesia to control the pain without questioning whether there was another reason
G for that pain if Dr Barton did not see another reason.
A I am sorry, if a patient was in pain they obviously needed pain relief.

Q Sometimes with very elderly frail people pain is a product of the aging process.
A Yes, I agree.

Q Sometimes it can be caused for other reasons. With this patient she came in and she
H had had an injury and one would have expected the pain, maybe, to have been getting less.

A A Yes.

Q But here we suddenly have, several days later, that she is actually screaming with pain.
A Yes, it was my entry.

Q That is why I was asking about it. What was the cause of that pain, what was the
B cause of it getting worse?
A I do not know, that is why I referred it back to Dr Barton.

Q And so pain often led to analgesia rather than investigation.
A Not necessarily. I am sorry ---

Q In this case it actually led to analgesia, did it not, it did not lead to investigation.
C A I suppose so, yes.

Q And that did not cause you any concern.
A No, my main concern was to get the patient's pain relieved.

Q Could the analgesia then get in the way of achieving the objective towards getting the patient better or actually dealing with the rehabilitation side?
D A I suppose it could, but then I do not think I am that qualified to just state it in that way. I rely on Dr Barton or I relied on Dr Barton being the doctor rather than me being the nurse. I can just pass on what I observe.

Q What was the point of having joint discussions between the nurses and the doctors? Were you not a clinical team in effect?
A To a certain extent, yes, but if I refer a patient to the doctor I go by what the doctor
E says, surely.

Q Right, without questioning whether there should be ---
A Because I had no questions, that is what I am trying to say.

Q So you did not want to ask in yourself why was this patient screaming with the pain in her back. You did not want to ask what that was about.
F A I assumed it was all to do with her condition anyway; she was a very frail lady in the first place. She came over with minimal use or movement in her arms – from rereading the notes. As I say, I cannot remember anything about this patient at all; I am sorry I cannot, but to my way of thinking I would have referred her on to Dr Barton for the relief of pain, but I cannot comment on the fact whether I thought at the time that there was some other reason because this lady came over with very limited movement. She was almost immobile so I assumed it was – sorry, I cannot think of the word now, my mind has gone blank – the result
G of her stroke.

Q When I as a lay person look at the nursing notes here and I look at 22 February, this person moved in with a possibility for rehabilitation, albeit slight.
A Yes.

Q Then I move to 26th or 27th when Dr Barton is actually meeting with the son and is
H saying the prognosis is discussed, and then the son is happy for you just to make Mrs

A Lavender comfortable – which actually we have heard from a lot of evidence is equivalent to thinking of the person moving to terminal care.
A Obviously as far as I can make out, and as I say I cannot remember, Mrs Lavender's condition had deteriorated to a point where there was no point in giving her further treatment. The prognosis was discussed with Mr Lavender, the son, and he did agree to making her comfortable.

B Q When we actually read through the notes it is difficult to track that through, this deterioration. I wonder what you have to say about that because the nursing notes do not actually evidence that very clearly.
A There were times when I was not on duty so I cannot say. I can only rely on my team to put things down. If I was there 24/7 ----

Q Several of the entries on this one are actually yourself.
C A Yes.

Q So I am not picking up from a nursing perspective the pattern of deterioration and moving from potential rehabilitation to end of life care but you cannot help us.
A I am sorry, I cannot, no.

D THE CHAIRMAN: Thank you. That does conclude the questions from the Panel, Mrs Joines. It just remains for the barristers to have the opportunity to ask any questions that may arise out of the questions that the Panel asked and it should be fairly short.

MR FITZGERALD: No, thank you.

Further re-examined by MR JENKINS

E MR JENKINS: We need to look at the nursing care plans because we have just looked at the summaries so far, so I am going to ask you to turn if you would, please, to page 1006. This is a nursing care plan, the named nurse is Yvonne Astridge, it is dated 22 February 1996 and the problem or need is said to be "Indwelling urinary catheter".
A Right.

Q It is dated 22 February, so the day that Mrs Lavender was admitted to Daedalus Ward.
F A Yes.

Q I do not think we need to trouble with much of the detail on that but if we can go to page 1005 I think this must be the continuation sheet of that nursing care plan, talking about the catheter.
A Yes.

G Q We do not need to trouble too much about the detail but nurses have made entries as the days have gone.
A Yes.

Q Including on 27 February a reference to haematuria.
A Yes.

H Q Is that blood in the urine?

A A Yes.

Q If we go one page further towards the front of the bundle we have another nursing care plan at page 1004.
A Yes.

Q But this one is stated on 24 February a couple of days after admission, plainly.
B A Yes.

Q And the problem is set out, "red and broken sacrum".
A Yes.

Q We see entries down towards the bottom of the page under the heading, "Nursing Action", and we see entries on a daily basis, so certainly on the night of 25th as well. What
C can you tell us about this particular problem, the red and broken sacrum, from this document? The problem is first noted on 24 February.
A Yes.

Q In other words, two days after admission. Are you able to tell us whether that problem would have been there on 22nd or whether it would have arisen after admission?
A It could have been there, but I think from this is resulted on 24th rather than on
D admission because I think that problem would have been put on, I should have hoped, the day of admission. This is dated two days after.

Q I understand, and if we look at what happened on 24th, the broken area was sprayed.
A Yes.

Q On 25th there is reference to the sacral area. I cannot read it, I am afraid, because of
E the quality of the copying, but it may be, "black and blistered". That night,

"sacrum very red and sore. Broken area sprayed with Betadine. Nursed on side".

A Yes.

Q On 26th there is the compound Betadine applied again.
F A Yes.

Q On the next couple of days, 27th and 28th, "area blackened and blistered.

"Black areas covered with Inadine and small white pad",

and that continues. Are you able to help us whether this lady's state, so far as just that
G problem is concerned, is stable or whether there is any change?
A There is obviously some breaking down in the tissue.

Q Thank you. Let us turn to another care plan, page 1008, if you would. This is a different problem, 22nd February it started, a leg ulcer on the right leg and dry skin.
A Yes.

H Q The desired outcome was to aid healing, and the nursing action to be applied is listed,

A

"Dress alternate days with Kattostat".

Would that be right?
A Yes.

Q Someone has entered something on 1 March, but if we go to the preceding page,
B 1007, this is the same date, 22 February, and it refers to the right leg ulcer and it being dressed.
A Yes.

Q Again, the pagination does not perhaps help us to understand this, but are you able to help us as to whether that is part of the same care plan as the page we have just looked at, 1008?
C A Yes.

Q Again, nurses making entries on a daily basis.
A Yes.

Q Let us go to 1010, very quickly.
A Yes.
D

Q This is a care plan in relation to Mrs Lavender being unable to care for her hygiene needs without aid, and I am going to suggest that the preceding page, 1009, records the care plan and what actually happens in relation to Mrs Lavender.
A Yes.

Q Dealt with on a daily basis and nurses making records.
E A Yes.

Q I want to look at a couple more. Page 1013, if you would. This perhaps is where it gets most relevant for Mrs Lavender. Turn to page 1012. On 22 February, "restricted mobility", is the problem that Mrs Lavender seems to be having. This is a problem that was recognised on the day she came in, 22 February.
A That is correct.
F

Q The desired outcome is to,

"Increase mobility and encourage independence".

A Yes.

G Q The nursing action is listed as to,

"Assist Elsie to transfer from bed to chair with two nurses. Refer to physiotherapists".

Is that right?
A Yes.
H

Q We see that there is an entry for 23 February, the day after she was admitted, where it is recorded that she transferred with two.
A Yes.

Q Meaning that she could go from bed to chair.
A But with the aid of two nurses.

Q I understand. If we go on to the next day, 24 February, there is an entry from Margaret Couchman.
A Yes.

Q "Bed rest due to painful joints".
A Yes.

Q It may be obvious, but from that note was Mrs Lavender transferred to the chair that day?
A No, she was kept in bed because she was complaining of painful joints.

Q What about on subsequent days?
A Again she was kept in bed so obviously there was no relief of any pain at all.

Q I think that continued, if you go back to page 1011, the preceding page.
A Yes. She remained on bed rest right up until the time they put her on a syringe driver.

Q Are you able to tell us, would the nursing care plan have been adhered to by the nurses making entries on this document?
A Yes.

Q The desired outcome was to increase her mobility and encourage independence. Are you able to tell us whether nurses were seeking to do that or not?
A Yes, of course. She would have been referred to physio and be seen by physio and obviously she just had to remain in bed because her joints were so painful.

Q Let us go to the next nursing care plan at 1014. This is dated a little after admission, "Painful shoulders and upper arms". The desired outcome is to,

"Relieve pain and make Elsie more comfortable".

A Yes.

Q The nursing action is written up as,

"Position patient for comfort. Elsie can lift her arms if given time and dependent on pain. Administer analgesia as prescribed and monitor effectiveness".

A Yes.

Q What you were asked by Mrs Mansell was about people choosing between investigating or giving pain relief.
A Yes.

Q I want you to help us. If a patient with painful shoulders and upper arm, just for example, is given pain relief, what may be the outcome in terms of their mobility?
A Obviously if they were given pain relief, their mobility would increase.

Q Increase?
A Yes.

Q If we go over to the earlier page, 1013, we know that throughout this period Mrs Lavender was given pain relief in various forms and in increasing levels.
A Yes.

Q I wonder if you can help us. Does this appear to be part of the same nursing care plan as the one we have just looked at?
A Yes.

Q "Painful shoulders and upper arms".
A Yes.

Q We saw on page 1014 that it was started on 27 February and on page 1013 this one starts.
A Yes.

Q The first entry is 27 February.

"Analgesia administered. Fairly effective. Able to help when dressing this am".

Are you able to interpret that for us?
A Yes. In fact because she had had pain relief she was able to move her limbs.

Q What about the next day, 28th,

"Right arm less painful. Able to lift it above head height".

A Yes, and so again the analgesia did help.

Q On 29th,

"Able to move arms for washing and dressing".

By 1 March,

"Complaining of pain in shoulders on movement".

A So obviously the analgesia she was receiving was not sufficient.

Q We see by 4 March,

"Seen by physio. Exercises".

A A Yes.

Q We have seen the earlier care plan suggesting that physio should be provided.
A Yes.

Q There is reference to turns of the head and neck retractions every two hours. "Analgesia increased". Are you able to help us with why the analgesia may have been
B increased?
A Obviously with doing the exercises that increased the pain. She obviously needed reminding, which I would think she was rather reluctant to do them. Whether that was for pain I cannot comment, but obviously the analgesia was increased because she was in such pain.

Q We have seen a similar entry on the summary to the one we see on the 5th,
C

"Pain uncontrolled, patient distressed. Syringe driver commenced".

Let me turn to another care plan, page 1015, this is I think the seventh care plan we have looked at. This one deals with constipation due to medical problems.
A Yes.

D Q It started on 1 March. We see the desired outcome and bowel action to be monitored. We see over time, between 1st and 6th March 1996, Mrs Lavender's condition changes.
A Yes.

Q By 3 March there is a reference to continuing to leak faeces.
A Yes.

E Q And a leak of faecal fluid or faeces continues over the next few days.
A Yes.

Q If one is looking for the condition of the patient in the nursing records, where do we have to look to see the full picture?
A In the nursing care plans.

F Q There is another care plan on the next page, 1016. This one is started on the day that she is admitted, 22 February,

"Requires assistance to settle for night".

The desired outcome is to,

G "Ensure patient has adequate sleep",

And I think this time we go forwards to 1017.
A Yes.

Q "Settled and slept well" is the first entry. "CO", sore shoulders.
A Complaining of sore shoulders.
H

Q On 23rd,

"analgesic given before settling. Comfortable night".

I think there is reference to DF118 x 2 given, and again dihydrocodeine that we have seen was administered.

A Yes.

Q Again, we have seen an entry for the next day and there are signatures for a number of dates, and it is not clear whether "dittos" have been put in or whether no entries have been put in.

A These would all have been done by the night staff. This was a night care plan for her. Where it says on 26th, "nursed on alternate sides", they do not do it now, but that would have been a ditto up until 1 March. So in other words, on 26th, 27, 28th and 29th her care did not change. She was still nursed on alternate sides, obviously because of her sore sacrum.

Q By 1 March it appears that Mrs Lavender refused medication.

A Yes.

Q It took a while to persuade her to take them is what we heard, but eventually took them.

A Yes.

Q Then we have, "leaking faeces +++".

A Yes.

Q How many pluses can you have?

A In some cases quite a lot.

Q It appears that the leakage "PR" – per rectum?

A Yes, per rectum.

Q Continued for the next couple of days. Again, so when you were asked about the nursing summary and a question of where is it recorded that the patient is deteriorating, do we need to look at the care plan for that?

A Yes. I am sorry, I might not have understood the question.

Q You were asked questions by Dr Smith about putting up a syringe driver.

A Yes.

Q You talked about the condition of the patient and you talked about a dignified and pain-free death.

A Yes.

Q The patients where a syringe driver was actually instituted, what if anything can you say about the prognosis?

A The prognosis would have been poor in the first place for us to have put up the syringe driver.

Q If a syringe driver had not been put up for those patients?

A They would not have had the calm, peaceful, dignified death, which would be upsetting to them, the relatives and the nursing staff I might add.

MR JENKINS: Thank you very much.

THE CHAIRMAN: Mrs Joines, that truly is it. Thank you very much for coming to assist us today. We are completely reliant on the presence of witnesses such as yourself to help us understand clearly circumstances and situations that often go back many years, and we are most grateful to you for coming to assist us today. You are now free to leave.

(The witness withdrew)

MR JENKINS: Sir, I am going to call Surgeon Rear Admiral Farquharson-Roberts. This witness dealt with Patient F, Ruby Lake, but I was not going to ask about any of the treatment that she received.

REAR ADMIRAL MICHAEL ATHOL FARQUHARSON-ROBERTS, Sworn
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to give us your full name, please.
A Michael Athol Farquharson-Roberts.

Q You are a medical practitioner?
A I am a registered medical practitioner. Pending the changes I am still on the Specialist Register.

Q I am going to ask for your professional qualifications.
A I am a Bachelor of Medicine and of Surgery in the University of London 1971. MRCS and LRCP in 1971 and FRCS by examination in 1976, and I have a certificate of accreditation from the Joint Committee of Higher Surgical Training in Orthopaedics dated 1983.

Q I think you were a consultant orthopaedic surgeon at the Royal Hospital, Haslar.
A Yes.

Q Are you still there?
A No, the Royal Hospital, Haslar has closed and I am now on the retired list for the Royal Navy.

Q When did you retire from the Haslar?
A I left Haslar at the end of 2000 to go on a sabbatical year before going into naval administration.

Q We know that the Royal Hospital Haslar would deal with patients, including patients who were not military personnel or members of their families.
A The Royal Hospital Haslar and its immediate predecessor, the Royal Naval Hospital Haslar, functioned as the district general hospital for the Gosport area in addition to being a military hospital, yes.

Q There were two facilities, I think, in the Portsmouth/Gosport are which would deal with trauma cases. One was the Queen Alexandra Hospital and the other was the hospital where you were a consultant, the Haslar.
A That is correct.

Q Are you able to tell us from the second half of the 1990s the respective size of the orthopaedic and trauma departments at the Queen Alexandra Hospital and the Haslar?
A In terms of beds, I am not absolutely sure but in terms of consultants my understanding is the Queen Alexandra has had five consultants and the Royal Hospital Haslar had, I think, toward the end, seven or eight, but then QA was increasing the number of consultants through the period as well.

Q Would it be right that trauma cases would be dealt with as emergency cases both at the Haslar and also at the Queen Alexandra?
A Yes.

Q If a patient fell and broke a hip, how are those cases dealt with surgically? By which I mean, are they treated as emergencies? Does one wait until the patient stabilises? How are they dealt with?
A Best practice was then and I believe is now that your patient should ... I was brought up to believe that you should not let the sun go down on a fractured neck of femur; in other words, they should be operated on either within the working day they come in or within 24 hours of coming in. Published evidence subsequently, up until the point I left clinical medicine, was to the same effect, that the patients did better the quicker they were operated on. After initial immediate resuscitation, you get them operated on as quickly as possible.

Q I understand. If we need to know the reasons why, one type of case would do better than others, please tell us, but I do not know that we need to know the reasons behind that research, as it were.
A Obviously it is multifactoral, but in general the quicker you operate the better.

Q I understand. Are you able to tell us what the pressures were, if any, on beds at the Royal Hospital Haslar and the Queen Alexandra Hospital in the late 1990s, the second half of the 1990s?
A Can I first of all give the basis on which I gained the information?

Q Of course.
A I was head of orthopaedics at Haslar up until 1996 and I then became clinical director of the surgery and anaesthetic services, so I was responsible for everything from accident and emergency through to theatres, ITU and everything while we still had one. In the late 1990s, and I am not sure of the date, that was made a joint appointment with the clinical director of surgery at Queen Alexandra Hospital Cosham, so I was in a management position, albeit at some remove, at Queen Alexandra as well as at Haslar. Haslar we were under much less pressure in terms of beds and in terms of theatre space than Queen Alexandra Hospital Cosham and also in terms of pressure on junior staff – and consultant staff, come to that.

Q Again from your position, would you have known how busy things were at the Queen Alexandra Hospital?
A Yes, they were much busier. They were much busier than we were.

Q If a surgical unit is operating on patients, do you need a bed to put the patient in after the operation?
A Yes.

Q If you are operating on a patient ----
A Sorry, with trauma patients, yes. I mean obviously there are day cases and so on, so it does not apply to every patient. The patients we are talking about, yes.

Q I should make it clear we are dealing with fractured neck of femur.
A Fractured neck of femur – you have to have a bed.

Q Broken hips.
A Yes.

Q Operations of that type?
A Yes.

Q If there are no beds in which to place a patient after an operation, what consequences are there for the surgeons and what they might wish to do?
A You have the patient in a bed before they go to theatre, so you have a bed to put them in afterwards. The pressure is when you have more backing up in the accident and emergency department. The pressures are on to speed up your throughput.

Q Are you able to help us: what was the level of pressure on beds in the late 1990s, both at your institution, the Haslar, and the Queen Alexandra Hospital?
A We felt we were under pressure, but we were well aware that it was nothing like the pressure the Queen Alexandra was under.

Q How does a surgical unit orthopaedic department deal with pressure when there is pressure on beds?
A Shorten the stay day. In other words, get the patients out quicker if you can.

Q You say, "If you can". What if you cannot?
A You end up cancelling routine admissions. That is the only way you can do it. If you do not have a bed to bring a routine admission in, a patient who is coming in to have a total hip replacement, to have their carpal tunnel done – you cancel those patients because you do not have the beds to put them in.

Q A routine admission, does that involve elective ----
A That is for elective surgery, yes. QA and Haslar, both patients were done from the same beds. The ideal is .... I am sorry, this is getting contentious. In my opinion, the ideal is to have your trauma beds and your elective beds separated

Q I understand. Can we look at the differences that there may be between elective cases and trauma cases if the operation to be undertaken is a hip replacement or a surgical repair of a fractured neck of femur, as an example? For elective cases, can one plan when the operation will take place?

A A Oh, yes. I mean, you plan when the operation will take place and fairly predictably – unless something happens – you can predict when that patient will go home and when the bed will become available again.

Q If one were to decide in a given case that there would be, let us say, a hip replacement, what steps, if any, would be advised in the period leading up to the operation?
A I am not entirely sure what you mean, so please do stop me ----

B

Q If you wanted to set up an operation for some weeks in advance, and, let us say, the patient was not in great shape some weeks before the operation, can one do anything with the patient?
A The practice has evolved and is still evolving with regard to that, but in the middle 1990s the practice would be to bring the patient into hospital 48 hours beforehand, stabilise them before they went down to theatre.

C

Q In the case of a trauma patient, let us say a patient who had fallen and broken their hip, fractured the neck of femur.
A By definition, they are not elective. They turn up on the doorstep and they have to be treated straightway.

Q Again, do you have the option of 48 hours with a patient in a bed before you
D undertake an operation?
A As I have already said, the ideal is to get them to theatre as quickly as possible. Sometimes pressures on theatres and sometimes the state of the patients' health preclude that. It may be that the patient's health does not allow it and you have to undertake or have a colleague undertake general medical treatment to get them fit enough to undergo an anaesthetic of whatever form you chose, or the other problem may be there may not be theatre time and the patient may wait to get to theatre.

E

Q Let us deal with a case where there is a fractured neck of femur, say a patient has fallen and been waiting some time before help is called, an ambulance, a relative, and they are taken to hospital. What can one anticipate as the outcome of that type of patient as against a patient who has an elective hip replacement?
A Let us start with the brutal truth. A fractured neck of femur is a pre-terminal event
F statistically. I cannot remember the exact figures but of the order of 70 to 80 per cent of patients with a fractured neck of femur are dead within a year. That is not the truth with total hip replacements. Looking around here, I suspect there are quite a few people – and I cannot remember the statistics – who have had hip replacements who expect to go on for quite a few more years yet. It is a different beast. Someone with a fractured neck of femur is already unwell. They have osteoporosis to get the fracture. They are relatively inactive, which is part of the causation of the osteoporosis. As I have said, all too often, with the best will in the world it is the start of a slippery slope. People are going to die. A fractured neck of femur is
G often a marker of the last couple of years.

Q I understand. A pre-terminal event.
A Yes.

Q Does the patient's age make a difference?
A Yes.

H

Q So far as the statistics are concerned?
A Yes.

Q In a fall and a fracture trauma case?
A I saw younger patients with fractured necks of femur. They tend to be more traumatic, in the sense they happen in road traffic accidents or with a freak accident. With younger people it is not such an event, in the sense of pre-terminal, it does not have an effect on their lifestyle. We are talking mainly about the elderly patient, and the elderly female by and large.

Q Is that because males do not live that long?
A No, it is function of osteoporosis. Women tend to get osteoporosis. They suffer a dip around the menopause when total body calcium drops, and then they run the parallel line to males (who do not have a menopause).

Q If we are dealing with patients in their seventies, in their eighties, or in the nineties, what do the figures suggest as the likelihood of a full recovery or even a partial recovery or rehabilitation for those sorts of patients?
A I cannot advise you with a full, up-to-date knowledge of the literature because I have been out of clinical practice since the end of 2000. However, the older you are, the more likely you are to perish.

Q I understand.
A And the more likely you are to have co-morbid illness, other illnesses: congestive failure, bronchial disease.

Q Can I ask you about where patients would be transferred to in the second half of the 1990s if they were transferred out of your then hospital, the Haslar.
A The ideal would be to get them back to the community, to home, with social service support in the home if they needed it, with community nurse support. That would be the ideal. There are some patients, however, who would not make it back. There are some patients who just would not get back into the community. Some, after all, have not come from the community in the first place. They have come from old people's homes anyway.

Q We have heard of some patients being transferred to the Gosport War Memorial Hospital.
A Yes, it was the community hospital for the Gosport Peninsula.

Q Can I ask you about physiotherapy that was available for your patients? I am talking about trauma patients – fracture neck of femur, elderly patients. What physiotherapy was available for them at the Haslar during the second half of the 1990s?
A In my belief, it was outstanding. We had full hydrotherapy facility, full occupational therapy, and full physiotherapy, as befits a hospital designed and built to treat military patients.

Q Outstanding physiotherapy. As the surgeon, would you have a role in saying what physiotherapy you would want your patients to have, or would it be an independent decision for the physiotherapists to make?
A The way we ran it, I was the consultant in charge of the firm and when I went on a ward round I would go around with the physiotherapist. The physiotherapist, he or she, was a

professional whose opinion I had to defer to and respect. I am not a physiotherapist. I cannot conceive of there being a disagreement between a physiotherapist and the consultant surgeon as to what was needed.

Q I understand. My question really was designed to find out what level of physiotherapy the patient would get. Would you have an input in saying, "This is what I would like for this patient"?

A I would not need to. The physiotherapists would be able to give the physiotherapy they thought appropriate. We used to have a ward physiotherapist. One physiotherapist I think looked after two orthopaedic wards and worked there full time and was responsible for the initial care, getting the patient first mobilised before they could go down to the physiotherapy department and have more aggressive physiotherapy.

Q How well staffed was the physiotherapy department?

A Very well staffed indeed.

Q Can I just ask you about ward sizes? You have told us there was a full-time physiotherapist for two wards.

A There were 28 beds on each ward. I am sorry, one was 27 and one was 28.

Q Did you know what physiotherapy they had at Gosport War Memorial Hospital, then?

A I knew one of the physiotherapists there socially, but I believe there were two or three. I do not honestly remember.

Q You have told us that the pressures on beds were rather greater at the Queen Alexandra Hospital than they were at your hospital.

A That is my belief, yes.

Q If a patient is transferred post-operatively at a time when they are not entirely stable, might that have a consequence for their prognosis?

A Can I walk back a little? We would refer a patient to Dr Lord, who was the consultant geriatrician, or one of the other consultant geriatricians, who would usually come and see the patient at Haslar and agree for their transfer, would make recommendations regarding further treatment before they were transferred, and would then make a bed available and transfer them to the Gosport War Memorial – at which point the patient would leave my care. We would get them as good as we could get them before they went.

Q I understand. I am not suggesting that the policy was in place to transfer out unstable patients.

A I am sorry, you misunderstand me. You are not working with fit, young men. I am thinking of the trauma that is coming back from Afghanistan. You are not working with that. You are working with people who have co-morbidities, other illnesses as well. We would get them as good as we could get them. They would not necessarily be fully stable in the sense that you mean.

Q Once you had got them as good as you could get them, was it appropriate for them to stay in a post-surgical bed?

A No. A post-surgical bed was just that. They had as much care as the orthopaedic unit could give them. We would not transfer them if they needed continuing care. If they had a significant wound problem that needed particular care; if they had a particular chest problem

A that needed particular care, we would not transfer them. If they had something that we deemed was capable of being managed within the community hospital, we would transfer them.

Q Can I ask about the Queen Alexandra Hospital and about the management of the Queen Alexandra so far as you were able to judge it from your position? You have told us your position was one where you knew very well what was going on there.

B A My perception was that they were transferring patients somewhat earlier than we would have done at Haslar.

Q And you were transferring as early as you could.

A As early as we felt able to, yes.

Q Are you able to help us with what would be said to relatives or the patients if they

C were transferred out from your hospital, the Haslar, after let us say a repair of a fractured neck of femur?

A With the best will in the world I was not able to see the relatives of my patients, all of my patients, necessarily even the majority before they were transferred or discharged. My juniors would advise, knowing that they would be in mind – if I can use a naval phrase – as to what I felt about the patient. The majority of the transfer and the advice to the relatives would necessarily be done by the nurses or the occupational therapists – again we had a very

D good occupational therapy department.

Q Again, it may be you cannot answer this but if a patient was treated at the Haslar, let us say an elderly patient, and they had broken their hip, they had come in for an operation, they had been got as good as you could get them and they were then transferred out to, let us say, the War Memorial Hospital in Gosport. Are you able to tell us what would have been said to the relatives as to what might be provided for the patient at the War Memorial?

E A That they were going to a community hospital. Fortunately a lot of the relatives knew the hospital and were aware of what it could do. We would say that we would send them there for continuing care but the probability is – the few times that I was able to talk to the relatives I said "Look, your mother, father et cetera is not going to be fit to go back to where they were before; they are not going to be able to go back to that level of care".

Q I think at the Haslar as a consultant you would have had junior doctors providing care

F for your patients.

A Yes.

Q How big was your team or your firm?

A It varied from time to time but I had a pre-registration houseman who I shared with one other consultant, an SHO who was exclusively mine and a registrar who I usually shared with one other consultant – a specialist registrar, this was under the old training scheme.

G

Q Indeed. How many patients would you have had on wards in your name?

A 25.

Q At any one time.

A Yes.

H Q I think you know Dr Barton.

A A As a colleague, yes. Socially we meet at the same cocktail parties.

Q I think it is a relatively small world in that part of the world so far as medicine is concerned.
A Yes.

Q But you would not describe yourself as a friend of Dr Barton; you know her as another doctor.
A I was thinking how to put this – we met outside briefly. The meeting was with a handshake not a mouaw mouaw – can I put it that way; does that give you an idea?

Q I hope it does. The Panel may ask you questions about that but I will not.
A I am sorry, I am not an expert on current social mores.

Q I am sure the Panel will take it as far as they need to. Would it be right that GPs locally would refer patients to you from time to time?
A Yes.

Q Would you have had Dr Barton refer patients to you?
A Yes.

Q Are you able to comment on the way in which patients were worked up by Dr Barton before they were referred to you or the quality of the letter that she might write?
A My impression always was that I got a good quality referral of a patient who needed to be seen.

Q Would there be a range of quality in referrals?
A Oh yes – "Bad back, please see."

Q Dr Barton was not at that end of the range.
A Far from that end of the scale.

Q I do not know, again, maybe you cannot help us, but would you have had any impression of the sort of care she gave to her patients from contact you had with the patient?
A My practice when I saw a fresh case was to sit down and read the referral letter with the patient. Occasionally a level of censorship was necessary but I was quite good at that. A number of times a patient would chime in and say "Ah yes, Dr Barton, she is very good". I hope I am not making Dr Barton blush but they did.

Q I think you had a family relative who was treated in the War Memorial Hospital?
A My father died in the War Memorial.

Q Are you able to tell us, was he there for one period of time or more than one?
A He was admitted twice, separated by about two and a half months I think.

Q Do you remember which ward he was on?
A I cannot remember, I am afraid. I know he was on two different wards on the separate times that he was in.

Q We know of a GP ward, a ward with GP beds, Sultan Ward, and the Panel has heard a lot about two other wards, Dryad and Daedalus.
A I think he was on Daedalus but I am not sure. He was on two different wards on the occasions that he was in.

Q Wherever he was, was it before 2000?
A He died in December 2000.

Q Are you able to tell us whether Dr Barton had any role in his care?
A I honestly do not know. He was looked after by Dr Lord who was the consultant geriatrician; that is as much as I remember I am afraid.

Q Would you have visited your father in the hospital?
A Daily, unless I was away for some reason. Either I or my wife did.

Q You are a man who would have spent much of his professional life in hospitals but what did it feel like for you going into the Gosport War Memorial Hospital? Did you have a sense of how things were going?
A I was also five years on the orthopaedic specialist advisory committee when the specialist advisory committees did hospital visits, so my experience is actually very wide of hospitals. Gosport War Memorial gave you – I have not been in there for a long time – a very, very good impression; it was a nice feel. Forgive me, but when you go on board a warship you can feel, before you even meet any of the sailors, if it is a happy ship – you can feel it. It is the same with the War Memorial. It was a good, efficient hospital, you could feel it – and it was clean.

MR JENKINS: Thank you very much. Would you wait there because you may be asked questions by some others?

Cross-examined by MR KARK

Q One thing I am not going to ask you about is social greetings.
A I did say that I had no expertise.

Q You in fact made a fairly lengthy statement to the police about Patient F, Ruby Lake.
A Yes.

Q You could not remember her yourself, I think, you were working with the notes.
A That is right.

Q There is a very limited amount that I want to ask you about her, but just coming back to the Haslar, this is not being suggested and I just want your confirmation – you certainly at your hospital were not shifting patients out of beds before they were ready to go.
A That was my edict as head of department and that was my practice.

Q You had expressed a certain view about the QAH, but people from the QAH may or may not agree with you, we do not know, but that was your view about the QAH.
A That was my impression, founded as co-clinical director and also on the basis of reports, informal reports received from my staff who visited and who then reported back to me, yes.

Q You said about fractured neck of femur that it a pre-terminal event and you gave us some pretty dreadful statistics about the likelihood of somebody – an elderly person presumably – surviving for longer than a year.
A Yes.

Q You said they had got osteoporosis to get the fracture.
A By and large, yes. It is an osteoporitic fracture. I am talking about the vast majority of fractures. Fractured neck of femur in the elderly is an osteoporitic fracture.

Q In elderly people.
A Is an osteoporitic type fracture, yes.

Q So if an elderly person falls they are more likely to get a break than a young person.
A If you fell over on the floor now I would be very surprised if you got a fractured neck of femur. If an 85 year old lady did I would not be surprised if she got one, let me put it that way.

Q You spoke about the quality of the physios and the physiotherapy generally at your hospital which I think you described as excellent.
A I said outstanding I think.

Q Outstanding. Occupational therapists very good.
A Yes.

Q Were your nurses very good?
A Yes, my nurses were and are outstanding. I can give you figures to prove that if you like.
A Nobody is going to suggest that your nurses were not outstanding, all right, we can take that as given. I do just want to ask you a couple of things about the notes of Ruby Lake, and if you turn to your left you will see a file – you can put B away if there is a slot to put it in, but could I ask you to take out file F? Could you turn to page 511 – it is the page numbers with a line either side, right in the middle at the bottom?
A Yes.

Q Just so we can orientate ourselves we are looking at a note, I think, by you on 10 August 1998.
A Yes.

Q The note that you have made is for,

"All necessary treatment and resuscitative measures".

A Yes.

Q Right. I think when you spoke to the police – and we can show you a copy of the statement if you would like to see it obviously – you do not remember making that note but you say:

"I do remember that I had as head of department given instructions that, for the avoidance of doubt, consultants' direction and guidance as to the management of patients was to be recorded in the clinical records, preferably in their own hand, when there was any possibility that it might be thought in the best interests of a patient for care to be modified."

A Yes.

Q Can I just ask you about that and why you thought it appropriate to make this note about this patient?
A Again, I am casting back ten years but I believe that at the time there were some reports in the wider press that patients were perhaps having care withheld. I think this was at the time of the, "Not to be resuscitated" at the bed end and I wanted it to be perfectly plainly understood that if a decision like that was taken it was taken at consultant level and it was not taken by a junior doctor. It was important that a consultant made the decision, which is why I made that ruling and told my consultants that they were to make the decision and record it.

Q Quite. It is two things, is it not? First it is to be decided at consultant level and, secondly, it is to be noted.
A That is right, yes.

Q Because were the decision different as it were – and we have seen in patient notes the record sometimes "Not for 555" and there are various versions of that but it is an extremely important decision, is it not?
A Yes.

Q You would expect any significant change in the patient's management to be recorded.
A Yes.

Q Can we please go to some nurses' notes at 613? This is in the day or so just before this lady is transferred. We have to bear in mind that this was a lady who indeed had fallen and had a fractured left neck of femur.
A Yes.

Q So she had the possibility of being rehabilitated but she is an elderly patient and there was a possibility, obviously, that she would die.
A Yes.

Q We are looking at 16 August and we can see that in the afternoon it is described as a comfortable afternoon – please glance at the earlier note, the seven o'clock note. She had previously had IVI fluids; she has had codeine phosphate for analgesia on her shoulder to good effect. Then "comfortable afternoon. Oxygen saturation 96 per cent on air" – which is reasonable, I think.
A Yes.

Q "Went out with family around the grounds. High in spirits on return. Legs re-dressed, clips removed left hip. Wound leaking".

Clips removed – would that be a form of suture?
A At that time my practice was to use clips rather than sutures to close the wound.

Q So this is the point at which they are taken out.

"Distal end of wound slightly open. Skin closure achieved with steristrips. Good oral intake of fluids. Sacrum redressed".

Then we can see Ruby had quite a good night's sleep after settling late and frequently calling out. "Taking good amounts of oral fluids." I cannot read the next word, something satisfactory.

A It is diuresis satisfactory.

Q Thank you. "Due to go to Gosport War Memorial Hospital." This patient is recorded as we see as being able to go round the grounds with her family, high in spirits and sitting out in chair. For this lady, who was I think transferred on the 17th it is not a particularly pessimistic outlook.

A No.

Q She is described by your SHO, if we look at page 519 again, 18 August,

"Well, comfortable and happy. Last pm spiked temperature 38.5, now 37.3. Mobilising well. To GWMH today."

Is that your SHO's note?

A It says ward round – "WR SHO" so I presume so, yes. I am afraid I do not recognise the signature or remember the bleep number.

Q I was just about to ask you was this the SHO that you have described as being your SHO.

A Most likely, unless that was a weekend. If 18 August was a weekend it could have been the duty SHO not mine, I do not know.

Q And you cannot tell us who it was.

A No.

Q Okay. Finally, could you please go to page 571? We are looking at a sheet of "as required" prescriptions and this is while this patient is still at your hospital – indeed, I think she has just arrived there because she is admitted to your hospital on 5 August, if that helps you. We can see that she is prescribed diamorphine intravenously – is that a variable dose we see?

A It looks as though it is 3 to 5 mg.

Q Is it your prescription or not?

A No.

Q Underneath that we see morphine and then "directions" – is that PCA?

A Yes, patient controlled analgesia.

Q Does that mean that the patient will have a button?

A It does, yes.

Q So the patient will be attached to a drip.
A Yes, usually. As I remember – and I am afraid this is years ago – there will be a separate PCA sheet giving the actual settings for the PCA.

Q So it will be set at a certain rate and then she can increase it if she feels that is necessary.
A No, it is set at a set dose and she can then administer the dose.

Q Is this pre-surgery?
A I cannot remember the date of the operation, I assume so. No, PCA would be given post-op. We did not give PCAs on the ward pre-operatively.

Q You could not, could you? The anaesthetist would have to do it.
A Our hospital's practice was that the anaesthetist or the anaesthetic department would set them up.

Q So this is immediately post-op. There is one drug I wanted to ask you about in the middle that we have heard about but have not actually seen, I think. That is Naloxone.
A Yes.

Q What is Naloxone for?
A I am not a pharmacologist and I am not a therapeutic, but my understanding is that it is an antagonist for morphine and morphine-derivative analgesics, reversing their effect.

Q I think you described it in your statement as, it is used as an antidote to a morphine overdose.
A Yes.

Q This is available, presumably, so if the patient for any reason was over-sedated, this could be administered very quickly.
A It appears, I note, it says on the PCA charts, so I think the PCA chart would be a better guide than this document.

Q But that was your understanding of its use.
A That would be my understanding of its use, yes.

MR KARK: Thank you very much.

MR JENKINS: Sir, I have only three or four questions and will be very brief. I am entirely in your hands.

THE CHAIRMAN: We will continue, if you are content.

<u>Re-examined by MR JENKINS</u>

MR JENKINS: Are you able to identify when you last saw this lady before her discharge on 18 August?
A I did ward rounds on Mondays and Thursdays and usually on Saturday mornings.

Q Do you want to look at page 517?

A "Ward round MFR on 14th". Sorry, consultants in hospitals, particularly in the Navy, are recorded by means of a three-letter abbreviation and my three-letter abbreviation was MFR.

Q That is a junior doctor's note or is it your note?
A It is a junior doctor's note. I think I now remember and I think I recognise the name. I think that was the then Surgeon Lt Coltman, I think, remembering the name, who is now Surgeon Commander Coltman.

Q We even know what he looks like because we have had him giving evidence.
A I think that is his note.

Q I think if you look over the subsequent couple of pages, there is nothing to indicate that you saw this patient in the days leading up to her discharge. She was discharged on the 18th.
A No.

Q Page 519, again it is the ward round by junior doctors.
A Probably.

Q There is no criticism at all.
A No. I can only be in one place at a time.

Q Of course. I think if we look at the nursing records, you have been asked to look at some but if I can take you to page 612, we can see a number of entries. Let us start on 15th, which is the day after you saw her.

"Some pain due to arthritis in left shoulder".

Page 612,

"She was frequently assisted to turn and move up the bed to make her comfortable. She was fully alert. Full assistance given with hygiene. Sacrum broken on both left and right buttocks and the sacral cleft. Dressing was applied".

There is reference to loose stools. There is reference to her left hip being redressed which was of course the operation site.
A Yes.

Q There was pain, she complains, in her left shoulder and chest. Over the page, it would seem she had a restless night's sleep. Left shoulder chest pain increased at one point and there was an ECG done. Some investigations were done which showed a high urea result and there is reference to her previous fluid overload and chesty cough. The doctor wanted her to be reviewed, and query intravenous infusion fluids needed. I think she had had them in the past. I do not know that we need to look up the documents. There is reference to codeine phosphate being given for shoulder pain. You dealt with the oxygen saturation and the rest of the note to 1900 hours on 16th,

"She had quite a good night's sleep after settling late and frequently calling out".

That was on 17th. I do not think you looked with Mr Kark over the page at 614, which is the rest of the day before and the day that she was transferred out,

"Seemed confused this afternoon. Reluctant to move herself up and out of bed".

It may be, it is not entirely clear, "from bed to chair".

"Phone call from Gosport War Memorial Hospital to move mane to Dryad Ward".

There is reference to her being pyrexial and paracetamol given. On the day of transfer,

"Increased shortness of breath. Recommended on oxygen therapy".

Again, does that suggest to you that she was stable at that time?
A It sounds as though – a retrospectoscope is a very easy instrument to use, but it sounds as though she is beginning to get ill.

MR JENKINS: Thank you. That is all I ask.

THE CHAIRMAN: We will take a break now. You will be taken somewhere, I hope, where you can get some refreshment and when we return I anticipate there will be questions from the Panel. We will return at five minutes to four.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. We are at the stage of questions now from the Panel and Dr Roger Smith is a medical member of the Panel.

Questioned by THE PANEL

MR SMITH: Rear Admiral, I should point out that we deduced that I am the oldest person in the room so please be kind when you answer these questions.
A I am sorry, I thought I was the only pensioner here.

Q You talked about the dreadful mortality of people who fall over and break their hips in this group, and you operate on them. Why do you operate on them?
A The survival is better if you do. There was a time, back 40 years ago, when there was actually a very big series – I am trying to remember where it came out of – of treating patients on traction and they actually did very well. However, that was in the days when it was almost one to one nursing care, so you do have the option of non-operative treatment, but nobody does these days because you can get them out of bed quicker, it is less demanding on facilities and the survival is better. If you leave a patient unoperated on, the longer they are left unoperated on, with modern standards of care, the more likely they are to die quicker.

Q So it is a matter of balancing risk.
A Yes.

Q It has been suggested by some witnesses that in the transfer process the referring hospitals were somewhat over-optimistic about the chances of the people they were transferring. It has even perhaps been suggested that they may have been slightly misleading

in the transfer information, perhaps in order to free up beds. Two things out of that really. One is, the nurses in the two institutions, the Memorial Hospital and Haslar; it has been suggested that patients were more mobile in Haslar because the nurses were sailors. Do you think there is any basis in that?

A Could I address the first point? I formed the same impression, but it is only an opinion with regard to early transfer. With regard to the nurses, a lot of the nurses in the War Memorial were ex-QARNNS – Queen Alexandra's Royal Naval Nursing Service. In 1996 very few of the QARNNS had actually been to sea so could not properly be termed sailors, but they were and are very high quality nurses. Recruitment, we pick the best. We are able to, so we tend to get very good quality nurses in the Armed Forces. That is one of the reasons why the survival rate in Afghanistan is so good, very good nursing care. One of the reasons.

Q The lady to whom you have been pointed, and you still have the file, was transferred to the Memorial Hospital. Notwithstanding that as Mr Jenkins pointed out, there had been things going on in the last 24 hours or so which might have pointed to some sub-co-morbid event occurring, and notwithstanding that Dr Lord, I think two days earlier, had not been over-optimistic about the lady's chances of rehabilitating, nevertheless, if I just take you to page 461 in that document, it should be the physiotherapists.

A Yes.

Q If I get my dates right, on 14th, which starts, "Brighter today", it says,

"Walked short distance with a frame and one".

Then on 17th it says,

"Bright. Sitting out in chair. Mobilised with Zimmer frame and supervision".

If they wrote that, what confidence would you have that they were being realistic in what they had written?

A One hundred per cent. I mean, people would not write something that was not true, certainly not in my department.

Q In a generality, if you had operated on an old lady's hip in an emergency and she is one of this group – it is this lady; let me not beat about the bush, it is this lady -- and you have applied your skills to somebody with a very high mortality, and when she gets to the rehabilitation hospital things go wrong in that she develops a lot of pain and she cannot wait there, she is in terrible pain. Her hip shortens – sorry, her leg shortens. She has to have a lot of pain relief. Bearing in mind that she is frail, she is at very high risk of dying and you have done the operation, is there any point in you knowing about that deterioration?

A First of all, can I pick you up? She did not go to a rehabilitation hospital. She went to a community hospital. That is the first thing. The second thing is I do not remember – if you want me to I will check the notes, but I think she had a DHS, a dynamic hip screw for a fracture. The whole design of that is to allow the fracture to collapse down. As I said, it is osteoporotic and soft bone, so the fracture will, if you like, crunch down. So shortening is to be expected and, regrettably, with it pain. Would I be expected to be told? If she had been still an in-patient it would have been brought to my attention on the next ward round, yes.

MR KARK: Can I just correct one error? I do not think this was the patient with the shortened leg.

MR LANGDALE: That is quite right. It is not this patient.

DR SMITH: Then I think I should not ask the question. I apologise. I think it would be wrong of me to ask this witness, albeit he is an orthopaedic surgeon, about another patient. I will not ask it.

MR KARK: Sir, the Panel is perfectly entitled to ask this witness questions if they are satisfied that this witness has the expertise to comment.

MR LANGDALE: Sir, I am guessing that Dr Smith is thinking of asking questions about Enid Spurgin. The problem is, and I quite accept what my learned friend Mr Kark has said, is that the witness will be presented with a completely fresh page and I suppose one could invite him to consider all that is known about the patient from the documents, but it seems to me that it might produce more confusion than clarity. However, I quite accept it is for the Panel to decide.

THE CHAIRMAN: I think Dr Smith has decided not to go there. There is just a very little from me, and I am a lay member. You indicated to Dr Smith a few moments ago that people would not write what was not true, certainly so far as your own hospital is concerned and that is a view that you are absolutely entitled to.

A It would be a disciplinary matter if someone had done so.

Q Can I put things from a slightly different perspective? Evidence that we have heard has been alluded to which is indicative of two things: on the one hand some nurses were of the view that the notes, the written material that accompanied patients or the transfer letters or that which came shortly thereafter was sometimes at variance with what they themselves found. Of course we have been exploring what the possible reasons for that are. One is clearly deterioration during transfer. Another possibly is that there was a difference between what the patient was actually like at the time the notes were produced. The reference to the sailors, I think, from the witness concerned was intended to convey her view that many of the nurses at Haslar were male nurses, sailors but male nurses, and that they somehow were taking more of the weight of the patient on their own shoulders when seeking to mobilise them, and that might be an explanation. Your comment on that, I think, would be helpful.

A I am not aware of the proportion of male to female nurses in 1996, however the QARNNS was and remains predominantly a female service. Queen Alexandra's Royal Naval Nursing Service remains predominantly a female service. I think, I am sorry, that that is fanciful.

Q I will not ask you to comment on the views in respect of QA unless you feel able to comment on the way in which they might have approached the transfer and the writing of transfer letters and records. We have heard that you have got some experience of that hospital and some responsibility there at the time, but not at the same level as you had at Haslar.

A My impression, formed from reports made to me by subordinates, was that they tended to transfer patients quicker than we did, earlier than we did. That was my impression. I appreciate that I am under oath and I am hedging round because I cannot give it didactically to you and say that that was so, but that was certainly the impression that I had at the time and that my nursing officers had at the time.

Q I am most grateful. That is very helpful. Still sticking with what appeared from official sources, if you like, and what appeared in writing, I think you said that when you were considering transferring somebody to Gosport, "We would refer patients to consultant geriatricians who would decide if they would be taken on". You referred specifically to two of the Gosport consultants. Do I understand from that, that the decision to take a patient from Haslar into Gosport would be one that would be made by a Gosport consultant?

A Yes. We could not admit the patients direct. We had no rights to admit the patients direct. It had to be by the consultants saying, "I will take over the care and management of this patient". I did not have and as far as I know no consultant had at Haslar, admitting rights to the War Memorial Hospital.

Q Thank you, that is extremely helpful. The other side of the coin is what might have been communicated to relatives of patients who were being transferred, or indeed to patients themselves. I think you have indicated that your hospital would say that, "We are sending them on for continuing care", but that when you spoke to relatives you would be a little more specific. I think you said, "I would say they are never going to be fit to go back to where they were before".

A I would try never to say "never". I would try and say, "I don't think she is going to be. " You always have to leave a little bit of hope. With patients and patients' relatives, I try to avoid being absolutely hard line. That was just my personal practice. I would not say, "You'll never go home." It would be, "I don't think she'll get back there. I really don't." That would be the line I would take.

Q I do not know the extent to which you will be able to comment on this, but evidence we have heard from a number of receiving personnel, if I can put it that way, at Gosport, is that they took the view that relatives were coming in believing that their patient relative had been transferred for purposes other than that for which they were transferred, and, more specifically, believing that the prognosis for the patient was a great deal rosier than it was. An example being, we are told, of relatives gaining the impression that the relative was being transferred to Gosport for a few weeks of rehabilitation, after which they would be able to return home or move on elsewhere.

A We formed the same impression, that that did happen with patients – not from Haslar – yes. But we formed that as an impression, not as firm evidence.

Q Very well. So far as Haslar is concerned, your view of that type of occurrence is that it could not have happened, would not have happened?

A I can only speak for my own directorate, from the surgical directorate, and inevitably most of the patients came from the orthopaedic, with which I had day-to-day contact. It would not have been done at my direction. It would have been done against it. I cannot say that somebody did not – I do not know for sure – but certainly it was not the way I directed the department should be run.

THE CHAIRMAN: That is very clear. Thank you very much. That concludes the questions from the members of the Panel. You are almost at the end. Now we just have to give the barristers the opportunity to ask any questions of you that may have arisen out of the questions the Panel have asked.

Further cross-examined by MR KARK

Q I have two very short matters in clarification from the Chairman's questions. You said that you did not have admitting rights from your hospital to GWMH. It would require, what, a GWMH consultant to refer?
A Yes.

Q Do you know if the same was true of the QAH or not?
A I do not know.

Q You were also asked about some evidence we have heard about a witness suggesting that there was a greater preponderance of male nurses at your hospital and therefore taking greater weight. You made, I think, a facial expression of exasperation, and also said it was fanciful. I just want to examine with you what you describe as fanciful.
A First of all, we did not have a preponderance of male nurses. I know that people have the impression that naval nurses are, but they are not. There is a preponderance of female. That was the first reason for my expression of slight disdain – not exasperation.

Q I am sorry.
A Second, I do not believe that a nurse would consciously or unconsciously lift the patient more. They would be aware of how much they were helping the patient. They know that. They are professionals.

MR KARK: Thank you very much.

Further re-examined by MR JENKINS

Q In answer to the Chairman's question about what might be said by junior doctors to relatives of a patient who was to be transferred out, are you able to tell us whether your juniors would have known precisely what facilities and what types of treatment were or were not available at the War Memorial Hospital?
A It is most likely that the patients' relatives were spoken to by members of the nursing staff and the answer would be yes. Junior doctors tend to come and go, and it may be that at the beginning of a turn a doctor was not aware of the facilities at the War Memorial Hospital and might have a different impression, but I hope that they would have sufficient sense to ask.

MR JENKINS: Thank you.

THE CHAIRMAN: That really is it, Rear Admiral. Thank you very much indeed for coming to assist us. It is only when witnesses such as yourself come before us that we are able to make anything like a realistic stab at assessing what was happening in a particular place at a particular time often many years ago. We are extremely grateful to you for coming to assist us in that regard today. Your testimony is complete and you are free to leave. Thank you.

(The witness withdrew)

DR JOHN HOWARD BASSETT, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

MR JENKINS: I am going to ask you to give us your full name, please.
A John Howard Bassett.

Q Dr Bassett, I wonder if you would give us your professional qualifications, please?
A MBChB, MRCGP, DCH, BRCOG.

Q I think you are a general practitioner in Lee-on-Solent.
A I am.

Q Which is, what, two miles around the coast from Gosport.
A On the Gosport Peninsula, yes.

Q I think you have been a general practitioner there for more than 20 years.
A Twenty-four years. Since 1985.

Q I think you are now the senior partner of the practice.
A Yes.

Q Is that where you have been throughout that time?
A Since 1994, a full partner of the practice.

Q I think you know Dr Jane Barton as a GP colleague in the Gosport area.
A I do indeed.

Q How long have you known her?
A As long as I have been a GP in Lee-on-Solent. Certainly within the first couple of years of joining the practice I would have met her. I could not say exactly when, but in the first couple of years.

Q How many GPs, roughly, are there in the Gosport area, would you say?
A Roughly 35 GPs.

Q Over the time that you have been there, would you know them fairly well, know how they are regarded, and know what their reputation is?
A Definitely, yes. More so in the 1980s and 1990s than possibly now, because there are probably more part-time GPs who have perhaps less commitment to the practice as partners than we would have done then and our association in the Gosport Peninsula with the hospital and the Gosport Medical Committee is probably less now than it was certainly in the 1980s and 1990s when we were a very close-knit community of general practitioners.

Q I understand. Might there be professional links, by contact with the same nursing staff, by contact with patients who might move from one practice to another?
A Yes. First of all, we were all members of the board of Gosport War Memorial Hospital and we all, certainly in the 1980s and 1990s, had admission rights. We had a Gosport Medical Committee which met quarterly to discuss patient affairs and the running

of the hospital as much as anything. As well as that, we had regular GP educational sessions to which all the GPs would be invited, and, socially, we had an active Gosport GPs cricket club which ran for 25 years. It only folded two or three years ago, and I was one of the youngest in the team, to give you an idea, at the end. Partners, wives and husbands were involved in that. It was very much a family affair, so we got to know all the GPs.

Q You have told us that you would know Dr Barton both as a GP locally and through the Gosport Medical Committee. Was that the committee of medical staff who might admit patients to the War Memorial Hospital?
A It was indeed.

Q We also had a minor injuries unit which was run on a rota with the GPs in those days, in the 1980s.

Q Would you have had contact with Dr Barton through the Medical Committee?
A Yes, I would have done.

Q Were you also involved in Gosport Primary Care Group in the 1990s?
A I was. Very much so. The Gosport Primary Care Group, for those who are not aware, was a forerunner to the Primary Care Trust, and really, in its infancy, was advising or working with the Family Health Service Authority, as it was, on the commissioning of services for the Gosport Peninsula.

Q I understand.
A There were ten practices in Gosport, 35 GPs. Each practice had a member on the Gosport Primary Care Group and I was one of those. I was the prescribing lead in the Primary Care Group, of which Jane was chair person.

Q She was chair of the Primary Care Group.
A She was.

Q For a short period of time or a number of years?
A Off the top of my head, several years, yes. Two or three years. At least three years, I would have said.

Q All right. From your knowledge of Dr Barton, both from committees on which you served, the Primary Care Group which Dr Barton chaired, and from other information from patients and other members of the caring professions locally, how would you say Dr Barton provided care for her patients?
A First of all, my experience with the Primary Care Group. She was a very competent, efficient leader of the group. She was supportive to me as prescribing lead. She was well respected by the members of the group, which comprised not only of doctors but nurses, managers/representatives from the Family Health Service Authority, and pharmacists – so a good range of health professionals and managers. I have to say that when Jane was asked to stand down from the committee in the late 1990s we were all shocked. I have to say that at the time we all offered to resign ourselves from the committee, and it is a testament to Jane that she was insistent that we should all carry on.

Q Forgive me, I was going to suggest it was about 2002 that she stood down when there was an investigation.

A A Yes.

Q Does that sound as if it might be right?
A Yes, whatever year it was.

Q Do you have patients who have been treated over the years at the War Memorial Hospital?
B A I do.

Q What we have heard is that it is a community hospital and that there would be many patients who are local residents in the Gosport area who would be treated there. You will have patients of your practice treated there.
A Yes – not under my care, these days, because I am not on a bed board, but certainly in the past, yes.
C

Q Would you at an earlier time have treated patients on Sultan Ward, which is the ward that we heard in the 1990s was a GP bed ward?
A Yes – not as many as perhaps some of the Gosport GPs, because of the distance from Sultan Ward, but certainly our practice admitted patients to Sultan Ward.

Q For any patients of yours that were treated on the wards where Dr Barton was a
D clinical assistant, are you able to help us with what level of care they were receiving – so far as you understood.
A I think Dr Barton in her role in the hospital would have been more involved with the patients who came under elderly care. The patients on Sultan Ward were under my care as a GP, if you like, but our paths would have crossed. Certainly I was not aware of any concerns about level or standards of care.

E Q I am grateful. You were the general practitioner for a patient whom the Panel are considering, a lady called Gladys Richards.
A Yes.

Q I think you are concerned about issues of confidentiality, touching on Gladys Richards and the care that she might have received.
A Yes.
F

Q I would like to ask you some questions, but very few, about her.
A I am concerned about confidentiality. I would just like reassurance from the Chairman that it would be appropriate for me to reveal some aspects about Mrs Richards.

THE CHAIRMAN: We are at present in open session and, as I indicated earlier, a transcript is made and, indeed, it is published. Is the suggestion that we should hear part of this
G evidence in closed session?

MR JENKINS: Sir, no, not at all. I wonder if I might clarify one matter with Dr Bassett.

THE CHAIRMAN: Yes, please.

MR JENKINS: I am only going to ask you about her medical health.
H A Yes.

Q I will not ask you about anything else.
A Yes. I know.

Q If those were the extent of the questions that I asked, and if the Panel are happy, are you content for me to ask you those questions in open session?
A I am, yes.

MR JENKINS: Sir, that is the basis. I know that Dr Bassett has had some concerns about confidentiality – understandably – but he knows that the Panel have access to medical records dealing with Mrs Richards.

THE CHAIRMAN: It is not that so much as the fact that this is a public session, it is open to the public, and there are frequently members of the press in attendance. If he has concerns about anything about this patient's health being asked in public, then he needs to be aware of the fact that it is not private, it is not limited to the people in this room.
A I do not think they are concerns. It is just a statement of fact, if you like, of the condition of the lady. It is nothing more than that.

Q If you are happy to be asked, in effect in public, about the health position.
A I think it would help to clarify.

MR JENKINS: I should add that I will be asking Dr Bassett no more than the sorts of questions that other witnesses have been asked about the 12 patients in this case in relation to Mrs Richards. I will just ask about her condition and his observations of it. I have to say from the perspective of this side we do not think there is any need for concern.

THE CHAIRMAN: That is absolutely fine. It is your witness; I do not think there is any assurance that I can give or reassurance that I can give other than that we are happy to hear if you are happy to tender evidence.

MR JENKINS: I am going to go on, Dr Bassett. You will have been this lady's GP for a short time or a long time?
A Four years.

Q I do not know when you last looked at any medical records for her, but are there reasons why this lady's condition may have stayed in your memory over the last ten years or so.
A There are.

Q There has been some publicity.
A Yes, because of the publicity.

Q What we know is that she was a lady of 91 when she had a fall and broke a bone in her hip.
A Yes.

Q With what regularity would you have seen her in the period before she was admitted to the War Memorial Hospital?

A A Probably in the six to nine months before she was admitted to the War Memorial I saw a fair amount of her. She was the age you have just described, a very frail lady with severe dementia who was really quite agitated and difficult with a tendency to wander and certainly a risk of falling within the nursing home where she was living, so it was not a surprise to me that she was admitted with a fractured neck of femur to the hospital.

B Q I understand. What we know – and the Panel have the medical records in front of them and I am looking at the records for this lady, page 108, which is an assessment in February 1998 by Dr Banks. Six months before she was admitted to the War Memorial Hospital she was described as a lady who has severe dementia and who, since Christmas, seems to have deteriorated further.

> "Her speech is very mumbling and incoherent although occasionally she comes out with a few audible understandable words."

C Does that reflect the patient that you knew?
A It does. I asked Dr Vicky Banks to review Mrs Richards, mainly because I was concerned about her agitated behaviour, the calling out and the effect on other residents in the nursing home, and her tendency to wander which was a risk to her own health for that reason.

D Q I understand. Dr Banks went on in that letter, again six months before the admission to the War Memorial Hospital,

"This is a lady with severe dementia with, I think, end stage illness, and as a result it is not surprising that she does spend considerable periods of the day asleep. She obviously needs some help to relieve the distress she experiences when she is awake"

- and there is reference to haloperidol and other forms of medication.
E A She was on small doses of haloperidol and I do remember that it was of some benefit. As I say, I felt more confident in prescribing it with the endorsement of one of my psychiatric colleagues.

F Q We have entries – for those who want to follow the entries in the medical records – at page 172 that she was admitted to the Accident and Emergency Department at the end of July 1998 and the indication was that she had started falling over over the last six months or so, and that the quality of her life had decreased markedly over the last six months.
A That would be a very accurate representation.

Q That is at page 172, Patient E. The earlier record that I had been reading from was page 108 and page 110.

G This lady underwent an operation following her fall and she was then admitted to the War Memorial Hospital and then transferred back to the original hospital for a further procedure. In your view how frail was this lady at about the time that she fell?
A Extremely frail. Fractured neck of femur in an elderly person has a high mortality rate anyway and somebody in Mrs Richards' clinical state, with severe dementia, very agitated – there would be no hope whatsoever of rehabilitation because of the lack of response to any sort of physiotherapy. It is a two-way communication so it did not surprise me at all when I heard that she had died.

H

MR JENKINS: I see. Thank you very much, Dr Bassett. Would you wait there because you may be asked a few questions by others?

Cross-examined by MR KARK

Q Just in relation to your last comment "no hope whatsoever of rehabilitation". When had you seen her prior to 30 July?
A Without her notes I could not possibly tell you.

Q Can you give us a clue?
A I guess from the point that she was in the nursing home – her general state certainly in the last six months was very, very poor. I cannot imagine that her clinical state would have improved so I could not actually tell you the date, no.

Q We have just heard from a Rear Admiral who was a surgeon at the hospital from which she was transferred, telling us about the quality of care at that hospital and the quality of the nurses and the quality of the notes. The note that was made at that hospital on 3 August following the operation was –

> "All well on ward, sitting out. Has nursing home place for family not happy for her to return to GWMH."

Then she is reviewed by Dr Reid who describes her as:

> "Confused but pleasant and co-operative. Able to move left leg freely. A little discomfort on passive movement of her right leg, Sitting out in chair. Should be given opportunity to try to remobilise. Will arrange transfer to GWMH."

The day before her referral she is described as:

> "Fully weight-bearing, walking with the aid of two nurses and a Zimmer frame. Needs total care with washing and dressing."

On what basis do you say she had no hope of rehabilitation? Are you saying no hope of going to a rest home?
A In my experience as a GP patients with a fractured neck of femur – I did not see her after she broke her hip but in my experience elderly patients who break their neck of femur have a high rate of morbidity and mortality following the operation if they survive the operation, and particularly with severe dementia I would have been surprised if there had been a major recovery even back to her pre-fracture state if you like.

Q I understand that and we understand that there is a high mortality rate but this lady was operated on. She was transferred, apparently in a state to be transferred to the GWMH and yet you are saying she had no hope whatever of recovery.
A I would have been surprised. Maybe it was the wrong word to use, "no", but little hope. I would have thought it would be unlikely. It would not come as any great surprise if she did not survive the episode of what is a major event anyway, a fractured neck of femur in a lady with very severe dementia.

Q I understand that, but that is a different way of putting it, is it not.

A A That would be perhaps the most appropriate way.

MR KARK: Thank you.

Re-examined by MR JENKINS

B Q We are fortunate that we do have some medical records for Mrs Richards. I am going to ask you to turn to your left – do you have a file with the letter E on it?
A Yes.

Q I have read to you Dr Banks' assessment of Mrs Richards in February 1998 and I am going to ask you to turn to page 90 if you would in that bundle. There are lots of different numbers on these pages, it is the typed number with a little line at each side. It may be that there is a large handwritten 9 on that page.
C A I am with you.

Q Dr Banks' request for DV from Dr Bassett.
A Yes.

Q DV refers to?
A Domiciliary visit.
D

Q We have got Mrs Richards' details and her date of birth and we have the date of this at the bottom, 4 February.

MR KARK: Sorry, does this arise out of cross-examination?

MR JENKINS: Yes, it does.
E

M R KARK: This is six months before the period that I asked the doctor about.

MR JENKINS: It does; we are going to go through the medical records and we have the GP records towards the end of the picture. I would say of course it arises out of cross-examination – unless there is any objection from the Panel. This is he GP who knew her for four years.
F

THE CHAIRMAN: The element that was being asked about is a full half year later. In order to deal with Mr Kark's point is it necessary to go back so far into the patient's history?

MR JENKINS: He did say he did not have his medical records and he would need to look at them. We have got them and I am going to come on to them – they are towards the end of the bundle and I was going to put it in context if I may.
G

THE CHAIRMAN: If you think it is going to help the Panel, Mr Jenkins, then do so.

MR JENKINS: I do. Page 90.

> "Severe dementia for some years. Very confused. 0 out of 10 on dementia scale. Wandering and worried that she might fall downstairs. Howling throughout the day. May also be depressed. Expressed a wish to die. Not eating, not taking medication."
H

There is a reference to you seeing her before Christmas and the Panel will see what is said.
A Yes.

Q Can I take you towards the very end of the bundle, page 773?
A Yes.

Q These are Lloyd George cards I think.
A They are; sorry, excuse my writing.

Q If it is your writing I think we can read it.
A I call it functional – the level of a five-year old but readable.

Q Is that your entry for 4 February?
A It is indeed.

Q Can you just read it to us?
A 4 February:

"Wandering downstairs. Constant howling. No appetite. Staff having to keep close eye. More confused, 'Let me die, let me die'. Only having haloperidol PRN – suggest 0.5 mg regularly, three times a day (TDS). Taking Trazidone [an anti-depressant] 50 mg, two at night. Very confused, denies headache or other pains."

The note on the side is

"Urgent DV Dr Banks. Discuss with Dr Banks end stage dementia. Agrees continue regular haloperidol."

Q If we go over the page do we come to early March 1998?
A Shall I read that?

Q Please do.
A

"Fell about five days ago. Discomfort right shoulder. Bruised and low back pain. Right lower lateral chest. Chest clear. Had been better on haloperidol 0.5 mg three times a day though occasionally wanders. Massaging hands with lavender oil soothes and relaxes. No serious injury. Paracetamol 500 mg TDS [three times a day]. Continue haloperidol 0.5 mg three times a day."

Q Is there then a repeat of paracetamol on 19 March?
A Yes.

Q Then an upper respiratory tract infection, a cough.
A

"Cough, chest clear. Advice only. More settled, less agitated. Slightly more drowsy but more acceptable. Continue haloperidol one ml twice a day."

Q If you go over the page is that an entry in someone else's handwriting?
A That is one of my partners.

Q About one of the daughters being concerned about the medication.
A Yes.

Q "Query in pain. Calling out and holding ribs."
A Yes.

B Q Was this lady able to communicate effectively verbally?
A No.

Q Then do we have an entry a couple of days later on 9 June, "Daughter concerned re haloperidol"?
A Yes.

C Q "Staff report agitated ++ if she did not have it."
A Yes.

Q "Permitted if she is not well. Daughters feel she should not have it." Can you read the rest of it?
A Sorry, "Granddaughter in agreement with it." The daughter felt that she should not have the haloperidol.

D Q Advice to?
A "Nursing staff."

Q Is the advice recorded over the page at 776?
A "Continue as prescribed. Refer family to me." I felt if there were divisions in the family – if there was a clinical need between myself and the nurses for the medication, E endorsed by Dr Banks, then I felt that was in the best interests of the patient. If there were divisions within the family, if some people felt she should and some she should not, I felt it was appropriate for me to air it, to discuss it with the family.

Q You felt the advice to the nursing staff should be to continue as prescribed.
A Yes, that was my judgment.

F Q Why?
A Because she was more settled on it. It was not for the good of other residents it was because she was actually distressed and these were small doses, and she was at risk with her wandering.

Q Is it the next day, 10 June, "Two daughters seen."
A Yes.

G Q "Collapsed three days ago."
A Yes.

Q Is it "Recovered since"?
A Yes, it is, sorry.

H Q Is that "pros and cons" ---

A

A "Pros and cons of the medication discussed and the care at the home."

Q Then a month later, towards the bottom of the page: "More agitated, screams out".
A Yes.

Q "Fire".
A Sorry, that is "Fine at night. Resettled, fearful."

B

Q Did you increase the haloperidol?
A I did, one ml twice a day.

Q If we go over the page, 23 July, this is a few days before she is admitted to hospital.
A Yes.

C

Q "Fell at the weekend?"
A "Fell at the weekend. To Haslar. Admitted, fractured nose."

Q Fractured?
A Nose. "Left wrist noted to be swollen yesterday." This is why I was called, I think. "Better today, not obviously in pain. Tubigrip." I guess the nursing staff were concerned that it may have been an injury that was missed to her wrist, hence the call for me to visit her.

D

Q Is the next entry yours for 19 August.
A The V is for visit, T is for telephone. "Mrs Jane Page, principal nursing home inspector. Complaint about the home from Mrs Lang, the daughter, to social services. Allegation of over-sedation. Discussed the reasons for treatment with haloperidol and trazidone and previous open discussion with daughters."

E

Q Does the last entry relate to Dr Barton?
A Dr Barton, further fall. Telephone call from – yes, it would have been from Dr Barton. "Further fall. Fracture/dislocation of the hip. Developed bronchial pneumonia and died peacefully."

Q Thank you. Is it from that history that you are able to give the view that you have?
A It is indeed. As I say, that is the first time. The reason Mrs Richards stuck in my

F

mind is because of the contact – some patients even from some years get stuck in mind – it was because of the contact I had with the family. The actual sequence of events I could not recall exactly because this is some time ago.

MR JENKINS: Thank you very much, Dr Bassett. Would you wait there because you may be asked one or two more questions?

G

THE CHAIRMAN: Thank you, Doctor. As I indicated, members of the Panel have an opportunity to ask questions of you. I am going to look now to see whether members have questions – there are no questions from members of the Panel. It follows therefore that your testimony is at an end.

Thank you very much indeed for coming to assist us today. It is only through the presence of witnesses such as yourself that this Panel is able to embark on the difficult task of piecing

H

together a true understanding of the situations and circumstances that pertained, often months

or indeed years before today. For your assistance in that regard we are extremely grateful. Many thanks; you are free to leave.

(The witness withdrew).

MR LANGDALE: Sir, in terms of tomorrow – one witness, not going to take too long, Mr Jenkins assures me – and then the expert witness, the length of whose evidence in total it is difficult to predict, but I anticipate both witnesses will be completed tomorrow, but we will have to see.

THE CHAIRMAN: Very well, thank you very much indeed, Mr Langdale. We will rise now and meet tomorrow at 9.30. Thank you.

The Panel adjourned until 9.30 am on Wednesday, 29 July 2009

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 29 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-FOUR)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning everybody. Mr Jenkins?

MR JENKINS: I know that a problem has arisen with the Panel secretary. We had anticipated there might be a slight delay but, obviously, things go seamlessly as always; I should have known better. I am going to ask for 10 or 15 minutes. I am hoping to call a witness first thing this morning. I have raised certain matters with Mr Kark and, indeed, with your Legal Assessor. We were having a discussion about certain legal matters which we had not quite concluded when the Panel came in. I am going to ask for 10 or 15 minutes so we can finish that discussion. It may be things can move on smoothly after we have had that time.

THE CHAIRMAN: I am wondering how firm that time is likely to be. In other words, whether the Panel should remain in or should we wait to be called in.

MR JENKINS: I would take your ease as they say. You will have made your own judgment yesterday about my time estimates and the reliability of them.

THE CHAIRMAN: They are no worse than mine!

MR JENKINS: Mr Kark is laughing. When I said to you I would be 15 minutes with a witness, Mr Kark says I was half an hour, so when I say it will be 10 or 15 minutes it may be better for the Panel ---

THE CHAIRMAN: Very well, we will rise now and we will return when we are told that you are ready for us.

(The Panel adjourned for a short time)

MR JENKINS: We have had some discussions. I am not going to pursue matters with that witness now. It may be there will be legal argument about that witness at a later stage. We have asked the lady to go home.

MR LANGDALE: The next witness to be called is Dr Sikora. He is sitting at the back of the room and I will call him forward now.

PROFESSOR KAROL SIKORA, Sworn

(Following introductions by the Chairman)

Examined by MR LANGDALE

MR LANGDALE: I announced you as Dr Sikora, but I think it is Professor Sikora. Is that correct?

A Correct.

Q Your first name is Karol – K A R O L?

A Correct.

Q I would like you to tell the Panel your qualifications, medical and otherwise.
A I qualified in 1972. I pursued a career in oncology, cancer medicine. My longest job was Professor of cancer medicine at Hammersmith Hospital where I have been for 23 years. I am now Medical Director of a joint venture between the NHS and the private sector, Cancer Partners UK.

Q Forgive me for interrupting, would you, first, just give your qualifications and then I will go through the history in a moment.
A My qualifications are BA from Cambridge; MBBCh Cambridge, having done that at Middlesex Hospital; MRCP which became FRCP; FRCR which is Fellow of the Royal College of Radiologists to learn radiotherapy; I am also a Fellow of the Faculty of Pharmaceutical Medicine at the College of Physicians.

Q Medical Director currently of Cancer Partners UK?
A Correct.

Q What are Cancer Partners UK?
A It is an interesting joint venture between the private and public sector to improve capacity in cancer services around the UK, both radiotherapy and chemotherapy.

Q Is it right that you were Professor and Chairman of the Department of Cancer Medicine at Imperial College School of Medicine?
A That is correct.

Q I think you are still a consultant oncologist at Hammersmith?
A I am. I spend one day a week running clinics at Hammersmith.

Q Is it also right that you run a Chair of Scientific Advisory Board of Source BioScience Plc, which is one of this country's leading diagnostic companies?
A That is correct.

Q I think you have said something about this already in your evidence – are you Dean and Professor of Medicine at what is this country's first independent medical school at the University of Buckingham?
A That is correct.

Q Also a Fellow of Corpus Christi, Cambridge?
A Yes.

Q I think you have indicated that you studied medical science and biochemistry at Cambridge, then after clinical training where was your first post at a hospital?
A My first consultant post was at Cambridge Addenbrooke's Hospital, where I was a consultant oncologist for five years.

Q After your training had you been, initially, a house physician at the Middlesex?
A Yes.

Q And then a registrar in oncology at St Bartholomew's?
A Yes.

A Q You were then a research student at the MRC Laboratory of Molecular Biology in Cambridge?
A Yes.

Q You then obtained your PhD and became a clinical Fellow at Stanford University in California before returning to this country to direct the Ludwig Institute in Cambridge, so back in Cambridge again.
B A Exactly.

Q As you indicated, you were a Clinical Director for cancer services at Hammersmith for 12 years. Is that right?
A Correct.

Q Involved in the setting up of a cancer research laboratory. Is that right?
C A Correct.

Q Also chairing Help Hammer Cancer, an appeal, which raised a certain of amount of money, in terms of millions, towards the construction of a new cancer centre at Hammersmith?
A That is correct.

D Q Just dealing with remaining matters, Deputy Director of Clinical Research of the ICRF?
A Correct.

Q From 1997 to 1999, Chief of World Health Organisation, WHO, cancer programme?
A Correct.

E Q From 1999 to 2002 Vice President of Global Clinical Research Oncology at the Pharmacia Corporation?
A Correct.

Q I am not going to ask you all the detail, but I think you have published a number of papers and written or edited a number of books?
A Correct.
F

Q Are you also a member of the UK Health Department's Expert Advisory Group on cancer?
A Yes.

Q The Committee on Safety of Medicines?
A Yes.
G

Q Do you remain an adviser to the World Health Organisation?
A Correct.

Q I think, Professor Sikora, you prepared a report in connection with issues in this case?
A I have.

H

Q I am going to ask you, first, about the material that you have had the opportunity of seeing, in the sense of it being provided to you one way or another. I think you have reviewed the notice of inquiry, that is Fitness to Practise Panel hearing notice of inquiry setting out the allegations against Dr Barton?
A I have.

Q You also had the opportunity, although I am not going to ask you about it, but you saw the Commission for Health Improvement or CHI report material?
A I did.

Q Which was back in 2002. You had the opportunity of reading the reports of Professor Ford?
A I did.

Q Have you also had the opportunity of reading transcripts of the evidence he has given to this Panel?
A I have.

Q You have also had provided to you the general police statement, as we have called it, of Dr Barton herself and you have also seen the statements she made with regard to twelve patients?
A I have.

Q It follows that you have seen statements that she made with regard to all twelve, nine of which I think were police statements prepared for the assistance of the police. May I also ask you, in terms of material that you have seen, you have seen transcripts of her evidence?
A I have.

Q Sir, I am going to ask a number of questions in leading form, simply to establish what it was this witness understood the position to be. It is all factual, it is not asking his opinion. I am trying to take you through certain matters of which you became aware with regard to the history of this case. On the information you have been able to gather from what you have seen and so on in terms of Dr Barton, you understood, you cannot give direct evidence for this, that she had been contracted as a clinical assistant for four to five sessions a week at the Gosport War Memorial Hospital?
A Correct.

Q We are familiar with the dates, 1988 to 2000. The hours, as you understood it, were flexible to allow her and her general practice to provide 24 hour cover to the patients at the hospital?
A Yes.

Q A total of 40 plus beds, I think it may have a total of 48 all together, designed for the long term care of elderly patients?
A Yes.

Q As you understand it on the information you have been given, the nature of the clinical case mix changed during the 1990s to include patients transferred from the acute sector for rehabilitation?
A That is my understanding.

Q As you understand it, no increase in medical or nursing time and no enhancement of social services, physiotherapy, occupational therapy or support staff to help to meet that new function?
A That is correct.

Q Is it your understanding that Dr Barton worked as a part-time GP locally with a personal list of something like 1500 patients?
A That is correct.

Q Furthermore, I am going to ask you more about what your understanding of the matter was because it will assist the Panel in terms of understanding the basis of your opinion about certain matters. Was it your understanding that Dr Barton had no specific training or postgraduate qualifications in internal medicine, care of the elderly or rehabilitation?
A That is correct.

Q In your experience is that normally the case with clinical assistant posts?
A That is the purpose of a clinical assistant.

Q Work, as you understand it, was supervised by two consultants initially, Doctors Lord and Tandy, with Dr Reid replacing Dr Tandy at some point in 1999?
A That is correct.

Q On your understanding those consultants all have major clinical responsibilities elsewhere and their contribution to the care of the Gosport patients was apparently limited to a weekly ward round which did not always take place?
A Correct.

Q Again, the Panel will have heard evidence about this but that is your understanding about the position. You were also informed about Dr Tandy being away on maternity leave from some point in the late 1990s, I think in April 1998, and the Trust made the decision not to provide any full-time locum cover for her until she returned in February 1999?
A That is correct.

Q We have heard evidence from Dr Tandy about it. You were also given information about Dr Barton's habitual work pattern – I am not going through it – the morning visit, returning not necessarily every day but around about lunch time to deal with the new admissions, clerking in and so on and then an evening visit depending on the needs of relatives and so on?
A Correct.

Q You were given the history about that?
A Yes.

Q You were aware of the evidence that Dr Barton raised the problem, or the difficulties, with increasing work load with more than one person, but no changes were implemented?
A That is correct.

Q Was it also your understanding, and the Panel have heard the evidence, that at no time during her twelve years at Gosport were any changes suggested to Dr Barton in relation to her mode of work, prescription habits or her abbreviated style of note keeping?
A Correct.

Q You have read the evidence that there has been in relation to her rapport with the nursing staff, which appears, so far as you can judge it, to have been excellent?
A It does.

Q What is your view in terms of the material you have seen as to whether it was effective or not in terms of the way her unit dealt with a pretty large patient volume with the staff that were available. What was your impression?
A My view, based on my experience as a clinical manager at Hammersmith including palliative care, is that the work load changed, the pattern of patients changed over a decade and although the staffing may have been suitable at the beginning of the decade, by the end of the decade the patient flows had changed, the dependency on nursing care had changed, but the staff had not changed in numbers.

Q In terms of criticisms of Dr Barton's work, is it right that you have summarised the common themes in the allegations against her as being – in relation to the fitness to practice allegations themselves, they can be summarised as being – that the lowest doses in the sliding scale of her prescriptions for diamorphine and midazolam were too high?
A Correct.

Q That the dose range was too wide?
A Correct.

Q Are you aware of the fact that Dr Barton has accepted, not in every case but in a number of cases, the dose range in the 20 to 200 mg range was too wide?
A Correct.

Q That the prescription created a situation whereby drugs could be administered but were excessive to the patient's needs, adequate assessment of patients was not made and properly recorded and, again, are you aware of the fact that Dr Barton has accepted that her recording, her note keeping and other recording, was not as it should have been?
A I do.

Q Also an allegation that advice from a senior colleague was not obtained when patients deteriorated?
A Yes.

Q In terms of Professor Ford's report, which you have considered and you have read transcripts of his evidence, you are aware of the fact that he looked at the generic issues around the use of pain control medication?
A Yes.

Q What is your view as to the only way to judge accurately a patient's needs for analgesics?
A The only way is to be with the patient and see what happens after a given dose of an analgesic that is given. The teaching in the World Health Organisation when I started ten

A years ago is very much doing things by the drugs; in other words where in the ladder of analgesics, strength of analgesics, you start; by the route, whether it is by mouth to start with or subcutaneous injection by infusion; by the clock, to avoid periods when the patient is in pain because the level of analgesic has dropped, and by the patient. The teaching is very much "by the patient" is the most important thing. So without seeing the patient, without looking at detailed notes, which are often not recorded in people that are terminally ill, it is impossible to make a judgment unless you were there.

B

Q Just going back over that, that sequence you have just dealt with in terms of the World Health Organisation approach, number one the drug?
A Correct.

Q What are we thinking of there?
A There are several drugs, increasing in strength, to get rid of pain. The WHO twenty
C years ago constructed what is called the WHO pain control ladder that is widely used round the world, especially in countries where there really is not much active treatment because of costs. The ladder is to begin with a mild analgesic – paracetamol, aspirin; to go to a middle analgesic, dihydrocodeine, for example, and then to go to an opiate such as morphine and diamorphine. That ladder is a way of getting the right drug in a sequence that is logical, to teach doctors and nurses to give a logical sequence for pain control.

D Q Would you look please at a file marked "1", in the collection of files to your left, in those boxes. Would you look, please, in file 1 at tab 4. In tab 4 we can see it contains a photocopy of something called the *Palliative Care Handbook*, which was something that was available at Gosport and other places as well known, I think also, as the Wessex Procedure. Look, please, at page 5 in tab 4. We can see there mention of the WHO analgesic ladder?
A Yes.

E Q Without troubling about the detail, is that the same thing, in effect, as what we were just talking about?
A The same one.

Q Thank you. That was the drug. We dealt with that. Then the route was the next thing itemised.
A The route – the most convenient route – for most patients is oral but some patients
F cannot swallow and sometimes the oral route is not adequate because they start vomiting because of the side effects of the drug. The next way to do it would be parenteral injection, which means injecting something under the skin. That could be subcutaneous, it could be intramuscular. Over the last twenty years the availability of subcutaneous pumps, relative cheaply, has meant that one can give 24-hour infusions, which give a much better pharmacological distribution of pain-killer drug, and therefore better pain control, over a longer period of time.

G

Q Does that bring us onto the clock, which was the next in the sequence you were citing?
A By the clock is the idea that you do not wait for the patient to complain. In every healthcare environment all over the world there will be a delay, even if the patient has one-to-one nursing, which is a great luxury. In most environments, patients do not have that, and therefore giving drugs by the clock means that you do not allow the analgesic level in the
H blood to drop to a level where the pain comes back and the patient is suffering, maybe for an

A hour or two hours, but intermittently. It is not just one or two hours. It is every few hours the level drops, and they start suffering. So "by the clock" is a way of teaching healthcare workers to avoid that trough in level, and therefore the pain.

Q Then you said "the patient".
A That is the most important. A patient's pain is judged by what they say it is. No one else can judge pain. Obviously if someone is completely well and they say they are in severe
B pain you want to work out why, but if a diagnosis has been made of the cause of that pain or distress – and it can be caused by multiple factors, especially in the elderly – then you want to make sure that the patient has enough drug by the right route to get rid of that pain.

Q We may have to come back to it later, but may I just ask you in the context of what you just said about material in relation to which the Panel have heard quite a lot of evidence. As you are aware, no doubt, from read the transcripts, reference has been made to the BNF?
C A Yes.

Q Principally the *Palliative Care Handbook*, and so on, all of which set out particular matters with regard to, and we are focusing here obviously on analgesics.
A Yes.

Q They set out dose ranges, what the drugs can and cannot do?
D A Yes.

Q What are possible adverse side effects and so on. You will obviously be familiar with all this?
A I am.

Q But in relation to patients who are reaching, or who are on, what has been described in
E the context of this hearing as a terminal care pathway is anything set out in any documentary material of which you are aware as to how much? In other words what sort of dosage and at what rate the patient should receive when they are on a terminal care pathway?
A There is no literature or guidelines on the actual doses because it is so patient sensitive. It is the individual patient who has to be judged there and then. There is no other way of doing it, so certainly in the WHO teaching literature, there is nothing about the absolute level at which to do things.
F

Q As you know, in relation to Professor Ford's report and his evidence, he was examining issues with regard to wide dose ranges, use of PRN prescriptions, drug combinations and the use of subcutaneous infusions and the use of anticipatory prescribing?
A That is correct.

Q We will come back to those, in some respects, later. Obviously everybody is
G proceeding on this basis and I think you are proceeding on this basis. The responsibility of Dr Barton as the physician responsible for Gosport War Memorial Hospital on a day to day basis, her responsibility lay in relation o all of those issues?
A Yes.

Q They are matters for her to deal with?
A Yes.
H

Q But as you are aware, and Dr Barton was only one member of a team?
A That is correct.

Q We will come back to that in due course.
A Did you find in relation to Professor Ford's report and evidence on these wider issues, that he had really addressed the question as to whether there was any practical solution for the circumstances that Dr Barton found herself in in that period?
A I could not find the practical solution. I think Dr Barton was using various recipes because it was the only practical solution to the situation she found herself in.

Q Again, we can come back to that in some more detail. What was your view as to what degree Professor Ford addressed the wide, individual variation between patients with regard to opiate needs?
A You must not base that on the actual patient data because there was no patient data presented to consider. Therefore "by the patient" was not being considered in that. I think also the dose ranges presented were from 20 to 200 mg per 24 hours in the pump, but of the 12 patients only one got above 100 mg.

Q I think it was broken down for you, and you set it out in your report, that the ranges were 120 in terms of the twelve the Panel are considering – that is in one instance, Patient A, and then the variation was 100, 90, 80, 60, 40, 30 and 20, in terms of the maximum amount of diamorphine that was being received by the patient at the time of their death?
A That is correct.

Q In relation to those – we have heard these figures before – in two the maximum was 20; in one the maximum was 30; two, maximum 40; two, maximum 60; two, maximum 80; one at 90 and one at 100, in addition to the 120 we referred to?
A Correct.

Q Would you help, please, with regard to this question in individual variation between patients to opiate need in your experience?
A It is very complex. There are multiple factors. First of all, psychosocial factors – people that are disturbed in unfamiliar environments feel more pain than if they are in a more relaxed environment – the availability of skilled nursing care and close relatives able to help reduces the need for analgesics. Then there are pharmacological factors: the fact that the patient may be metabolising the drug in different ways, partly because they have other disease problems, such as liver and renal problems, and also because there are different kinetics in how each of us as individuals disposes of morphine-like drugs. So there are many, many factors that play, and that is why the teaching is "Look at the patient and see what happens," rather than use any pre-conceived dosage or formula.

Q In terms of care for patients, we have heard evidence about this to some degree already. Does one have to look at the question of how is a patient best cared for by considering different aspects of care. We have heard about – and you have indeed just referred to, as it were – psychological support?
A Correct.

Q The importance of good nursing care?
A Yes.

Q And obviously drug therapy to relieve anxiety, distress, pain, whatever it might be?
A Correct.

Q Where does the balance lie? Is it impossible to say where the balance lies between those aspects of patient care in relation to the type of patient we are considering in this hearing?
A It is very difficult, and certainly in elderly patients it is much more difficult because they may not be able to communicate exactly what the problem is in the way a younger patient may be able to.

MR LANGDALE: I am going to ask, with some hesitation, that the Panel receive a document. My learned friend Mr Kark has seen it. It is not a document prepared by Professor Sikora himself. He has seen it. It has been prepared by those instructing me and it is an attempt to show by way of a chart that the level of morphine which a patient will receive if it is administered subcutaneously. It is not absolutely mathematically precise, and the Panel will see that it has been divided into two charts. One shows the picture if the half life of the morphine is two hours; the other shows the picture if the half life of the morphine is four hours. The Panel have heard a certain amount of evidence, in particular from Professor Ford, about the sort of level you would expect the morphine seemed to have peaked at, and so on, in the course of the evidence you have already heard. I am putting this in with the agreement – and I am grateful for it – of counsel for the GMC, simply to assist the Panel to get an idea. It is not set in stone, and I am going to ask Professor Sikora to deal with it in very general terms. I wonder, sir, if those documents could be put in.

THE CHAIRMAN: They will be D7.

MR LANGDALE: Thank you very much. That is D7. D7a will be the two hour one, and D7b for the four hour one, perhaps.

THE CHAIRMAN: By all means.

MR LANGDALE: Perhaps Professor Sikora could also have a copy. (Document marked and circulated) Sir, I stress, this is not his document. (To the witness) Professor Sikora, I am going to invite you to look at this with us and ask you some very general questions about it.
A Of course.

Q We are looking at subcutaneous infusion of diamorphine. Both of these charts are headed "Diamorphine Blood Levels" on the assumption that it is a dose of 20 mg subcutaneously over 24 hours. First of all 7a, with a two hour half life; secondly, 7b, a four hour half life. Looking first at 7a, the way in which this document has been set out shows on the left hand column the hours. In other words, after hour one – at the top on the left – 0.83 mg has (in my words) gone into the patient?
A Correct.

Q So at the end of an hour, it is 0.83, assuming a two hour half life. The rest of the plan sets out the figure you reach after each one of the hours up to and including hour eleven after administration?
A Correct.

A Q If it is a two hour half life we can see how the amount of morphine in the patient, allowing for the fact that at each stage you have to take into account the remaining morphine from the previous infusion and how it declines. On the right hand side you have the amount, so after two hours, 1.46 and so on. Then, after eleven hours it reaches the peak that at any one time would be in the patient's body, 2.86?
A Correct.

B Q I am told Mr Barker has rounded up these figures to avoid any kind of misleading impression. Looking at the position with regard to the four hour half life, 7b, the same method has been used, and we can see that in relation to the first hour the same amount has been received by the patient, but as you go on, if you assume a four hour half life, the amount in the patient's body is in general terms higher?
A Yes.

C Q Because the morphine is there (again in my words) for longer?
A Correct.

Q On this particular exercise, again staying with the 20 mg over 24 hours, after 21 hours the peak has been reached of 5.32?
A Correct.

D Q This is just an exercise to try and demonstrate a general picture. It is not meant to be, as I say, a certain standard, but in general terms without your having checked the figures – they are not yours – is that the sort of view or understanding we should have with regard to the way the morphine gets into the patient, stays there and eventually declines?
A Yes. It is a good teaching exercise on the value of a subcutaneous pump rather than intermittent injection, where you would have peaks and troughs. Peaks may have an overdose of morphine or diamorphine, and a trough where you get breakthrough pain. With a E subcutaneous pump you reach a plateau and you can see with the two hours you reach the plateau actually at about the fifth or sixth hour. There is very little rise from 2.41 up to 2.86. With the four hour half life patient, you see you reached the plateau when you get to about 13 hours. It really goes up very little from then.

Q So in the case of the four hour half life plateau it is reached more or less after thirteen?
F A Correct, yes.

Q And the lower figure for the two hour half life. Thank you for dealing with that. I am going to ask you a little bit more about your area of expertise, and about your experience with regard to palliative care generally. As you set out in your report, your area of expertise is cancer medicine?
A Correct.
G

Q And you have been a consultant in that discipline for getting on for 30 years.
A I have.

Q Does that experience of yours include the palliative care of elderly patients suffering from cancer?
A It does. The majority of patients with cancer are elderly and palliative care is, unfortunately, necessary for many patients.
H

Q As you have already indicated you have worked as a consultant at two teaching hospitals, Addenbrookes and also the Hammersmith Hospital.
A I have.

Q You have obviously had appropriate support from more junior colleagues.
A I have.

Q It is also right to point out that you yourself have never had to practise in an isolated clinical environment.
A That is the case.

Q So you have never been in the same sort of situation as Dr Barton for instance.
A No.

Q When you were clinical director for cancer services between 1986 and 1998 at the Hammersmith Hospitals NHS Trust did that include the management of the palliative care services?
A It does. We created a palliative care position among the consultants and, with the local hospice, we developed palliative care as a separate sub-specialty within our department.

Q It may be that one will have to draw some distinction between the palliative care of cancer patients and patients who are not suffering from cancer. We can come on to that later and it may be an issue which will be explored with you, but I just want to ask you about this: in terms of the whole concept of palliative care – and your experience in this particular field obviously embraces the period of time that the Panel are concerned with in this hearing, the 1990s – can you give us a thumbnail sketch as to how you saw it in terms of palliative care either originating in hospices or whatever it might be; a little picture of how things have developed?
A When I began in cancer medicine as a registrar there was really no palliative care. It developed in London at St Christopher's Hospice and migrated around the UK, both in hospitals and in community settings, together with charitable support from the Macmillan Fund, which was one of the major drivers of the palliative care movement. Today it has changed beyond all recognition. Initially it was just for cancer patients, now the protocols and the way in which the teaching is given applies to all situations including a common pathway of terminal decline which happens in all diseases, so the lessons from cancer have been applied right across the board. Currently there are major forces trying to get palliative care more into the community; the current Government has an initiative to allow people to choose where they wish to die, and that is a very challenging effort, whether they wish to die at home or in a hospice or indeed in a hospital. It is difficult to implement because obviously it costs money – it is not about drugs necessarily, it is about staffing to make sure that people can die in the home, for example, which is much more consuming of staff time.

Q May I ask you this, again in general terms: is there any significant difference between the approach to be adopted in palliating symptoms of pain, distress, agitation and so on – again, my words because we have heard different labels such as terminal restlessness and so on – in patients who are suffering from some form of cancer and patients who are suffering as a result of some other problem such as illness, comorbidity, whatever words we use?
A I personally do not think there is and I think it has been very tragic that it has taken our profession so long to recognise that. The lessons from cancer, where palliative care has

A really been developed, are now being applied across the board to all terminal phases of illness and, indeed, hospices are opening their doors now to non-cancer patients for the first time. I suspect the origin of this is that cancer is thought of as an incurable illness; many other diseases are not thought to be incurable and that was the reason for that distinction. A terminal pathway is a terminal pathway by definition.

Q We have heard evidence that certainly for a period in the early 1990s a nurse or two B or three nurses at Gosport War Memorial Hospital were concerned about subcutaneous analgesia, in particular diamorphine, being administered to patients who were not cancer patients. There was a concern of that kind or at least a thinking process of a similar kind elsewhere was there?
A There was.

Q We heard evidence from Professor Ford who said in relation to Patient C – Eva Page, C the lady who was suffering from the carcinoma of the bronchus – that in his view it was acceptable and appropriate to prescribe and administer opiates to relieve anxiety and distress, whereas he certainly seemed to be indicating at other parts of his evidence, as you may have read, that in his view opiates such as diamorphine should be administered simply for the relief of pain. What do you say about that?
A The only way to decide is to judge it by the patient. Diamorphine is a valid drug for people in severe distress and various other indications, not just for pain, but it has to be a D clinical decision, done on the spot.

Q It is right to say that he accepted that there was a body of opinion which might hold the same view as you just expressed in the country at large. In looking at your consideration of the position Dr Barton was in, did you go on the basis that when she took on the job in the first place it was on the basis that she understood it would be a commitment which could initially be managed within the time constraints of her comparatively limited sessions?
E A That is what I assumed.

Q And as you have already indicated you proceeded on the basis – I do not think there is any dispute about this – that the nature of the clinical workload at Gosport changed very significantly as the 1990s moved on.
A It did.

F Q In terms of what you have seen of the evidential picture in this case, what do you say about the adequacy of clinical consultant support provided to her?
A Dr Barton was, however competent, untrained in any specialty other than general primary care, general practice, and the patients were managed by a named consultant. There would have been on the notes, maybe even above the bed, the name of that consultant. That is normal practice throughout the world. The consultant was responsible for patient care. My understanding is that the consultant ward round was once a week, sometimes once every two G weeks, and for a period when there was maternity leave not at all – for nine months presumably. Clearly there was a system problem in terms of consultant monitoring of patient care. It may be acceptable if it really is a nursing home type of atmosphere with just long term admissions with no changes, but certainly towards the end of the nineties that was not the case. These people were being discharged from neighbouring acute hospitals with serious medical problems and it would imply there should be consultant cover almost on a two or three day a week basis.
H

Q Similarly with regard to the evidential picture presented to you, did the staffing model at Gosport continue on the basis of low dependency care of elderly patients or did it in any way change as a result of the change in the patient mix?
A I only changed after the various investigations; until then there was no change and there was no change in the back-up professionals such as occupational therapy, physiotherapy, radiology and so on.

Q If that is the right evidential picture I would just like to ask you about the situation that is created as a result for those concerned with trying to care for patients of this rather different kind. It is a truism perhaps for us to state, but perhaps one would make it clear with you, that obviously drugs form an important part of good palliative care. There is no dispute about that.
A Yes.

Q In the context within which we are operating in this hearing there are drugs to control pain, anxiety and distress – I will use those three labels as being convenient shorthand ways of describing it. What about the importance of good nursing care, what would you say about that?
A Good nursing care is vital in this situation and obviously it allows not only psychological care for the patient but also the monitoring on a regular basis of what is happening and therefore there is an inter-relationship between drug therapy and its monitoring and the availability of staff.

Q What is the consequence, therefore, in terms of the practicalities as to what is to be done with any particular patient or patients within a particular category. What are the practical consequences if nurses are trying to provide good care, the clinical assistant is trying to provide good care, but the ratios and the resources are as you understand them to be? What is the practical consequence?
A If we take the relationship between nursing care and drug therapy there is no doubt in my mind that if the availability of nursing care is low and there are few nurses for many patients, then in doing the prescribing you are going to have to start at a higher dose and have a sliding scale to allow decisions to be made quickly. There also was not medical cover as far as I can see, the medical cover was inadequate, and therefore the idea that you could call a doctor and get action within a three or four-hour time period was unrealistic in the set-up as described in the various documents, so the nursing, medical and drugs all are intertwined.

Q You say the impact in terms of what the doctor is going to prescribe and have administered in terms of drugs is going to be affecting the doses. How do you square that with what is in the patient's best interest?
A The idea is to write out a prescription that can be delivered with freedom to the clinical observer at the time; in other words it does not require someone to be called from the other side of Portsmouth to come and make the decision, the people on the spot – who inevitably were the nursing staff – could make a decision about what to do. That is the attraction of having a sliding scale and a subcutaneous pump, it allows the person on the spot to take the clinical decision, looking at the clinical parameters and make their own decision. Of course, different people, different staff, will come to different conclusions, but at least they can do what they think is the best for the patient.

Q Are you aware of the evidence from the nursing staff – although their evidence varied to some degree – about the practice of seeking approval or consent or authorisation (whatever

the right word is) from Dr Barton, in default of her from an on-call doctor, in relation to decisions of that kind?

A I am, and that seemed an eminently sensible way to approach it. If Dr Barton was there she knew all the patients so she could guide the decision. If she could not be contacted someone in the practice who was on call could be contacted, but they would not know the patient so inevitably – and certainly in my experience – you would go with whatever the nurse was asking for, unless there was some special reason not to. The third way is that the nurses make the decision on their own if they could not get hold of anybody.

Q Just looking at it as a matter of practicality, if you had got full resources – say in a teaching hospital – in terms of the administration of analgesia of the kind we are talking about, what is the best picture? Assuming you have got the resources what do you try to do with regard to administering opiates?

A If you have got a patient who is in distress what you really need is to assign much more nursing time – maybe not one to one but getting towards that level. In a teaching hospital there may not be a resident doctor but there will be someone on call 24 hours a day who could come and change the prescription if necessary, so the combination of being able to change the prescription 24 hours a day, to have a doctor there 24 hours a day if necessary and to have good nursing care available, very frequently making observations, is a luxury that was not available, from what I have read, at Gosport.

Q If the luxury is available does that have an impact on whether it is appropriate to titrate doses up? Just give us the picture with regard to what you would do if you had all those resources available.

A If you have all the resources available and you are able to titrate things in real time you do not need to leave a blanket prescription, you can just change it as you go. If the resources are not there you have to leave a wider range to allow whoever is there to adapt to the circumstances the patient finds themselves in.

Q If you have not got the resources to titrate up in steps, say after every four hours checking and so on and so forth, what is appropriate in terms of the initial dose if your objective is to prevent pain or to control pain?

A In terms of diamorphine I would say at least 20 mg to start with.

Q I will come on to that in a moment; so that may be affected by the practical situation you are in.

A Absolutely.

Q Apart from relieving the distress of patients, if you are operating in the sort of circumstances that Dr Barton was operating in, what about the distress of their relatives or close family?

A That can be very distressing. It is part of therapy – one treats the patient but one is treating the whole carer group as well and to see an older person who may be severely demented, suffering because of some physical illness as well, and disturbing the family is profoundly unpleasant. Doing something about that is part of good practice.

Q You have seen the general picture – I am not asking you about individual patients – with regard to opiates being prescribed with quite wide dose ranges and with, as I think you described it, an effective minimal dose.

A Correct.

Q We have covered the picture with regard to what discretion the nursing staff had in relation to the administration of these drugs but in terms of your experience of doctors involved in palliative care teams, do they all share one philosophy in relation to the actual level of the starting dose of diamorphine?
A Absolutely not. In cancer medication the drugs for cancer are rigidly adhered to around the country. If you have 100 oncologists they will be using the same drug dose. If you go to palliative care it is much more subjective how you do palliative care and there is much greater variation between different palliative care physicians about the starting dose and the scales that they use.

Q Can I come back to something you mentioned a moment or two ago in relation to a starting dose with diamorphine. I appreciate different patients and different situations but in general a starting dose of diamorphine of, say, 10 to 20 – or 20 as we have commonly come across in this case – what do you say about that generally speaking, bearing in mind it is subcutaneous delivery by means of a syringe driver over 24 hours?
A To me 20 mg seems a reasonable starting dose.

Q I would like to ask you about plasma levels of active drug achieved over a 24 hour period. What do you say about that in terms of the level?
A The plasma level – one is trying to achieve a level where one can get rid of pain over a smooth curve of 24 hours and the levels with 20 mg depend on how quickly the drug is metabolised, how quickly it is destroyed by the body. That is a variable and we have seen the two charts, the two hours and the four hours, which show that in both cases you inevitably reach a plateau.

Q In relation to the sort of plateaus, appreciating it varies from patient to patient and so on, but just looking at the broad brush picture, with those sorts of levels of morphine in the body would they be such as to be likely to lead to dangerous side effects? Just taking our 20 mg administration.
A Over a 23 hour period, even in an opiate naïve patient – someone that has not received opiates before – it would not lead to serious consequences in most patients.

Q Again, there is no dispute in the evidence in this case that whether a patient has been on some form of opiate before subcutaneous administration may affect, first of all, when you start subcutaneous analgesia and the amount that it is appropriate to administer.
A That is correct.

Q That, I think is a given in this case. It is also the case, as you will see from the pattern of the prescriptions, that the analgesia administered in the form of diamorphine, also on many instances had the addition of a sedative or tranquilising drug, midazolam?
A It did.

Q First, in general terms, anything unusual with patients falling into this sort of category in the administration of diamorphine and midazolam together?
A No, and indeed the BNF is quite clear. There are a series of drugs tabled there that can be given in the same syringe driver at the same time.

Q In terms of any other drugs that had been administered in the syringe driver in this case, haloperidol is one we have seen from time to time and also hyoscine?

A That is correct.

Q Looking at those.
A They can be mixed and the are used for different indications; haloperidol for people who are severely distressed and agitated depression, and hyoscine especially if the terminal event involves a lot of fluid gathering in the lung which is very distressing both for the patients and for relatives. Hyoscine essentially dries up the membranes of the lung.

B

Q In terms of the dose, the dose needed of an analgesic and an anxiolitic in relation to the dose, the amount, when considering the need to allay symptoms in the individual patient in general, is that affected by the increase that patients experience as a result of fear, isolation, unfamiliar environment and so on. Does that affect the dose that you think it is appropriate to administer?
A I believe it does and, basically, pain has multiple components and anxiety, distress and lack of familiarity increase fear. That fear means to get the same analgesic effect you have to give more drug. That is why cocktails of drugs, midazolam with diamorphine, are effective because one takes away some of the fear allowing the analgesic, where there is pain, to have a better effect.

C

Q So one has to be looking at the combined effect and the combined situation?
A Exactly, and the art of good palliative care is to make the decision as to what the key problem is to vary the doses appropriately.

D

Q In terms of patients who are on the terminal path, an expression that has been used in this case more than once – I am looking at your report on page 6, the third paragraph down – you deal with what you describe as dying patients. I would like you to deal with the question of the size of the dose that may be appropriate because, obviously, a given in this case, you do not have to worry about drug dependency with regard to a patient in that situation?
A One of the fears in giving opiates to any patient is that they will become dependent on the drug and you will have to wean the patient off the drug just like an addict. That does not apply to people who are dying, whatever the cause of that death. The only way to sort out the correct dose is to make individual patient assessments. Physicians who are not in palliative care, or indeed in oncology, tend to be very sparing on opiates and one of the problems in many general wards for surgery and medicine is that there are patients in serious pain even still, and palliative care education is one of the ways to try and deal with that.

E

F

Q You have already covered the point, and we have already heard it from other witnesses in this case, that pain and distress are enormously variable from patient to patient. We have heard about what the severity of the pain may depend on and you have covered that in your evidence. In terms of the causes of deterioration – you will have seen from the transcripts you have read that patients are described as deteriorating and so on – I am not asking about individual patients in this case but, in general terms with elderly patients with multiple sometimes comorbidities, what is the practicality in terms of the clinician endeavouring to establish the cause of the deterioration?
A In most of the situations where patients are deteriorating, especially if they are doing so rapidly, there is absolutely no point doing more investigations. At Gosport it would not have been possible to get urgent investigations, x-rays or blood tests and unnecessary to do so. Only good clinical decision making can really contribute and a clinical assessment on the spot by a doctor or nurse and a decision how to vary the drugs appropriately.

G

H

Q If I could ask you to deal with this issue in general terms. In terms of the doctor concerned, in this case obviously the clinical assistant Dr Barton, trying to determine what is the product or what is the contribution of the medication you are providing to control symptoms as to where the balance lies, how can you check whether you are right?
A The only way is to go back an hour, two hours, later and see what has happened. It is a continuous circle of monitoring and then varying the dose appropriately, changing the composition of the drugs in the syringe driver appropriately.

Q What do you say about the stopping of subcutaneous analgesia, first stopping it to check whether the patient is suffering more from their condition or more from the sedating effect of the drug or the respiratory depressive side of the other drug that has been administered?
A I think it would be very difficult to do that. It is very rarely done in any clinical situation when one knows the patient is on the terminal pathway. It would almost, to me, be unethical to make the patient suffer unnecessary pain in the last few hours or last few days of life by doing that experiment.

Q What about reducing to see if the pain breaks through again. What is the appropriate approach there?
A That is certainly possible, but on the whole a good clinical assessment would mean that it is unlikely that you get to a point in a dying patient where you start reducing the dose.

Q The reasons for that being unlikely with a patient who is on a terminal pathway?
A Because, inevitably, if you reduce the dose enough, you will get symptoms coming back and why would you want to see that?

Q In your report you dealt with the issue of, what I always mispronounce, parenteral fluids. I do not think it is an issue that the Panel is any more concerned with in terms of allegations in this case because it is clear that at Gosport they did not have the facilities to hydrate patients in that way and we have heard about the different views as to the propriety of trying to hydrate in these sort of circumstances. If anyone wants to raise the issue with you, no doubt you can deal with those questions but I am not going to ask you about it.

THE CHAIRMAN: Mr Langdale, the witness has been up for a little over an hour. Would that be a convenient moment?

MR LANGDALE: Yes, I do not have a great deal more, but it is more than five minutes.

THE CHAIRMAN: We will have a break now. You will be taken somewhere you can get some refreshment and some rest before you come back for further questions. I am going to say 15 minutes, 11.20am.

(The Panel adjourned for a short time)

THE CHAIRMAN: Professor, you of course remain on oath. Mr Langdale?

MR LANGDALE: Professor Sikora, I am dealing with matters which are contained on page 7 of your report. I have covered issues with you with regard to the combination of anxiolitics, such as midazolam and haloperidol with diamorphine and so on and I am not going to go over that material with you again. I would like to ask you about the practical

position. In a hospital with full resources, if a doctor is able, with the aid of nursing staff and so on, to give a much more closely monitored assessment of the condition of a patient than if the resources are rather more limited because of the practical consequences of lesser resources, if it is the case that a doctor with less resources, with the sort of resources that we are talking about at Gosport War Memorial Hospital, is aiming to control pain and distress symptoms to prevent the patient suffering from pain and distress and with any one possible dose range – just take a dose – at which to start the administration of subcutaneous analgesia or indeed the level to which it is to be increased, if there is no absolute set rule as to precisely how much should be prescribed, there is a variation, in terms of a doctor tending to go higher rather than lower within the possible or permissible range, what do you say about where the choices really lie?

A I would believe the choices lie between increased suffering if the dose is not enough, or increased suffering is the delay in which you can get someone to rectify the low dose to convert it to a high dose, or starting at a higher dose. If there is one to one observation, if there is a doctor on call who can change the prescription, it is a very different situation to what was happening in Gosport.

Q You have covered the position with regard to anticipatory prescribing which you touch upon in relation to the third paragraph of this particular page of your report, and I am not going over the procedure, you have already indicated what your understanding of it was. What effect does the reduction of staff levels proportionate to the increased and different patient mix, what effect does that reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?

A It means that there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore, using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances.

Q Did you take on board the fact that so far as you could judge it – it is for the Panel to decide, not you, but as far as you could judge it – what Dr Barton was doing had the approval, certainly did not have the dissent, of the consultants, nursing staff and pharmacist?

A Absolutely, and there was no formal appraisal in those days and clinical assistants were exempt from appraisal until relatively recently so there was no mechanism of feed back, but there was tacit acceptance. The charts were written up and if a consultant does not look at the chart that is his responsibility in my mind.

Q Looking at the situation in general terms with regard to the general practice and the general procedure adopted by Dr Barton, taking into account the position that she was in – we have looked at the different aspects – what is your view as to what the alternatives were in terms of being available to her?

A She could live in the place 24 hours a day, that would be one alternative, or otherwise what she did seems to me perfectly reasonable. As I say in the report, it is a very vulnerable end of health care all over the world. It is a forgotten area, it is an area which not much is invested in; nothing to do with the NHS, it is throughout all health care systems.

Q Would you enlarge on that. You say "a vulnerable area" and isolated as it were, what do you mean by that?

A Isolated because geographically it was isolated from mainstream medicine. Junior doctors were not available to Dr Barton or the whole of Gosport War Memorial Hospital.

A The patients had multiple comorbidities. Once they went into the terminal phase they were outside mainstream medicine. That is quite fair, they needed to be given symptom control in an environment which is not luxurious in terms of staffing.

Q You say this is a world wide problem. In relation to palliative care generally, do you mean?
A Britain has exported some of the finest palliative care regimens outside to the rest of
B the world, I think we have driven that. There is no doubt that palliative care all over the place is under resourced and terminal care particularly so.

Q Considering the position again, broad bush, what were the practicalities, apart from walking away from the job, for any doctor in terms of doing anything different to what Dr Barton did?
A Developing systems internally to try and cope with the problem, which I think she
C did; trying to lobby for more staff which, from reading the various bits of evidence, she did. One of the problems is that it was an outpost of the main Hospital Trust and, therefore, the management control did not seem to be clear how the place was being managed from the centre. How would you actually go about getting better resources and whose responsibility was it? I would say it was not the responsibility of a five session clinical assistant to have to do that.

D MR LANGDALE: Professor Sikora, that is all I am going to ask you because were you not asked to look at the individual twelve patients and check all their records, and so on and so forth. Obviously you have seen material relating to them in your reading of the transcripts, but I am not asking you to go into individual cases. That is all from me at this stage. Would you wait there because you will be asked some more questions.

THE CHAIRMAN: Thank you, Mr Langdale. Yes, Mr Kark.
E

<u>Cross-examined by MR KARK</u>

Q Professor Sikora, I was going to start where Mr Langdale left off. That was to just examine with you what you have not reported on, as it were. So far as the material that you were given, I do not think you were given any of our patient notes, were you?
A That is correct.
F

Q So you have not actually examined the individual cases of those patients?
A That is correct.

Q In terms of what the Panel have looked at but you perhaps did not – and this is not criticism of you whatever – although you had Dr Barton's statements, the notice of inquiry, Professor Ford's reports, and you have read his evidence and her evidence – I do not think
G you were given the patients' relatives' statements?
A No, I was not.

Q The nurses' or the consultants'?
A I have seen the transcripts.

Q You have seen the transcripts – of whom?
H A The consultants.

Q And the nurses?
A Some of them.

Q And the actual prescriptions that were written by Dr Barton. I know, obviously, you have seen the reports about them. You have seen what people said about them. Have you examined the prescriptions yourself?
A I have not examined the original prescriptions.

Q For that reason, quite properly, you have not sought in your report or your verbal evidence now to comment on the treatment of any of the patients?
A That is correct.

Q So far as your own practice is concerned, you are a cancer specialist?
A I am.

Q You are, if I may say so, a very well known cancer specialist. You would not class yourself as a geriatrician?
A No.

Q And obviously you deal frequently with people who are in the terminal stages of illness, do you?
A I do.

Q And have to be treated with palliative care or by palliative care?
A I do.

Q As you are probably aware, I think only one of our patients in fact had a carcinoma of the bronchus?
A That is correct.

Q Just thinking about the position at the Gosport War Memorial Hospital obviously you have not practised anywhere similar to that community hospital, or the like?
A I have been responsible for palliative care in a community hospital.

Q In a consultant role?
A No. In a management role.

Q As I think you commented in your report, there are various things one can say about the Gosport War Memorial Hospital. First of all, there seems to have been a lack of supervision over what Dr Barton was doing?
A That is correct.

Q It may well be that the consultants whom you have spoken about were not as available or indeed as active as perhaps they should have been?
A It is difficult to judge.

Q And you have also spoken about the changes in the nature of the patients in the latter half of the nineties. Just looking at that for a moment, that was a nationwide problem, I think. That is not restricted to the Gosport Peninsular, is it?
A No. It is ubiquitous.

Q That was happening, fortunately or quite possibly unfortunately, in community hospitals up and down the country?
A Correct.

Q And so people in Dr Barton's role – and her role, again, was not unique, was it?
A No.

Q The role of clinical assistant where a doctor would be visiting a community hospital and not there on a full time basis is – was – a very well known position?
A Correct.

Q And so people in Dr Barton's role would be having to deal with that sort of change nationwide in community hospitals, up and down the country?
A There would be local variation on the severity of the issue.

Q Absolutely. I absolutely take you point, and we all understand, that when a doctor is prescribing for a patient, and you have very much highlighted this, it is important obviously to observe the signs and symptoms of a patient?
A Correct.

Q And I think in your report you commented on the difficulty of going back through sparse, sometimes sparse, notes and then forming an opinion about the management of the patient?
A Correct.

Q I expect that you accept that there are circumstances where a prescription can be so obviously wrong, or a plan of treatment or lack of treatment can be so obviously wrong, that an expert is entitled to comment?
A Yes.

Q Because that, of course, is the nature of expert evidence?
A Absolutely.

Q So far as the issue of note-making is concerned, you have not commented on it particularly but, again, the vast majority of doctors working in a hospital environment, particularly one suspects in the NHS, would describe themselves accurately as very busy?
A Yes.

Q And quite possibly overworked?
A Possibly.

Q And perhaps particularly geriatricians?
A The numbers of patients involved are large.

A Q And although we know that doctors are taught to make notes about everything that they do, it is not always possible?
A No.

Q Some notes, I expect you would agree, are rather more important than others?
A They are.

B Q I am going to run through it, if I may. A note of an assessment when a patient first arrives at a hospital can be fairly critical to give the doctors and nurses a starting baseline?
A It can.

Q Such a note can be critical for the future care of the patient, because without it you do not know where you started from?
A It can.

C Q You would expect, would you not, in general terms for major changes in the condition of the patient, or deterioration of a patient, to be made?
A Yes.

Q You would expect in general terms for major changes in the management of a patient to be noted?
D A Yes.

Q And when there is a major change in the drug regime, and by way of example, starting opiates where a patient has not been on opiates before, you would expect a careful note to be made about that decision?
A Yes.

E Q And the decision to enter into non-curative palliative care is a particularly important decision in a patient's life, is it not?
A It is.

Q And is that something which in your own practice you would either note down yourself, or I expect now you may be too lofty to do so, but you would certainly ensure that doctors under your management would note it?
F A Yes.

Q You have spoken about starting doses. I think in your report you say this:

"A range of starting doses between 10 mg to 20 mg"

– and you are referring, I think, to diamorphine?
G A I am.

Q

"A range of starting doses between 10 mg to 20 mg subcutaneously delivered by a syringe driver over 24 hours would in my opinion be reasonable."

A Correct.
H

A Q In what circumstances?
A When someone has chronic pain. When someone is chronically agitated and is going into a terminal phase of their illness.

Q Plainly you would not write out such a range unless you felt there was good reason either for believing that the patient was at that time in chronic pain, although perhaps that is a misnomer. Chronic pain means long term pain, does it not?
B A Correct.

Q Or very soon to be visited by serious pain?
A Yes.

Q In general terms, and you have been dealing with this sort of patient for a long time, a range of the starting dose between 10 and 20 mg – is that something that you yourself have
C written in the past?
A Yes, yes.

Q And it is the sort of prescription that you would expect to see among those practising under you?
A Yes.

D Q What matters, of course, is the patient, as you said, in front of you?
A Correct.

Q And an attitude of "one size fits all" would be wholly inappropriate, would it not?
A It would.

Q You also said in the course of your evidence, and this was not quite consistent with
E your report, I think you said, "A starting dose of 20 mg seems a reasonable dose". I did not quite understand in what circumstances you intended that to be read?
A I think in a unit where the doctor cannot return within an hour, and where the staff ratios are relatively low. There it would be reasonable to start at 20 mg rather than 10 mg, for example.

Q But for what sort of patient? What are you referring to?
F A For a patient who is either in pain or severe distress, or likely to be in pain.

Q Over what time period? Presumably before the doctor can get back?
A Yes. Twenty-four hours, I would assume in this case.

Q I do not know if you are aware of this, but in relation to this particular hospital, we have heard a number of things about the cover that was available there.
G A Right.

Q We have in fact heard that there was effectively – that horrible expression – 24/7, but there was in fact round the clock on-call cover. Were you aware of that?
A I was, but it was clear from some of the statements that that cover was very variable in terms of its actual delivery.

H

A Q So far as the starting dose is concerned, you have spoken about the WHO, the analgesic ladder. I just want to ask you a little bit about that. Do you still have that binder near you? You have been an adviser to the WHO, although in a different capacity of course, and I do not think you took any role in the devising of these particular guidelines. Indeed, the analgesic ladder, I expect, has been around as long as you have, Professor Sikora?
A Yes. It was there twenty years before I arrived.

B Q It is a very well known basic medical principle, really. Does it go hand in hand with the titration of doses?
A It does. It does, and the ladder itself is about the type of drug, so by the drug, by the route, by the clock and by the patient. These are the four bits in the WHO, but the ladder is specifically about moving from mild pain control to severe pain. One of the problems right across the world is the unwillingness of systems to actually move patients through to the severe pain when it is indicated.

C Q And these guidelines and, indeed, the guidelines in the BNF that you have not looked at, but these guidelines are devised to deal with people potentially in chronic pain?
A That is the case.

Q People dying of cancer and other serious illnesses?
A The guidelines were made for cancer but, as I think I said earlier, the palliative care
D movement across the world is adapting very similar guidelines to other areas of terminal care outside the oncology world.

Q And the guidelines, can we assume, were devised by people on the basis of knowledge built up from dealing with patients in chronic pain?
A And it applies also to acute pain that is not caused by something ---

E Q You are quite right. You are quite right to correct me. I keep using "chronic pain". I mean both chronic and acute pain.
A Yes.

Q So it is to guide those who are dealing with patients at the patient's bedside, perhaps, who are in serious pain?
A Correct.

F Q This is not a purely academic exercise, is it?
A This is not an academic exercise.

Q You do not have the BNF or the *Palliative Care Handbook* in your pocket, as it were, and then you throw them out of the window as soon as you are confronted with a patient?
A Exactly.

G Q These are there to help you prescribe for the patient in front of you in chronic or acute pain?
A They are also there to help health workers, whatever their rank, to give benefit to patients.

Q We have heard quite a lot about the effects of these drugs on the elderly. Again, I do
H not want to spend very much time with you on this issue, but I do not think you have been

A asked to deal with it specifically. Again, we have looked at the BNF. We have looked at the palliative care guidelines. It is a well known principle, is it not, and fact that the elderly are more susceptible, more sensitive, to the use of opiates?
A That is the case.

Q And just by way of example, the sort of half lives that we are looking at in these two documents, that the defence have produced, D7a and b, if one is dealing with an elderly
B patient, possibly with renal impairment, you would not be looking at a two hour half life, would you?
A No. It would be nearer four.

Q Four or above?
A Could be above.

C Q Let us put 7a away, and let us look at 7b. What I think you said was that it demonstrates that there is a plateau at 13 hours and the effectiveness of the drugs goes up a small margin, as it were, beyond 13 hours, but it reaches its effective point – is that fair – at the 13 hour point?
A It probably reaches it in some patients a bit before that, but then it plateaus off slowly.

Q Just looking at the column on the right hand side, and I am focusing on 7b because it
D is much more relevant to elderly patients, is it not than others?
A It is.

Q We can see that after five hours you in fact only reach 2.71 mg?
A I think it is 3.13.

Q I am sorry. Thank you. It is the one below – 3.13. And so 3.13 mg; if you had a
E patient who had what I think is described as breakthrough pain ---
A Yes.

Q --- and you wanted to give them an immediate relief from pain, you might give them – what – a 2.5 mg dose or a 5 mg dose by injection?
A That would be possible, so you get an immediate spurt of plasma level.

F Q And you would hope, would you, that that sort of dose would deal with breakthrough pain?
A It could deal with the breakthrough pain, but then you would have to do it again in four hours.

Q I understand that.
A It may not be possible.
G

Q I entirely understand that. That is the peaks and troughs problem?
A Correct.

Q What this does demonstrate is that a syringe driver is not actually very well equipped to deal with a patient who is suddenly in pain?

H

A A Not a patient that is suddenly in pain, but that is usually not the case. The patients develop pain slowly and the attraction of the syringe driver, once it is there it goes on smoothly for 24 hours a day.

Q In terms of setting your starting dose with a syringe driver, and we have talked about the analgesic ladder and titration, it is important if at all possible to have titrated to the dose which you want to start the syringe driver at. That is very bad English, but does it make
B sense?
A That would be the ideal situation to go for, to have either oral morphine or long-acting morphine or, in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine.

Q Because unless you do that there is a serious danger that you are either going to start too low or too high.
C A That is the case.

Q With your syringe driver.
A Exactly.

Q I have dealt with the *Palliative Care Handbook* and the WHO guidelines but the principle of titration does not go out of the window because you are dealing with a patient in
D pain; it is very relevant, is it not, for a patient in pain?
A It is. One of the reasons the subcutaneous drivers are not mentioned in any WHO book is because they are from low resource environments where you do not have the luxury of them, but they are recognised as a superior form of long term pain control.

Q The principle of titration does not mean, does it, that you need to have a nurse sitting watching the patient for a 24-hour period at the bedside, it means fairly regular review and
E occasional notice, is that fair?
A It does, but it also means variable prescription and, if necessary, injections every four hours.

Q Certainly, but if you were trying to titrate the dose to get to a point where you knew you could control the patient's pain, presumably you would have your nurses observe the patient every hour or two – sorry, you are nodding.
F A Yes, that would be the case.

Q And then make a note of it every four hours perhaps.
A Yes.

Q I think that actually is the guidance given by the Liverpool Care Pathway, is it not?
A It is.
G

Q You spoke about the use of opiates and I think you were talking about for a dying patient.
A Yes.

Q Who is very fearful and agitated.
A Yes.
H

Q Do you yourself use opiates in those circumstances?
A Yes, I have done.

Q You have done.
A I have done.

Q Can you just tell us something about the circumstances in which that occurred?
A Death is very difficult to deal with for all of us, however experienced you are at seeing it, and the specialty of palliative medicine has made it much easier for the broader community of physicians and other health professionals. Sudden declines are very common within a 24-hour period – a patient goes from being relatively stable into a decline – and with older people it is very difficult to work out what the cause of that decline is. If patients are in pain or distressed then some form of medication is necessary, and that can be done in a variety of routes. Ideally one begins with the oral route but often patients cannot take it – they have sickness, they vomit up the drug that is given, and therefore converting to a parenteral route is the next step. The advent of subcutaneous pumps about 20 years ago through palliative medicine really changed the way in which the terminal pathway can be implemented in patients that are estimated to be within three or four days of death. One of the problems is that it is very difficult to make that estimate, it is very difficult to know the true situation, and I have certainly seen that in my patients – that patients have died much more rapidly than I would ever predict and, conversely, people have hung on for weeks.

Q It follows from that that if you take the decision that your patient is on a terminal care pathway too early you may get it wrong.
A You might.

Q What I was asking about in fact was the use of opiates in the agitated and distressed dying patient who is not in pain, and I was asking about the circumstances in which you yourself have used opiates in those circumstances.
A Can you just repeat that – the patient in pain or not in pain?

Q Not in pain.
A Okay.

Q Do you use opiates in those circumstances or do you use sedatives?
A No, I use opiates and sedatives.

Q Can you just tell us about the circumstances?
A The most vivid memory is a patient who was in severe distress, a relatively young man, not an old patient, and we just could not get rid of the pain – sorry, we could not get rid of his distress. He was not in any pain.

Q What was his distress arising from?
A A fear of death. He was extremely agitated and it could not be allayed by his family; the nursing care was superb, we were well-staffed. We decided to put a subcutaneous pump in and give diamorphine.

Q That was to give the patient a sense of euphoria and calmness.
A A sense of euphoria and a smooth passage.

A Q Right. Was that a relatively unusual event?
A Unusual in a young person, not so unusual I do not think in older people.

Q You have spoken quite a bit about diamorphine, but of course in this case I think it was invariably used in conjunction with midazolam.
A Correct.

B Q You can confirm, can you not, that midazolam itself has a powerful sedating effect?
A It does.

Q One therefore has to be doubly cautious when using the two together.
A Yes.

C Q I am sorry to keep coming back to it, but it is relevant to what you just said, if a patient is on a terminal care pathway we can take it that that does not avoid the necessity of using the analgesic ladder or the guidelines so as to ensure you are not over-sedating.
A Correct.

Q Because the danger is otherwise that you can end up with an unconscious patient who does not need to be.
A That is correct.

D Q Or a dead patient who does not need to be.
A Correct.

Q You spoke about the possibility of stopping a syringe driver completely perhaps in the circumstances we have heard in this case, if a relative wanted that to happen. There would be no difficulty, would there, if there were strong reasons for doing so, good reasons for doing so, in reducing the amount of opiate to see if you could find yourself in the position of having a conscious patient but a patient without pain.
E A There is a fine balance and it can only be done on an individual patient basis. People do not die from at one moment being completely well and pain-free and not distressed and then at another moment they keel over and that is it. That is not the sort of patients that were at Gosport in any case.

F Q I entirely understand that but if you have a patient who one day has been talking and eating, let us say, and the next day is unrousable and a relative wants to be able to speak to that patient to find out if that is the state in which they wish to be, you would consider, would you not, reducing the dose if you felt it appropriate so that the patient could be roused to speak to?
A It would depend totally on why they had been started on that but just to do it for the relative's wish to speak to them is not reasonable I would have thought.

G Q It depends on the level that was needed in the first place.
A It depends on the whole clinical circumstance.

Q You spoke about the possibility of having to start at a higher dose than you would otherwise want to if you have inadequate staffing levels, and I just want to ask you a little bit about that. Was it your understanding and the basis for that comment that the nursing levels
H at this hospital were inadequate?

A A They seemed to be inadequate from many of the documents I have read towards the end of the period, in the late nineties, not so much the beginning of the nineties.

Q Can I just read a comment. We have heard from a lot of nurses and I am just taking the words of a nurse that we heard from just yesterday, a sister, who was asked this:

> "Did the nursing notes suffer in any way as a result of the increasing workload?
> A No. I must point out I had an excellent team of nurses. I am afraid I am a bit old school and I like to think my standards were quite high and my nursing staff knew of this, and if there had been any backlash from this, they would have either come to me or gone to management and it would have been discussed, but I never found that the extra workload affected my nurses' care in any way at all."

B

That was Sister Joines. If the position was in general terms that the nursing care on these two wards that we have been dealing with has been described as either very good or excellent, yes? You are nodding and it will not appear on the transcript.

C

A Yes.

Q Although Dr Barton's time was plainly limited, as we have heard, we have heard from a number of nurses that although the patient type changed and they had to account for that, the patients did not suffer as a result.

D

A Right.

Q You are not saying, are you, that in the circumstances in which Dr Barton found herself at this hospital she was entitled to ignore either the *Palliative Care Handbook* or the *BNF* when writing out her prescriptions?

A Well, did she ignore it?

E

Q Apparently, yes, she said so.

A Okay.

MR LANGDALE: I am sorry, that is not what her evidence was. She was not saying "I ignored ..." She was well aware of what was in the *Palliative Care Handbook* and the *BNF* and she took her decisions for reasons which she explained to the Panel. She was not ignoring it in the sense that my learned friend is suggesting.

F

MR KARK: We will have to check the transcript. My recollection is – perhaps it does not matter what my recollection is but certainly Dr Barton accepted that she was not following the principles in either the *BNF* or the *Palliative Care Handbook*. I do not know if that is challenged as well.

MR LANGDALE: You say "the principles" – she gave the reasons why she prescribed as she did and the reasons for them not being according to specific guidelines set out in the *BNF* and the *Palliative Care Handbook*.

G

THE CHAIRMAN: Can we work on an agreed basis that she made a conscious decision not to adhere to the guidelines. Would that be a reasonable way of proceeding?

MR LANGDALE: Speaking for myself I think that covers it.

H

MR KARK: We have a measure of agreement. Can I just ask you this: are there circumstances in which you yourself have taken the decision not to adhere to the guidelines?
A Yes.

Q What have those circumstances been?
A Relevant to this to give much higher doses of analgesics in certain circumstances.

Q Can I ask you what those circumstances were, please?
A They are all related to cancer and they are all in patients with really severe pain and in one case distress and agitation that was really very distressing for the family.

Q Were you there on the spot?
A I was there on the spot. I was called by the senior registrar who was not able to deal with the situation. It is very unusual but it does happen, even in a very well-staffed environment.

MR KARK: That is all that I ask, thank you very much.

Re-examined by MR LANGDALE

Q Professor Sikora, two matters arising out of the questions you have just been asked by Mr Kark. May I take up the last matter you were asked about when you said what you yourself had done. In terms of the *BNF* is there any guidance in the *BNF* as to the dose that is appropriate in patients who are on a terminal pathway?
A That is avoided in all literature because there is no written dose that is standard, it has to be decided on the spot.

Q Something that you said earlier on when Mr Kark was asking you about the analgesic ladder and so on and asked you to look at the particular passage in the *Palliative Care Handbook*, you said if I have noted it correctly that there was a reluctance – I think you said worldwide – to move to the higher strength or stronger opiates. I may not have got your words down precisely but in broad brush terms is that what that was saying?
A That is correct.

Q Could you just enlarge on that?
A In many countries it is not the availability of the opiates, it is the willingness to use them. Often on cancer wards the patients gain because people are used to it but on non-cancer wards there is much more hesitation. That is changing but it is there. There are also professional differences, so nurses may be much more reticent to use opiates compared to physicians and I guess it is to do with the recognition that the patient really is terminal. Nurses that are there caring for the patient all the time may not wish to acknowledge that inside and therefore are much more hesitant before committing a patient to that, and that may be one of the reasons for the difference.

Q There has been some evidence – I do not know whether you will have picked it up in the transcripts that you yourself have had the opportunity of reading or not – that in the hospitals, the common hospitals that we have been encountering in these cases – the Haslar and also the Queen Alexandra Hospital, the two main local hospitals – there was some evidence to the effect that in the hospitals for patients who had received some kind or surgical

intervention or some kind of acute treatment as it were there was a tendency to tolerate higher levels of pain in patients than you would find, perhaps, elsewhere.
A Absolutely, that is a common phenomenon in all hospitals. When I had my appendectomy I made sure I got my own private bottle of analgesics.

MR LANGDALE: We will not go into that. That is all I need to ask you about that. Sir, that is the last of the questions I need to ask in re-examination. Thank you.

THE CHAIRMAN: Thank you Mr Langdale. Professor, we have reached the point when it is for the Panel to consider whether they have other questions for you. I am afraid we operate in a somewhat lower gear to learned counsel and we are unlikely to be in a position to launch straight into questions. What I suggest, Mr Langdale, Mr Kark, is that we go into camera now for the Panel to consider such questions as they may have and say at this stage not before two. After the luncheon break hopefully we will be in a position to proceed.

Professor, we will rise now. You remain on oath so please do not discuss the case with anybody during this period. You are very free to leave the building and you can have, as a consequence, a somewhat longer lunch than might otherwise have been the case, but please be back here for two, at which time I hope, but cannot guarantee, that the Panel will be in a position to go forward. Thank you very much indeed, ladies and gentlemen.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

(Luncheon adjournment).

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back everyone. I am sorry we lost an additional half-hour but it just goes to show I was correct when I consoled Mr Jenkins with the observation that my time estimates are no better than his.

Professor, I remind you that you remain on oath. What will happen now is that individual members of the Panel will put their questions to you. When we have done that, there is a final hurdle, which is that counsel themselves have an opportunity to ask you any questions that might arise out of any of the questions that we have asked. Is that clear?

THE WITNESS: Thank you, yes.

Questioned by THE PANEL

THE CHAIRMAN: Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Professor Sikora, much of the evidence you have been giving us is related to terminal care and patients who are on a terminal care pathway. I understand you to say that when moving on to a terminal care pathway, there is an expectation, there is a clearly defined diagnosis, that we have patients for whom there is no further cure for their medical conditions.
A Right.

Q Part of those medical conditions is really around extreme pain so the management of that pain takes the priority. When we are considering the patients we are considering through this hearing, we have patients who have been admitted to the hospital for continuing care and for rehabilitation. They have then speedily moved, seemingly speedily moved, on to a terminal care pathway. What standards would you expect there to be in place as we move into a different pathway?

A In an ideal world, you would want to compare this unit with another unit. You would want to be able to audit. Audit really came in acute NHS facilities around the time of this incident, during the 1990s, but, even to this day, has not come to the chronic long term care environment in the way one would like. What one would really like to see is, using information technology, was there something different going on during different time points and you cannot do that because there is no comparator. You are quite right, it is difficult to know retrospectively. One assumes that patients are going there for chronic rehabilitation and that was something that changed with time, and a certain percentage of those patients will suddenly deteriorate over a week or so and go into a terminal phase. I do not know from the evidence I have seen what the denominator – we know there are 12 patients being considered here – I do not know what that was out of. Was it out of 20 patients in which case it would be a little alarming, or was out of several thousands of patients which would make it not alarming?

Q I accept what you are saying, but I would like to direct your attention not to any particular patient, but if we are thinking around any standard relating to any particular patient as you are moving from one to another, so protecting the patients' interests and all those sorts of processes, what are the sort of standards that you would expect around processes for individual people to protect their interests?

A One would like to see a multidisciplinary team discuss the patient before doing it. However, that, certainly with the staffing structure as alluded in the evidence, would not be possible. I do not believe there was a conventional multidisciplinary team meeting to do just that, certainly not one that can be convened quickly to deal with a patient who is deteriorating over a 24 hour period, for example. To my knowledge there are no written standards of that sort of thing around, certainly in the 80s and 90s. Now people are much more careful about starting a terminal care pathway and document it much more thoroughly, but 10 to 15 years ago this was not the case.

Q Although there was not a disciplinary team, there were consultants around that Dr Barton could consult with, who perhaps were the people who were responsible for those patients when admitted. What would have been your expectations round that?

A My expectation would be that Dr Barton and the nursing team would make the decisions and the consultants would ratify it when they came round. I would not have thought they would come especially to see a patient out of hours. That would be unusual and really not possible. It is clear that the consultant's attendance was not on a regular basis for some of the time, it was not even weekly some of the time, therefore you could not get that ratification, so I think Dr Barton and the team of nurses are acting on their own in many ways with the sort of decision. They would not be able to get advice as to whether to go or not go on a terminal care pathway, they would have to make the decision themselves.

Q You are saying that in a multidisciplinary team meeting everyone would have had to have seen the patient to have made that decision?

A A Not usually, but some of the staff would have seen the patient but they would sit around, discuss the patient, those who had seen would contribute and then an agreed decision would be made, but that takes time.

Q It does, but it is a far cry from it then becoming Dr Barton's decision and the nurses' decision?
A I understand.

B

Q What would have been an intermediate step – phoning the consultant, discussing?
A It would be difficult for the consultant to contribute down the phone. I think he or she would have to come and visit if they were going to make a meaningful contribution. They could be contributing to policy but not to an individual case.

Q Let us look at another standard about the choice for patients. What about patients' C involvement? If a patient is suffering from dementia and is not articulate and cannot contribute, that is one set of circumstances, but when patients are actually articulate, what about their actual involvement in the choice about whether it is going to be terminal care or perhaps more invasive surgery?
A I think it is very rare surgery versus terminal care, it would be very unusual for that to happen. Involving patients is something that, again, there has been a huge change of patient empowerment over the last 15 years. My clinics with new cancer patients take a lot longer D and my colleagues in cardiology say the same thing. All the options are gone through and the patient is then involved in choosing the decision-making. That certainly was not the mode of operation in the 1990s – the challenge in these particular circumstances, the very age of the patients in many cases and the fact that they had multiple comorbidities. Many of the cases, I am sure, reading the evidence would not have been able to take part in the decision-making in a meaningful way. Their families would but they would not.

E Q I will bear in mind within that that you do not actually know the individual patients because you have not looked at their circumstances.
A Exactly.

Q I move on to a slightly different point, because all the time we have to look at how we protect the interests of patients. You said that in terminal care it is open to the discretion of the clinician, the doctor, as to the dosage of opiates that actually may be used. What F safeguards should there be in place to prevent that patient being over dosed?
A Audit and monitoring: in other words, the pharmacy; there should be monitoring in what is going on in real time with good information technology, which was available – local computer programmes were available but not in place; consultants checking protocols and checking that policy is adhered to; nurses who were also involved in this should be the same; and management, who are ultimately responsible for day to day operation and strategic development, should also be involved in the process. There should be checks. The difficulty G is the change in era. Today there are checks everywhere and people are very conscious of this aspect. In the 1990s there was not anywhere.

Q Clinical governance was in place, was it not, in the early 1990s?
A I suspect Gosport was the sort of place where governance reached last because of the nature of it.

H

Q From the perspective of the personal accountability of the doctor, how would you see the standards being managed? You talked about the audit and you have talked about management and overseeing the doctor, from the personal accountability of the doctor when making such critical decisions when to move someone into terminal care, how would you see that doctor making sure that their standards were very transparent and overt?
A I imagine the best way in those days was discussion with the consultant ultimately responsible for that patient – named consultant, named patient – and Dr Barton; obviously, if it cannot be done immediately at the next available opportunity. The problem, again, from the evidence is that the consultants were busy, mainly elsewhere. It is not that they were not working, it was just that were tied up in clinics and ward rounds elsewhere within the Portsmouth system. To them it is relatively low priority.

Q Is that sufficient justification for the doctor not to make that a priority?
A Dr Barton or the consultant?

Q We have heard that the consultants could be available. If Dr Barton wanted the consultants to be available, they could be available. You are saying that a good standard would be for the doctor to discuss the patient's condition with the consultant and then to jointly form a decision, or at least discuss it the next time that the consultants are on the ward. I am looking at the standard for that and you are saying they were busy people, but that cannot overcome what is actually in the interests of the patient, can it?
A Absolutely not, but I would imagine that the patients were discussed with the consultant at the next available visit but, unfortunately, that visit may not be for two weeks after a decision had been made and that is one of the issues. The ideal situation is to have a daily meeting of some form where every patient is discussed, but that would not have been possible for Dr Barton with her plan, or her self constructed job plan, because there was no formal job plan for her.

Q What accountability does the doctor have to make sure that there are certain standards put in place?
A To me it would be the responsibility of the consultants to make sure that they have a system in place that allows their patients to be protected. It was not up to Dr Barton to construct that, she was the part-time clinical assistant who was implementing policy that was the responsibility of the consultants.

Q A final question from me. I understood you to say when you looked at it that you saw that the Gosport had no easy access to x-ray equipment or to acute services, but what you are not saying is that moving to a terminal pathway can be justified because you do not have access to those services?
A No.

Q Have I understood you correctly, or were you saying you might move to a terminal pathway because you do not have those sorts of services?
A No. The only option if you are going to have x-rays and other investigations done, was to transfer the patient over 20 miles. If a patient is near death, that would seem almost cruel to me because the chances are that whatever is causing the symptoms is going to get worse if you start transferring patients. Also acute services, certainly on the south coast during the 1990s, were very over stretched, so you would be moving patients around on a regular basis which would be difficult.

MRS MANSELL: Thank you.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

MS JULIEN: Good afternoon. Some of my questions slightly overlap so, unfortunately, I may need you to go over some ground you have already gone over, but from a different perspective. My first question is in relation to the range of the doses of what you described as a cocktail of opiates, the wide range of the cocktail. I think you had said that the wide range allowed the nurses freedom and flexibility, I do not know your exact words. My question is that, in a situation where there are fewer resources, the nurses using that wide range would be going in straight at the higher rate than they would possibly in another situation. What I am concerned about is, if there is not titration from the beginning, how do you think, under that sort of regime, the risks to the patients could be managed?

A The only way to manage the risk is closer observation. The reassuring factor, looking at the data, is that there was only one patient given at the higher end, at 120 mgs, of the diamorphine. The majority of patients were actually under 80 mgs, so it looks as though, from that evidence, there has been a titration process in place and the nurses were following it. I have not seen the patients, but one assumes the 120 mg patient was had severe problems and that is why the dose was given at that level.

Q The range allowed them to be in a position that they could have gone higher?

A They could have gone to 200 mg, yes.

Q It may be that they did not, but they could have.

A Exactly.

Q That is really my point. In that sort of situation, how would the risk be managed, particularly in terms of adverse effects?

A The way to manage it would be to have the pharmacy monitoring it, producing weekly, monthly reports so you can see any trends in the patters of diamorphine, midazolam and other drug usage.

Q It is the pharmacist who has to manage the risk?

A There was a ward pharmacist, the clinical pharmacist and it would be they who were responsible for patterns of drug use that were changing with time.

Q Would that be sufficient to prevent over sedation of the patient?

A Together with observation by the nursing and medical staff, that should be.

Q If it is a weekend or late at night and it is just the nurses and they are working within that regime, the pharmacist is not necessarily going to be around at that sort of time. Is that sufficient to manage the risk?

A I think all one can do is observation by the staff. What one does retrospectively is to have the pharmacy audit to see if there is a pattern change which happened. That would ring the alarm bells if there was.

Q Would that sort of system be in place at that time in your experience?

A I have seen no evidence that it was in place.

Q You have seen no evidence that that was in place, so the nurses were working under a system where they had quite a lot of discretion?
A They had discretion. The fact that they did not go to the top end immediately and there was a distribution of doses, suggests that they were using that discretion appropriately, although, as you know, I have not seen the individual cases so I cannot comment on that.

Q You accept that there could have been a situation where they may not have done that, it was left open?
A Indeed.

Q Going back to the terminal pathway situation, I think you said that once a patient gets to the point where they are on the terminal pathway, that would not be the time to conduct or to initiate any sort of investigations. I think you said it was a time for good decision making?
A Exactly.

Q What about before you get to that point, would a doctor need to be sure that they had carried out all the investigations before they got to that point?
A I think these patients in many cases had been actively treated not at Gosport but another hospital, and transferred there, so the whole purpose of Gosport was to try and free up space in the acute hospitals, and also to provide a more gentle environment for the management of a patient. If a patient started deteriorating for whatever reason, if there was thought to be a medical problem that could be elucidated, they could be sent for further investigation. On the other hand, if they were beyond that, if they were deteriorating rapidly, there would be no point and a decision would be made just not to further investigate the patient. That would be the normal practice.

Q The doctor would have to be sure in herself that she had carried out all the investigations, because you are saying there would be no point once they were on the terminal pathway?
A It would be based on the history. It would be based on the medical details of that individual patient. Over the last few months, why have they come to that point? If there are factors that are essentially irredeemable – renal failure, cardiac problems, chest problems and so on – you make the decision there is no active treatment that can be done. In cancer it is slightly easier because you have good ways of monitoring the cancer. In general medicine, it is a bit more difficult. In post-surgical procedures such as hip surgery, and so on, it is a bit more difficult, and in patients that cannot give you a history, it is doubly difficult but I think you can come to a point where you say, "No more active treatment. Tender loving care only," and you put the patient into that pathway. You deal with the symptoms as they arise.

Q And that pathway can take quite a lot time to get to the end of?
A It is extremely variable. It can be 24 hours or it can be 24 days.

Q Let us suppose in the event that it is 24 days, under no circumstances would you consider it would be appropriate to conduct any sort of investigation or another opinion?
A Unless the investigation was going to lead to a change in treatment, and that seemed very unlikely in this group of patients, even a simple chest X-ray – what would it do? Would you really start patients like this on antibiotics, for example? So why do the chest X-ray? We always teach students that diagnosis is only a guide to treatment.

Q Possibly you could consider it. You may not actually carry it out but it does not mean you close the door and you do not consider it?
A You could consider it. I am sure there were patients transferred back to the acute sector over the years from Gosport.

Q Just moving on to the syringe drivers in general, there was a point where you were talking about the possibility of reducing, or taking someone completely off a syringe driver, I think you said that it could be seen as unethical to do so. My question is this: in a situation where a patient could be taken off and a level of consciousness could come up to a level but they have not actually started to experience pain – maybe just before that pain threshold if you understand what I am talking about?
A Yes, I do.

Q Surely that would not be unethical at that stage, would it?
A It would require close monitoring because otherwise the patient could be in pain for several hours before anything is done about it. It is possible to do that.

Q The hospital could do it. And if they were experiencing some pain but not intense pain, but some pain that they could communicate?
A If they could communicate, you could then increase the dose again. They go back to a higher dose.

Q And it would not be unethical to do that, but I think to stop everything would be unethical, which is really the only way to find out what is going on – to stop all medication and see what happens to the patient.

Q So stopping would, but a reduction would not?
A The problem with a reduction is, you would have to do it stepwise and monitor the whole thing. It may take several days before you knew what was going on. There are circumstances in medicine where we do stop everything where we are not sure if it is the drugs that are actually contributing to the medical problem. We stop everything and see, but in a very controlled and monitored environment.

Q And that could be seen to be in the best interests of the patient, would you say?
A It the environment is properly monitored it can be, but it depends on the type of patient. I would have thought with this group of patients, to me, it does not seem likely that you are really going to get any benefit. The idea is to make these people comfortable.

Q Does the reason for not stopping its impact and reducing, whether you think it would be ethical or not, the reason for doing it? I am thinking of, let us suppose, the next of kin want to speak to the patient, or want to make necessary arrangements, what would be your take on that?
A I think that would be difficult. I think if the patient had had severe symptoms, I would try and persuade the relative that it would be unkind to do that sort of thing if they wanted to. Patients do surprising things in the terminal phase. Sometimes people suddenly wake up and suddenly have a lucid moment. They talk for ten or fifteen minutes, and they express their wishes – and this does happen – but on the whole the terminal event tends to be a progressive downward spiral as the organs shut down. So it is really unkind to suddenly stop everything and try to get the patient to... We have ways of counteracting diamorphine with drugs. If someone takes an overdose we have an antidote that we can give, and is given

A across the road but it would be unethical, I would have thought unethical, to do this in this group of patients where the illness trajectory is definitely downhill.

Q So in those particular circumstances unethical, but you are not saying it is a blanket situation?
A No. There are circumstances where we do do it, and it would not be unethical.

B Q My other question is about the options available to Dr Barton. You had said at one point that you considered the various options or alternatives would have been available to her once she found herself in that particular situation. I think you had started to talk about her resigning being an option, but you were not able to pursue that. I just wanted you to elaborate on that?
A One option for her is walk away from the whole issue – just say, "This is no good. I cannot stand it." The other option would be to discuss the issues with the consultants, which
C ---

Q Yes. I think you did talk about that. I was specifically interested in her resigning.
A Right.

Q Just what your view is about that.
A I think morally it would be difficult to do. She would be leaving. The next person
D would come along to the same circumstances, so changing the system would seem better than just walking away from the system, to get the whole thing better. I think the difficulty is, there was no clear leadership amongst management, both general management and medical management, that she could go to so far as I can see from reading the evidence.

Q We do know that after Dr Barton resigned there was an improvement in terms of resources.
E A Right.

Q Do you have any different take on the matter, knowing that?
A I think the public outcry at the time was great and the health authority had to do something. They funded a full time position permanently based at the hospital, not offsite at all, afterwards.

F Q And my last question relates to note-taking. You would accept that keeping clear and accurate records. It is part of good clinical practice?
A Yes.

Q It is part and parcel of clinical practice in general?
A Yes.

G Q Would you say it is an integral part?
A It is an integral part.

Q Would you say it has equal weighting to actually providing treatment and care?
A I think if you had to chose or the other, you would choose the care first and the notes afterwards. There is no doubt that is the way. The other thing is doctors in different specialties and different levels of experience tend to write less and less as they get older.
H Certainly comparing my notes in outpatient clinic to the registrar's notes – the registrar fills a

page and I put two lines down. I like to think that there is enough information in those two lines. And the medical student fills three pages, and that has always been the case in my experience.

Q In principle they have the same weighting though? The treatment and the ---
A To me the treatment and care are more important than the note-taking, but the note-taking is important because it decides future treatment.

Q But according to *Good Medical Practice*, when you look at it, there is not a hierarchy. It has equal status?
A I did not write *Good Medical Practice* but I would have thought, if you had the choice, if you were lying on the street and you had a man with a notebook or a man with a stethoscope, you would choose the man with a stethoscope.

Q But you do accept that it is an integral part of clinical practice?
A I accept fully it is an integral part.

Q And do you accept that if a doctor does not give sufficient weight to note-taking, that he or she does that at her peril?
A I think, again, it is difficult for an individual. My notes last week, because I was in a hurry for a variety of reasons, were brief. No one has told me that my notes were too brief. I had no feedback. I had the feeling from the papers I read that Dr Barton had no feedback about this.

MS JULIEN: Thank you very much.

THE CHAIRMAN: Thank you. Mr William Payne is a lay member of the Panel.

MR PAYNE: I am going to take you back right to the first part of your evidence that you gave because I want to be refreshed. I do not expect you for one minute to be critical of any colleagues, but I want to discuss the input that you said that you first made when you were first asked questions by Mr Langdale with regard to the consultants that were looking after the ward. I think you said – and you have also just said it to my colleague – there was insufficient leadership, no clear guidance and you did not say "insufficient input" but you went on to be very kind, and say they were obviously very busy people, but there was not a lot of input from the consultants above. Can you tell me how you came to that conclusion, to start with?
A A combination of reading the papers before and then the transcripts of this, and listening to them talking. There is no doubt that management in hospitals and health care facilities is best if there is one person that is clearly responsible, a single person that is clearly the place where things get solved. That one person has to be available and approachable and willing to be approached, not just by his medical colleagues but also nursing colleagues, even the cleaning ladies if there is some problem. There has to be that in good management. That was clearly not the case here, and that was the impression I got from the transcripts and the notes.

Q I think you said that the name above the patient's bed was the person who was in charge, and that was the consultant?
A Yes. That is the tradition in British hospital. It is the consultant's name, not the patient's name.

Q Thank you. I believe that you also said that Dr Barton had had inadequate training for the role that she was expected to do as the nature of the work changed. Am I correct in that?
A She was a GP, and she was trained as a GP. She had done no specialist training in internal medicine or palliative medicine or, indeed, care of the elderly as far as I know.

Q Right, thank you.
A She was competent, I would have thought, from her training to be a clinical assistant but by its title "clinical assistant" implies there is someone that is not the assistant who is looking after her.

Q Right. If you have someone in that situation that you identified as not necessarily having the adequate training, and you have a consultant who obviously had the adequate training, who should be responsible for making the decision to put someone on a terminal pathway or an end of life pathway?
A Ultimately it is the consultant's responsibility, definitely, but having said that they can delegate that to people on the spot, and they did delegate it to people on the spot.

Q How did you come to that conclusion, that they had delegated it?
A They were not there. Without seeing the patient, it would be difficult. Even if they knew the patient, and the patient had changed, and they did not come to see the patient, and they were not running the place on that basis – they were not available to come on a Tuesday afternoon, for example, suddenly to see one patient, it would disrupt their normal clinical patterns of work, then they would have to delegate, and that is what they did.

Q You went on to speak about the best way to assess the needs and requirements of a patient is to be by the bedside and see them?
A Correct.

Q And if you were going to have to make a decision with regards to, say, pain relief, then the best decision would be after you had seen the patient?
A Yes.

QBut would you agree with me that it is also – I have to use the word – "guesswork", but there has to be some form of working it out, and a stab in the dark to start with perhaps. Would you agree with that?
A I would, and that is the purpose of the sliding scale; that you start off at one end and you can go higher if necessary, so getting started is a stab in the dark.

Q Would that be more difficult if you have not had adequate training for the specific area that you are working in?
A It is a difficult question because a lot of my generation of doctors were trained by observation in the work place, and no formal training programmes. I do not mean in cancer medicine, but in things like palliative care. I had to do palliative care as a registrar without any training whatsoever. We did it. The consultants were not interested in talking about it and that sometimes happens.

Q Can I just take that slightly further with you? We have listened to your C.V., and you are very eminent in your field, you are a leader of your field probably, but if you were being

taken out of that scenario and placed into a different field, you would not feel too comfortable about making the decisions for someone else, would you?
A No. I thought long and hard what I would do if I had been in Dr Barton's shoes in Gosport. I cannot see any other way out as to what happened. She was delegated. The consultants were there. They knew they were responsible. They could not get more hours at Gosport. Whatever they did there was no way they could spend more time there. The ward seemed to run well and the system worked as far as I could see.

Q But if you were in that situation, Professor, and you were having to make a decision, and you are not adequately trained and you are having to use opiates, for instance, would you not rely to some degree on the use of knowledge that is available to you, like the BNF or the Wessex Protocol, for guidance with regard to the size and the width of the drugs you are going to prescribe?
A Unfortunately the BNF does not have that. It recommends 10 to 20 mg as a start dose, but it does not have an upper limit of the range in it. It does not have a range, in fact, so I think that will be very difficult. A competent GP is trained to give opiates, is trained to give palliative care in patients' homes. This is an extension of that primary care role.

Q Correct me if I am wrong, but the BNF does give a guide to the conversion from, say for instance, Oramorph onto diamorphine?
A It does.

Q By subcutaneous ---
A Exactly.

Q Would it be for someone who, as you have described it, has not had the adequate training to use that as a guide to move forward, initially at least?
A The conversions at two-thirds of the dose of oral morphine – that is presumably what you are alluding to – a patient on 60 mg of morphine ---

Q A third to a half.
A A third to a half, morphine to diamorphine, continuous over 24 hours, that is at two-thirds of the dose to diamorphine. The evidence I have looked at – I agree I have not looked at all the notes – suggest that that was adhered to essentially when the patients had been on opiates before.

Q So you would not be aware that perhaps those doses were maybe twice and three times higher than the recommendations from the BNF?
A The reason for starting the subcutaneous pump was that some event had happened to require a change in the management from oral dose. It may be that the patient was being sick, but in most cases it was because, as far as I can see from Dr Barton's statements, there had been a deterioration in the patient requiring more analgesic and therefore the conversion may not be quite correct. It may not be exactly the same. It would be at a higher level basically.

Q Can I just press you a little more on that? If someone comes to you, let us say, who has been on step one – paracetamol perhaps – would it be appropriate then to write out, even as an anticipatory prescription, a prescription for diamorphine that is three times higher than, say, the minimum start?

A It depends on the clinical circumstances. If that patient is in severe pain we may go to a very high level and then maybe come back. Lots of things depend completely on the clinical situation.

Q What would be the situation where you would come back?
A If the pain disappeared or if the symptom, whatever the symptom of the distress or anxiety, also disappeared.

B

Q If a patient is heavily sedated with, say, midazolam, if you have introduced that as well which leads to heavy sedation, how will you know that you have over-prescribed the diamorphine?
A It is an educated guess, as I think you said earlier, and clinical skill that you realise that the symptoms have now gone and the patient is comfortable. That is the level at which you continue.

C

Q You think that the system was working acceptably here.
A I think for that decade it was working in an acceptable way. I could find no evidence of huge, inappropriate doses being given of any of the drugs in the syringes.

MR PAYNE: Thank you very much indeed for answering my questions.

D THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: Good afternoon, Professor. Let us go back to the terminal pathway. The terminal care pathway is predicated on knowledge that the patient is in the terminal stage. In your world of cancer that is pretty well defined, is it not, it is a chronic process that is pretty much predictable.
A Yes.

E

Q Apart from one patient in our bundle, 12, there is not a patient with cancer, so I want to ask you this really. First of all, if you are dealing with pain does the object have to be to render the patient pain-free or is it a reasonable alternative to get the patient to a position where they are in a degree of pain that is acceptable to them?
A I would prefer to be pain-free and usually it is achievable, to get pain-free without troubles from the side effects of the medication including over-sedation side effects by

F judicious use of the drugs in most patients. I would certainly rather be pain-free.

Q I think you suggested that in the terminal phase it is reasonable to have a patient drowsy or even unconscious if you know what the course of their illness has been.
A Yes.

Q That is fine for chronic pain.

G A Yes.

Q And you have said that it would be unethical perhaps to withdraw some or all of the treatment to see what they are like, except in exceptional circumstances.
A Yes.

Q What if the pain, as part of a chronic decline in an old person, with many

H comorbidities, was an acute pain and because of the acute pain a syringe driver was started

with the full knowledge and intention that it would not be stopped, that the terminal pathway had now been entered?
A I think the implication in that question is that the syringe driver was the termination event, and I do not think that was the case. I do not think anyone would consider that in this country. The syringe driver was there ---

Q Explain to me what you mean by that, nobody would consider that.
A You are suggesting that the syringe driver was used to bring about a terminal event.

Q I did not suggest that.
A I am sorry, I misunderstood. Basically if a patient is in acute pain and one agrees that the patient has no way of coming back to a normal existence the symptoms are treated in the most appropriate way. In some patients a syringe driver is the most appropriate way.

Q If he was in acute pain how do you know if the pain has gone? It is a silly question.
A Death is a mysterious business, as you know, and the events that put a patient into the decline and the timing of the physiological events are really completely unknown and under-researched – for obvious reasons it is a very difficult area to research. To me a doctor's duty is to get rid of symptoms. Sure, if a patient has no other disease and they are in some short term problem – say acute post-operative recovery – things may be different. But that was not this class of patients here; these patients had chronic disease, long term illnesses, that were gradually going down, and some of them exhibited a sudden deterioration which involved symptoms, so getting rid of those symptoms when the patients are deteriorating in the most appropriate way seems reasonable.

Q But would you still apply the adjective "unethical" in that situation if you were to pull back on the dose to see?
A Unethical only in the sense that patients are suffering and have suffered. You have got them out of suffering with the medication and now you are going to make them suffer again to satisfy the curiosity of seeing the effects of the drug versus the effects of the disease.

Q What if that change of tack and that treatment were applied in a situation where there was not pain?
A That is more tricky but distress and anxiety are well-known pre-terminal events and seeing a patient is distressed, often shouting, often very disturbed and very disturbing to families, sometimes with death rattles and so on, is a very disturbing experience for everybody including the patient, so stopping the drugs under those circumstances would not make much sense.

Q With your expertise would you be prepared to answer a question about a patient with very advanced dementia who did not have cancer?
A If they have got symptoms – whatever they are, not symptoms of dementia but symptoms of anxiety, distress or pain – they should be treated like anybody else. The difficulty of course is getting the response.

Q Are you happy to answer a question if I put it to you about such a patient?
A Yes.

Q Do you have experience of looking after elderly demented patients who do not have cancer?

A A Only as a registrar in medicine.

Q I will ask it because it is pertinent to our inquiry. Would you agree, from that experience as a registrar, that elderly demented patients in hospital, because of inter-current illnesses or events, can become extremely agitated?
A Yes.

B Q As an acute event.
A Yes.

Q And that such episodes can be well-defined episodes – that is to say they occur and they resolve.
A Yes.

C Q So then if such an event occurred and to that patient was applied a terminal pathway because of that event, what would you expect to be the justification for such a decision?
A Starting a patient on terminal pathway would require more than just having dementia, there would have to be some other underlying problem that was going on that was basically pointing out the fact that this patient was coming to the end phase of their life, so that would trigger the terminal pathway, not the dementia as such.

D Q Such a treatment renders the patient unconscious. This is not pain: would it be unethical to pull back on the treatment or stop the treatment to see if the agitation had gone away?
A It is possible to do that but, as you know, it would require adequate monitoring to do that sort of procedure.

E Q Just in relation to old people you drew attention to the distress of a fear of dying, and I think you talked about a young man with cancer. You may not be able to answer this but you may through your experience. Is the fear of dying a prominent problem in the elderly or the very old or does it tend to wane with age?
A I certainly do not know of any information on that or any data that it does that. One would like to think it wanes and older people have a much more realistic approach about death generally when you talk to them, even people that have not got serious, life-threatening illnesses, but it depends completely on the circumstances around the terminal event whether
F people get frightened or not.

Q Thank you. You said that titration is the ideal but what if I put it to you that it is the norm?
A I would say that it may be the norm under certain circumstances but not everywhere.

G Q I am not into semantics so I will not go further than that. This is a side issue because you said in a certain context that the consultant cannot make the decision – it was a decision about terminal care over the telephone. I wonder how different that is to you being phoned by a registrar in the night when you are on call and given the full details of a patient's situation and then being able to make a decision that helps that registrar.
A There is a similarity but then we have 24/7 cover by registrars, 24/7 cover by SHOs or foundation year doctors, which was not present in Gosport. Occasionally even now I do get phoned up by the registrar to say do you want to resuscitate the patient, for example; if I
H know the patient it is usually quite easy, if I do not know the patient – and these consultants

A in Portsmouth had a lot of patients under their overall care and they could not possibly remember the details of all the patients I would have thought – it would be very difficult to know what to do.

Q Even with a very experienced clinical assistant who had been there for ten years or 20 years.
A Exactly.

B

Q Right. Can we turn to guidelines? You have said that you stepped out of guidelines.
A Yes.

Q I am sure we all have. When you step out of guidelines what do you do?
A You write it down.

C Q Why?
A So you do not come to the GMC I guess. No, so that people can understand, so that other staff members understand the rationale for you diverting from guidelines.

Q To justify it.
A Justify it, yes.

D Q Would you expect to do that on an individual patient basis every time you do it?
A I do not do it every time, it depends how unusual the event I am doing and how far I am going from the guidelines.

Q Some doctors – indeed quite a lot of doctors – when you mention the word "guidelines" groan.
A They do.

E

Q We have even heard one doctor here say that they are tramlines, but guidelines are there for a purpose are they not? They are there to guide us as to what to do. Dr Barton has made, in her evidence, a number of references to not taking account of or ignoring guidelines in the form of either the little green book, the *Palliative Care Handbook* or the *BNF* when writing prescriptions for syringe drivers. She cites as her justification her long experience, and indeed Mr Kark on one of those occasions asked her about writing such a prescription F that was called anticipatory, some days before it was started. He asked her what the justification was for making that decision about that level in anticipation that something would happen and she said that it was based on "knowledge of the patient, having seen him the previous week, and long experience of starting doses of subcutaneous analgesia when needed, faced with a particular patient." I wonder if you would find that an acceptable thing if that was applied to one or two patients.
A Yes.

G

Q If it was applied to a large number of patients is that acceptable?
A The number of patients flowing through Gosport during Dr Barton's period working there must have been several thousand so one would imagine that a handful of patients where she had experience, she knew the patient, she could predict what was likely to happen seems reasonable in an experienced GP.

H

A Q Does it become reasonable that the norm is rejecting guidelines on the basis of your own experience?
A I think we all do it, all doctors do it.

Q You said in certain circumstances.
A Yes, in certain circumstances where one's experience is that this patient is going to suffer if we do not do something then we go away from guidelines.

B

Q What if you have had no training?
A One of the difficulties now is we are comparing practice 15 years ago with practice today. Why tramlines comes out is that guidelines are a relatively recent invention and certainly in the 1990s there were very few guidelines.

Q The *BNF* has been around for 300 years or more.
C A Okay, but the guidelines in the *BNF* are about analgesics mainly – and other drugs obviously – they are not about patient management. Now there are guidelines everywhere for every aspect of patient management as you know and we do frequently divert from them.

Q You alluded to the fact that, like me, you were not trained, you got experience, but if your experience is gained in a place where there are no checks and balances how valid is that experience?
D A The checks and balances are relatively recent additions to modern medicine. Certainly when I trained as a medical student and then as a registrar there were really no checks on what I was doing, it is just that things have changed.

Q Do you think you got there by luck?
A No, I think I did not have any disasters by luck but I did not get there by luck.

E Q Just one other question. You said that it was perfectly reasonable to start at 20 mg of diamorphine in a syringe driver and you have gone through a number of discussions about that. But if I tell you that the *BNF* cautions that the elderly should receive one-third of the dose of an adult then would you agree that that 20 mg becomes 60 mg equivalent?
A I am not sure it does say that but it tells you to be careful of the doses in elderly patients; I do not think it had any specific – I could look it up for you.

F Q We will, just to be sure that I am on the right track. It is in bundle 1 again, I have in mind half to a third. If you look at page 7, this is from September 1997. This is "Prescribing for the Elderly" and it says "Guidelines" on the left. It starts "First always question"?

A No, I am looking at the wrong --

G Q It is behind tab 3, page 7.
A Fifty per cent of the adult, not a third of the adult.

Q Let us take that. That becomes the equivalent of 40 mgs in an adult, otherwise called an adult.
A Right.

H Q Is 40 mgs, as a norm, in anticipation that pain may occur, a reasonable starting dose?

A A It might be depending on the clinical circumstance.

Q I did not ask about that, I asked about the norm in anticipation in case something happened.
A I reply again that it totally depends on the clinical circumstances, not just the patient but what the clinical background is that is leading to the clinical situation and how reversible it is, or non reversible it is, and the speed of deterioration. A lot of this is like watching a
B ballet where what you are seeing is a series of still shots, you are not seeing the movements and, therefore, you cannot predict what is going to happen. You have to do it looking at the stills.

Q Is that not the point?
A If you need that sort of evidence, if you need to see the ballet, you will not relieve the symptoms, you will be watching what is happening all the time and not actually taking
C effective action.

Q You are describing something of an unpredictability in these patients.
A Death and life is unpredictable and these patients are unpredictable.

DR SMITH: Thank you.

D THE CHAIRMAN: You are down to me. I am a lay member, as I am sure will become very apparent. I would like to pick up very quickly on one of the points raised by Ms Julien when she was talking about note-taking. Note-taking is an integral part of clinical care, is it not?
A It is.

Q Any suggestion that, on the one hand you will take care of the patient and then you will do the notes, is by definition inappropriate?
E A Yes.

Q You talked earlier about the delegation of some fairly important functions. One of them is the whole issue of when that decision that the change over is occurring and that the patient is now moving from general care or general palliative care into that terminal pathway. Who do you perceive the delegation extended to in the making of the decision as to when you move from one to the other?
F A To me, the consultant is responsible and the delegation was to Dr Barton to make the decision. In an ideal world that decision would be reviewed at some point in the future but not at the time. It was not necessary at the time.

Q You would be quite happy that Dr Barton was more than competent to make such a decision?
A Yes.
G

Q What about the nursing staff?
A They were not making the decision to start a terminal pathway, they were involved in the decision about the dose escalation.

Q With respect, not just that. You have talked about anticipatory prescribing and I think you have dealt, very specifically, with instances where there would be an absence of
H consultation with Dr Barton because she was not available and an absence of consultation

with any other doctor because they were not available. One of the consequences of anticipatory prescribing of a syringe driver where there is no start date on it, inevitably is that there is at least the risk that nursing staff, of their own volition, will make that judgment, no doubt with the best of intentions, but that is a risk, is it not?
A It is.

Q Is that in your view an acceptable risk?
A I think for the period of time and the location in terms of the structure, it was an acceptable risk. I cannot see any other way of getting appropriate symptom control. These are not well patients, the ones who are being written up for the syringe driver. They are not people who are ever likely to go out of hospital, so the decision is made to give them the best palliative care as quickly as possible if they do develop symptoms and the person on the spot, in this case the nurses, make the final decision and then it is reviewed the next day by the doctor.

Q They do that in the presence of an open ended prescription which takes the patient directly on to what you describe as the cocktail of opiates and the syringe driver. You also discussed with Mr Kark, and indeed with Dr Smith, what you had indicated was the ideal approach, which was, I think you said, to spend up to a couple of days defining, through titration, the appropriate dose for the patient to start on the syringe driver?
A Yes.

Q The reason why in the ideal world you would want to do that rather than go directly on to the syringe driver, or the reasons, is what?
A So that you give an accurate dose, no more than is needed and no less than is needed, and the patient's comfort is assured for the next few days.

Q No more than is needed; what are some of the effects of that, of not over sedating?
A All drugs have side effects and, therefore, one wants to avoid those side effects, including sedation.

Q I will come to the side effects, but just the sedation itself to be less obscure about it. Is it that, if you do not over sedate, you are going to have an alert patient?
A An alert patient that has no symptoms is great, but, sadly, that cannot often be achieved. You have to get a certain level of sedation to get rid of certain symptoms.

Q Absolutely right and I think you said to us a few moments ago that usually it is possible to get pain free without side effects and over sedation by judicious use of the opiates?
A Yes.

Q What I am suggesting is that when you said, "In the ideal world what we would do is titration over a period of up to two days", that would indeed be a judicious use of opiates?
A It would.

Q Its consequence, if it was done properly, would be that a patient would be able to remain pain free whilst at the same time sufficiently alert to spend his or her last hours or last days, at least part of the time, in the company of their family in a meaningful way.
A I think death is, what one reads about it, from the practicality there is a great difference. It is very difficult. When you actually have patients dying, the vagaries of the

process are tremendous. The only way to ensure comfort in any environment, even when you have doctors on call all the time and so on, is to make sure that the patient's symptoms are treated, and that was the reason for the WHO Guidelines on Pain Control, but it also applies to other symptoms than pain.

Q I am sure we have all taken on board very clearly that in the terminal situation a patient can, for perfectly natural reasons, become drowsy, become unrousable and so on. What I am concerned about is your phrase, "judicious use of opiates to best effect". It seemed to me that what you were saying was that, if one were to have this judicious use of opiates through a period of titration, it would reduce the risk of a patient being treated for what appeared to be symptoms, such as agitation and restlessness, as a result of the terminal process, but which were actually created as a consequence, as a side effect, of the over use of the opiate. By titrating you make that much less likely to happen. Was that your point?
A Yes, but the titration is far more labour intensive than just putting up the syringe driver.

Q You said that to us and you said one of the reasons for not going down that particular route was that a doctor would have to keep coming back every four hours or so. I did not quite understand that because the system that Dr Barton had developed of anticipatory prescribing with a range of doses, surely would allow for that. If, before one reached a prescription for the syringe driver one had a prescription, in effect for this up to 48 hour period of titration whereby the nurses themselves are able to monitor the patient, and indeed they are there to do just that, then they will go and administer because they have a prescription for it an increased individual dose if there is a need for it, but if there is not, then they would not do it. As a consequence, the patient could not become over sedated and, as a consequence, there would be less likelihood of the patient exhibiting symptoms as a result of the overdose of opiates that might be mistaken for end of life restlessness or agitation?
A I think if the patient was titrated orally with oral morphine, either slow release morphine or soluble morphine which acts quickly, one could get the 24-hour need. The difficulty is that if you start giving it intramuscularly or subcutaneously by bolus injection and you want to change that dose, that requires much closer monitoring to get the 24-hour level. It also allows variable prescriptions. I have never seen a practice where people, other than oral morphine, write variable prescriptions of intramuscular morphine in advance, whereas with the subcutaneous pump it is common practice to have a range of doses.

Q Aside from breaking a new path, because I do not think that is something that this doctor has been accused of not doing, you say that there would be a need for a greater degree of – I forget your words exactly – supervision and monitoring.
A Exactly.

Q How would that be more so than every four hours going to see how the patient is, making a determination as to whether you were (a) going to give any further sedation of opiate or diamorphine intramuscularly at all; or whether you were going to give the same as the previous dose; or whether you were going to give more?
A Intramuscular prescriptions are one at a time. It would be difficult to see how you would give a variable dose and know what was going on because you could have a different person every four hours – it has to be given every four hours – coming along and drawing up a different size of injection and then the kinetics would be all over the place. With subcutaneous pump the kinetics are smooth, with the oral medication the kinetics are smoothing out because of the time taken to absorb the dose.

Q Your clear evidence is that it would be in impractical to adapt that course?
A It would be.

Q The risk of not taking that difficult course, of course, is that you are going to therefore go straight to the syringe driver. Is that right?
A Yes.

Q That, without titration, carries with it the risk that you get the dose wrong and over sedate the patient.
A You begin at a low dose and work up with the syringe driver.

Q There has been a considerable discussion about whether a dose is low or not, but the risk would be in the abstract that, whatever dose you chose, you would run the risk of over sedating the patient?
A That is always the case with any form of analgesic.

Q The particular danger when that analgesic is an opiate is what?
A Respiratory depression, sedation.

Q Both of which lead ultimately to?
A To death.

Q What we are looking at here, it appears, is a regime where the single, most important element is to keep a patient pain free at all times?
A Yes.

Q You have discussed the potential for discussing with the patient, prior to putting them on to a syringe driver, whether that is a course that they would want to take and you rightly point out that in many cases that would not be something that elderly patients, with the sort of comorbidities we have been looking at, might be able to participate in?
A That is right.

Q In the cases where – and there may only be a few – they would be able to do that, would you regard that as an essential prerequisite before putting them on to that particular path?
A I would certainly try and explain what was going on and get their views on it, but that may not be possible in this group of patients.

Q I am specifically referring to those for whom it might be possible.
A In my experience it is pretty rare because people who are either in severe pain or very distressed just want the distress and the pain to end, they do not want to enter into an intellectual discussion about it or, indeed, have the existentialist thought about death with you.

Q Even in those very rare circumstances, do you think it should be for you to decide whether or not the patient wants to enter into that discussion, or would you feel it appropriate to at least give them the opportunity to do so?
A It may be that this group of patients could not get involved in the discussion.

Q If they could not, what would have been lost?
A Their consent to it, but I would go ahead.

Q If they could not consent, then you would not have lost the consent. You have only lost the consent, have you not, when they could have given it and you did not ask them?
A Yes, that is the case.

Q The whole business of keeping the patient pain free, is not automatically achieved by placing them on to a syringe driver with this combination of opiates, is it?
A Absolutely not.

Q Because breakthrough pain, at some stage there is the potential they are going to require more opiates?
A Yes.

Q The only way to be absolutely sure that your patient never again experiences pain is to keep increasing the dosage on a daily basis?
A That is the case, or not, to reduce it, to keep it steady and make sure they are still pain free or symptom free.

Q If you are doing either, but particularly if you are increasing it every day, the end result is obvious, is it not?
A Not having studied the patient, I am not sure it was increased every day.

Q I am talking in the abstract?
A In the abstract yes.

THE CHAIRMAN: Thank you, that completes my questions and, therefore, all the questions from the Panel. I am conscious that you have been grilled by us since 2.30. We normally reckon an hour is about enough. You have had coming up to an hour and a half. We will take a break now, because I am sure counsel will have more than one or two questions for you. Am I right in that, I think so, yes.

MR LANGDALE: I think I saw Mr Kark nodding, so I will be guided by him.

THE CHAIRMAN: We will return at ten past four.

(The Panel adjourned for a short time).

THE CHAIRMAN: Welcome back everyone. I hope you have had a chance to refresh yourself a little, Professor Sikora. I am going to pass you now to Mr Kark.

Further cross-examined by MR KARK

Q Professor Sikora, I am going to work backwards, as it were, from the Chairman's questions round. I just want to deal with the topic that you were dealing with shortly before the break. That is the issue of titration. I want to make sure that I understand it. First of all, is it right that it is easier to titrate before you start a syringe driver?
A Both are possible, and it depends on the clinical circumstances. If things are very slowly changing, then normally what happens, you begin at a low dose of an oral analgesic,

A often a mild one, and go up the ladder, get to the opiate, titrate the opiate and then convert to a syringe driver. That is if there is a slow progress of the symptoms. If the progress is more rapid, which does occur, you may decide to just go straight into the subcutaneous pump.

Q If you are trying to deal with pain immediately, I think we have already established that a syringe driver is not actually the way to do it. To deal with acute immediate pain, you do not start the syringe driver, do you?

B A Very few patients get the sudden onset – one minute they are pain-free, the next minute they get sudden onset severe pain. It is usually a build-up that comes.

Q But the best way of titrating, as you said, I think, is you start with oral doses. You find out what the level is that will deal with the patient's pain and then, if necessary, you can convert to a syringe driver?

A Correct.

C

Q I just want to understand how titration works with a syringe driver. Have you still got this schedule that was produce, D7b?

A Yes.

Q From what you told us, the patient is not going to get to the plateau that you have described until about 13 hours into the medication?

D A Pretty close to the plateau, much sooner than that, but I agree they do not get into the final end of the plateau till then.

Q So it might take ten hours, not thirteen hours, but it takes a good while?

A It does.

Q You may then find that you need to increase the dose because the patient is still in

E pain, and you are going to increase it incrementally. Just using this table for a moment, let us imagine that we do not follow the guidelines and we double up, and you add another 20 mg to the syringe driver. If we go to hour 13, just to see if I can follow this, what will be in the patient's system before the new dose is put in is around, is it, 4.88?

A Yes.

Q And then, when the second dose of 20 mg is put in, so the patient is now receiving 40,

F they are going to still be receiving 4.88 but additionally to that, in the first hour, another 0.83?

A Correct.

Q That increased dose itself, of course, takes a long time to work up to the system?

A It does.

G Q If you are trying to deal with immediate pain, I suppose there is a danger that you increase the syringe driver by too much in order to deal with that immediate pain, but in hour 12-13 you are going to hit a problem, are you not?

A There is. The aim of the syringe driver is to reach a steady state over a 24 hour period, and just keep repeating that. Now, what one does if one doubles from 20 to 40, one has the plateau for 20, and if at any time you add another 20, you gradually go up to a new plateau.

H

A Q Yes.
A Within 12 hours.

Q And there is a danger, is there not, if you do that too quickly that you are not just dealing with a patient's pain, but you are going to over-sedate them in ten hours' time?
A Certainly these drugs have side effects and, as you mentioned, that is one of the side effects. When you add an incremental dose to a syringe driver, you have to be thinking
B forward, as it were, to what that is going to peak to in ten or eleven hours' time?
A Yes.

Q That is very helpful. And so does it follow from that, that your responsibility for monitoring the patient is obviously that much greater?
A It is.

C Q You told the Chairman when he was asking you questions about delegation, that nurses were not taking the decision to move to palliative care, and that may or may not be wrong. I just want to know on what basis you said that. Is that because you have taken that from Dr Barton's statements? Where have you got that from?
A Because only a doctor can write these drugs up, and therefore the doctor has to be involved in the decision. The nurses cannot write them up.

D Q No, I am sorry. Okay. I might have misunderstood you. When we have an anticipatory prescription, we have a prescription sitting on the sheet - yes?
A Yes.

Q For a syringe driver to be started?
A Yes.

E Q That can be started by nurses, can it not?
A Indeed, that can, but the doctor has made that decision that if the pain gets to a certain level, as judged by the nursing staff, they are empowered to start it.

Q Of course, it is difficult for the doctor to make that decision if the patient does not have any pain at that time – at the time she or he writes a prescription?
A But if they know the patient, and they can assess the progress of the disease, rather
F like ballet, they get the moving picture, then it may reasonable to do that.

Q I understand that. If they had known the patient for a good period of time, and they see how things progress ---
A Yes.

Q --- is that what you are talking about?
G A Exactly so.

Q You spoke on a number of occasions about "this group of patients", and you said, for instance, "These patients have chronic diseases and long-term illnesses". You said earlier, "I cannot see the benefit of reducing the drugs to this group of patients". How are you grouping this?
A I was reading ---
H

A Q They are twelve individuals.
A After the denominator that is unknown to me or presumably to us here, simply by reading the statements from Dr Barton on these patients, which I have read.

Q I am not criticising you for this, but which you accepted?
A Yes.

B Q Because, of course, it is dangerous, is it not, to look at this as a group of patients because these are twelve individuals?
A Yes.

Q Some had hip fractures, one had a broken arm, some had sacral sores, some had dementia. It is dangerous if you start grouping ---
A It is. All had distress in common, and most had pain in common.

C Q On the basis of Dr Barton's statements?
A Yes.

Q I see. Dealing with Dr Barton, you were being asked questions by Mr Payne about the issue of training, and I think your view. We have heard a bit of evidence about some training that Dr Barton had, but your view was that Dr Barton did not have specific training
D in palliative care, and obviously she was not a geriatrician, as it were, although she dealt with old patients?
A Yes.

Q For a doctor in that position, the guidelines, the Wessex protocol, which I expect you have heard of ---
A I have.

E Q --- and the BNF take on an even greater significance, do they not?
A Yes.

Q The guidelines are there to guide the average doctor?
A Yes.

F Q Is that fair?
A That is the case.

Q And of course there are circumstances, as you have told us, where a doctor can step outside the guidelines, but they have to exercise considerable caution when doing so?
A Yes.

G Q And note it?
A Yes.

Q You said in your answers to Ms Julien that the fact that the nurses did not go to the top end demonstrates that the nurses were using their discretion appropriately. That is my précis; that is not by any means an exact note of your comments, but does that properly reflect an observation that you made?
H A The twelve doses and the twelve patients was a wide range, the top dose given.

Q Yes.
A Which would imply that there is some form of titration going on.

Q I just want to examine how you feel able to say that, not having seen the notes?
A Simply that if all patients had been put onto 100 mg, for example, every one of the twelve patients, that would imply that that is what they are using as standard, and they are not really using a sliding scale. The fact they vary from 20 to 120, with the average between 60 and 80, that suggests the sliding scale is being used appropriately.

Q It certainly suggests that a scale is being used, does it not?
A Yes.

Q Whether or not it is being used appropriately depends entirely on what the nurses were actually reacting to when they either started the syringe driver, or when they increased it, does it not?
A That is correct.

Q If it was inappropriate at the start, or that the increases were inappropriate, then the fact they did not get up to 100 mg does not matter ---?
A No.

Q --- at all, does it?
A Absolutely.

Q You were asked by Mrs Mansell about checks and balances, and Dr Barton was in a particular position at this hospital. She had the check, as it were, of the consultants?
A Yes.

Q But they were coming in less frequently than perhaps one might hope. They came in apparently on a weekly or fortnightly basis?
A Yes.

Q And she was not working in a hospital environment – an acute hospital environment – when she was surrounded by other doctors doing a similar sort of thing. But she did have, as we understand it, those consultants on the end of a telephone, did she not?
A Right.

Q Of course, for a doctor in Dr Barton's position, it takes a certain insight, I suppose, to say to yourself as the doctor, "I think I had better pick up the phone and speak to a consultant about whether I am going to start a terminal path with this patient." That requires the doctor to think about what she or he is doing?
A Yes, but I assume she did that on ward rounds. Patients were discussed on ward rounds.

Q With whom?
A With the consultant, when the consultant came round.

Q I think you said it was the responsibility of the consultants to adopt the role, to take the role of checking?

A A Yes.

Q But again, there is a personal responsibility, is there not, on the doctor who writes the prescription, to ensure that their practice is appropriate?
A Yes.

Q Just finally this on the issue of notes – again, you were asked about this by Mrs
B Mansell, and I think you said, now, before a patient is started on a terminal pathway or even a palliative pathway, you would expect there to be a multi-disciplinary team decision. Yes?
A Yes.

Q And you said that that should be noted, and the reasons should be noted now, but were you saying that was not the case ten or fifteen years ago? Are you saying that even ten or fifteen years ago a doctor should not have made a note that a patient was being put on a
C terminal pathway?
A In a sense, the prescription could serve as the indication that that has started – the very prescription is a note. But in an ideal world certainly you would expect to see at least a one line note saying this has happened, and maybe an annotation of the reasons.

Q It is not just an ideal world, is it, the cake with frosting on the top? It is pretty basic, is it not, ten or fifteen years ago to make a note that you are entering a patient on a terminal
D pathway?
A I have not seen the notes, so I do not know what notes were made.

Q But that would be a pretty basic note to make?
A Some sort of annotation would be optimal.

MR KARK: Thank you.
E

THE CHAIRMAN: Mr Langdale.

Further re-examined by MR LANGDALE

Q Professor Sikora, I am only going to take about half a dozen matters arising out of questions you were asked by the Panel. I am going to take them more or less in the order in
F which the Panel members dealt with them. The question of – my words – Dr Barton consulting the consultant before concluding that a patient's condition was such that they were in a state of terminal decline – again, my words. Did you realise that the evidence from the consultants was that they did not expect Dr Barton to consult them about that? Did you realise that that was the evidence?
A I did not realise.

G Q So in relation to a clinical assistant in the position of Dr Barton, with the consultants not expecting her to consult with them, and not expecting her to consult with them about whether a syringe driver should be started or not, what do you say about the clinical assistant's position?
A She or he has to do the best they can within their capacity, within the system and the constraints of it, and I have done the same. When I was first a consultant, I consulted on many patients by telephone with a senior colleague at another hospital before making a
H

clinical decision. In the end he told me politely not to bother him. "You are now on your own. Just do it. You make the decision," and I suspect that may have happened here.

Q In relation to the question of nurses, as it was put to you, the risk of nurses going in at a higher rate, I am not going to trouble you with the detail that we have heard in this case about whether nurses started at the bottom of the range prescribed, or did not, but just so we can consider this in relation to the case of the patient who, when he died, was receiving 120 mg of diamorphine in 24 hours, I think you indicated it would depend on how it was built up.
A Yes.

Q This particular patient had been on Oramorph for something like four or five days before diamorphine at 80 mg was started. He was on that for two days, and then the dose had 50 per cent added to it, so it became 120, and he was being treated with medication in terms of the diamorphine at 120 mg per day for six days. Is that something which would appear to you to be a consistent kind of build-up, or not?
A Yes, yes.

Q In terms of Dr Barton as clinical assistant, matters were raised with you about her training. It is not suggested in this case, and has never been suggested by the GMC, that she was not properly, adequately trained to be a clinical assistant.
A Absolutely not.

Q And I think it follows from what you have told us that that was the view you had formed?
A Yes.

Q In relation to a clinical assistant being somebody who was a competent and experienced GP, would there be anything to cause anyone concern in relation to such a person being entitled to make a decision as to what was an appropriate amount of opiate to prescribe to a patient in this elderly type of patient group?
A I would imagine that is perfectly within the capability of an experienced GP.

Q Similarly, in relation to whether it was appropriate to commence the administration of opiates by means of a syringe driver?
A Yes, again, within the capability of a GP.

Q We have heard evidence about GPs being responsible, not only in general, but also in Dr Barton's case, for people who are on a syringe driver, say, at home?
A Yes.

Q It was suggested to you that the significance of the experience of a clinical assistant like Dr Barton would be affected by whether their experience had been or had not been subject to any checks and balances in the sense of other people having some input into what they did. Were you aware that before Dr Lord and before Dr Reid were consultants, there were also consultants – I think Dr Wilkie was one name, Dr Grunstein may have been another, although I may not be remembering them correctly – who were in place right from the time that Dr Barton started as a clinical assistant?
A I was unaware of that.

Q Were you aware that we have an example in this case in 1991 of Dr Logan, another consultant who was in post at the time, giving clear indications as to what he thought was appropriate with regard to the administration in particular of diamorphine?
A No, I did not have that information.

Q In terms of the *BNF* I think it was put to you that it had been in existence for 300 years – unless I misheard the evidence. What was the position with regard to the length of time the *BNF* has been in existence so far as you are aware?
A Certainly not more than 40 years.

Q We can check on that. You were also asked about the question of acceptable risk with regard to anticipatory prescriptions. Obviously this is clear, there is no dispute about it, that with an anticipatory prescription which has a range there is a dose range, quite a wide dose range, there is a risk that a member of the nursing staff might administer to a patient an unacceptably high dose of analgesic, within the range but unacceptable because it did not meet the patient's condition. You indicated that of course there is a risk; does the nature of the risk, the degree of the risk, depend on the trust the prescribing doctor has in her nursing staff?
A Yes, a nurse under these circumstances is perfectly entitled to give a patient a pump with 200 mg for 24 hours because they have made the assessment that that patient needs it. So there is a degree of trust and there is no evidence from the 12 cases that that was happening.

Q Would the degree of trust placed by a doctor in her nursing staff depend on her experience of their actions over a period of time?
A It would.

MR LANGDALE: A question was asked by a member of the Panel about the issue of dementia. Sir, the reason I am not going to pursue this with Professor Sikora is because I think I know which patient may have been in the Panel member's mind but I do not think it is appropriate to ask Professor Sikora about it because I shall immediately go into what were the other features of the patient's case, so I am going to specifically avoid going into a specific patient. That concludes what I have to ask; thank you very much.

THE CHAIRMAN: Thank you, Professor. That then completes your testimony. We are most grateful to you for coming to assist us today. As you will have gathered there are a lot of issues that at the end of the day the Panel are going to have to wrestle with and reach a conclusion on; your expert assistance in that area is of course greatly appreciated and we thank you very much indeed for coming. You are free to go.

(The witness withdrew).

MR JENKINS: Sir, you will recall that at the start of the day I was intending to call a witness but after some discussion with Mr Kark and your learned Legal Assessor we delayed that witness and sent them home. I would like nonetheless to call that witness and a couple of others tomorrow. I know that there is objection from Mr Kark.

THE CHAIRMAN: Just that witness or the other couple as well?

MR JENKINS: They are in a similar category to the witness and so the argument that we are about to embark on relates to all three of them. Sir, you now get some legal argument – you may want to take a break first or you may be happy to embark on it. I do not think it will be terribly long.

THE CHAIRMAN: We may want to take a break after we have heard it and consider it.

MR JENKINS: You will certainly have to take time to consider it. The issue is this: if I am allowed to call the witnesses then obviously they can come tomorrow. If I am not allowed to call the witnesses I do not want them to come tomorrow and then be told to go away again. If it were possible I would be very grateful if a decision were reached today. You will be aware, I am sure, of the practice that is sometimes followed at the GMC where Panels deliberate, reach a decision and give the parties their decision and hand down reasons for the decision at a later time. If that were something that was convenient to the Panel I would be very grateful if that could be followed today because I recognise, of course, that on occasion it is the drawing up of the reasons for the decision that may take a longer period of time – the decision itself may be taken relatively shortly.

THE CHAIRMAN: We are certainly happy to attempt to embark on that course but I do observe that we are already past twenty-five to five. If the arguments are of themselves both quickly put and relatively straightforward we might be able to accommodate you, but if there is anything of substance we may not be able to. We are certainly willing to try at this stage.

MR JENKINS: Why do I not crack on? The rules that govern these proceedings – at the moment we are rule 27(g) which is the rule that says:

> "The Practitioner may then address the Committee concerning any charge which remains outstanding and may adduce evidence, oral or documentary (including his own) in his defence."

Clearly, we are at the defence part of the case where the defence are calling such witnesses and such evidence as they wish. There is a fetter on that and we have looked at rule 50 before that deals with evidence. Can I remind you what it says? It is in these terms:

> "The Professional Conduct Committee [this is a Fitness to Practise Panel but it is under the Old Rules] may receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them, provided that ..."

It then goes on to say if it would not be admissible under criminal proceedings the Panel can receive it if they have received advice from the Legal Assessor and they think that their duty of making due inquiry into the case before them makes its reception desirable.

What I would like to call is evidence from three individuals, two of whom are patients of Dr Barton and all three of whom have had a parent treated by Dr Barton at the Gosport War Memorial Hospital at the time when Dr Barton was there, that is before she resigned in early 2000. The patients themselves are able to speak about their treatment by Dr Barton; each of them can speak of the way in which Dr Barton treated the parent. Two of them are nurses and one of them is the practice nurse at the general practice where Dr Barton works and has done for many, many years.

The evidence of those individuals obviously includes an opinion as to how Dr Barton treated the patients – whether that be the witness or their parent – it includes evidence as to how Dr Barton treated her patients at the War Memorial Hospital during the relevant time. It obviously includes a view as to how conscientious Dr Barton was and the extent to which she was acting in the best interests of the patients.

I know there is an objection to calling evidence about other patients and the objection is this, that you as a Panel are only dealing with the 12 individuals listed in the Notice of Hearing and in respect of, let us say, Patient A, part of the allegation relates to a specific prescription and the suggestion is that that prescription was or was not appropriate or not in the patient's best interest.

I agree entirely that the evidence of other individuals relating to other patients does not assist you as to whether a specific prescription for Mr Pittock was appropriate for his then needs or not, but there are of course other allegations against Dr Barton included in the Notice of Hearing. It is alleged in respect of every single patient that Dr Barton failed to assess them before prescribing for them, it is alleged in respect of certainly two of the patients that Dr Barton did not carry out an assessment or an examination of that patient.

On those allegations any evidence that goes to Dr Barton's conscientiousness, of her wish to do what was best for the patient, is evidence in respect of the suggestion that she did not assess the 12 patients in front of you. It is evidence as to disposition, it is evidence as to her general commitment to patient care, it is relevant evidence on factual allegations that you have to determine.

To take a different example, if someone were accused of dishonesty on a specific occasion the defence would obviously be entitled to call evidence to say this man is honest; he is honest on other occasions. It is evidence as to disposition and it is plainly relevant on factual matters that have to be determined. I say exactly that analysis applies here to the allegations in the Notice of Hearing that Dr Barton failed to assess any of the 12 patients.

There are issues in this case. You have heard general allegations about Dr Barton's practice. You have heard allegations about how she dealt with relatives, how she dealt with patients. You have heard from about four individuals the suggestion that she was brusque or cruel – I think that was one word used of her conversation with one of the relatives. We are entitled to meet that evidence otherwise the evidence that you hear is entirely one-sided, and we are entitled to meet that by calling evidence, evidence from witnesses who were there when a patient was spoken to or who are patients themselves.

The case has ranged fairly widely so far as the Gosport War Memorial Hospital is concerned. One of the panellists – sir, I think it was you – asked one witness whether the wards were "safe". We are entitled to call evidence to deal with that allegation if it is a concern that the panellists have, any one of them or all of them. We must be entitled to call evidence to deal with that suggestion.

What I say – keeping it short because of the time – is that we are entitled to call evidence from other patients, from the relatives of patients who have seen how Dr Barton deals with patients and patients at the War Memorial Hospital, and that that evidence is relevant to the

hearing that you are embarked upon. That is the application and the basis upon which I make it.

THE LEGAL ASSESSOR: Sir, I do not wish to add unnecessarily to the length of time but I simply would like to establish this if I can, Mr Jenkins. If one looks at rule 27(2) when the Panel retires at the first stage it has to consider two matters, firstly whether the remaining facts alleged in the charge are proved and, secondly, whether such facts would be insufficient to support a finding of serious professional misconduct.

I obviously would like to keep my advice as short as possible and I wonder whether Mr Jenkins is able to concede that the evidence he proposes to lead is not relevant to the issue of serious professional misconduct. If that concession is not made it may well be that I do have to give some advice to the Panel about that because that would affect the issue of that evidence's admissibility.

MR JENKINS: I am sorry, could you say that again? The difficulty with 27(2) is that it has got a double negative in it and sometimes it is difficult to quite understand what is meant. The Panel are enjoined to consider, once they have considered factual questions and made determinations on the facts –

> "The Panel shall consider whether such facts as have been so proved or admitted would be insufficient to support a finding of serious professional misconduct and shall record their finding."

I am prepared to make the concession and I do not invite the gloss that I know the Legal Assessor was considering when he and I discussed the matter at an earlier stage. What I say simply is that the evidence I seek to call from other patients and others who are the relatives of patients treated by Dr Barton and at the War Memorial Hospital during the relevant period is directly relevant to some of the factual findings that the Panel have to make and it is certainly relevant to other evidence that has been given, other issues that have been raised, including raised by the Panel in the evidence that you have heard so far.

R KARK: I do not perhaps need to say very much because Mr Jenkins has not only presented his own argument but he has anticipated, on this occasion correctly, mine, so I can be quite short.

This really is simply character evidence. Of course there are circumstances where you should receive character evidence, we all know about the case of *Campbell* and the line that was followed thereafter, but what those cases provide is that you have to consider what evidence is actually relevant and is going to help you in relation to the specific charges that you are considering. For instance, if a doctor is charged with offences of dishonesty it is obviously appropriate that you should hear evidence that that doctor has not been convicted previously of offences of dishonesty and has a good character, so the only issue is whether it is going to help you to hear from either the relatives or the patients themselves who have been treated properly.

The GMC have not suggested to you that other than in relation to these 12 cases that have been put before you Dr Barton otherwise generally was not assessing her patients properly or prescribing properly. These charges are what you have to do. There may be all sorts of other cases where she has assessed patients properly.

Mr Jenkins wants to call some evidence as I understand it from people who have nothing to do with these patients that you are dealing with at all to say that they were properly treated. It is not going to be any part of my speech that anybody else was not properly treated; I am concentrating for my part on behalf of the GMC on these patients and these issues. It is entirely a matter for you to decide whether you think this sort of evidence is going to help you to make those decisions or not.

*MR JENKINS: Can I reply? You do have evidence about other patients. If you go to tab 6 of bundle 1 you have got the information from Giffin, Tubritt and others relating to patients whose details we have never seen; we do not know who those individuals are. You have been asked to look at that evidence relating to other patients. Shirley Hallman has talked about at least one other patient – we know nothing about that patient. We do not know who they are, we have been in no position whatsoever to contradict what has been advanced. Mr Kark has called that evidence in front of you and for him to say we are only concerned with these 12 is not right. He has placed evidence in front of you in relation to others. We have not objected because it was part of the history and we have allowed that to go before you, but to say you are only concerned with these 12 is simply not right. It is true that you only have to make factual findings in respect of 12 but the case is wider than that and many, many questions have been asked that go far wider than the 12 patients. It has been suggested by Mr Kark or raised as a question did she do this in every case? We have not seen the records of every case that Dr Barton did. We have been in absolutely no position to respond to that sort of suggestion. There were hundreds or thousands of patients that went through the system – we have seen the notes I think of 42 and you have got 12.

All we can do to respond to that sort of suggestion is to call evidence in respect of other patients. That is what we are seeking to do. It would be wholly wrong for us to be shut out from doing that.

Patient B, the allegation in the Notice of Hearing at 3(d) is:

> "In relation to your management of Patient B you
>
> (i) did not perform an appropriate examination and assessment of Patient B on admission;
> (ii) did not conduct an adequate assessment as Patient B's condition deteriorated."

Where is the evidence as to that? The evidence is that there is a lack of a note. Have you heard from a single witness who says there was no assessment undertaken? No, there is not. What you have got to do is to deal with the evidence that you have heard, but if there is more evidence in addition to some of the nurses that you have heard from and Dr Barton herself, who would say, "Yes, she was a very conscientious doctor, she always wanted to do what was best for her patients" that must be relevant to the issue is Dr Barton likely to be right when she says she did perform an examination and assessment, she did conduct an assessment as Patient B's condition deteriorated. Of course it is relevant and of course we should be allowed to call it.

Forgive the vehemence but it is a way of keeping the submissions short.

THE CHAIRMAN: Thank you very much Mr Jenkins. I will hear now from the Legal Assessor.

THE LEGAL ASSESSOR: Sir, I hope to be short without being vehement. Mr Jenkins seeks to call certain evidence from three individuals relating to the character, skills and patient examination practices of Dr Barton – I hope that that summarises the situation fairly.

Mr Kark seeks to put down a marker at this stage concerning the timing of that evidence and the use to which that evidence may be put. He is concerned as to whether Mr Jenkins is straying into the area of pure character evidence. I only offer advice, what you decide is entirely a matter for you.

We have heard character evidence already from some of the witnesses called on behalf of Dr Barton and from other witnesses. That frequently happens in cases before the GMC, sometimes because of timetabling difficulties, but more often because the witness concerned is able to give mixed evidence as to fact and character. It would be a waste of time and resources to have to call that witness twice over at different stages of the proceedings.

It does not mean that all the evidence you have so far heard is relevant to the first stage of your deliberations. In due course I will give a detailed advice as to precisely what evidence you can take into account at each of the stages of your deliberations, but I give the following advice now. When you go into camera during the first stage of your deliberations, you are considering not just whether you find the outstanding facts proved but thereafter also whether any facts proved or admitted would be insufficient to support a finding of serious professional misconduct. That latter part of the process I will not address again, given the concession made by Mr Jenkins.

There are, you may think, two possible uses to which the proposed evidence could be put at this stage. First, to the issue whether Dr Barton is guilty of the allegations. It is said that, because Dr Barton treated other witnesses well and considerately, that tends to show that the allegations are not made out; and, secondly, it is evidence as to Dr Barton's skill and character generally.

In order to be relied upon by you, any evidence must be relevant to the specific allegations faced by Dr Barton. You may find it helpful to consider separately the issues of good character and general medical skills on the one hand and Dr Barton's examination practices on the other. Although it is a matter entirely for you, you will no doubt wish to consider the position very carefully before you conclude that any character evidence as to the medical skills is relevant to the fact finding part of the first stage. This is because the allegations are patient specific, they are not general allegations as to, for example, the overall competence of Dr Barton generally. You will decide the allegations on the evidence you have heard. Some of the unadmitted allegations relate not to the issue of whether Dr Barton did or did not do something, but to the issue whether what she did was, for example, inappropriate. You may think that there, the proposed evidence, whether as to skills, character or examination practices, would certainly be of little assistance to you in your fact finding process. Furthermore, you will hear in due course that Dr Barton is agreed to be a person of good character. If that is the case, I will advise you formally in due course that her good character may be taken into account when you consider her credibility and any allegation that she has acted discreditably. Do these aspects, namely the general medical skills and character, amount purely to personal mitigation? It is a matter for you.

Moving on, some of the allegations do allege that Dr Barton did not do something, for example assess a patient. Mr Jenkins wishes to call evidence as to the fact that Dr Barton properly did assess other patients. It is not in dispute that Dr Barton clearly did assess patients with the exception of the patients charged. Moreover, the fact that she assessed one patient does not mean that she necessarily assessed the patients you are considering. You may also wish to take into account that the evidence Mr Jenkins wishes to call in this respect is not professional medical evidence. It is clearly the case that purely personal mitigation is not to be taken into account by you at the fact finding stage. The issue for you to consider is to what extent, if at all, the proposed evidence goes beyond mere personal mitigation and assists you as to a live issue at the fact finding stage.

I conclude by saying that it is open to you to admit a part only of the disputed evidence.

THE CHAIRMAN: Thank you Legal Assessor. Mr Kark, do you have any observations on the advice just tendered?

MR KARK: No.

THE CHAIRMAN: Mr Jenkins, do you have any observations?

MR JENKINS: No, thank you.

THE CHAIRMAN: We will go into camera now. We will call you back reasonably shortly to tell you how we are getting on and how we propose to handle things.

STRANGERS THEN WITHDREW, BY DIRECTION OF THE CHAIR AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. I will put you out of your misery quickly, Mr Jenkins. We cannot give you an answer today. If we could have done, we would have done, but not just your vehemence, but the strength of your arguments has convinced us that this is something that should be given proper weight and proper consideration. At this end of the day, even if it were just to reach a decision, it would still be taking us a substantial period of time.

We have done our best to crystal-ball gaze as to how much time the process will take us, starting from 9.30 tomorrow. Our most realistic estimate is that we should say to you not before two o'clock. By that time we should have both an answer and a full written determination for you.

There is always the possibility in these cases, as you know, that we run into difficulty and discussion and require further legal advice, in which case, before we can take that advice we need to call the parties so that they can hear it and comment on it. For that reason, what I am going to do is to ask the lawyers in the case, please, to ensure that the Panel Secretary has a contact detail for each that will allow her to call you and get you to this room within about 30 minutes of the call. I think you can safely say in any event, it would not be before, say,

10.30. We are unlikely to plough straight into difficulties, but if we do have those, we will not want to wait and delay you until 2 o'clock before we can put them before you.

MR JENKINS: Thank you for that. I quite understand.

THE CHAIRMAN: Please make sure before you depart that the Panel Secretary has those details. We will resume in camera tomorrow morning at 9.30, and we are hoping at this stage that we will be able to go back into open session not before 2 o'clock which, hopefully, will not be too long after two.

Thanks you very much, ladies and gentlemen.

(The Panel adjourned in camera until not before 2.00 p.m. on Thursday 30 July 2009)

(Parties were released until 2.00 p.m. on Thursday 30 July 2009
but to be contactable after 10.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 30 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-FIVE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
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THE CHAIRMAN: Good afternoon everybody. In so far as three o'clock is not before two, my estimations yesterday were not entirely wrong, but I do apologise for the extra time that we have taken.

DECISION

Before the end of proceedings yesterday, you made an application to adduce evidence on behalf of Dr Barton from three witnesses, two of whom are patients of Dr Barton, and all of whom have had a parent treated by Dr Barton during her time at the Gosport War Memorial Hospital (GWMH). You stated that their evidence will give the Panel some insight into Dr Barton's general disposition and patient care practices at the time. It is your submission that their evidence is relevant to certain aspects of the fact-finding exercise that the Panel has shortly to perform.

Mr Kark, Counsel for the GMC, opposed your application on the basis that any evidence given by these witnesses would be either character evidence, or evidence not specifically relating to the allegations in the case. Mr Kark submitted that the GMC's case relates only to the care received by the twelve patients that have been considered during this hearing.

The Panel has considered your application. It has had regard to your submissions and those of Mr Kark. It has also noted the advice of the Legal Assessor in relation to relevant evidence at the fact-finding stage. The Legal Assessor has advised that it may be helpful to consider separately the proposed evidence as to good character and general medical skills on the one hand, and Dr Barton's examination practices on the other.

Dealing with Dr Barton's examination practices, the Panel notes that there are specific allegations as to failures in her examination and assessment of twelve patients. It appears that

A the proposed evidence does, in part, concern the issue of patient examination by Dr Barton at GWMH during the period under consideration.

B It is not in dispute that Dr Barton assessed patients other than the twelve with whom we are directly concerned. The Panel notes that the fact that Dr Barton assessed other patients does not however, mean that she necessarily assessed these twelve.

C The Panel recognises that a large number of witnesses have already been asked general background questions by all Counsel and by members of the Panel. As you pointed out, there were questions for example, as to the safety of the wards and Dr Barton's interaction with relatives. It would appear to be inconsistent if evidence on such issues were now to be

D excluded. If adduced, the proposed evidence might or might not assist the Panel in determining the factual issues before it. The Panel will only be in a position to make such a judgement, if it permits the evidence to be adduced.

E

As to evidence concerning the Doctor's good character and general medical skills, the Panel recognises that such evidence can have no relevance to the fact-finding process, and the Panel notes your concession that such evidence is not for the Panel to consider in relation to serious

F professional misconduct under Rule 27(2)(ii). However, the Panel recognises that, for the reasons given by the Legal Assessor, such evidence has already been elicited from many witnesses. The Panel takes the view that it is well able to set aside consideration of such

G evidence until the appropriate stage is reached, and that it would be wrong and unnecessary to require witnesses to return on a second occasion to give such evidence.

H It is on this basis that the Panel has determined to accede to your application.

There is a matter that the Legal Assessor would like to raise.

THE LEGAL ASSESSOR: Thank you, Chairman. It is simply this. If one looks at the transcript of yesterday's hearing, Day 34, 29 July, there are two matters which need correcting in terms of the transcript of the legal advice I gave. I am confident that I gave advice, in fact, in the terms which I am about to correct. Could people please go to page 64 of the transcript.

MR KARK: Sir, we do not yet have it.

THE LEGAL ASSESSOR: Perhaps a note can be made of it.

THE CHAIRMAN: We have the transcripts just coming out. (Same circulated)

THE LEGAL ASSESSOR: If one looks at page 64 of the transcript, the bottom paragraph on that page starts with the words "In order to be relied upon by you", the third sentence in that paragraph should read as follows:

> "Although it is a matter entirely for you, you will no doubt wish to consider the position very carefully before you conclude that any character evidence or general evidence as to medical skills...".

That is the first correction. In that paragraph if one goes to the third last sentence, starting with the word "Furthermore", that should read:

> "Furthermore, I anticipate that you will hear...".

I am confident, in fact, that those are the words I used when I gave my advice yesterday. Thank you.

MR KARK: Sir, certainly I accept those corrections. Can I just make a comment about your determination and it is not in any way seeking to go behind it at all.

At the beginning of the determination, it certainly sounded as if you were indicating that in your view as a Panel at this stage which you are soon to reach, in other words the fact-finding stage, character cannot be relevant. There are circumstances where character can be relevant if it is character evidence of a particular nature. In due course, no doubt, your Legal Assessor will give you advice about that. It is just to put down a marker now that I am sure you were not indicating that, should you receive contrary legal advice in future, the Panel was indicating in no circumstances would you be accepting character evidence as being relevant to the allegations. If, in so far as the Legal Assessor advises you that it may be, then no doubt you will review that position.

THE CHAIRMAN: I am sure that that would be right. We were looking at the position from the point at which we are currently. I think that you had indicated to us that it was not appropriate for us to take character evidence into account at that fact-finding stage, in terms of the allegations.

MR KARK: What I was saying was, character evidence of this nature, rather than character evidence generally.

THE LEGAL ASSESSOR: Perhaps I could just emphasise the fact that in the advice I gave yesterday – in fact we have just looked at it – I have already stated that I will advise the Panel formally in due course that Dr Barton's good character may be take into account, assuming that is a matter which is agreed. That part of the determination, I am sure, will be read in the light of the advice that I gave yesterday.

MR JENKINS: I am going to ask if the determination you have just reached has been reduced to writing. I am sure it has. I would like the chance to have five minutes just to look at it, to ensure we adhere to it.

THE CHAIRMAN: It has, and there can be no reason why you should not now be given a copy. If you would like five minutes to read it, you will certainly have that five minutes.

MR JENKINS: Thank you. I would be grateful. (After a short pause) Sir, thank you very much. Can I say, we have had to re-jig the witnesses slightly as a result of matters yesterday. I would like to call one lady who was the practice nurse at the GP practice. She did not, in fact, have a relative who was at the War Memorial Hospital. To the extent that I said yesterday she did, I had mis-recalled the information I had been provided about her, and that is my fault. However, I would like to call her. Knowing as I did this morning that I had misled you yesterday about that, it is right that I should say that before I call her. She is a practice nurse. She will have seen Dr Barton dealing with patients on a regular basis, and I raise that before calling her in case anyone wants to raise any objection, given the ruling that you have given. We have had to re-jig patients. I am going to call someone other than someone we were intending to call, but this person did have a relative who was treated at the War Memorial Hospital and I hope to call her this afternoon as well.

THE CHAIRMAN: While we are on the subject of *mea culpa*'s, on reflection, Mr Kark, I think that we might better have drafted that paragraph in relation to good character by the simple addition of three words. Where the paragraph begins "As to evidence concerning the doctor's good character and general medical skills, the Panel recognises that such evidence *from these three witnesses* can have no relevance to the fact-finding process." I think that was the implication, albeit a silent one of what we were intending at that point.

MR KARK: It is always slightly difficult thinking these things through on one's feet, but having indicated that you need to hear it before you can decide whether it might have relevance, it might be better to reserve your judgment, as it were, on that amendment.

THE CHAIRMAN: That is a further interesting point. I am grateful. I was not suggesting I would make an amendment in any event. It was merely to illustrate, I think, what was in our mind rather than the general point of evidence. It was the specific evidence that was sought to be adduced today.

MR KARK: Just having heard from my learned friend in the spirit of abiding, as it were, with your clear wish to hear evidence and then deciding afterwards what weight you are going to give it, I am not going to raise any further argument at this stage which might delay us even more.

THE CHAIRMAN: Thank you very much.

MR JENKINS: I will get on and call some witnesses if I may. I am going to start with Patrick Carroll, please.

PATRICK GWYLYM CARROLL, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

MR JENKINS: I am going to ask you to give us your full name, please.
A My full name is Patrick Gwylym Carroll.

Q What do you do, Mr Carroll?
A I am a qualified occupational therapist.

Q When did you qualify?
A I qualified in 1989.

Q I think you are registered with the Health Professional's Council.
A Yes, that is correct.

Q At some stage did you work in Gosport?
A Yes, I worked at Gosport War Memorial from 1994 until 2004 delivering occupational therapy to in-patient wards as well as direct referrals from general practitioners out in the community.

Q We know about several wards at the War Memorial Hospital during the 1990s, Daedalus Ward and Dryad Ward, and we have heard of Sultan Ward, which we have been told was a GP led ward. Is that right?
A Yes, that is correct.

Q We know that Dr Barton worked there from before the time you started in 1994 and she left the War Memorial Hospital in the year 2000.
A Yes.

Q Did you come across Dr Barton during the time you and she both worked at the Gosport War Memorial?
A Quite routinely in terms of working with patients from Dryad Ward and Daedalus Ward as well as occasionally patients on Sultan Ward. Sometimes I would also take direct referrals from Dr Barton to see patients who were out in the community still living at home.

Q How would you be seeing patients on Dryad or Daedalus Ward? How would you come to see them?
A The role of occupational therapy is to facilitate discharge from those wards. Generally, going back to 1994 to 2000, those wards were very slow stream rehab, or what was called continuing care then, so we would only occasionally get referrals for patients who were considered to have improved or stabilised to a point where they were to be considered to go home to live independently or with support, or alternatively we might occasionally do assessments related to the level of care they might need in terms of whether they were going to go into residential care or nursing home care.

Q How would you come to know that a patient was on those wards and that your involvement might be beneficial.
A They would generally be referred by the sister in charge of the ward and then that would mean that I would go along to either a ward round or a specific meeting with the multi-disciplinary team to discuss the referral.

Q What would you say was the level of cover that you were able to provide patients on those two wards, Dryad and Daedalus Ward?
A For general referrals it was ad hoc cover. Traditionally the patients who were admitted to those wards were not anticipated reaching a level where they would be able to live independently in the community. So the service I worked for at the time was not funded to cover those wards but we covered the hospital anyhow, and as they were not that frequent, we would be able to cover it on an ad hoc basis. So we were able to deliver what was required, but there was not a formal agreement or formal service in order to do it.

Q Ad hoc means just that, as required, does it?
A Yes. If they asked we would go and see the patient.

Q Does it follow from what you said that it was not part of your job description to provide cover for those wards? It was not planned that those wards would have cover.
A Not specifically, but we had capacity to be able to do it and because they were not frequent referrals it would be a case of prioritising the workload so a referral from Dryad Ward may take an extra few days to pick up, but we would be able to do it. If we were overloaded with referrals from the other wards, particularly Sultan, those would have to take priority, but it was not unmanageable.

Q How much time were you able to allocate to the patients on Dryad or Daedalus Ward?
A As much time as was needed to discharge the patient. If they were capable of being discharged home they would get a full, comprehensive occupational therapy assessment in the hospital, usually because those patients had been so dependent we would take them out and do a home visit to see whether they could manage in their home environment as well.

Q What, during the period that you and Dr Barton overlapped – 1994 to 2000 – was the general level of mobility and the prospects of rehabilitation for those patients on those wards that you were aware of?
A I guess we probably saw between 10 and 20 per cent of the patient population going through those wards. It tended to be that it was fairly unusual for a patient to stabilise and recover to the point where you could consider them living independently in the community with special services support.

Q Did the mix of patients on those wards stay the same over that period of time?
A I think yes and no. Yes, they did, but what changed was the expectation of rehabilitation and getting patients home. The drive became that it was much more expected that we would not just shrug our shoulders and say, "This person has to go into care". It would be, "How can we enable them to go back and live in their own home?" So it was a general shift, I would say, within the hospital and the drive of the NHS to move away from continuing care; i.e. somebody who is admitted on an open-ended admission to the expectation that they would move through the ward and move on to some other place, either their own home ideally, but often into residential care or nursing home care.

Q How much contact would you have had with the senior nursing staff on the two wards, Daedalus Ward and Dryad?
A I would be on there at least weekly, sometimes three times a week. What we do is we walk the wards and we would ask and see who were the new admissions; what was the likely potential for their care; what was the estimate in terms of was their medical diagnosis such that they were likely to stabilise and improve? Could we think about them going home? So it is a case of primarily building a relationship with the ward sister and keeping an eye on it, because it is a two-way process. You do not just rely on the ward telling you. You want to be seen on the ward so that you are giving advice because sometimes the opinion of the occupational therapist that somebody can go home is going to be different to the ward team's.

Q Absolutely. Would you have had time to form a view as to the standard of care being afforded to patients on those two wards, Dryad and Daedalus Ward?
A Yes, because you are on the wards quite frequently and from my perspective there was never any concern that the standard of care was anything other than good to excellent. I think within health services you sometimes do get a feel that people will be wary about wards, but that was never anything that I picked up or felt within the War Memorial.

Q I have asked you about two wards, Dryad and Daedalus Ward and you have just given me an observation. Does that apply to both wards?
A Yes, and Sultan as well.

Q What would you say of the standards of nursing care for the patients, again on both of those wards?
A I think the standard of nursing care was good to excellent. I would not characterise any of the wards at the War Memorial as being anything other than having above average care generally on the wards.

Q The Panel knows that on Daedalus Ward Sister Sheila Joines was in charge on the nursing side for much of the time that you were there.
A Yes.

Q Then the ward manager was Philip Beed.
A Yes.

Q On Dryad Ward, throughout the time with which we are concerned, certainly from the time you were there, it was Sister Gillian Hamblin.
A That is correct.

Q Again, what would you say about those three individuals as nurses, sisters in two cases and ward manager in the other?
A I think if I had to list them in order of people I had the best rapport with, I would probably say Sister Hamblin first, then Philip Beed and then Sister Joines. Sister Hamblin and Sister Joines were what I suppose we would now describe as classic, old school ward sisters where basic nursing care was paramount and they did rule the ward. They were the authoritative figure on the ward. I had no difficulty working with either of them. I would say the level of patient dependency was often higher on Dryad ward than Daedalus Ward and so we did not necessarily, as an occupational therapist, anticipate a high number of referrals from that ward. We tended to get a few more from Daedalus Ward.

Q What would you say from your perspective about the success that was being had with patients being treated, both by the nursing and medical staff but also yourself?
A I think if you consider what the wards were there for, it was a balance between sometimes the frustration that they had a tendency to get patients better when maybe it was less expected. They get patients to a level of independence where you really could consider discharge home and that would create more work for my service and myself because domiciliary visits would be required for those patients because they had been so dependent. You could not trust what you saw in the hospital. You had to see it within the patient's own environment, so if anything I think they tended to get rather more patients than I would have expected to the level where they could live independently.

Q What would you put that success down to?
A I could only put it down to the care that they received because sometimes patients would be transferred in pretty poor states and it would takes sometimes several weeks to stabilise them. On Dryad Ward I would often say to Sister Hamblin, "Let us see what the patient is like in a couple of weeks or three weeks", just to be sure that they had stabilised and part of that was me protecting myself so I could actually plan my diary in enough time. So my impression was that they provided very high levels of care.

Q What about Dr Barton, what would you say about her?
A From my perspective I think sometimes it is difficult to build a rapport with general practitioners because sometimes they hold themselves aloof, often for very understandable reasons, or there is a tendency to prescribe other professional's practice. They would say, "I want Patient X to have occupational therapy" and then do not define that; they do not define the problem, whereas referrals from Dr Barton would be much more of an open discussion about, "Do you think you could see this person? Do you think they would benefit? Could you get them out on a home visit/" It was much more of a professional dialogue rather than a fire and forget type of referral, which I think generally my experience of general practitioners is that they like to fire and forget.

Q What would you say, from what you saw, of Dr Barton's commitment to patient care?
A I think the level of involvement she had with the patients was extremely high. It was certainly different to other GPs I have worked with. She was very concerned that patients received a good level of care within the context of what is quite a difficult thing; it was quite difficult to provide in those days good medical care within a community hospital. It tended to have been developed, I felt, from an informal agreement and Dr Barton, if you were going to see a GP, you would see Dr Barton. Generally I would say I would have expected or been aware that she would have popped into the hospital almost daily, and that is really quite unusual in comparison to some of the patients who were admitted on to Sultan under the care of their GP. Dr Barton would be somebody who is around that you could have a dialogue with and you felt your point of view was being heard and very much felt like you were part of a team being led to provide the best outcome for the patients concerned.

Q You would have been on those wards doing a walk through, you have told us.
A Yes. That is how I would pick up the referrals. In terms of working with the patients, if we were carrying out assessments to see whether somebody could wash and dress, we might be on the ward for an hour, an hour and a half, in the morning

where we would take over that process with the patient from the nursing staff in order to see how much the patient can actually do for themselves so we can make a clinical judgment about how they might cope at home where carers might not be completely reliable and they might have to get themselves washed and dressed.

Q You told us you might be dealing with 10% or 20% of the patients on the wards.
A Yes.

Q Why were you not dealing with the other 80 or 90?
A Sometimes because they were simply too medically unwell. Sometimes it was - I do not know whether now it would be, but then it would be obvious that the patient was not going to be able to go home. Some of the patients were, effectively, receiving palliative care. They were not going to improve to the point where perhaps they could even be discharged from the hospital. A lot of transfers into that ward would come from the acute hospitals and there is great pressure on the acute hospitals to clear their beds, they need to get their beds clear, and if they have a patient who is clearly not going to be able to go home they would want to transfer them into a continuing care bed or a very slow stream rehab bed in order to relieve the pressure on the acute side, and sometimes there would be a tendency for those hospitals to perhaps - I think the kindest way would be to enhance the patient's capabilities and potential in order to facilitate the transfer, so we might be told somebody is mobile with one and then when they are on the ward and we carry out an assessment they either are not mobile or they are mobile with three physiotherapists and a walking frame. I suppose it is playing within the system in order to move patients through.

Q Are you able to help us with the practice of transferring patients from one facility to another and whether that may have any consequences for the patient?
A I think it is sometimes underestimated that a patient in the acute trust might have transferred through three wards and then, sometimes very late at night, would have been transferred by ambulance to the War Memorial. So somebody who could be described as stable after 24/48 hours in an acute hospital, the stress of the ambulance journey, the stress of the transfer, could set them back quite considerably and have a marked impact on their medical state. So often we would want to delay even thinking about an assessment or a referral for several days after somebody had been transferred.

MR JENKINS: Thank you very much, Mr Carroll. Would you wait there because you may be asked a few questions by others.

Cross-examined by MR KARK

Q I have very little to ask you. Can I just deal with the comment you just made about, effectively, playing the system to get the patients transferred out of hospital? Are you saying that in relation to both the QAH and the Royal Haslar?
A They were the primary transferring hospitals so, yes, it was certainly known that it would happen.

Q So far as the patients that you saw on Dryad and Daedalus wards, do we take it you saw those patients who were referred to you by the medical staff?
A Yes, and we would also discuss potential referrals in the ward rounds, so we

would discuss other patients in terms of what their likely potential was because I would be trying to establish what my workload might become in the next couple of weeks or so.

Q I understand, but if Sister Hamlin or one of the nursing staff or, indeed, Dr Barton says of a particular patient, "Well, this one is for palliative care", or end of life care, would you make your own individual assessment of that patient?
A Not generally. Occasionally we would because if somebody was for palliative or end of life care and they wished not to die in the hospital, they wished to go home, then the Occupational Therapy Service would be involved in terms of identifying providing equipment and assessing that the equipment was appropriate to that person's needs.

Q If that was an option for that particular patient?
A Yes.

Q I understand. Forgive me, but you have been speaking about occupational therapy. How close is that to physiotherapy?
A The two professions overlap quite a lot. Occupational therapy is centred around functional activity. So a physiotherapist would work with somebody to retrain them to gain range of movement and particularly around gait and transfers. An occupational therapist is concerned with how you might use that ability. So, for instance, a patient might regain fully after a stroke their ability to move their arm but if they have cognitive deficits it will be the occupational therapist who identifies that through their inability to make a discrimination between their shirt and their underpants when you are doing washing and dressing practice. So occupational therapy is what can you do with the ability; physiotherapy is much more focused around regaining an ability.

Q Can we take it you work quite closely with the physiotherapists at the same time?
A Yes. Often we would do joint visits to somebody's home in order to ensure, for instance, that if we were looking at them being able to ascend and descend a staircase you might take a physiotherapist with you because that is their area of expertise and I would be concerned with looking at whether the patient needed, for instance, an extra rail.

Q For those patients who were referred to you, no doubt there were times that you were busier than others but you did not find you were unable to fulfil your commitments?
A No. If the patients needed to be seen we were able to see them. Occasionally they might wait maybe a week maximum before we could pick up the referral but that was understood on the ward as well.

Q Was that the same, as far as you were concerned, with the physiotherapist?
A I believe the physiotherapists were contracted to provide a service to the wards so they would tend to have more capacity to be able to do it.

Q They had greater capacity than you did?
A Yes.

MR KARK: That is all that I ask you. Thank you very much.

MR JENKINS: I do not have any re-examination. Thank you.

THE CHAIRMAN: Thank you. We have reached the stage, Mr Carroll, when it is open to members of the Panel to ask any questions of you if they have any and I am going to look now to see if they do.

Questioned by THE PANEL

MRS MANSELL: It is just a point of clarification really about the multidisciplinary teams that you talked about. Who would form the multidisciplinary teams?

A The core of the multidisciplinary team would be the doctor, whoever was responsible for that particular patient, it would be the nursing team on the wards, it would be the physiotherapist, the occupational therapist, occasionally speech and language therapy might be involved, often a social worker or somebody from adult services would be along for planning meetings if patients needed support in the community post-discharge. Also I would argue the patient and their relatives were part of the multidisciplinary team as well.

Q Thank you. So on Dryad and Daedalus it could be either Dr Barton, could it, who would be the doctor or would it be the patient's GP because it was always about patients going home?

A On those wards it was Dr Barton. On Sultan Ward it would be other doctors because a patient would be under the care of their GP then.

Q How easy did you find it to get a multidisciplinary team pulled together?

A I think sometimes you would struggle getting somebody from adult services, but, generally, the rest I would say nine times out of ten we were able to get everybody together for the planning meetings and to deliver the care.

Q Without a tremendous amount of planning or forward thinking?

A I would say providing you had around about five days to seven working days you could pretty much guarantee to get everyone together.

Q Some of those patients, because it was a slow stream stroke patient that you may be rehabilitating, was a lot of that not just about getting patients home but to increase their capacity on the wards?

A I think expectations have changed in the last ten years in terms of the standards that we set ourselves as clinicians. Going back ten years, I think we were only just learning the necessity to keep working with everybody all the time. That is not to say that we would write patients off, but if a decision was made that somebody was going into nursing home care I had a limited resource so I would make the decision that there was little or no point in carrying out washing and dressing training with somebody because after discharge that was pretty much going to be done for them by the care staff in whatever residential home they went to.

Q So your focus was primarily for the patients who were going to go home?

A Yes.

THE CHAIRMAN: That concludes the questions from the Panel members. There is one final hurdle. I now have to ask the barristers whether they have any questions arising out of the Panel questions.

MR KARK: No, thank you very much.

MR JENKINS: Nor I, sir. Thank you very much.

THE CHAIRMAN: Very well. That concludes your testimony. Thank you very much for coming to assist us today. I do apologise if you have had to wait a bit but you are now free to go. Thank you.

(The witness withdrew)

MR JENKINS: Sir, I am going to call Susan McConnell, please.

SUSAN LESLEY MCCONNELL, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q I am going to ask you to give us your full name, please?
A Susan Lesley McConnell.

Q Ms McConnell, I wonder if you would give us your professional qualifications?
A I am a State Registered Nurse and a Registered Midwife.

Q When did you register as a nurse?
A 1969.

Q As a midwife, I think about four years later?
A 1973.

Q Have you worked as a nurse alongside Dr Barton?
A As a midwife.

Q And when and where was that?
A I first met Dr Barton in 1985 when I went to work at the maternity unit in Gosport as the senior midwife.

Q You say "Gosport"; is that the War Memorial Hospital?
A No, it was not that. It was Blake Maternity, which was a GP unit.

Q And did that subsequently close, and was it transferred to the War Memorial Hospital?
A It transferred to the War Memorial Hospital in 1992, I think.

Q You would have worked with Dr Barton from 1985?
A Yes.

Q And how did she come to be working with you at the Blake unit?
A Blake maternity unit was a GP-led maternity unit at the time and Dr Barton together with all the other GPs in Gosport were responsible for the care of their patients whilst they were in Blake.

Q And did that system follow, once the unit was moved to the War Memorial Hospital?
A Not precisely. A lot of GPs opted out of maternity care or obstetric care, but they did continue to see their patients in the War Memorial.

Q So you would have seen Dr Barton in the Blake maternity unit?
A Yes.

Q When it was running. And would you have worked with her after the Blake unit closed?
A Yes, into the War Memorial.

Q In the War Memorial Hospital?
A Yes.

Q So how many years in total would you say you had worked with Dr Barton?
A About eighteen.

Q Did you have the opportunity during that time to form a view as a fellow professional of Dr Barton's skills and abilities as a doctor?
A Yes, I think so. I think Dr Barton was an excellent GP.

Q Tell us why you say that?
A Because her care was always for the benefit of the patients. She was careful and considerate to the patients. She valued the opinion of colleagues, like myself, and always acted in the best interests of her patients.

Q Do not all doctors value the opinion of colleagues?
A No, I am afraid they do not, at least not nursing colleagues or midwifery colleagues. Whenever we called Dr Barton or asked her to come in, she always came in immediately and would always say, "Why are you calling me? What is the problem? What do you think?" And would listen to the staff, the midwifery staff, and not just come in and do what she thought.

Q Right?
A She would discuss it with us and was delightful to work with.

Q You would have seen her dealing one to one with patients?
A Oh yes, yes.

Q How was she in dealing with patients?
A She was always extremely kind and caring towards her patients, and they were always delighted to see her because when we went to the War Memorial the patients used to come in from either St Mary's, the main maternity unit, or they would deliver in Blake, and we would always ring the GPs to say, "Your patient has arrived." When we told the patients, "Your GP

A is coming in to see you", Dr Barton's patients were always very excited that she was coming in to see their new baby, or to see them.

Q Could you say the same for all the other patients, about their GPs?
A Not always, no. Some of the patients would say, "Why? Why is my doctor coming in? We do not need to see them."

B Q Tell us a bit more about the War Memorial Hospital. I think a relative of yours was a patient there for a period?
A My mother was in the War Memorial Hospital for a number of years. She was often admitted. She was chronically ill for about 15 years before she died and she was admitted to all the local hospitals, including the War Memorial, and whichever hospital she was admitted to she always wanted to go to the War Memorial Hospital, because she loved it there. The care that she received was excellent and she was very happy there. She was in all the wards
C in the War Memorial Hospital at one stage.

Q We know of Sultan Ward as a GP-bedded ward.
A She was in Daedalus.

Q There was Dryad and Daedalus Wards as well?
A She was in both of them.
D

Q Was she in Dryad too?
A Yes.

Q And we know that Dr Barton was there as the clinical assistant from when Daedalus and Dryad opened in 1993 to when she resigned in 2000. Would your mother have been on Dryad or Daedalus within that period, between 1993 and 2000?
E A I would think she was because she was in and out of hospital so much, and she must have been in at one stage because she was MRSA positive. It was Dr Barton who came to tell me she was MRSA positive. She came to tell me because she felt I should know, to get myself tested, because obviously I was working with newborn babies.

Q Again, what was the standard of care that your mother got when she was at the War Memorial Hospital?
F A It was very, very good. She was very well cared for.

Q The Panel has heard evidence from various sources about the War Memorial Hospital. They have heard observations from different people: many people who worked there and some others who had relatives who were treated there. But as someone who worked there, and someone who had a relative treated there, what would you say of the general standards that were applied on Dryad and Daedalus Wards, as examples?
G A I think the standards of care were very good. As a nurse you notice the way people are treated and the way people look when you walk into a hospital ward. You can see if they have been cared for, if they have been bathed and their bed has been made and if they are comfortable. I always felt whenever I went into any of the wards in the War Memorial Hospital that that was a good, high standard of care that the patients were receiving.

MR JENKINS: Thank you, Ms McConnell. Would you wait there, because you may be
H asked a question or two by others.

MR KARK: No thank you, no questions.

THE CHAIRMAN: Clearly no re-examination.

MR JENKINS: No.

THE CHAIRMAN: And no cross-examination. We have reached the point now where members of the Panel can ask questions of you if they have any. I am going to look to see if there are any questions. (The Chairman conferred with Panel members) There are no questions from members of the Panel so you have completed your testimony.

Thank you very much indeed for coming to assist us today. It is most helpful when we have witnesses who are able to come and tell us from their own experience what happened and how things were, often many years before. It assists us in the task that we ultimately have to address. Thank you for coming. Thank you for your assistance, and you are free to leave.

THE WITNESS: Thank you.

(The witness withdrew)

MR JENKINS: I am going to call Gillian Hughes, please, as the next witness.

GILLIAN TINA CAROL HUGHES, Affirmed

(Following introductions by the Chairman)

Examined by MR JENKINS

Q Can you give us your full name, please?
A Yes. It is Mrs Gillian Tina Carol Hughes.

Q Mrs Hughes, I think you know Dr Barton?
A I do.

Q How long have you known her?
A About 25 years.

Q I think you are a patient of her general practice?
A Yes. She is my GP, to myself and my two children, who are 23 and 13.

Q And did she also look after your father at some period of time?
A Yes. She looked after my father. My father was transferred from Haslar Hospital to Gosport War Memorial Hospital in the very beginning of 2000. When he was transferred, Dr Barton met us on his arrival.

Q Right?
A And introduced herself, and told us that she would be looking after my dad's welfare while he was in hospital there.

Q Was she his GP? Is that right?
A No, no.

Q So she had not met him before?
A No, never.

Q So it was the beginning of 2000 he was transferred from the Haslar. Was it Dryad Ward, did you say?
A Yes, yes. He went to Dryad Ward, yes.

Q And I think sadly he died at the War Memorial Hospital?
A Yes. He died on January 24, 2000.

Q Dr Barton was the clinical assistant, the doctor looking after him, whilst he was there?
A Dr Barton was the doctor who met us on the arrival of my dad and explained to us the situation of what was going to happen, carrying on and everything. We said to her, we knew that my dad was dying. He had cancer and we did not want him to be in any pain whatsoever. We wanted to make sure that he was well looked after while he was in there.

Q How old was your dad when he was transferred there?
A 86.

Q What would you say about the standard of care that he got when he was at the War Memorial Hospital?
A We were always kept up to date what was going on. After about a week, my father was in there, he was put onto a syringe driver and I cannot remember the nurse's surname – Gillian somebody. I do not know her surname. She told us and explained to us what had happened and everything, and that my dad was on the syringe driver. Dr Barton also told us that the reason was, it was because he was... You know. We knew what was going to happen. We knew he was gradually dying, but we would go in there a couple of days after. He would be there chatting away to us. He was aware of what was going on. I could not have asked for better care that was given to my dad at the time when he was in there.

Q But you have your own experience of Dr Barton?
A Yes.

Q That is your doctor, and that of your two children?
A Yes, especially my little girl. Mind you, she is not little any more. She is thirteen.

Q I do not want to ask about any particular medical conditions that anyone may have for either you or your children.
A Oh, no, no.

Q But you have needed to see the doctor a few times over the years?
A Oh yes. Many, many times. Yes, especially with my little girl. She suffers from epilepsy. I was a nervous wreck when she got taken into hospital, but Dr Barton reassured me that under proper medication everything would be controlled and she would be all right. Nothing would happen to her. Of course, as a parent you always think the worst. I used to say... She would say, "Look, she is going to be fine." She gave her nickname, and she called her "Baggage". After a period of time when she got on with the medication, my little

girl sent her a picture of "Thank you" for looking after her, and she put on there, "Thank you, Dr Barton. Love from Baggage."

Q What would you say about Dr Barton from our perspective as a patient?
A As a patient?

Q Yes.
A I have never had any qualms or anything wrong. She has always been there. She always reassures me, whatever the matter is. After my father sadly passed away, she constantly contacted me to make sure that I was okay, and if I needed any help she was there for me, and especially a period of time when my son – I had a bit of trouble with my son. She just guided me through and said he was 18, and he had a life. "He'll still be there. You'll still be there for him." A couple of times I wanted to go on depressants, and I thought "No." But the reassurance I got from her was that I did not need it. She was just there to tell me that everything would be all right, and it was, and it always has been.

Q It sounds as though she was going beyond the medical problems.
A Yes. I mean, if I had a problem, I knew I could go and talk to her and come out of there feeling on Cloud 9, and I knew that whatever advice she gave me, I knew would be correct and I would be all right, even with my children as well.

Q Can I come back to your father?
A Yes, of course you can.

Q He was put on a syringe driver after a period of time when he was in hospital.
A Yes.

Q Can you just remind us, after he was put on the syringe driver, you obviously went in to see him.
A I used to go in and see my dad every day. I took my little one in with me.

Q How was he coping on the syringe driver?
A He was fine. One day he would be asleep when you went in. It depended on what time of day you went in and most of the time it used to be about dinner time I would go in. He would be awake and start gobbing off at us, "What you doing here? Get out of here. I don't want you here", sort of thing.

Q So he would be his usual self?
A Yes, typical, and I thought, "Here we go again". Then like one time you could go and he would just be asleep and he would be quite happily laying there asleep, and we knew that he was not in no pain. He was quite comfortable and looked after by all the staff that were in the hospital. Unfortunately the day he died is the hardest thing that I have really got to try and get over, because the hospital phoned us the night my dad died. They said they phoned me and I never ever received a phone call. They assured me they did, but I was there and it is something that I have had to live with since.

Q I understand.
A As I say, when we finally did get the message it was via the police, because they were trying to get hold of my brother as well. We went in on the following day and that day, later on, I received a phone call from Dr Barton to say to me, "I am here if you need me", which I

thought was marvellous. I did not expect a response like that and if I needed help with any arrangements whatsoever, she was there to help me.

Q Did you need to call her in fact after that?
A No. But if I needed her she was there. She phoned a couple of times even after my dad's funeral. She phoned a couple of times just to make sure that we were still all right. As I say, I never expected that sort of thing and to me that shows that she really cared what she was doing. She was caring about people.

MR JENKINS: Please wait there because you may be asked one or two questions.

MR KARK: I have no questions, thank you very much.

THE CHAIRMAN: It seems that members of the Panel do not have any questions, so thank you very much. You have completed your testimony. Thank you very much for coming to assist us today. It is very much appreciated. You are free to go.

(The witness withdrew)

ANN DEAN, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q I am going to ask you to give us your full name, please.
A It is Ann Dean.

Q Would you give us your professional qualifications?
A Registered General Nurse and Registered Midwife.

Q I do not think you qualified on the south coast.
A No. I qualified in Glasgow.

Q What was your nursing career after you qualified?
A I think I was a staff nurse for about 18 months perhaps and then became a ward sister. I was a ward sister then for about 10 and a half years before getting married.

Q That was in Glasgow where you were a ward sister, was it?
A Yes.

Q What kind of ward?
A Surgical ward. I then became a practice nurse thereafter. I worked initially for my husband who was a single-handed general practitioner. I worked for him for a very short time.

Q Was that in Birmingham?
A That was in Birmingham. Then he joined the Navy and we moved to Gosport, and that is where I encountered Dr Barton.

Q I think you worked at the practice where she was a general practitioner.
A I worked at Forton Road Surgery, yes.

Q Did you work there for two periods of time?
A I did. I am a bit hazy about the dates.

Q I do not think the precise dates matter.
A I think it was 1994 until the end of 1995, so maybe for 18 months. I was then gone for about 18 months and then came back and worked for about five years, approximately.

Q So six or seven years in total that you have been practice nurse at the practice where Dr Barton and other doctors worked.
A Yes.

Q We know that there were a number of doctors in the practice.
A Yes, six I think.

Q How did you find Dr Barton whilst you were working with her there?
A I found her to be an excellent colleague. She was very approachable, very supportive of the nursing staff and by my observation all the other staff in the practice. I found her to be very caring and considerate of patients.

Q Would you have seen her with patients?
A Not a lot but on occasions. I did work with her when we were doing childhood immunisations and also perhaps when I would call her to the treatment room to have a look at a leg wound or whatever, or maybe to examine a patient that I did not feel should wait to be seen really.

Q If there were discussions about patients, or if you were seeing patients together with Dr Barton or in meetings at the practice, would you have been able to form an impression of Dr Barton's commitment towards her patients?
A Absolutely.

Q Tell us what that impression was?
A She was totally committed to them. She was very caring. She always put them before herself on many occasions. She would be ready to leave the practice, ready to go out of the door and I certainly have asked, could she possibly see another patient and she would just turn about and go back and see the patient. She had a lovely manner with the patients and always came over as very caring, and as for her clinical expertise, I was very impressed. I never had any occasion to doubt that at all.

Q I am not asking for names, but could you say the same of her colleagues, the other doctors in the practice?
A She stood out as being particularly caring and attentive.

Q What about her clinical judgment, so far as you were able to see that being exercised?
A I never had any worries. She always concurred with my own judgment. As an experienced nurse I never had any doubts about that.

Q Would you have had feedback from patients?

A A Yes.

Q As the nurse did you find yourself talking to patients about which doctor they might want to see?
A I do not think it was every necessary for me to talk to them about which doctor they would want to see. The vast majority of patients wanted to see Dr Barton.

B Q That is in a practice of six doctors.
A Yes.

Q Was that always possible?
A Not always possible at all. They would come to see us specifically because they wanted a back door in to see Dr Barton, because she was so caring and just so wonderful with them. Lovely manner with every patient, no matter who they were; patients with all sorts of
C difficulties, she was so nice and so good to them.

MR JENKINS: Thank you very much. Will you wait there because you may be asked questions by others.

MR KARK: I have no questions. Thank you.

D THE CHAIRMAN: There are no questions from the members of the Panel so it follows that that completes your testimony. Thank you very much indeed for coming to assist us today. It is very much appreciated and you are free to leave.

(The witness withdrew)

E MR JENKINS: Sir, that is all the live witnesses I have this afternoon. What I can do, though, if it is convenient, is read some statements to you. These are statements that are agreed, as I understand it, and there is no objection to them being read from across the room. I am going to start – I have a copy for the shorthandwriter (document handed) – with Angela Southam. Her statement is dated 19 July 2009. It is signed by Angela Southam and it has this endorsement:

F > "This statement consisting of two pages signed by me, is true to the best of my knowledge and belief and I make it knowing that if it is tendered in evidence I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true".

MR KARK: I am sorry to interrupt. Is there a spare copy of this statement?

G MR JENKINS: Yes of course. Can I say, I am going to be reading a statement from Fiona Smart and two statements from Dr Grunstein.

MR KARK: We have the Grunstein statement and the one from Fiona Smart. (Document handed)

MR JENKINS: The statement reads as follows:

H

STATEMENT OF ANGELA SOUTHAM, Read

"I am Angela Southam of Jubilee House, Medina Road, Cosham, Portsmouth. I am a Clinical Nurse Manager at Jubilee House, which is a continuing care assessment/end of life unit based in the community. I have held this position since 2005. Prior to this I was a senior nurse from 2002 – 2005 at Jubilee House, and a staff nurse there from 1998 – 2002".

Forgive me, I break off from the reading. This is relevant in relation to the evidence the Panel heard from Shirley Hallman. She gave some evidence about Jubilee House and this is Jubilee House. I go back to reading the statement,

"The unit is essentially nurse led, with local GPs carrying out the day to day medical care of the patients under the authority of Consultants. Consultants will carry out ward rounds every two weeks.

The Unit has 25 beds, most of which are occupied at any one time.

"The GP on duty will attend to see patients for about three hours each day, usually between 12.00 pm – 3.00 pm. These hours do vary slightly depending on the needs of the patients. On occasions they may be a little less or a little more. The only variation on this is when the consultant attends to carry out a ward round, usually each Thursday, when a GP will then be in attendance for that ward round which takes place in the morning.

On occasion, when patients are admitted to the Unit in the afternoon or when a patient deteriorates, the GP may return to the Unit following afternoon surgery, in order to attend to the patients. If it is necessary for there to be clinical input out of hours, an out of hours service is available to the Unit.

These arrangements, in terms of the nature of the medical input at the Unit, the periods and amount of time spent each day by the GP and the number of beds have not altered since 2000".

The next statement I read is that of Fiona Smart. Her statement is dated 15 July 2009. It is signed by Fiona Smart and it carries the same endorsement as the statement that I have just read to you, namely that it is true to the best knowledge and belief of the maker. I will not re-read that. The statement reads as follows:

STATEMENT OF FIONA SMART, Read

"I am Fiona Smart of Omega House, 112 Southampton Road, Eastleigh, Hampshire. I am Associate Director for Clinical Standards at NHS Hampshire at the above address.

Having worked as Services Manager for Community Hospitals in East Hampshire, I was appointed as Interim Divisional General Manager for Fareham and Gosport Division of Portsmouth Healthcare NHS Trust in January 2000. As such, I was responsible for two community hospitals in the area, Gosport War Memorial Hospital and St Christopher's Hospital, District Nursing and health visiting and physiotherapy,

dentistry and occupational therapy Trust wide. My appointment was initially on an acting basis and I was then appointed to the substantive post.

In my capacity as Divisional General Manager, I met Dr Jane Barton on a number of occasions. I believe that she was involved with the Primary Care Group at this time.

I recall that Dr Barton came to see me on one occasion, when we had a conversation about the pressures associated with her work at the Gosport War Memorial Hospital (the Hospital) where she was a Clinical Assistant in Geriatrics. I recall that I was told Dr Barton would come to the Hospital at 7:30 in the morning in order to do a Ward Round, and would also have to undertake weekly Ward Rounds. I was told that her partners were not sufficiently supportive of her to enable her to get back to the Hospital to carry out further work as she would wish. Our discussion was about the need for her to be available in the hospital later than had been her practice. Whilst I recall that the level of dependency of patients had increased over time and they were generally less well on admission, I cannot now recall if this was specifically discussed by us.

The demands on Dr Barton were such that she felt obliged to resign at the end of April 2000. A copy of her resignation letter was passed to me",

Sir, I break off. The Panel have it.

"and in consequence of that I felt it appropriate to write to her, which I did by way of a letter dated 19th May 2000."

Again, the Panel have it.

"A copy of that letter is attached to this statement and marked 'FS1' [an exhibit], the letter being written in my previous married name of Fiona Cameron. In that letter I made the point that over the period Dr Barton had been at the hospital (which I stated in error as 7 years) there was little doubt that both the Client Group and the workload had changed. I was aware of and acknowledged that Dr Barton's contribution, commitment and support to Gosport War Memorial Hospital. I fully acknowledged her 'contribution to the service whilst working under considerable pressure'. I would not have complimented Dr Barton in my letter unless I had felt that this was clearly appropriate and deserved.

Although I did not know Dr Barton well, I felt she was a person of integrity. She had a reputation for being very straight talking, and her level of forthrightness may have meant that some would feel that she was brusque. I considered her very easy to deal with.

In my letter to Dr Barton I stated 'acceptance of the above pressures, coupled with your resignation, has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising'. The review proposed enhanced medical input. In due

course a number of changes were made to the service at the War Memorial Hospital. A full-time staff grade doctor was appointed in September 2000, providing greater medical input. There was also an additional consultant session to provide greater consultant support."

That statement is signed "Fiona Smart".

STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

Sir, I am going to read three statements from a Dr John Grunstein. The first is a police statement. It is dated 4 November 2005. He gives his age as over 18 and his occupation as a retired medical consultant. The statement carries the same endorsement in the same terms that I have read before. He says:

"I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000."

He sets out his qualifications and CV. I will read them all, if I am asked to, but he gives his date of birth in 1935, the medical school was the London Hospital, Whitechapel, between 1968-1963. That is what it says. His medical qualifications, 1963 MRCS, LRCP, 1963 MB, BS Lond. Higher registrable medical qualifications, 1968 MRCP Lond, FRCP Lond. Relevant appointments, 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital. 1971, appointed Consultant Senior Physician in Geriatric Medicine to the Portsmouth Health District and successor organisations. 2000 retired.

"Since retirement I have continued to work as a part-time locum in various capacities.

Responsibilities in Gosport:

a. Shortly after I was appointed I initiated an outpatient service in Gosport.
b. I shared responsibility for the continuing care wards in Gosport. Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.
c. In 1992, I believe, I gave up all responsibilities in Gosport.

Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants."

Sir, the Panel have it and have seen it in bundle 1.

"This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment,

A I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr BARTON was an experienced doctor with her own general practice in Gosport. I remember her being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed with similar capacities). She had a liking for these very frail elderly patients.
B Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attends ward rounds, outpatients and day hospital sessions in order to get 'hands on' training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as 'in depth'.

C Dr BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I remember her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Programme - Elderly (CATPE). This was a series of lectures given in the training of most
D aspects of Elderly Medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would have also heard about the 'analgesic ladder' which describes the incremental use of drugs to control pain and distress. The
E analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

F Routine business ward rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients.
G I would expect my advice to be followed as ultimate responsibility for patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON",
H

A - he then names a doctor that we have heard named as "Dr X" -

> "and others from other practice worked on the wards while she was unavailable."

"She" obviously meaning Dr Barton.

B

> "My department did not vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.
>
> Admissions to all elderly medicine continuing care wards (long stay wards) were authorised by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

C

> During their time in hospital the patients own General Practitioner had no responsibility for supervisory rights.
>
> During the time that I had specific responsibilities in Gosport (1971-1992). Patients transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in

D

> Gosport.
>
> Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

E

> The bulk of patients transferred to Gosport were considered too incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

F

> The survival time of new admissions was short (on average less than a month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.
>
> I considered Dr BARTON to be an outstanding, caring and compassionate Physician."

G <u>SECOND STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read</u>

Dr Grunstein wrote a second statement for the police. That one bears the date of 19 January 2006. It carries the same endorsement which I do not read. It says:

> "I am Dr John Albert Henry GRUNSTEIN, a retired Medical Consultant and previously worked at the Queen Alexandra and Gosport War Memorial

H

> Hospitals, Hants.

I worked for a time with Dr Jane BARTON.

I produce as exhibit ...",

- he gives the exhibit number -

"... Dr BARTON's application for the post of Clinical Assistant in Geriatric Medicine dated 17/3/88, a letter from Miss K SOUTHWELL, Portsmouth and South East Hampshire Health Authority of 18th March 1988 to me and my correspondence of 19th April 1991 confirming that Dr BARTON received ten half day sessions from 27th - 31st November 1989.

I cannot recall why she was trained a year and a half after her appointment. The letter is addressed 'To whom it may concern' so I think there may have been something in the GP contract which required additional formal training.

I do not believe I ever interviewed Dr BARTON formally."

That, like the previous statement, is signed by Dr Grunstein.

FURTHER STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

There is a further statement from Dr Grunstein. That carries the same endorsement as the others before it. This one is dated 2 June 2009. Again, signed by Dr Grunstein. He says:

"I am Dr John Albert Henry GRUNSTEIN",

- and he gives his address in Soberton, Hampshire. He says:

"I was ... a Registered Medical Practitioner, and was formerly a Consultant Physician specialising in elderly medicine, employed by the Portsmouth and District Health Authority and successor Trust organisations. I retired from full-time practice in 2000.

As indicated in my statement to the police of 4th November 2005 I qualified at the London Hospital, Whitechapel, in 1963."

He gives his qualifications that I have already given. He says:

"Although I retired from full-time practice in 2000 I continued to work for a time as a part-time locum in various capacities until 2006.

Again, as I indicated in my police statement, shortly after I was appointed, I initiated an outpatient service at the Gosport War Memorial Hospital. In addition, I shared responsibility for the continuing care wards in Gosport which were initially sited in the Northcote and Redcliffe annexes of the Hospital. I believe I shared Consultant responsibilities for these Annexes with Consultant, Dr Bob Logan.

Initially my responsibilities in Gosport included carrying out outpatient clinics, and visiting the GP Wards, when asked to see patients admitted by local General Practitioners. As I have indicated, I shared responsibility for the medical care of the patients on Northcote and Redcliffe Annexes.

GP clinical assistants provided day today clinical care and dealt with emergencies. Elderly medicine consultants and registrars were available for telephone advice and occasional emergency visits. It was more usual to transfer patients with difficult problems back to the DGH.

From my appointment in 1971 I saw a number of clinical assistants come and go at the hospital. In due course, when the post became vacant, Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Hospital - in March 1988. Indeed, I believe that she was the only applicant for the post at the time. I think we were very glad to get someone who had an interest in elderly medicine, who had a liking for frail, elderly patients, and who was competent. Unfortunately, in my experience there were others involved in elderly medicine who were less competent, reliable and dedicated than Dr Barton. For example, when asked to see a patient one might have the impression that they were somewhat reluctant to do so. Dr Barton was certainly in the category of a good Clinical Assistant.

As a Consultant in Geriatric Medicine I did not send patients to Gosport whose medical needs were unsorted or where rehabilitation had realistic prospects for discharge from hospital. This was because fundamentally it was a long stay or so called slow stream unit not equipped to deal with patients requiring this type of active management. Thus patients sent to Gosport were in the main those we did not think could be discharged to their own homes or residential homes.

Exceptions might be those with large sores requiring lengthy healing and those awaiting transfer to alternative accommodation.

Over the period 1988 to 1992, when I ceased to have responsibilities in relation to Gosport. I think the needs of patients did not alter that much. I, and the other Consultants, chose to send patients to the hospital who needed care, as opposed to investigation and very active treatment. The patients we admitted there were not those in need of rehabilitation, diagnosis and active medical management. We would have admitted patients there because we had concluded that there was no other place for them to go, and they were unlikely to improve. Geriatricians and other specialists need to keep empty beds in District General Hospitals (DGH) so that it is always possible to admit emergencies. None the less I resisted attempts to fill vacancies in our Gosport beds with unsuitable patients, when there was pressure on DGH beds, for the reasons outlined above.

I recall that when I arrived in 1971, some of the patients had been there for many years, inevitably due to the initial unsuitable selection for the unit.

I believe that in 1988 Dr Barton as Clinical Assistant was not likely to have been required to care for patients with technically demanding medical needs on a day-to-day basis. I felt that Dr Barton was able to do the amount of work required of her at that time within the allocated sessions. (I have been reminded that this was 4 sessions to include out-of-hours work). I believe the wards were visited daily, new patients were briefly clerked and there were weekly ward rounds with the consultant. I think we alternated both consultants and annexes.

In working with Dr Barton, I felt I was in the presence of someone who knew her stuff. I am conscious that Dr BARTON did not write much by way of medical records. However, I felt she was doing a very reasonable job. It is fair to say that in my last years as a Consultant we had much better notes in long stay units because we had doctors there who were expected to create much more detailed notes. However, I believe that by the time I retired we would have effectively had 1.5 doctors to cover what Dr Barton was responsible for at Gosport.

As a comparison, Kingsclere Ward at St Mary's Hospital was a double ward with acute rehabilitation patients on one side, and long stay beds on the other. I think there were about 40 beds on the Kingsclere Ward. By comparison with Gosport, I remember being surprised that we were able to fund a full-time medical appointment to look after the medical needs of those patients.

Over the period of Dr Barton's appointment until 1992, I thought that in the context of the type of patient coming to the hospital, the patients were being properly and adequately assessed on admission by Dr Barton. At the same time, I knew that it was impossible to insist on the dotting of Is and the crossing of Ts which might seem to have been required by the job description.

I felt it was extremely important for the referring unit (preferably the consultant) to write usually no more than about a paragraph with essential information for the admitting doctor at Gosport, as I know how difficult it was for the receiving doctor to go through what would be a very thick set of notes and distil the most pertinent information. I am afraid this did not always happen.

Although I was not at the War Memorial Hospital after 1992, my understanding was that the Wards there started to be used for patients transferred for rehabilitation. Certainly in the 90s there was a great deal of pressure on District General Hospitals to get patients out of hospital who were perceived to be bed blockers. It would have been patently obvious that work at the War Memorial Hospital would have become much more onerous, with more patients being taken on for rehabilitation.

When I retired, I was involved in the transformation of the long stay ward in Petersfield to a Rehabilitation Ward. In consequence of this, the GPs who were involved in providing care were given more sessions. None the less there were protests from the GP's, nurses and ancillary staff at the number of admissions.

Another difficulty was the tendency for patients to arrive from the DGH late in the day. This causes particular difficulties for GPs.

After my close Gosport involvement ceased in 1992, I was not directly aware of acutely ill patients being sent down to Gosport, although it is possible that I might have been made aware of disquiet from Dr Barton that patients were being transferred to the Hospital who were too ill. Certainly I would never countenance the transfer of an ill patient – ie someone in need of active management. The transfer of an ill patient would only be appropriate where everything possible had already been done for them at the District General Hospital. Geriatricians recognise that the act of transferring a frail ill patient often has a deleterious effect on their health. Mortality rates amongst this group are increased.

I have a recollection of being aware of some sort of problem on one of the Annexes with one or two of the nursing sisters there at some point before I ceased working at Gosport in 1992. I do not recall any Nursing Staff expressing concern about the use of opiate medication and syringe drivers.

I understand that Dr Barton came to employ a method of prescribing for patients on an anticipatory basis – where it was perceived that the patient might require medication at some point in the near future. I can see that from a background in general practice, someone might be concerned to consider provision of medication in anticipation of the development of pain for example, over a weekend when a doctor might not be immediately available.

I recall that we had policies whereby it was not necessary to call out a doctor from the Surgery or at night in order to confirm death if a patient had died. The nursing staff could then confirm the death. I believe that this was permitted at the War Memorial Hospital. I do not recall a specific phrase being utilised to the effect that the doctor was happy for the Nursing Staff to confirm death, but there would be nothing odd about this. Indeed I do recall that some such instruction was sometimes written in the notes, if the Clinician perceived that the patient might die.

Of Dr Barton, I would say that she was someone in whom one was able to place confidence. She was intelligent and knew her stuff. She could be quite blunt on occasion, but she looked after her elderly patients in a way which I felt was caring and expert.

She was assiduous in attending the educational training sessions provided for her upon her appointment and subsequent sessions described in my statement to the police.

We thought ourselves lucky to have her as a colleague in Gosport."

That statement is signed by Dr Grunstein.

THE CHAIRMAN: Thank you very much indeed.

MR JENKINS: We have run out of evidence, I am afraid, for the day.

THE CHAIRMAN: Good, because I think we are out of time too. Thank you very much indeed. You have given us a great deal to digest. I think we are going to rise now and we will resume tomorrow at 9.30, please.

MR JENKINS: May I tell you what I have for you. There is another nurse that we are going to call who deals with a number of patients. I do not propose to go in great deal with the entries that she has, but it is right that you should know that a number of patients can be dealt with tomorrow.

THE CHAIRMAN: It is always helpful to have an insight into what is coming. Thank you for that.

MR KARK: Speaking of what is coming, can I just raise timing. I know it is late in the day, but I will just raise timing and try to look forward for a moment.

Tomorrow it is very likely that Dr Barton will be closing her case and that is the last of the evidence that we are going to hear on her behalf. Then we come to the issue of speeches, unless there are any further submissions to be made, but I do not think there are.

So far we have managed to get through, I think, seven weeks of the case without asking for any time, but I am considering asking for time, just for a day in fact. That is in order to prepare speeches. What we have been working on as the evidence has progressed is a document which we hope is going to assist. The nature of the document is this. We have broken up the case into the various issues that you are going to have to decide and then in relation to each patient, and within each of those sections we have put what we view to be the relevant evidence from every single witness.

Taking an issue such as Patient A, by way of example, you have a précis from the transcript, with transcript references, of every witness that the GMC called or read who spoke about that patient, coupled with direct lifts from the transcript of everything that Professor Ford said about that particular patient.

It is a fairly lengthy document. I do not hesitate to tell you – I think at the moment it is about 130 pages long. However – however – it does distil what is in fact, so far as we are concerned, the first 24 days ---

MR LANGDALE: Sir, I am sorry to interrupt. It is always irritating. I was aware today of the general nature of the document that my learned friend Mr Kark is talking about. I would rather he did not go on any more telling you about it because I think whatever document is produced by the GMC will be something which more properly would be a product of discussion between us. I can see certain difficulties which may arise in relation to the format. What I ask is that we have an opportunity of discussing it. My learned friend has been kind enough to indicate he is going to send me, much as I am enjoying the thought of 100-plus pages to look at tomorrow, the document as it is – it may not be in its final form – so I can see what it is in general terms. I can see there may be an issue as to what should or should not be placed by way of a document before the Panel.

I can fully see, and I join with him in suggesting that we have a day to consider speeches, which will probably mean what Mr Kark has in mind – beginning his speech on Tuesday rather than Monday. If that is what he is asking for, and I think it is, I certainly agree that

would be sensible. However, I think we had better have some discussion about what may or may not be appropriate, as I stress, to place before the Panel as a document, as opposed to references and so on.

THE CHAIRMAN: I agree with that entirely, Mr Kark. At this stage in the proceedings, I think we can hear about this tomorrow if you do not mind.

MR KARK: Yes, sir. I was raising it because we were asking for time. I was going to invite you on Monday to take time to read that document because that will shorten matters considerably on which I have to address you. I was not revealing what was in the document, rather the nature of it. This is not going to be an agreed document necessarily. It is part of our case. There we are; we will raise it again tomorrow.

THE CHAIRMAN: But your aim would be that we would spend Monday reading that document? And whilst we were reading, that would give counsel the opportunity to be ---

MR KARK: Elsewhere.

THE CHAIRMAN: Yes. Very well. Can I ask you – is that document going to be a preface to a skeleton argument or is that, in a sense, the skeleton itself?

MR KARK: It is not a skeleton. It is all of those transcript references to which I will be referring in my speech. It is to avoid you having to turn up transcripts.

THE CHAIRMAN: Yes.

MR KARK: That is the point of it.

MR LANGDALE: Perhaps we can have some further discussion of that tomorrow when I have seen what it is. In any event, whether the Panel needs time on Monday to read any document or not, I suspect it will still be appropriate for us to have a day, apart from tomorrow and no doubt the week-end, so that speeches will be given on Tuesday.

THE CHAIRMAN: I think that must be right. I think the Panel have an interest in knowing not today, but tomorrow perhaps after some discussion, whether we will have the benefit of written skeleton arguments or whether that is not going to be the case.

MR LANGDALE: As I say, it is not going to be a case of skeleton arguments but perhaps we can discuss this some more tomorrow.

THE CHAIRMAN: I will just put a marker down for one other point that perhaps can be dealt with immediately after we finish evidence tomorrow. That is that the Legal Assessor himself has a number of points which he would like to raise with counsel, to ensure that they will be dealt with by counsel in your later submissions.

Very well. Thank you very much. 9.30 tomorrow, please.

(The Panel adjourned until Friday 31 July 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 31 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-SIX)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody. Mr Jenkins.

MR JENKINS: Could I call Siobhan Collins please.

SIOBHAN COLLINS, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q Can you tell us your full name please?
A Siobhan Marie Collins.

Q I think it is Mrs Collins.
A Siobhan will be fine.

Q I am going to call you Mrs Collins. Would you tell us your qualifications please?
A I am a registered general nurse.

Q When did you qualify as a nurse?
A I qualified in Ireland, in Limerick, in 1997 – 1987, sorry.

Q That is all right. Did you work in Ireland for a few years after qualifying?
A Yes, I worked in Ireland for quite a number of years. We moved to this country in 1994.

Q Where did you move to when you moved to this country?
A We moved to Gosport.

Q I think you continued nursing in the Portsmouth/Gosport area.
A Yes, between the Queen Alexandra Hospital in Portsmouth, and I started at a local nursing home as well. Then I moved to St Christopher's in Fareham.

Q We know St Christopher's; it is a small hospital.
A It is now closed, yes, but it was a small cottage hospital. Then I came to work in Gosport War Memorial on the bank in late 1996/1997 and then I got a contracted post there in November 1997 on night duty.

Q Forgive me, some of the Panel are lay people, they are not nurses or doctors, "on the bank" means you were working ---
A On the bank was not agency – it was difficult at that time to get a job at Gosport War Memorial so it was where you like did an interview but you were not actually given a specific post, and if they needed you and they were short they would call you. It was at random work really.

Q Like reserve staff.
A Yes.

Q I understand. You got a full time post at Gosport War Memorial Hospital.
A In November 1997 I was contracted for 25 hours on night duty, so that worked out at

A two nights one week, three nights the next.

Q Did you ever work days once you were fully at Gosport?
A Yes, that was on a reserve list really. I enjoyed the odd day shift as well so I used to fill in for holidays and things like that, so I would work days periodically, yes.

Q I understand. Which ward did you work on when you worked nights?
B A I worked on Dryad Ward.

Q So from late 1997.
A Yes.

Q And I think you continued working at the War Memorial after the millennium for several years.
C A Yes, until 2003.

Q I am particularly concerned with the time leading up to the year 2000 and in the early part of 2000, so 1997 to 2000 is the period with which I am concerned. I want to ask you about matters on Dryad Ward.
A Okay.

D Q Who were the consultants who were treating patients at Dryad Ward during that time?
A We had Dr Ian Reid, Anthea Lord, Dr Logan.

Q Is that Bob Logan?
A Bon Logan, yes. I think there were one or two others on a locum basis.

Q Are you able to tell us why there were so many names that you have just given us?
E A There seemed to be a huge turnover of consultants; it was no sooner that one was settled in the routine of doing the regular wards and they were sidelined to something else and another one arrived.

Q There were locums as well you told me.
A I think there were, yes, quite a few times.

F Q Would you ever have been present for ward rounds, when ward rounds took place?
A Yes, I have been once or twice but not as the main nurse. I liked to sometimes come in for the ward rounds because it gave you a fuller picture really, rather than just being on night duty all the time.

Q Was that you coming in off duty as it were?
A Yes, I did that once, but sometimes I would have been on a reserve for that afternoon
G on a day shift perhaps.

Q I want to ask about the types of patients that were on Dryad Ward when you were there at the end of the nineties; are you able to help us with the sort of conditions that patients had?
A We were a continuing care ward, that was our remit, and patients were transferred to us from either Haslar Hospital or Queen Alexandra Hospital. As time went on the patients
H were definitely much iller when they arrived to us, quite a lot were quite poorly and I would

feel safe to say that I did not feel they were ready for transfer when they were moved. That was probably because there was a huge demand on acute beds in Queen Alexandra. They were trying to make space where they could and they were trying to move people on in order to alleviate their problems.

Q You had worked at Queen Alexandra Hospital you told me before going to Gosport.
A Yes, I had worked there for a while, yes.

Q Had those problems been there when you worked there?
A There was a certain demand on beds but I did not really witness that, I have to say, when I worked at Queen Alexandra.

Q Of the patients that were being admitted into Dryad Ward, you have said they were admitted for continuing care.
A That is right.

Q What did that mean, continuing care?
A Continuing care meant to us that they would either stay with us long term or perhaps we would encourage some gentle rehabilitation if we could at all possible, and they would then move perhaps to a nursing home. Continuing care really is for patients who were, unfortunately, not well enough to enter into an intensive rehab programme with a view to going home – that really would not be a continuing care remit.

Q Were the facilities at Dryad Ward good enough to engage in intensive rehabilitation?
A No.

Q In what way were they not?
A We did not have a regular physiotherapist on the ward; they came for a few hours here and there but we did not have somebody specifically assigned to us, which would be essential really if you were to have an intensive rehabilitation programme.

Q You have told us that pressures on beds in other hospitals meant that patients were coming to you.
A Yes.

Q What was the condition of the patients typically that were arriving in the last few years of the last century?
A In the last few years I would say that certainly half if not more were very ill, very poorly, ill patients with quite a catalogue of ailments really.

Q What would you say about how stable patients were medically?
A I would say a lot of them were unstable when they were admitted.

Q You had been nursing ten years or so at that time.
A Yes.

Q So you had quite an experience of nursing patients. What would you say about the suitability for transfer to Gosport of some of those patients?
A I would think that some of them probably were not adequately stabilised before they were transferred. It is quite a big, cumbersome task, especially for somebody who is quite

poorly and ill to be moved into an ambulance, then driven around and transferred again. It actually contributes quite a bit to their illness and I did feel they were not properly stabilised in the acute sector before they were moved to us.

Q If patients arrived at Dryad who were not properly stabilised before they arrived, they underwent transfer, how in general terms did the condition of some patients change – if it did – once they arrived at Dryad?
A Some patients were transferred back because we did not have any acute facilities as such and if they needed intravenous treatment of any description or further investigations they were transferred back.

Q Clearly some were not transferred back.
A Some were not transferred back; they would be people who had really gone past an acute illness but due to a catalogue of a lot of ailments had become terminally ill really is the word.

Q Can I ask you about Dr Barton?
A Yes.

Q How much contact would you have with her whilst you and she were working on Dryad Ward?
A In the morning time my shift would finish at 8.45 so on a week morning, Monday to Friday, I would see her most mornings and when I would be finishing my shift she would come to the ward, usually at about 7.30. When I was on day duty I would probably see her maybe in the afternoons when she came back in to clerk a patient. There would have been other times I would have had contact with her over the phone regarding a patient we had on the ward.

Q Let us go through the day as it were with you. If you saw Dr Barton in the morning would you have started handover or completed handover when she arrived at about 7.30?
A We normally had our nursing handover at that time.

Q Right.
A And then the ward sister would usually do the handover with Dr Barton. I did on occasion do that when the ward sister was not there.

Q Right. I should have asked, what grade of nurse were you?
A I was an E grade at that point.

Q So a staff nurse.
A Yes.

Q Would you ever be second in command on the ward?
A Yes.

Q If you were second in command and Sister Hamblin was busy might it be you taking Dr Barton round the patients?
A Yes.

Q When Dr Barton was in in the morning and you or Sister Hamblin or one of the other

nurses were telling her about the patients would Dr Barton see any patients?
A Oh yes, we normally walked round each bed, she said "Good morning" to the patient, asked them how they felt and she saw everybody on the ward, all patients. It was not just conducted from the nursing station.

Q I understand. If there were any results from any tests or if there were any further tests required.
A That would then be discussed.

Q Would that be dealt with in the morning or later in the day?
A It depended on when they had arrived, those results. If we had got them late the previous evening they would be dealt with the following morning; if they arrived in the course of the day she would be contacted to say they had arrived and these were the results.

Q If you were taking Dr Barton around patient by patient, what would you be telling her about the patients as you went round?
A I would have told her how they had been since her previous visit the previous day, what acute problems might have cropped up in that previous time. If they had expressed that they were in any discomfort whatsoever, either pain perhaps – a lot of elderly patients do suffer from constipation and she would then prescribe something if that was required, or any other issues really that would have arisen we would discuss each and every one.

Q To take an example, if a patient had an acute problem, let us say chest pain, and Dr Barton was told about it in the morning when she came round, would you ever see an examination?
A Yes, she would examine the patient. We would obviously have recorded their vital signs, blood pressure, pulse, respirations, temperature, anything like that. She may sometimes order an ECG as a result of that but she would examine the patient to see what was the cause.

Q If there was any change in medication for the patients.
A She would make that change, yes.

Q She would be using the prescription sheets in the morning if that were necessary.
A That is right.

Q I am grateful, thank you. How busy was she on that morning ward round?
A I would imagine it was quite intense really because she came to our ward, Dryad, on which we had 20 beds, and then she went to Daedalus Ward where there were 24 beds, so it was quite a lot of patients to see really.

Q You told us that if patients were transferred in Dr Barton would see them.
A Yes, if they had been transferred from an acute ward she would either come back in the afternoon to clerk them in or, if she was not available, one of her colleagues at the surgery would come.

Q Would you be present ever when Dr Barton was clerking in a patient?
A I have there once or twice, yes.

Q On those occasions what happened?

A A We normally had the nursing and medical notes of the patient transferred from the other hospital with them.

Q Yes.
A She would obviously go through that and then she would go and see the patient, ask them how they were feeling, examine them carefully.

B Q What sort of examination would there be?
A She would normally conduct quite a thorough examination really and then make the appropriate notes. She would listen to any concerns the nursing staff had since the arrival of the patient and the arrival of Dr Barton coming to see them on the ward. We would obviously have done some preliminary assessments when they came – vital signs and perhaps a Barthel score, a Waterlow score which is quite indicative of their capabilities really, of what they are capable of doing for themselves.

C Q What about pulse and blood pressure?
A Yes, we would do all vital signs.

Q The nurses would.
A Yes.

D Q You said that the notes would normally be available.
A There were a few occasions when the patients were transferred and the notes did not come with them for some varying reasons and we may have had to wait a day or two until the clerk had found them, and then they came across.

Q I understand. You said quite a thorough examination Dr Barton would do.
A Yes.

E Q Involving what?
A She obviously went to the bedside, spoke to the patient; she would examine them, listen to their chest. As well as that I am almost certain she would have felt their tummy for any signs of any problems there and if there were any relatives present she would have spoken to those.

F Q You have seen doctors clerking in patients in other settings, have you?
A Yes, I have.

Q What would you say about Dr Barton's clerking in compared with that of other doctors?
A I felt she was very thorough.

G Q Would Dr Barton be in the hospital at any other times? You have dealt with the morning for the ward round; we have dealt with clerking in patients. Would she be in at other times during the day?
A Yes, if there was a family that had requested to speak to her, she would come back at different times to speak to them once an appointment had been made or had been arranged.

Q Were you ever there for those discussions?
H A No.

Q Did you see Dr Barton speaking to family members on the ward?
A No.

Q We have heard that on occasion a patient may be written up for medication, which they did not then need. They might be written up for PRN?
A That is right.

Q And on occasion that would involve a syringe driver and drugs such as diamorphine or midazolam that might be written up some time, maybe days, before a patient might require it?
A That is right.

Q Can you tell us why, in your view, that was being done?
A That took place, what I would say prescribing in anticipation really, simply because our out-of-hours cover for the hospital was very, very poor and, in the event of a patient being unwell, we would the have to call somebody and say, "Mr So and So is actually very unwell and in severe pain", and we may then have to wait three to four hours, sometimes a lot longer, for somebody to come and prescribe something. Now, I will say that a syringe driver medication ordered in anticipation would only have been charted for patients who were at that point very unwell and unlikely to survive.

Q I understand. If a patient was written up in an anticipatory way for a syringe driver, in what circumstances might the syringe driver be started?
A When it would be indicative that the patient was in a lot of pain.

Q How would you know that? What would be there for nursing staff to see to indicate pain?
A If they are conscious, they are able to tell you that they are actually in a lot of pain. If they are not, sometimes if they make appropriate gestures, if you say, "Can you squeeze my hand if you have pain" and that is consistent once you have asked them two or three times, and it is actually consistent that they can do so. Patients who could be extremely agitated from time to time when they are in pain, you can note by their facial expression, by moaning sometimes.

Q We have heard that some patients might have bedsores or the skin was breaking down and on occasion special mattresses were used?
A That is right.

Q Patients were turned two-hourly and things of that nature and dressings changed?
A That is right.

Q If you are nursing a patient and changing their position every two hours or changing their dressings or changing the sheets, what might that tell you about the patient, if you are moving them for that sort of purpose?
A When they are moved, that is a time when pain will in fact manifest itself, quite clearly. Some people, once they find a little position, then they do not want to be moved from that because it causes them intense discomfort and pain, and they will in fact become very anxious when they are then moved with the idea that this is actually going to to cause me pain and hurt.

Q If it appeared that a patient's level of pain was such that it would be appropriate to start a syringe driver, who would make that decision or how would the decision be made?
A If it were in the day time, Dr Barton would be contacted.

Q If she was not on the ward, how would she be contacted?
A We could ring the surgery where she worked at Forton Road and we could speak to her there.

Q What about if it was out of surgery hours?
A If it was out of surgery hours or at night time when I worked a lot of the time, I would call the night sister to come and review the patient. They would make an assessment; we would assessment together, and then it would be a decision we would both come to to see if it was appropriate for them to start on a syringe driver for pain relief.

Q What about if it was evening, not night time?
A In the evening, we would still probably contact Dr Barton up till about I would say 10 o'clock at night time.

Q So you had a phone number for her?
A Oh, yes, we had a home phone for her.

Q If you contacted Dr Barton outside working hours, how did she deal with it?
A Well, she would listen to our concerns and then one of us would probably say that we do feel that the patient is very ill and in a lot of discomfort now and in a lot of pain, and she would say, "Yes, I am happy for you to begin a syringe driver".

Q If it was in working hours or the evening, Dr Barton would be contacted before a syringe driver was started?
A That is right.

Q If it was at night time, she would not be, but a decision would be made involving senior nursing staff?
A Yes.

Q What about after a syringe driver had been started, if it was felt that the level of analgesia being provided was insufficient or needed to be adjusted in some other way, up or down?
A We could increase the syringe driver only on --- We obviously would not increase it, what shall I say, with a huge jump in dosage; you would gradually go up until you had reached an element where the patient was in fact comfortable.

Q You he told us Dr Barton would be contacted or a senior nursing staff would be involved in the decision to start the syringe driver?
A That is right, yes.

Q Who would be consulted, if anybody, before a decision was made to change what was going into the syringe driver?
A Likewise, Dr Barton would be contacted, yes, in the same sequence.

Q If you were starting a syringe driver, at what level would you start the medication?
A We would start at the minimum dose for somebody who had not already been on oral opiates, so to speak, and then, if they had been on oral treatment previously, we had a conversion chart that would convert the oral dose to the equivalent to put in the syringe driver.

Q Who else knew that medication was being written up in an anticipatory way?
A Everybody knew that attended the ward; all the nursing staff knew, any other doctors that saw the patients knew.

Q How do you know that the other doctors knew?
A Well, they would come, review the patient and obviously look at their prescription chart and it was there for them to see.

Q We know that some patients died on Dryad Ward.
A Yes.

Q The Panel has seen that in some cases an entry in the medical records along these lines was made by Dr Barton: I am happy for nursing staff to confirm death.
A That is correct.

Q Was that something you ever saw?
A Yes, I did see that.

Q What did you understand was the meaning behind that entry?
A That entry would be made when somebody was in fact very poorly and it was imminent. So Dr Barton then would make that entry. She was quite satisfied that a senior nurse was capable of checking to make sure that the patient had in fact expired, really, and would make the necessary note to that.

Q If, on night duty, a patient died and there was not the possibility for nursing staff to confirm death, what would happen or should happen – if the patient dies?
A There always was ---- We had adequate nursing staff that that situation really would not arise.

Q Can I ask you about patients who may be approaching the terminal stage of their lives?
A Yes.

Q What would you say about levels of consciousness that patients who are dying may be in, if someone is a day or maybe a week away from death?
A Levels of consciousness would vary really from one patient to another. Some patients can be conscious right up to within a very short time, minutes, before death; others may actually be unconscious for quite a considerable number of days prior to death, so it does really depend on the individual involved.

Q What about patients who are taking no medication, who are not on a syringe driver or opiates, does the same apply to them or are they in a different category so far as levels of consciousness?

A A They probably might be more conscious, but then again that does depend on the actual conditions they are suffering from.

Q You were involved in dealing with a number of patients that this Panel has heard about.
A Yes.

B Q What would you say about the level of nursing care that was being provided for patients when you were working at Dryad between 1997 and the middle of 2000? How good a job were you doing?
A I think we did quite a good job actually.

Q Why do you say that?
A I feel at that time we did not have a very big change-over of staff, which was excellent
C from the nursing point of view. When nurses came to the hospital, they tended to stay and we did not have a lot of agency or bank – that is what I started out as – and I would say that we were all relatively well experienced in looking after poorly people.

Q Was it a nice place to work?
A Yes, it was a nice place to work.

D Q Why was that?
A It was not a very big hospital; it was quite small. Staff knew each other from other wards. In the event of one ward being short on one shift and their having maybe an extra member of staff on another ward, they would come across and help, or vice versa. It worked really as quite a good unit, I would feel.

Q How friendly were the relations between nursing staff who treated patients on Dryad?
E A Quite good I would say, yes.

Q What about the standards of medical care that were being provided for patients over the same period? You told us that there were a number of consultants, and some came and went, doctors and locums?
A Yes. I would say the standard of medical care was very good actually. We had a very good element of trust between the nursing staff and Dr Barton specifically. She knew us
F quite well over the years and I think we were all very much aware of where we stood with medication and things like that, and nobody would enter into administering any medication lightly without a full consultation, and we had a very good element of trust and a good rapport where we all felt we knew what to do in a situation.

Q The Panel knows that there were some concerns expressed by one or two relatives of patients at the War Memoriam Hospital?
G A That is correct.

Q And that there was a bit of publicity about things, and indeed a police investigation?
A That is right.

Q From your perspective, what would you say about whether things were done appropriately or inappropriately for patients?
H A I think things were done appropriately for the situation we were in at the time.

Q I am going to ask you to explain that – "for the situation we were in at the time". We know things changed and a full-time doctor was appointed?
A That I right. We did not have that facility at the time. Perhaps in hindsight we should have all got together and said, "We have not got enough medical cover, it is not good enough". We did not and I feel I do not believe for a moment that any patients suffered in any way as a consequence of the reduced medical staff. I just think we compromised between us to reach quite a good, excellent, understanding as to how we would manage the situation.

Q What did suffer if you were dealing with more complex patients than had been there earlier or if you had insufficient medical cover, as you have just told me? What did suffer?
A I would think in some situations where we had to transfer patients back to QA, obviously patients did suffer, certainly in those instances where they had come over maybe today and then in two days' time they had to go back in an ambulance, be transferred back. Patients would have suffered in that case, but the patients that stayed with us I would not think suffered in any way.

Q How busy were the nursing staff during again those two or three years that I am asking about, 1997 to 2000?
A We were busy. Yes, that is true.

Q We have seen some paperwork and you and I are just about to look at some paperwork. We know there were lots of care plans for patients. Nursing summaries ...
A Yes.

Q ... and other documents such as Barthel and Waterlow scores. If nursing staff were very busy in dealing with patients what would you say about the standards of the paperwork that were being completed during those years?
A I would say, in hindsight again, our paperwork could have been better but at the time I think we spent more time with patients than writing about them. That is what I feel.

Q I do not know whether you would have seen Dr Barton's notes?
A Yes, I did.

Q Her clinical notes about patients. If you were giving medication you would certainly have seen the prescription sheets to see what was prescribed for patients.
A Yes, that is right.

Q Are you able to give us a commentary on Dr Barton's medical notes and the extent to which they may have suffered because of pressures of time?
A I am not certain that I am adequately qualified to make that comment but, in my opinion, her notes were brief, but what was not written, information regarding patients, would have exchanged through conversation, either at the desk, at the nursing station, or at the patient's bedside, over the phone through conversations. That, obviously, was not recorded in the notes but there would have been a huge information exchange through conversation itself.

Q I understand. What would you say about Dr Barton's wishes for her

patients?
A I would say she had their best interests at heart, that she wanted them to be comfortable and that she really prescribed medication in order that they would be comfortable and not in pain.

Q We know that after she resigned in 2000 that she was replaced by a doctor who was there full-time, nine to five, Monday to Friday.
A That is right, yes.

Q That the level of consultant cover was increased as well for the ward.
A That is right, yes.

Q How did that change things once there was a full-time doctor there at Dryad and Daedalus?
A It made quite a big difference really because this doctor was there for seven/eight hours a day, could prescribe medication – we did not then need really this anticipatory prescription because he was there to see them as things arose.

Q So were syringe drivers used after Dr Barton left, so far as you recall?
A Yes. Not as much.

Q What about the doses? Did they remain at the same levels once this new doctor came or did they change?
A They might have changed slightly but that would have been titrated on an individual basis for each patient, but, overall, I would not say the doses changed.

Q Can I take you to some specific patients?
A Yes.

Q I am going to start with Ruby Lake, please. If you look to your left and in front of you there is a file marked F.
A Yes.

Q I think there is only about one entry that I need to ask you about, maybe two. It is not done to confuse you, but there are several sets of pagination at the bottom of these pages. If you turn, please, to page 388. In this file the numbers match, so 388 is written three times on this page. It gets more tricky in the other cases. I hope you will have a nursing care plan ...
A Yes.

Q ... for Ruby Lake? The named nurse is named as Lynne Barrett.
A That is right.

Q We have an entry for 18 August 1998.
A That is right.

Q Signed by you, I think?
A That is right.

Q I think you have signed the first three entries?
A Yes.

A Q Two on 18 August and one on the following day?
A Yes.

Q Your writing is so clear that I do not think I need to ask you to read it for us. We have had other less legible forms of handwriting. The second line, you have said:

B "Woke very distressed & anxious. Says she needs someone with her."

Would you have given the Oramorph that you have then written up?
A Yes, I would.

Q You have said:

C "... with little effect. Very anxious during the night. Confused at times."

A That is right.

Q Does it follow that you kept an eye on Mrs Lake as the night went on?
A Yes. When I say that she needed somebody with her, she was obviously
D quite frightened as well so it would be safe to say that probably a member of the nursing staff would have probably sat with her for a while to see if she settled and she would have to be monitored very closely then during the night.

Q I do not know if you recall this lady, Ruby Lake?
A I vaguely do, yes. I recall that she was very poorly when she came in.

E Q I think if you turn, please, to page 368E, we see that Mrs Lake was started on a syringe driver on the 19th.
A Yes.

Q I do not know that you have any entries on that page?
A No.

F Q If you turn three pages further towards the front of the bundle, to 368B.
A Yes.

Q Do we have some Oramorph there?
A Yes.

Q Does that show the Oramorph that we have just seen?
A Yes, on the 19th, just after midnight.

G Q A quarter of hour after midnight, 10 mg, that is 5 ml, and you have initialled it "SC". That is you. Yes?
A Yes.

Q If you go back to 388, please? Then we have an entry for 19 August?
A Yes.

H

A Q Which is in your handwriting, "Comfortable night". Does that relate to the night of the 19th to the 20th?
A Yes.

Q You say, "Settled well. Drowsy but rousable this a/m". "this a/m", would be the 20th?
A Yes.

B Q Thank you. Because you say, "Sips of oral fluids tolerated. Syringe driver satisfactory". That is the syringe driver we have just seen had been started on the 19th?
A That is correct.

Q "Sips of oral fluids tolerated". You are giving Mrs Lake drink?
C A Yes.

Q Thank you. You can close that file, certainly for my purposes. I am going to take you to Mr Cunningham, which is our file G which is probably in the two rows of files on your left. There are two grey boxes to your left. It should be in there.
A Yes.

D Q In there I hope you will find an entry at page 874, so it is really very near the back of the main tab. I do not know if you remember this gentleman? He had an old war injury from the Second World War, which meant he had a spinal problem and we know about a very bad bed sore on his sacral area. A pressure sore.
A He had quite a horrendous sacral sore actually.

Q Yes. I think the entry we have on page 874, the other page number is 880 of 928, an entry by you on 21 September of that year, dealing with the dressings on
E his buttock. Yes?
A That is right, yes.

Q Again, I think if we were to look a few pages forward and a few pages back we will see the various nursing care plans that dealt with Mr Cunningham?
A Yes.

F Q Back to 874, you say dressing was applied at 1830 hours.
A That is right.

Q "Absorbine cream", obviously some form of treatment, "to black necrotic area, zinc & caster oil to surrounding skin. Very agitated", you have said, "@ 1730 [hours]"?
A Yes.

G Q Oramorph you indicate given at 2020 hours?
A Yes.

Q "Pulled off dressing to sacrum"?
A That is right.

H Q I am going to ask you to turn to page 861 as well. There are entries for that same day ...

A A Yes.

Q ... showing that Mr Cunningham was admitted from the Dolphin Day Hospital that day, the 21st?
A Yes.

Q Seen by Dr Barton and Oramorph was given before his wound was dressed. Those are notes by Shirley Hallman.
A Yes.

Q There is then indication that he remained agitated until about 2030 and the note we have just seen from you indicates that Oramorphine had been given at about 2020.
A That is right, by me.

Q Subsequently, the syringe driver was started at eleven p.m. at night, 2300 hours?
A That is right, yes.

Q There is then, for the following day, a note saying that the syringe driver had been started the following evening:

> "... for pain relief and to allay his anxiety following an episode when [Mr Cunningham] tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers",

- and we see the rest.

A Yes.

Q If we go back to 874, was that what you were referring to, "Pulled off dressing to sacrum", or was that something different?
A No, that was something different.

Q If he had exposed himself, pulled out his catheter, would your note have referred to that?
A Yes, I believe it would.

Q Easy to deal with the bed sore with this patient?
A No, he had quite a horrific bed sore actually where it actually had to be packed in the actual - it was quite a hole, so to speak. What we did there was we tried to use Absorbine to help to get rid of that necrotic tissue and then what we did was we applied zinc and caster oil on the surrounding skin because we did not want to damage the good skin with the Absorbine, so that prevented that getting on there. Then the hope would be to actually remove all that dead tissue and then, quite a long process, gradually the wound would granulate from inside out, hopefully. That was the plan.

H Q From your experience of nursing patients with that sort of pressure sore/bed

sore, what level of pain can people be in?
A I would imagine he had quite a severe pain. The surrounding tissue would obviously be extremely tender, especially where the pressure sore was positioned. He was actually sitting on it all the time so it was very hard to relieve the pressure from it, so that in itself would cause quite an intense amount of pain. There probably would have been quite a few of the nerve endings in the surrounding skin exposed where the necrotic tissue had moved away slightly which would have caused quite a severe amount of pain as well.

Q I understand. We have heard that people react differently to pain.
A Yes.

Q People experience pain in different ways.
A Yes, they do. We all have a different pain threshold, I would imagine. Some people can tolerate it quite well. Others cannot.

Q Yes. Again, looking at the bed sore with this gentleman ---
A I would imagine anybody, even with the highest level of pain threshold, would have experienced quite severe pain with this type of complaint.

Q I understand. Thank you. I am going to turn to Patient J, please. I think it is the file that will be on your left. Sir, there are two entries in the records with Else Devine, Patient K. I am not going to take Mrs Collins to those. I think there is one entry in the case of Mr Wilson, Patient H. Again, I do not think it is necessary to take Mrs Collins to those. (To the witness) The file for Patient J, if you would. I think we have an entry by you on page 78?
A Yes.

Q Barthel, I think?
A That is right.

Q How do you know it is you?
A It is my writing.

Q We see that the Barthel score goes down over time.
A Yes.

Q Down to 1. Are you able to help us with which is your writing? All of it?
A All of it is my writing.

Q So the three assessments over the course of that week, on 23 August, 30 August and 1 September 1999?
A That is right.

Q All done by you?
A Yes.

Q If you go over the page to page 79, this is a nursing care plan dealing with sleep ...
A That is right.

Q ... it says. Not "sheep", "sleep".

A A Oh yes. That was meant to be an "l".

Q Yes. I think it is your handwriting from the top of the grid, as it were?
A Yes, the whole page.

Q I understand. Again, I do not think I need take you through the detail of it. I think there are other entries that you have made with respect to this patient. We
B see some on page 38, do we? 82 first.
A Yes.

Q You will see why it is that I say your handwriting is easy to read, compared with what is above, "condition remains ill", is it, "but comfortable"?
A That is right.

C Q "Oral hygiene attended to". Tell us what that means, if you would?
A That would mean that when patients are at end of life really they sometimes mouth breathe, is what we call it, so they breathe with their mouth open slightly. So as a result of that their mouth is very dry and, obviously, it is very uncomfortable for them. So what we would do is use some swabs, some glycerine and lemon swabs, to clean the inside of the mouth and just keep it moist and their lips moist if they were unable to take any fluids orally.

D Q Over the page, page 83, this is another nursing care plan, dealing with constipation.
A Yes.

Q Entries that you have made?
A Yes.

E Q We do not need to go through the detail. I do not think there are entries by you on the following page, 84, but another nursing care plan, clearly, that you have written up on page 85?
A Yes.

Q I do not know if you remember this gentleman? He was very, very big.
A That is right.

F Q We have heard that a different mattress had to be brought in for him.
A That is right, yes.

Q They started him off with two beds on the ward and then they had to get another mattress.
A That is right.

G Q Again, I do not need to take you through the nursing care plan dealing with the elimination of urine, but you have done another care plan dealing with personal hygiene on page 87?
A Yes.

H

Q There is another nursing care plan set up a day later on page 97. Mr Packman was admitted to the ward on 23 August, which I think triggered your care plans – the ones we have seen.
A Yes.

Q This is one on the follow day, 24 August.
A Yes.

Q Dealing with malodorous sores to buttocks and between thighs and blistered areas to his feet and heels from pressure sores.
A That is right.

Q We have seen records to indicate that it needed six people to move him from one bed to his new mattress.
A Yes.

Q I do not know if you recall trying to move Mr Packman.
A I was not involved in that move so to speak, he was not moved from one bed to another when I was on duty.

Q I do not know if you recall him having a serious downturn three days into his admission.
A That is right, he became very unwell.

Q And I do not know if you were aware that he was experiencing melina.
A That is right, yes.

Q It is blood in the gastrointestinal tract.
A It is indicative of perhaps a gastrointestinal bleed when melina occurs.

Q I do not know that there are any entries made by you about passing blood rectally but if you turn to page 63 as an example.
A Yes.

Q There are indications that on the 25th, two days after his admission, Mr Packman was passing fresh blood rectally.
A Yes.

Q On the 26th there is an indication four lines down into the entry for that date, "Unwell at lunchtime. Colour poor, complaining of feeling unwell."
A Yes.

Q And then subsequently a further deterioration. These are entries by Sister Hamblin.
A That is right.

Q If you were on duty over those days would you have known about his condition?
A Yes.

Q I do not think there are further entries over the subsequent days in your writing about Mr Packman. We have heard that he remained at the War Memorial and died some days later.
A That is right.

Q The last patient I want to take you to is a lady called Enid Spurgin, Patient I. Page 91 if you would.

(After taking instructions) I should have stayed with Mr Packman for one more bit. You remember Mr Packman.
A Yes.

Q What would you say about him being transferred back to another hospital; you have told us that some were?
A It was discussed. If he was to be transferred back that would be for further investigation really regarding his gastrointestinal bleed and it was decided that on the whole he was unlikely to survive the journey back to QA and on admission there they would probably decide that he was too unwell to undergo any investigation or any surgery. Following discussion it was decided that he would be kept at the War Memorial and basically kept comfortable and out of pain.

Q Who were you involved in discussing Mr Packman with?
A That would have taken place at handover between night and day but it probably would have been discussed with his family or Dr Barton would certainly have discussed it with some of the senior nurses on day duty at that time.

Q We know that Dr Reid was involved at some stage, a couple of days later, in this gentleman's care.
A Yes.

Q Let us come to Mrs Spurgin if we may, page 91 please. Again, it is the typed numbers.
A Yes.

Q There are entries by you on this nursing care plan.
A That is right.

Q Nothing of particular detail save you have noted that she slept well on 31 March 1999.
A That is right.

Q And on 1 April you have made a note about the wound in the right hip was oozing large amounts of serous fluid and some blood.
A That is right.

Q There are further entries by you on 6 and 7 April.
A Yes.

Q There are no more by you on that page but over the page, it should be page 94.
A Yes.

Q For 11 April we know from the previous day something appears to have happened. She had been leaning to the left and was now experiencing difficulty swallowing.
A That is right.

Q On the 11th we know that the syringe driver started about that time. You have indicated "Condition ill, tolerating sips of oral fluids. Not anxious to be moved in any way."
A Yes.

Q She did settle for long periods – we know that was a Sunday, 11 April.
A Yes.

Q There are two entries by you for 12th and a further entry for the 13th.
A Yes.

Q What we know with this patient is that Dr Reid saw her. I am going to ask you to turn to page 174 if you would.
A Yes.

Q If we just look at the diamorphine on that prescription chart we know that she was administered the syringe driver with 80 mg of diamorphine.
A Yes.

Q At 8.00 am on the 12th – that was a Monday.
A Yes.

Q We know that Dr Reid saw her some time that day, probably in the afternoon, and that he took the view that the patient was very drowsy and that the administration was at too high a level.
A That is correct, yes.

Q So the dose was discarded and a lower dose of diamorphine was instituted and we see that that was 40 mg of diamorphine.
A Yes.

Q That was set up at 16.40 hours on the 12th.
A That is right.

Q If we go back to your entry on page 94, what we know is that this was a night shift that you were working.
A Yes.

Q "Condition remains ill." We know it is night because the care plan that you have written says "sleeping".
A Yes.

Q So it is your entry for the night of the 12th and into the 13th, is that right?
A That is right.

Q "Condition remains ill, urine very concentrated." You have written:

"Oral hygiene attended to. Syringe driver satisfactory. Appears to be in some discomfort when attended to."

A That is correct, yes.

Q Discomfort then, notwithstanding the syringe driver then at 40 mg over 24 hours.
A The syringe driver was at 40 mg at that point, yes.

Q I think the last entry I need to ask you about is page 146. Again, it is a brief entry by you on the third line, just about incontinence.
A Yes.

Q I do not know if you remember this lady at all.
A Not particularly, no, I could not say I do.

MR JENKINS: I understand. Thank you very much, Mrs Collins. Would you wait there because you may be asked a few questions by other people?

THE CHAIRMAN: Mr Kark, the witness has been on the stand for over an hour. Unless you have very little I would propose to take a break now.

MR KARK: Not a lot but not very little.

THE CHAIRMAN: Then we will give the witness a break. You will be taken somewhere now where hopefully you can get a cup of coffee or tea and relax for a few minutes before we come back to continue with questions. We will return, please at 11 o'clock.

(The Panel adjourned for a short time).

Cross-examined by MR KARK

Q I am going to follow the same sequence as Mr Jenkins did but I have got far fewer questions of you. You told us about Dr Barton's practice of examining the patients and I just want to understand when it is that you say she examined them. When they were clerked in do you say that she performed a full examination then?
A Yes, I believe she did.

Q You said she would examine them thoroughly and make the appropriate note.
A Yes.

Q So far as that is concerned we have heard that when she clerked patients in she would generally come back at lunchtime.
A Perhaps lunchtime or in the afternoon.

Q Would that be a less hurried occasion than the ward round?
A Yes.

Q What opportunity did you have for seeing what note it was that she was making?
A Once we had got the notes from the acute ward that would have been transferred with the patient, then she would obviously, following her examination, make any entries that

A would have been perhaps different to what had been in the notes that had been written or any extras that she needed to add on.

Q What I was asking is what opportunity you had for watching this process because you were generally night staff?
A I was generally night staff but I did do some day duties.

B Q What percentage of your time did you spend on day duties?
A I would say I did on average 25 to 30 hours a month to fill in.

Q About five sessions a month.
A About five or six sessions a month roughly.

Q Your evidence is that when you saw her examine patients you were never aware of
C her not bothering to make a note or making too short a note.
A She always made a note certainly, yes.

Q Were you ever present when changes of medication became necessary or a change in the condition of the patient and Dr Barton was there?
A No.

D Q Apart from occasions when she clerked patients in on what occasion would she thereafter examine the patients, were you there when that sort of thing happened?
A Sometimes in the mornings, yes. She would come in at 7.30, roughly about that time, and she would go around each of the 20 patients that we had.

Q She would not have time to examine every patient, would she?
A No, she would speak to them, just say good morning perhaps, and if there was not any
E change she moved on to the next one. If anything had presented itself during the night or any acute things she would deal with that.

Q And make a note about it?
A Yes, if needed be.

Q In relation to anticipatory prescribing what you said – and this is just my quick note,
F which will not be nearly as good as the transcriber's – is that that did take place. It was in anticipation because the out-of-hours cover was very, very poor.
A That is correct.

Q I just want to explore that with you. We have heard that Dr Barton's practice itself provided round-the-clock out-of-hours cover, either with practitioners at the practice or locums. Were you aware of that?
G A Yes, I was aware of that but at times we would have had to wait quite a considerable length of time before any of them would have been able to come to the ward to see the patient.

Q Could you get them on the telephone generally?
A Usually.

H Q That would either be Dr Barton herself or one of her partners.

A A That is correct, but we would not have been able to begin any medication unless it had been charted on the prescription sheet. We were not allowed to take verbal orders for controlled drugs over the phone.

Q So far as the syringe driver medication being prescribed in an anticipatory way, what you told us was that that would only be charted for patients who were very unwell and unlikely to survive.

B A Yes.

Q Does that mean in reality patients who were assessed to be dying or assessed to be for terminal care?

A Yes.

Q You told us about the fact that if the syringe driver was started, in your understanding

C it would be an indication that the patient was in a lot of pain – those are the only circumstances you said that you would start the syringe driver.

A Yes, that is correct.

Q How would you note that?

A First of all it would be necessary to look at what the patient was in fact suffering from which would be indicative of whether that would be causing them pain. For example, a

D fractured femur ---

Q Can I stop you for a moment because we might be at cross-purposes.

A Sorry.

Q My question was how would you note that; in other words what note would you make?

E A In our records.

Q In your records, yes.

A I would have written that the patient was in fact complaining of pain, was in fact very distressed, very anxious, especially it depended on what level of consciousness the patient was in. If they were conscious they would tell you that they had pain and then I would make a note of that. If they were not then it would be something else that would be indicative.

F

Q Anxiety of course can be an indication of pain but many ---

A Not always.

Q Quite. Many patients may be anxious for many reasons.

A Yes.

G Q And that would not always be an indicator for morphine, would it?

A No, it would not.

Q You also told us that you would "start on the minimum dose if not already on oral and if the patient was on oral morphine we had a conversion chart".

A That is right.

H

Q You were not asked more about that but can I just ask you a little bit about it. What sort of chart was it?
A We had a chart in one of our folders which basically did a conversion from oral to subcutaneous or oral to IV treatment.

Q Right.
A It is also in the *BNF*.

Q I was just about to take you to two documents that may help you. Please take up file 1, tab 4, page 6. First of all, look at the beginning of this document, which is page 1. Do you remember this document at all?
A Yes.

Q You do. Did you have these available to you on the ward?
A Yes, we did.

Q Did you on occasion refer to it?
A Yes, quite regularly.

Q If we look at page 6, do we see a heading "Use of Morphine"?
A Yes.

Q If you go to paragraph 7:

"When oral administration is not possible because of dysphagia, vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver."

A Yes.

Q "The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between 1/3 – ½ allowing some flexibility depending on the requirement for increased or decreased opioid effect."

Were you aware of that?
A Yes.

Q Is that a principle that you applied?
A Yes, we knew that conversion to morphine was half and conversion to diamorphine was one-third.

Q Sorry. When you say "conversion to morphine was a half"---
A From oral to subcutaneous, you halved it for morphine.

Q Diamorphine is generally what we are dealing with.
A It was one-third.

Q And you were aware of that?
A Yes.

Q Then, if you go to tab 3, you will find the BNF. In fact, you will find several BNF, but I am going to invite you to look at the first one, which I think is relevant to your period there which is '97.
A Yes.

Q Have a look at page 5. Do you recall this document?
A Yes.

Q Can you see that there is a conversion rate at the bottom of that page as well?
A That is right.

Q After the first entry, which is 5 mg every four hours converts to 15 mg, which in fact is a half, thereafter it is approximately one-third?
A That is right.

Q Converting from oral down to diamorphine. You knew that?
A Yes, we did.

Q Was that reflected in the chart that you had or is this one of the charts?
A This is one of them, yes. That is right.

Q So the document that you are referring to in the folder is either the BNF or ---
A The BNF or a palliative care book.

Q So you as nurses would have had those charts available and no doubt you would have been very careful indeed to try and stay within those guidelines?
A Yes.

Q I want to ask about staffing levels. You said – and again forgive me, it is my poor note and if you think I am mis-quoting you, you should back at me – "I think things were done appropriately for the situation we were in".
A That is right.

Q "With hindsight perhaps we should have got together and said we do not have enough medical cover". Then you said, "I do not think patients suffered but we did compromise in order to deal with the situation".
A Yes.

Q Then you clarified it by saying that the only patients who suffered were those who were transferred back. I just want to explore that a bit. First of all, do you think there was in effect some element of compromise because of your staffing levels?
A I think our note-keeping and record-keeping was compromised.

Q Because we have heard that Dr Barton's notes, and I think she accepts, were not terribly good.
A Yes.

Q And you are saying the nurses' notes were not on occasion terribly good.
A That is correct.

A Q Would you agree that that is quite a potentially dangerous combination, is it not?
A No, I do not. I think that perhaps the actual written notes left something to be desired, but what we exchanged through handover and information exchanged through conversation would have left no area for discrepancy.

Q So you are telling us that in effect you were happy with what was taking place but reliant, in part at least, on oral hand-overs?
B A Yes.

Q In relation to the 20 or 24 patients that you were dealing with?
A 20, yes.

Q Did the compromise, such as it was, extend, do you think, to starting patients on syringe drivers earlier than they would otherwise have been started on them?
C A No.

Q Or giving them higher doses of opiates?
A No.

Q You told us, however, that when the new change came in, Dr Barton left and a new consultant came in who was there I think did you say eight hours a day?
D A Yes, he was staff grade. He was not a consultant.

Q He was not a consultant but a full-time doctor?
A Yes.

Q You said that syringe drivers were still used but not as much?
A That is correct.
E
Q Did you understand why?
A Because I believe that there was an element of nervousness, to be truthful, on starting them, due to the circumstances that had been highlighted previously.

Q Does it follow, if that is right, that syringe drivers were used less and levels went down as well – levels of opiates in the syringe drivers?
F A Probably, yes.

Q I am going to turn very briefly to the individual patients that you were asked about. The first one was Ruby Lake, file F. I am not gong to turn up al the notes each time but just on this occasion can you turn to page 388 again?
A Yes.

G Q This lady had actually transferred to your hospital on the day that you made this note, I think, on 18 August. Do you remember that?
A Yes, that was her admission date.

Q She was an elderly patient, was she not?
A Yes.

H

A Q Did you fid that this was not an uncommon event that when faced with new surroundings a patient, particularly an elderly patient, might well be confused, disorientated and anxious?
A Yes, a change in their environment often caused them to become quite confused really because it is quite a new situation for them.

B Q Were you aware that up until arrival at your hospital this woman had not been on any regular opiates, apart from codeine phosphate?
A Yes, I was aware of that.

C Q I think earlier in the day she had received 5 mg of Oramorph, effectively almost on admission when she arrived or very shortly after she arrived. Can you help us: how did you fix on the figure of giving this elderly lady 10 mg of Oramorph?
A Well, she had settled for a little while, as I had noted, up until about midnight and then she was in fact very distressed and very anxious, so then I gave her 10 mg, which would have hopefully had --- I arrived at that dose basically because I had seen that into the night this lady also had had a fractured hip, so that would have meant a considerable amount of pain and I would have discussed it with another nurse and we would have decided that probably 10 mg would have been appropriate for her to have.

D Q You see, in this note what you are talking about is anxiety, in that she wants somebody to sit with her.
A Yes, that is correct, which somebody would have done.

Q Were you aware that she had been written up for temazepam?
A Yes, I was.

E Q Temazepam would have helped her sleep, would it not? It would have sedated her?
A It probably would have helped her sleep but if somebody is very distressed and very anxious, temazepam is not really going to be of any major significance because you need to help reduce the anxiety, certainly, and the distress.

Q Did you understand that Oramorph can in fact on occasion increase and elderly patient's confusion?
A Yes.

F Q You knew that?
A Yes, I knew that.

Q Would you have been the senior nurse on duty this night making this decision?
A I probably would have been the nurse in charge of the ward, but I would not have been in charge of the hospital.

G Q Oh, no, I understand that. So far as this decision is concerned, you would have taken the lead?
A Yes.

Q There is no reference here, is there, to any pain?
A No, there is not.

H

Q Can we turn now to file F, please? We do not need to go back to the file but perhaps I should have asked you. It is obvious, is it not, that if Oramorph is not written up, it is not the sort of drug that you could give without a doctor's prescription?
A Oh, no, never.

Q And if temazepam only had been written up, presumably you would have given temazepam?
A Possibly, but I would have felt that it probably would not be of any benefit to this lady. Even though I have not made a record that she as in any pain, I think it would be fair to say that somebody following a fractured femur would have a significant amount of pain.

Q It depends how long after the operation I suppose?
A It does to a certain extent, yes.

Q I as going to turn on to Mr Cunningham, Patient G. You have described this gentleman's, I think you called it, quite horrendous sacral sore --
A That is correct.

Q I just want to look at the timing very briefly with you of these events. There appear to have been two occasions in fact when he pulled his sacral dressing off?
A That is correct.

Q The first one was after you had applied Acerbine to the sore?
A That is right

Q We have heard a bit about Acerbine. It is quite unpleasant stuff, is it not?
A It is, yes.

Q And you have to put on gloves to deal with it?
A Yes, that is correct.

Q Can it sting?
A Oh, yes, it can.

Q Just so that you are reminded of your own notes, I think you were on page 874 of the document that you were referred to. If you want to have reference to it, please do. The notes that you have made were that he was very agitated at 17.30?
A Yes.

Q That was an hour later, and I am just trying to get the timing right as it is all a bit upside-down, is it not?
A That is correct.

Q An hour later you apply a dressing at 18.30?
A That is correct.

Q Just short of two hours after that you give him some Oramorph?
A That is correct.

Q At what stage do you say he pulled off the dressing to the sacrum?

A I would anticipate probably after he had had the Oramorph.

Q And you say that because?
A Because I made that entry at the end of my shift before I was going off.

Q When would your shift end?
A My shift would end at approximately 8.30.

B

Q In the morning?
A No, at night. I was obviously on an afternoon shift here.

Q Sorry, you are quite right. When you are knocking off, as it were, you go back and you make a note in this patent's records about what had happened to him at 5.30. Yes?
A Yes, that he was extremely agitated earlier on. I would not have given him the C Oramorph straight off because as I recall this gentleman had some mental health problems, and sometimes you can actually talk to them and help them and they may settle, and, especially having the sacral sore, I had felt that maybe he would settle, but obviously he had not.

Q Can we see how things progressed after your note? If we go to page 861, this is Nurse Lloyd I think?
D A That is right.

Q So this is after you have gone off duty?
A That is correct. She was obviously on a night duty.

Q And after you had given him 10 mg of Oramorph at 8.20?
A That is right, yes.

E

Q "Remained agitated until approximately 8.30", so that may appear to be the Oramorph kicking in?
A Yes.

Q But then this note, and you do not know what happened that night, do you?
A No, I do not.

F

Q "Syringe driver commenced as requested". Is that a note you have ever seen before?
A No, I have not seen that previously.

Q And you cannot help us as to who might have requested that?
A I cannot really. I know Nurse Lloyd was a D grade on the ward, so I am sure she would have had to discuss it with somebody, either a night sister or a doctor.

G

Q The syringe driver seems to have been started at about eleven o'clock?
A Yes.

Q Then he is described as being peaceful.
A Yes.

H Q You cannot help us as to the background to that at all with that patient?

A A Not during that night.

Q Patient J, please. I do not have anything to ask you about Enid Spurgin so we can move to Patient J. I am sorry. Having said I was not going to do this, of course I am. I am going to ask you to turn up the note again, page 78.
A Yes.

B Q Your attention was drawn to the Barthel score. Is this all your writing?
A Yes, it is.

Q Your attention was drawn to the fact that it had gone from 6 down to 4 down to 1. What is that? About a week?
A Yes. It is quite a deterioration.

C Q It is quite a deterioration. This patient (as we can see if we want to turn up page 147, which is the drug chart, when you first made your note on 23 August) was not on any morphine at all.
A Yes.

Q On 26 August he was started on Oramorph and by 29 August he was on 60 mg of Oramorph a day. Then on the 30th he was started on the syringe driver.
D A Yes.

Q That might well account for that Barthel deterioration, might it not?
A Yes, in combination with his medical issues.

Q We cannot ignore the opiates that he was receiving, can we?
A No.

E Q You spoke about a discussion which took place in relation to the transfer back of this patient because of what you perceived to have been, correctly I suggest, his GI bleed.
A That is right.

Q Can you actually remember this discussion?
A Not clearly, no.
F

Q Are you saying in reality - because before I explore it with you, it may be important - "that must have happened but I cannot actually remember it happening now"?
A Yes.

Q So you would not be able to help us as to who was involved or when it took
G place?
A No.

MR KARK: Thank you very much.

<u>Re-examined by MR JENKINS</u>

H Q Can I just ask you about two matters? The first is Ruby Lake, Patient F. You were asked about her and how it came to be that you gave Oramorph when

A you did.
A That is correct, yes.

Q If you just want to open the file again, because I am going to ask you to look at one additional document. It is just in front of you. We were looking at page 388.
A Yes.

B

Q Again, this is the day that she came in, 18 August 1998. You were on nightshift and you saw her that night?
A That is correct.

Q You gave some Oramorph and you have not made a note. You told us she was in pain?
C A No, I have not made a note.

Q I wonder if you could just go back one page to page 387?
A Yes.

Q This is a document signed by Lynne Barrett, staff nurse, on the dayshift when Mrs Lake was admitted.
D A Yes.

Q On the 18th. In the box dealing with pain, she has written, "yes".
A Yes, that is correct.

Q What would that mean to you?
A That would mean that when Lynne Barrett did the assessment on this lady when she arrived at the ward and she asked her these questions: Lynne would have
E asked her, "Are you in pain", and she would have answered, "Yes".

Q I understand. Thank you. You can put that away. You were asked about conversions of oral morphine to diamorphine, you told us. Intravenous diamorphine as well. Would you have dealt with conversion after 2000, after Dr Barton left, and in the years that followed?
A Yes.

F

Q Can we just go back to the circumstances in which a syringe driver would be started?
A Yes.

Q Or the dose administered via a syringe driver might be changed. Yes?
A Yes.

G

Q What you told us was that if a syringe driver was to be started, Dr Barton would be spoken to if the syringe driver was started during the day or during the evening. Yes?
A That is correct.

Q At night you would speak to a senior nurse?
H A Yes.

Q Someone above your grade of nursing?
A Yes.

Q Clearly. Who would be doing the conversion? Would it be you or somebody else?
A It would be me in conjunction with whatever other nurse I was discussing it with. I would never feel comfortable to commence a syringe driver without discussing it with another nurse. That was our policy. So there would be two nurses involved in the decision and in the conversion.

Q Again, most of the time, if you are able to tell us, would it just be nurses discussing it or would the doctor be involved?
A The doctor would be involved, I would say most of the time.

Q The decision to start the syringe driver, does that indicate that the patient's condition has changed?
A Yes.

Q Are you able to tell us how frequently it would be that you are simply starting a syringe driver for a patient who has already been on oral opiates and you are just transferring the mode of delivery from an oral route to subcutaneous route?
A Yes, that happened quite regularly.

Q But the patient's condition had changed in the circumstances?
A Yes, they would probably have deteriorated in the sense that they may no longer be able to swallow correctly and then it is not appropriate to try to give them oral medications at that point.

Q You have told us as well that if their pain increased?
A Yes. If they had a significant - well, we would not have started a syringe driver if they were still able to take things orally. We could, in fact, ask to have the oral dose increased to a much higher level and see if that would work.

Q What you have told us is that the range of diamorphine written up for the patient, where it might be a variable range you would start at the lowest dose.
A We would, yes.

Q Unless they had already been on some other medication?
A Yes.

Q If it is discussed with a doctor or a senior nurse, why are you doing the conversion?
A It would have been discussed, obviously, but in the situation where perhaps in the night where two nurses would make the decision, we would start with the lowest dose.

Q But if you are increasing what the patient is getting via the syringe driver, if they are on the syringe driver and you are increasing the level of medication given via the syringe driver ---
A We would gradually increase.

Q I understand, but do you need to do a conversion for that, if you are just

increasing?
A I would do, for my peace of mind.

MR JENKINS: I understand. Thank you very much.

THE CHAIRMAN: Thank you, Mrs Collins. We have reached the point I mentioned earlier in the morning when it is open to members of the Panel to ask questions of you if they have any and I shall check now to see the position there. There are no questions from the members of the Panel so it follows that your testimony is at an end.

Thank you very much indeed for coming to assist us today. It is enormously important for this process that panels such as this enquiring into events that very often take place months, indeed years, in the past do have the benefit of live evidence from witnesses such as yourself who were there and can help us to build up a clearer picture of the circumstances and situations of the time. For your assistance in that regard today we are extremely grateful. So thank you very much indeed. You are free to go.

(The witness withdrew)

MR JENKINS: Sir, I am going to read some statements to you. They are statements from Gillian Hamblin. She is not well. Mr Kark has seen her medical certificates from her GP to confirm that she is seriously unwell. I am told by Mr Kark there is no objection to these statements being read but that they are not agreed statements. She is not well enough to come. I can tell you, and Mr Kark knows, she was not, unfortunately, well enough to give evidence at the inquest. What the coroner was told was she was keen to give evidence but simply not able to do so because of her medical condition.

You have heard, I think, statements from Staff Nurse Giffin, which were in a similar category, a witness who had made statements in the past but was not able to make evidence before you. It follows that there is no transcript of Sister Hamblin's evidence at the inquest that can be read to you.

MR KARK: Can I just confirm that is right. Strictly, you would normally in a criminal case have to give leave for this sort of evidence to be heard because it is not agreed evidence. I accept that there is a proper basis for it to be read to you because she is, unfortunately, extremely unwell and there is no other way of you receiving her evidence, but I think just for the sake of the record, as it were, you formally have to make a decision that you are willing to accept this evidence. It is not objected to at all.

THE CHAIRMAN: I will take brief soundings. Yes. All of the Panel members are quite content in those circumstances for us to receive the evidence in the form of it being a statement read by Mr Jenkins. Thank you.

STATEMENT OF GILLIAN ELIZABETH HAMBLIN, Read

MR JENKINS: Sir, thank you. I have two statements that we have prepared. I have been asked to read extracts from statements that Sister Hamblin gave to the police and I am happy to do so. So far as the statements that we have prepared,

there are two copies on the desk in front of the stenographer. This is the first statement. It is dated 23 October 2007. It carries an endorsement similar to those that I read yesterday, namely that the statement is true to the best of the knowledge and belief of the maker and it is made knowing that she will be liable to prosecution if she has wilfully stated in it anything that she knows to be false or does not believe to be true. It says this, "Gillian Elizabeth Hamlin", she gives her address in Gosport, Hampshire.

"I am a Registered General Nurse, having qualified in 1970. I had first become involved in nursing in 1965 as a cadet and commenced a three year qualification course in 1967 at Hackney Hospital, East London, working on all wards until my qualification as a Registered Staff Nurse on a Surgical Ward.

Following my qualification I worked in a variety of hospital posts before taking up an appointment as a nurse at the Gosport War Memorial Hospital in 1976. At that time, the Hospital had a male ward, a female ward, a further ward for children, together with a casualty department, an out-patients department and an operating theatre. Each patient at the Hospital would be looked after by his or her own General Practitioner.

After about 18 months, I moved away from the Gosport area. My late husband was in the Royal Navy and was posted to other parts of the country. I therefore held various roles at other hospitals, before returning to the Gosport War Memorial Hospital in 1987 and moving to the Redclyffe Annex in February 1988. Initially, I held the post of Staff Nurse on the Redclyffe Annex, which was located a short distance from the main hospital, dealing with palliative care and long stay patients. In due course the structure of the Hospital then changed, with the male ward becoming known as the Daedalus Ward, and taking both male and female patients, and Redclyffe annex moving to the main hospital and becoming Dryad Ward in about 1995. I then become the Nursing Sister on Dryad Ward. Dryad Ward would deal with continuing care patients, palliative and terminal care, post-operation and fracture patients generally of the age of 65.

Over a period of time the bed occupancy rate on the Ward increased. Consultant Geriatrician, Dr Ian Reed decided that the Ward should be taking more patients in order to free beds at the Queen Alexandra Hospital. The nature of the conditions from which the patients suffered also changed over time. This process of change in terms of the nature and dependency of patients changed gradually over a period of time. By the mid 1990s the position was becoming problematic, and it steadily escalated from that point. Patients would be transferred to the Ward with a much greater level of dependency, and indeed patients would come to us when they were more acutely ill, still requiring acute care, when previously they would have been kept in a hospital elsewhere for a longer period of time, and would have been more stable on transfer to us from the Gosport War Memorial Hospital. We had a greater level of orthopaedic cases, and experienced difficulties as we were a continuing

care ward, so we were not entitled to occupational therapy and thus physiotherapy.

I recall telling Dr Reed that in order to take such patients we would need other services such as physiotherapy, but this never materialised. I recall that I specifically raised my concerns about resources and the fact that it was not appropriate to transfer patients to the Ward in many instances when Consultant Dr Ian Reed became Medical Director. I met with him and with Barbara Robinson, the Patients Services Manager. I recall that Dr Reed said words to the effect "*We'll sort it out Gill*", but in fact no changes were forthcoming. Unfortunately, this appeared to be a standard response on the part of Dr Reed. The Physiotherapy Department did try to help by showing Ward Nurses what to do by way of physiotherapy, but this was on an ad hoc basis, and not satisfactory. We also required input from the Occupational Therapy Department. This too was only provided on an ad hoc basis.

Although there was this increasing demand in terms of numbers of patients and their dependency, there was no increase in staff numbers. This was again a matter which I endeavoured to raise with managers, including Barbara Robinson, but nothing resulted from it, and we were simply told that we had to get on with it.

For much of my time as Sister in Charge of Dryad Ward, medical input was provided by a Consultant and a part-time Clinical Assistant. The Consultants changed regularly over the years. The Consultant would attend once a fortnight to carry out a Ward Round, unless he or she was unavailable, for example, on holiday, when no consultant would attend for a month. One or two of the Consultants were helpful in giving advice if required at other times. By way of example, Dr Althea Lord, was willing to be contacted at any time. By contrast, however, on the occasions when I endeavoured to telephone Dr Ian Reed, he would simply indicate that the relevant General Practitioner on duty should be contacted, so that ultimately I did not consider that it was worthwhile contacting him.

Consultant input did ultimately increase following a complaint about a matter which I think may have arisen at some stage in 2000, and Consultant Ward Rounds were then carried out once a week.

For much of the time I was responsible for Dryad Ward the Clinical Assistant was Dr Jane Barton, a local General Practitioner. In addition, she was Clinical Assistant to Daedalus and Sultan Wards. I believe that she was appointed as Clinical Assistant in October 1988, resigning in 2000.

Dr Barton's position throughout the time that she was employed as Clinical Assistant was a part-time one. She did, however, carry out a significant amount of work even on that part-time basis. Following Dr Barton's departure in 2000, a full time Clinical

Assistant was appointed in her place, Dr Joseph Yikona, to carry out the same work Dr Barton had done on a part time basis.

In my position as Ward Sister I was able to assess the medical and nursing requirements. It was clear to me that Dr Barton had way too much work to do, particularly as the demands of patient numbers and dependency increased. I recall Dr Yikona complaining one day about the amount of work he had to do, and I made the response: 'How do you think Dr Barton felt, and she had Sultan Ward as well which you don't have?'

I do not believe that Dr Barton had adequate consultant backup and support. As an example of the lack of consultant involvement, in my time as a Sister on Dryad Ward I was not aware of any calls from consultants in order to check on patients under their care.

A once a fortnight ward round was, in my view, in no way adequate in dealing with the needs of patients, certainly from the mid 1990s onward, and for the support of the nursing staff and Dr Barton.

Throughout my time as sister in charge of Dryad Ward there was no increase in umbers of nursing staff. The various consultants were aware of the problems in relation to staff numbers, but did not seem to be able to do anything about it. I felt able to raise the issue of nursing staff expressing my concern, but the culture at the time was not such that this enabled me to raise the question of the lack of medical resources.

I recall that at one stage I arranged for all the nurses on Dryad Ward to talk to Dr Ian Reed to discuss our concerns about nursing members. I cannot now recall precisely when this meeting took place, but I am clear that nothing resulted from it by way of any increase in nursing numbers. Indeed, I recall that at the end of the meeting Dr Reed came to me to indicate that he would not be available on the ward for a period of six weeks and that it would be necessary to employ a locum.

I left the Gosport War Memorial Hospital in 2004, having been on sick leave from 2002.

From my years of experience in working with Dr Barton, I can say that she was fantastic with all of our patients. As a part-time clinical assistant, she would come to the hospital at about 7:30 each weekday morning and carry out a ward round, seeing every patient. The ward round would be carried out with me if I was on duty or with one of the senior nurses if I was off. Every patient on the ward would be seen by her and she would endeavour to speak with each of them. She was concerned to get to know them and their families. On the ward round we would report to her about the patient's condition and what might have happened overnight. Dr Barton would not examine each of the patient's records as a routine, but only those we directed, where the patient needed more by way of review or, for example, if results had become available and further assessment of a patient was then needed. Dr Barton would then leave Dryad Ward at about 8:00 in the morning in order to carry out a similar ward round on Daedalus Ward. Having completed that ward round, she would then leave the hospital to attend at her local surgery.

On the ward round, Dr Barton would examine the patient if there was any particular problem or concern, as needs be. In many instances, given the nature of the patients on the ward, the nature of the problem more often than not was related to the patient's chest.

Dr Barton would then return to the ward at lunchtime on at least three of the five weekdays in order to clerk in patients who had been admitted, or review patients further if they were ill or deteriorating. She would also be willing to see relatives if they were concerned to meet with her then. Similarly, Dr Barton would return to the hospital in the evening to see patients, if there were problems and we needed her assistance, and again to see relatives. The need for her to attend in the evenings was generally less than at lunchtimes, but she would certainly be willing to come to the ward if it was necessary. Indeed, Dr Barton made it perfectly clear that the nursing staff could call her at any time to review a patient's condition or for advice and she was entirely happy with this.

In addition, Dr Barton would generally attend the consultant ward round once a fortnight, though on occasions she had to cut this short in order to attend a session at her GP surgery.

If we needed to contact Dr Barton on the telephone we would generally do this up until about 7:00 pm. In my experience it was rarely necessary to contact the doctor after that time, although there were occasions when we called her beyond 7:00 pm, for example, if we had concerns about a particular patient or were dealing with a particular family. The only time when we tried to leave her in peace was when she had a weekend off, not being on–call as a GP over the weekend. When Dr Barton was not due to be on-call at a weekend she would come in on the Friday and go through absolutely everything with us to make sure that all that needed to be done was done with us and for the patients and I would describe her as fantastic in this regard.

As some measure of the way in which we found her assistance to be of a very high order, we felt lost when she was off on holiday or away ill. Her GP partners who stood in for her did not achieve the same standard in her place.

When a patient was admitted to Dryad Ward, a member of the nursing staff would carry out routine observations, including blood pressure, temperature, pulse and testing the patient's urine. A nurse would always be present when clerking in by Dr Barton took place so I was present on many occasions when Dr Barton then proceeded with her review. In my experience, the nature of the patient's medical notes which were available on transfer varied. Sometimes all the notes were available, sometimes a limited selection, and on occasions nothing at all. Dr Barton would, if the material was available, scan the history in relation to the admission and would then carry out a full assessment as I would expect on a full clerking in by the doctor. Although she would not re-do the basic observations already carried out by a member of the nursing staff, she would review the relevant body systems, including chest and abdomen, and of course paying attention to any relevant area or condition from the patient's history.

I am conscious that Dr Barton's entries in the medical records were brief. This was so both for her initial assessment or clerking in, and her subsequent reviews of patients. Her notes did not reflect all of the various things which were actually undertaken for the patient. The initial assessment would be a full one, even if not noted in a comprehensive fashion. In my view, the important points in relation to the patients were written down, but Dr Barton would not repeat what was already contained in nursing notes or list a whole series of negative findings. From my experience over the years in working with Dr Barton, it was quite clear to me that her notes were necessarily brief, resulting from the considerable demands on her time. Quite simply, she had so much to do that it was not possible for her to attend to all of her clinical duties in seeing and assessing and indeed carrying for the patients, and then making comprehensive notes about her reviews. In my view, the quality of her care was not compromised or limited, but given the constraints on time, she had no alternative but to keep her notes more limited in order for her to cope.

I am conscious at the same time that the nursing records were not as extensive as might be found elsewhere, and similarly these deficiencies were attributable to pressure of time. The choice was one of limited care and the completion of paperwork, or proper provision of care with paperwork suffering on occasion. This was essentially the same choice facing Dr Barton.

Dr Yikona's hours were generally 9:00 am to 5:00 pm, although I recall that there were occasions when he was there until 7:00 pm catching up with her paperwork. In my view, the actual amount of medical care delivered by Dr Barton was no less than that provided by Dr Yikona. The difference between them was that Dr Yikona would have the opportunity to write up medical records due to the greater amount of time available to him. The only difference in terms of delivery of care was that it was possible for Dr Yikona to take bloods and arrange x-rays rather than waiting for another team member to do this.

I recall that over time a practice of prescribing medication on an advance basis arose at the Redclyffe Annexe. We would find that it was necessary to ring a GP at a weekend in order to commence a small dose of medication or if it was necessary to increase medication in the context of providing palliative care to patients where there could be a developing level of pain and distress, and an increase in tolerance of medication. The practice developed with patients who were perceived to be terminally ill and an increase in medication might be required, anticipating that it might not be easy to contact a doctor to enable the medication to be given, for example at weekends. I recall that when Dr Barton originally took up her post in 1988, some general practitioners when on duty at weekends would not be willing to come in when requested, but would delay for a period until it was convenient for them, with the result that patients might be in pain for a long time. The situation therefore developed whereby Dr Barton would write up medication with a range of dose specified which might then be given if the circumstances merited it. This was a practice which arose at a point at which Dr Barton had come to know the nursing staff well, and similarly we had come to know her well, so that there was significant and appropriate mutual trust between us all. Accordingly, it came to be the position that if Dr Barton on admission or indeed subsequently perceived that a patient might become terminally ill, she would be prepared to prescribe medication which might be appropriate by way of palliative care on an advance basis, with a dose range. On

A occasion, it was not actually necessary to administer medication prescribed in this way. It was, however, available if necessary.

I felt that the nursing staff had adequate training and information concerning palliative care and treatment. Dr Beewee, consultant on oncology at the Countess Mountbatten Hospital, would come to give us lectures in palliative care and, for example, use of syringe drivers. In addition, it was possible for us to contact doctors at the Countess B Mountbatten Hospital and the Rowens, a local hospice, if further advice was needed. With this knowledge and access to advice, and from the experience of working together, there was an appropriate level of trust between Dr Barton and the nursing staff, that the nursing staff were in a position to evaluate the needs of a patient in terms of relief from pain and distress, and consider what would be appropriate by way of a starting dose of medication to relieve these, or indeed by way of increase in such medication.

C

In my direct experience, the vast majority of initiations of such medication, and increases in it, took place during the day. Indeed, increases in or initiation of such medication might take place in consequence of the ward round conducted with Dr Barton even if the actual administration of medication or its increase was commenced later on. Similarly, such increase or initiation might take place after a discussion at lunchtime or in the evening, directly with Dr Barton. If, however, such D liaison with Dr Barton being present was not possible, Dr Barton would be phoned when the initiation or increase in medication took place.

On occasion liaison with Dr Barton took place after the increase in medication had been initiated, but in those circumstances it would be very shortly after, and Dr Barton would at that point have the opportunity to review the position.

E In the event that Dr Barton was on duty at a weekend, she would be contacted in this way in the event that it became necessary to consider an increase in or initiation of medication. If, however, she was not on duty at a weekend we would tend not to phone her, but would contact the Duty GP. In my experience the Duty GP would generally review the position over the telephone with the benefit of the prescription already made by Dr Barton.

F In my experience Dr X was the only GP who did not like authorising the administration of medication with an advance prescription in this way. Accordingly, the nursing staff would tend to ring Dr Althea Lord in the event that Dr X was on duty. Dr Lord was herself entirely content to consider initiations and increases of medication on the basis of such advance prescriptions.

From my own knowledge, every consultant responsible for Dryad Ward was aware of G this practice of advance prescribing. It would have been readily apparent to the consultant when carrying out a ward round, simply from reviewing the drug charts of patients where such prescriptions had been recorded. Each consultant reviewed the drug charts with such prescriptions in my presence on ward rounds. From my knowledge, through discussion with all the various consultants, all were aware of how this system of prescribing operated. I am aware that Dr Lord would write such prescriptions herself when she considered it appropriate, had it not already been done H by Dr Barton. Dr Jane Tandy too adopted this practice. Although aware of it, no

consultant ever raised any concern about this prescribing practice with me, neither was I aware of any expression of concern by consultants to anyone else. No restriction on this arrangement was indicated to the nursing staff by any of the consultants, and there was never any indication that the arrangement should not be applied.

When reviewing matters with Dr Barton, or when she was on holiday or not on duty at a weekend, with other doctors, there would be a substantive discussion about the patient's condition and the nature and extent of any pain and distress, and the circumstances in which that was presenting at the time. In reviewing a patient's pain and distress, in my experience the nursing staff were always concerned to consider the cause of the pain, for example, if it might be through repositioning of the patient, in which the increase in medication was potentially not required.

I am aware that from time to time Dr Barton recorded in the records a phrase to the effect 'I am happy for the nursing staff to confirm death.' I understood from this that Dr Barton would not necessarily need to be contacted, for example if a patient died at night or when Dr Barton was conducting a GP surgery session, simply for her to confirm death. Formal certification of death was of course another matter entirely. The nature of the patients admitted to the ward, and the nature of their conditions was such a not insignificant number of patients admitted would die on the ward. The understanding Dr Barton and I had from this phrase was that she recognised the potential of the patient to die, not that she believed the patient necessarily would die.

Sadly it was the case that patients were transferred to Dryad Ward in a state in which they were dying. Indeed, we had patients admitted who died within two hours of admission as their transfer had clearly been inappropriate given their condition at the time. As I understood the position, such transfers would take place in order to free beds elsewhere. Towards the end of my time as Sister on Dryad Ward it became standard practice for one of the managers to ring the ward to ask how many beds were available, and if any patient had died overnight. If a patient had died, the manager would then ring the Queen Alexandra Hospital in order to advise them, and a patient could then be admitted. I became disgusted by the way in which patients were admitted to the ward in a condition which clearly indicated such a transfer should not have taken place, but unfortunately there was nothing I could do in this regard. It was simply something which was way beyond nursing control, and as nurses all we could do was care for the patients as best we could.

The inappropriate transfer of patients in this way was something which developed over time. As there appeared to be a greater developing pressure on the Queen Alexandra Hospital so there was a corresponding increase in pressure on us through the admission of such patients.

I am not aware that any of the consultants raised concerns with Dr Barton or with members of the nursing staff about her genital standard of care of patients, her note keeping, the extent of her initial and subsequent assessment of patients, or her prescribing practice. Similarly, I am not aware of anyone else expressing any such concerns. No such concerns were ever expressed to me directly at any time. For my own part, I had no such concerns about Dr Barton's practice.

In my experience, Dr Barton had a gift for assessing patients, being able to review their condition and know what was right for them. I had not encountered a General Practitioner in my practice who had that quality. As a reflection of my view, I would be entirely happy to have Dr Barton as my own GP.

In my view, Dr Barton was a very caring person, and I was unable to fault her at all. I believe that my nursing colleagues were of the same opinion. It was possible for us to make contact with her at any time, even when she was not on duty. Her attitude towards patients was brilliant, and our patients idolised her. I do not recall any patient having a bad word for her. Dr Barton was always professional, and she would go the extra mile to get anything which a patient might require. She was by some very considerable distance the most caring doctor with whom I have worked.

As nurses we found that she was always willing to listen to us. If on a very rare occasion I was concerned about a dose of a drug, I was able to say so to Dr Barton. A starting dose might have been recorded as 20 mgs of Diamorphine, for example, and we might have considered that 10 mgs was appropriate. I found that Dr Barton was entirely willing to discuss such issues and to agree when appropriate. In fact, my recollection is that on occasions when I considered that a smaller starting dose might be appropriate, and that was then initiated, it then became apparent that an increase to the starting dose previously prescribed by Dr Barton was in fact necessary. In my experience, Dr Barton never had any concern about a nurse raising a prescribing issue with her, and she was more than willing to discuss such matters with us.

I found Dr Barton to be extremely hard working. Dr Barton was also compassionate, listening to patients and relatives. At the same time, she would 'call a spade a spade'. This was not a lack of compassion on her part. She was, for example, anxious to know that relative should know where they stood, and that she did not dress up matters in order to make them more palatable.

I am aware from direct discussions with all of my nursing colleagues on the Ward that we all felt highly of her. I never doubted her ability, or indeed had any cause to, and no member of the Nursing Staff suggested otherwise to me.

All of us were profoundly concerned when Dr Barton came under investigation. We went to Dr Lord, asking her what we could do to help her, but we were told: 'Nothing – keep quiet!'.

In the course of police investigation in relation to the treatment of patients at the Gosport War Memorial Hospital, I made a statement on 16 March 2005. In that statement, on page 2 the following observation was recorded: 'On their visits Dr Barton would prescribe the drugs that were required by each patient. This was a new concept to staff at this time'.

I do not know quite what I had been asked by the Police to produce this observation. I believe I may have been referring to the fact that syringe drivers were a new development on the Ward at one stage, and that Dr Barton would write up the drugs for that as required.

A

In discussing matters with relatives, including use of syringe drivers, both the Nursing Staff and Dr Barton would take time with relatives to explain what they involved, and why they were necessary. Sometimes relatives would be concerned that a relative might need an increase in medication because of pain which was apparent to them on a visit, and we would ensure then that the patient was reviewed and the issue discussed with the relatives. In my experience, we spent hours with relatives, and Dr Barton gave them as much time as she physically could.

B

In a further statement to the Police dated 30 September 2005 it is recorded that I stated the following: 'The practice of increasing the dosage to alleviate the pain and anxiety was not always recorded as it was evident that the patient needed the increase.'

C

By this I meant that the reasons for the increase in medication were not always recorded – not the actual fact of the increase itself. As I have indicated, the pressures of time, with the increase in numbers and dependency of patients, but without a corresponding increase in staff, meant that we were not in a position to make as detailed records as we might have wished."

Sir, that statement is signed Gill Hamblin. There is another dated 16 February 2008. You will be pleased to hear that it is much shorter. It has the same endorsement as the others that

D

I have read and it reads:

"I am Gillian Elizabeth Hamblin", and it gives her address in Gosport in Hampshire.

"I make this statement further to my statement of 23 October 2007, in relation to events at the Gosport War Memorial Hospital in Hampshire.

E

In that statement, I described difficulties which were encountered in relation to record keeping, both on the part of the Nursing Staff and the part of Dr Jane Barton, the Clinical Assistant on Dryad Ward.

I also described the arrangement which came to exist concerning the prescription of certain medications in a dose range, which prescription could be made anticipating the future need of the patient.

F

From my knowledge, I do not believe there was a situation in which a patient was ever put at risk by the more limited note keeping that the Nurses and Dr Barton were effectively forced to. We routinely communicated at handovers, ward rounds, and generally, concerning the condition and treatment of our patients.

G

Similarly, from my knowledge, I do not believe a patient was ever actually put at risk through the system of prescribing which was operated. The Pharmacist for the Hospital, Jean Dalton, attended on the Ward each Monday, reviewing all the drug charts and the drug stock. She would give advice and guidance, but I do not believe she ever raised criticism, or that concern was ever expressed by her about the arrangements for prescribing in the way that we had adopted."

H

That is signed Gill Hamblin.

I have also been given some contents of statements by Gillian Hamblin with regard to Mr Wilson and I am happy to read those. It looks like a fair old chunk of it, but I will start.

MR KARK: I was just going to say: I wonder if we could have 10 minutes and we might be able to shorten how much is needed to be read.

THE CHAIRMAN: We will break for 10 minutes, ladies and gentlemen.

(The Panel adjourned for a short time)

MR KARK: Mr Jenkins and I having just agreed how much of these can be read, this has quite properly raised another issue, which is whether the witness has actually signed her police statements because they may not have been signed, and so we are going to have to make some inquiries about that. I am afraid it may mean that we will need a little time to make those inquiries.

THE CHAIRMAN: Does "a bit of time" extend over the weekend?

MR KARK: No, I hope not. I would certainly hope to resolve it within the next hour.

THE CHAIRMAN: Very well, is there anything else we can usefully do – I can think of one – while that hour is elapsing? I take it that this is an inquiry that will be made by your instructing solicitor, Mr Jenkins?

MR JENKINS: Well, not really; I think it is really for Mr Kark to make that inquiry. He will have better liaison with the police than we have.

THE CHAIRMAN: But somebody on your team, Mr Kark, rather than you personally?

MR KARK: Yes. I will ask Mr Fitzgerald to start making some telephone calls.

There is one other matter that we can usefully raise. Apart from the reading of this statement, is that the end of the defence case, if I can just inquire?

MR LANGDALE: Yes.

MR KARK: I was going to raise the issue of the document that we are keen to put before you. It seems that there is going to have to be argument about that. Mr Langdale indicated to me this morning, I think before he had a copy, that he does take fundamental objection to it. Now that he has seen a copy, I do not know if those objections are alleviated at all, but I will take it for the moment that they are not.

MR LANGDALE: I have not seen anything yet.

MR KARK: We copied it and I intended that one should be given to Mr Langdale about 9.30 this morning. My apologies.

MR LANGDALE: It does not matter.

MR KARK: I can see that it has been copied and it is nestling next to my instructing

solicitor. I think it is probably best that Mr Langdale has that now. I do not know if it is worth me prefacing why we think you should have it in any event. I think there will be objection to it because, as I have said, Mr Langdale takes a stance, as it were, I think irrespective of the contents. I do not know if it is worth using some time now just to hear the very short points that I wanted to make as to why you should be willing to receive it.

MR LANGDALE: From what I have been told of the content of the document, I do not think there is going to be any difficulty about us dealing or at least outlining the problem between us now, it would certainly save some time, because my objections remain the same. I do not think I need to see it to know that I am objecting to its content, but I will try and take a look at it while Mr Kark is out.

THE CHAIRMAN: Similarly, we will have to decide without seeing it ourselves. I see no difficulty why we cannot deal with it as a preliminary matter.

MR KARK: On that later point, and again it is a matter entirely for the Panel, what we could do, I suppose, if you agree to it, is to see one page of it, just to see what the format is, just to see if that is going to sway you one way or the other.

Can I just begin by making the points that I wish to make about why we think it would be of considerable assistance to the Panel to receive this document?

The GMC has called or read some 40 witnesses to speak about the practices at this hospital, to speak about Dr Barton, and to speak about the 12 patients that you are dealing with.

You heard, as part of the GMC's presentation of its evidence on 24 days or so of evidence and, as you know, those 24 or so days of evidence generated several thousand pages of transcript. I have got mine in either four or five lever-arch files.

You heard evidence in relation to each patient and each patient has their own multi-factorial issues. It has been demonstrated throughout, frankly by all of us, me perhaps most of all, that it is difficult to keep 12 patients in mind; it is impossible to keep the evidence relating to each issue in mind. Although we called the patient relatives in as best an order as we could, thereafter we called nurses, consultants, doctors and the expert, none of whom dealt with the patients in order, as it were.

This document we hope to provide you with does give you, first of all, a map, as it were, of the central issues in the case, not just those which assist the GMC but including things like Dr Barton's work and her character, about which a great deal has been said, and much of which assists her. Through each of the issues that has been raised in this document we have striven to present a balance of the evidence.

The document contains only evidence. There is no commentary in it whatever. Where evidence has been summarised, and by necessity some evidence has been summarised, and also where it is quoted directly, you are provided with the reference in the transcript by day and page so that you can, on any occasion in which you feel the necessity to do so, go to the evidence in its expanded form.

I would say that this is not a wholly novel idea. You are not a jury sitting in a criminal trial. You are a professional disciplinary tribunal. Panels often ask for written speeches. They

A often ask for skeleton arguments and they often ask for schedules of evidence or schedules of exhibits and the like to help them to work through the material that they have. This, it has to be said, is a large and complex case. I do to know, but it may be one of the largest and most complex cases that any of you as a panel member has had to deal with. In order to keep the evidence relating to each document in order, this document will, we believe, help you enormously.

B Finally this, and this may be the biggest attraction of all. It is likely to cause a cut in the length of my speech by something like, I expect, two to three hours because it means that I will not then have to read out large parts of the evidence, which you will have in the document in front of you.

As I say, we think it is very difficult to bring back to mind each issue and each witness who has given evidence about each issue. Although it is a lengthy document and I remember the C exasperation from yesterday when I said it was 130 pages, it is a vast reduction on the amount of transcript that you might otherwise have to read, and so that is why we would like to put this document before you as a tool to assist you.

MR LANGDALE: Everything I say, obviously, is on the basis that I have not seen the document. I am learning a little bit more about it from what my learned friend has said, but may I just outline now what we submit are serious and real objections D to proceeding in this way?

What Mr Kark is seeking to do is to put before you a document which is not evidence. In relation to documents which are not evidence, the normal rules and procedures, as I understand it, are that such documents may be placed before a Panel by agreement, and, assuming of course the Panel says it is ready to accept such a document and we have one or two classic incidents in this case. The very E helpful patient histories, by agreement, reflecting material that is contained within a large number of documents, selected by agreement and put into a form which I think everybody has found helpful. So I am not objecting to the possibility of something which is not evidence being put before you. Similarly, there have been other aspects in the case where material has been put before you.

I have no objection if my learned friend finds it convenient to put before you a F schedule saying, "Professor Ford on diamorphine Day 32", whatever it might be, and provide you with a reference document, no objection to that at all, but what is being suggested is that you would receive a selection, or a digest, I am not quite sure how one properly describes it, of evidence which has been given before you, selected being the important word, and forgetting, it would seem, that this Panel has to consider, whatever the complexities and difficulties in the case are, all the evidence. Our job, the lawyers, is to present our respective cases to you and G address you at the conclusion of all the evidence as to what are the matters which we respectively seek to remind you of or draw your attention to, interspersed, of course, with comment. That is why we are here.

We are not here to produce for you, either independently or jointly, "This is what you should be looking at". That is not your job, with all due respect. My friend is presenting this as part of his case, in effect. I am leaving aside any practical problems with this suggested course for the moment. It seems to me to be entirely H novel and, for what it is worth, I understand the experience of my learned friend,

Mr Jenkins, and Mr Barker instructing me, that they have not encountered a case where this procedure has been adopted in the format that I understand is being suggested and it will really not do, with all due respect to my friend, to say, well, this is not a criminal trial. Juries in criminal trials have to deal with masses of evidence, totally untrained people, often in relation to trials which have lasted for months. It is not suggested they receive selected digests of evidence from both the prosecution and the defence. One can imagine any judge trying such a case to go through the roof if such a course was being suggested. I appreciate this is not a criminal trial but this Panel's job, time-consuming as it may be, difficult as it may be, is to decide which bits of the evidence the Panel finds acceptable, believable, credible, whatever words one use, carrying appropriate weight and which do not.

The danger is if one seeks to introduce a document like this is that there will be a channelling, maybe unwitting, but a channelling of the Panel's attention on to certain areas which might lead to not paying enough attention to other areas. This is not a case where the Panel have to perform some superhuman memory test. None of us, of course, can remember all the detail. We all have to refer to notes, we all have to refer to records we have kept of the evidence. The Panel has full transcripts of every single word that has been said and I have no doubt at all, it is perfectly apparent, the Panel have, where they are listening to evidence in the case, made their own notes about particular points, for obvious reasons.

The Panel has the opportunity to check every single piece of evidence that has been given. It is not a case of the Panel having to somehow perform some superhuman feet, as I have already said. The Panel already has the patient histories, setting out the digest of a mass of documents by agreement. It is not really a task which either needs to be assisted by something like this or, indeed, will be assisted, in my submission, by something like that because it is not going to save time at all in the end. You will be asked, as I understand it, to take a day to read 130 pages, or whatever it is, which means Mr Kark will not be on his feet for quite as long. Well, we are all pleased when barristers cut down the amount of time on their feet, we are all conscious of the difficulties of having to listen to one person addressing you for a significant length of time, but this is not an appropriate way of doing it and I have to say I find it difficult to see how this is going to save any time at all.

I have indicated that I was leaving aside practicalities. May I just turn to them for a moment? If the Panel decide this document is appropriately provided to them, all 130 pages of it, I have to interrupt my preparation of my final presentation of the case for Dr Barton by looking through all of this document myself, deciding (and this is not something you can do in five minutes) "Oh well, what about this other bit", and then having to apply my mind as to what should be added to it, if it is supposed to be some kind of overall presentation of evidence in this case, and I can indicate to the Panel what it is I propose to do in terms of addressing you in due course.

I am proposing to make a presentation which will involve reference to certain parts of the evidence. I hope, cutting it down to reasonable proportions. I shall be able to give the Panel a reference every time I refer to the evidence of whatever witness it might be and I shall be able to précis in words to the Panel what it is the effect of that witness's evidence was on that particular point. It may be I will be quoting directly from transcripts and making direct reference to it. That is the way I have

prepared what I am proposing to do and it seems to me, with respect, that is the proper way to do it because it means the Panel is given the opportunity to decide what it is it needs to focus on.

I hope it saves time. It will mean the Panel will not only have the pleasure of re-reading the transcript of what I have been saying, just as it can with Mr Kark, you do not all have to sit there writing notes as to what counsel is saying, you get a full transcript. You can then make reference to the particular passages by turning up the transcript if necessary yourselves and deciding whether that point is a good one or a bad one or can be ignored.

I am not going to go on any more. It seems to me the course that has been suggested raises more problems than it solves and runs into a major problem in terms of it being, in effect, the placing before you of a document which is not evidence and which is not placed before you by agreement.

THE CHAIRMAN: Give me just one moment, please, Mr Kark. (After discussion with the Legal Assessor) Yes. I am sorry. Mr Kark.

MR KARK: There could be no objection, in our submission, in us putting before you a skeleton argument of our submissions, and panels often receive that. Attached to such a skeleton argument could easily be an appendix of all the transcript references that are going to come up in the speech. This document is, effectively, no more than that. It is a reference tool. Mr Langdale does not object to you being given the witness name, the date and the page number but the reality is that he knows that it will take you longer than you have at the end of this case if you are going to make reference to every single one of those references, getting out each transcript and going through them, and this is simply a convenient way of presenting that material which I want, on behalf of the GMC, to put before you.

I accept it is not an agreed document. Mr Langdale, I know, will and has been assiduously going through the transcripts for those parts which help him. I have no objection at all if they, the defence, want to produce something similar. Mr Langdale has an extremely experienced junior who from now until next Wednesday when Mr Langdale stands up has four days to read these 130 pages and indicate to Mr Langdale what, if anything, needs to be added. It is a matter for the Panel but we submit it would help you.

THE CHAIRMAN: I am not going to ask anything of either of you for the moment but I think the Legal Assessor wishes to say something.

THE LEGAL ASSESSOR: Yes. I have drafted something but I would appreciate a few minutes, certainly before one o'clock, just to put it in final form to incorporate some of the matters mentioned in submissions, but I should be ready before one o'clock.

THE CHAIRMAN: In that case I might ask a couple of questions. I am not in any sense suggesting or trailing this as a way forward, in fact, I would find it quite horrific, but, Mr Langdale, would it be right that if instead of presenting us with such a document Mr Kark, God forbid, decided to read it to us, there could be no objection to that, given that he is not giving evidence?

MR LANGDALE: Sir, no. If he was, my words, fool enough to do it in that way, it could not possibly be presented to you in that fashion and, may I indicate, if that was the course that was going to be pursued it would, no doubt, provoke a worryingly long extra amount of material which would have to be presented by the defence. It is no good saying, with all due respect, "Here is what Professor Ford said about this, this is our digest of it". You, members of the Panel, are going to have to look at that in the context of what Professor Ford was saying. I am certainly not, unless I am ordered to, going to produce a kind of counter-document to say, "Well, these are the points we want to make", because the way I have structured my proposed presentation of this case is to deal at one and the same time the way the GMC are suggesting the approach should be, or reminding you of what Professor Ford has said about this, by way of précis and then saying, "What about this?", "You ought to consider that", "The evidence of so and so was this effect", whatever it might be. That is the way to present it. It seems to me not only is that commonsense, it seems to me obviously the most helpful way that the Panel can have the case presented.

You are going to have to look at transcripts, unless you think that the summary and whatever it is that the barrister has said to you covers the case, or you think, "I remember that point, I don't need to look at the transcript". I mention this not just forensically, totally genuinely, I cannot see it saving any time.

THE CHAIRMAN: I think the pragmatic issue is one that we will obviously be considering as well as the matter of objection, but there is one, perhaps, observation that is worth making to both of you at this stage which is in relation to the issue of your objection that this would involve, in effect, the channelling of evidence.

With respect, every time the gentlemen of the Bar examine or cross-examine or re-examine a witness they are seeking to put before us those areas which they think are of interest, but, as you have seen, and it may not always sit comfortably but the Panel has its own duty of enquiry and the members of the Panel have exercised their right to ask questions which may not have been directed to specific points that counsel have felt were appropriate. The reason I raise that is that I think it is probably clear, therefore, that whatever any of you put before us, it is always our right to make of it what we will and to go beyond it if we so wish.

Reference was made to the size of this case and the experience of the Panel. There are at least some of us who have sat on cases, I regret, that extended quite considerably beyond the time that this case is likely to last and, in general, I can say I have sat with every member of this Panel before. It is a Panel that is experienced in dealing with large amounts of material, at the end of the day, and without giving anything away there are a number of techniques that panels do use in these sorts of cases to enable them to take on board and analyse and deal with large amounts of evidence. We will be doing all of those things. Regardless of anything we hear from you, I can tell you now that at the moment we have been thinking that we would be needing something like three days independent reading and reflection before we even start to talk to each other, after your speeches.

My observation is simply this: in that background, whatever you care to present to us may or may not be extremely useful or, frankly, of limited use, but, in any event, this is not a Panel that is going to be channelled in any given direction. We

have all been taking our own note, we all have our own ideas as to where particular issues have crystallised. There is some value, as you say, in the approach that you seek to take in giving us your indication of where you think those areas are and in so far as you may give us transcript references, those are always very useful because it obviates the need then for the Panel to be looking for that particular phrase before we can move on from it, but other than that there is arguably no need for us to receive any written document from you. Our view is that we tend to find whatever is produced to be of great use but we do not ever take it uncritically.

MR KARK: Sir, can I just say I am not intending in any way to put a set of blinkers on the Panel and say, "This is the direction that you should go". It has been quite obvious throughout this hearing that there is a very strong independent element to this Panel as to what they want to look into and in no way am I seeking to undermine that in any way, but this is simply a way of making, frankly, my speech easier for you to comprehend so that you follow the references which will be in a ready form. You can hand the document back after the speech, you might shred it if you do not find it useful, but you might just find it useful during the course of my speech.

MR LANGDALE: We can go on batting this ball back and forth. I think it may be sensible if I do not say anything more at this stage.

THE CHAIRMAN: We will hear from the Legal Assessor.

THE LEGAL ASSESSOR: Mr Kark and Mr Fitzgerald, on behalf of the General Medical Council, wish to produce to you at this stage of the proceedings a document into which they put a great deal of work. It is no mere skeleton, it is a substantial document, it seems, of some 130 pages. It contains reference not only to the evidence in direct form but in précis form as well and the defence object, as we have heard, stating that it presents a one-sided view of the case. There is no specific guidance in the Rules to assist you. It is a matter for you, although you may wish to look at rule 50(1). You have a discretion to decide, Mr Kark, whether to hand in the document but you have to exercise that discretion judicially. In other words, you have to weigh up carefully the pros and cons of doing so, bearing in mind your duty to be fair to Dr Barton as well as to the GMC.

You may think that the application by Mr Kark is in some respects similar to the application he made in respect of his expert's reports, although, of course, the evidence had not then been given by the expert. If it assists you, you may wish to look at the advice I gave in respect of that at day two, page 20 of the transcript, your main determination appearing at page 23 of day two, and also in respect of the fresh application made by Mr Kark at page 52 of day nineteen.

I advise that you should take into account the following matters: firstly, it would be unusual in the extreme, I advise, for a document of this size to go before a jury in a criminal trial and certainly without the agreement of the defence. It would also be unusual in the extreme for a jury to be given a written copy of a closing speech. The reason, no doubt, for that is that there is a danger of something which is not evidence being given a special status it does not deserve, even if the written transcript is no more than a copy of the speech.

Long as the document is, and, no doubt, it is fair from Mr Kark's perspective, it is necessarily selective. That is something one must expect. You could in theory rely on the document as a statement of the GMC's case, but because it is not admitted and because it is selective you are not able to rely on it as correctly reflecting the full evidential position and this, you may think, severely limits the use you can make of it. It means you can take nothing in it for granted, and that out of fairness to the defence you will have, for example, to check any précis against the full record of the relevant evidence, to ensure than nothing favourable to Dr Barton is left out. In summary, you may think that Mr Kark's proposed document is a shortcut, albeit a lengthy shortcut, to the GMC's case, but does not avoid your having to read all the evidence in the case. You may indeed think that it will in fact add to, not shorten, the amount of reading which you have to do.

This is a case in which you already have a good deal of material. You have daily transcripts, exhibits, and schedules. Importantly, you have the chronologies. You have to consider whether the additional material which Mr Kark proposes to hand in at this stage will assist you at the fact-finding stage, or whether it may in fact simply add to the burden of reading and cross-checking which you already have. I am not suggesting that the Panel cannot distinguish between the GMC's submissions on the evidence, and the evidence itself. But I am advising the Panel that it needs to consider carefully whether the GMC document will, in fact, assist it in its task.

It is, of course, the case that, if you admit the document, Mr Langdale QC and Mr Jenkins could be given time to respond in kind, should they so wish, but the situation then is that you might be confronted by two large documents. Each of these would have to be read carefully; you would have to check it against its counterpart; you would still have to check both of them against the record of evidence actually given.

It is, of course, open to you to invite both Mr Kark and indeed Mr Langdale QC to provide you with a much shorter document, whether amended chronologies or some fresh document, which contains references to the transcripts and other material, and upon which oral submissions can then be made. It is open to you to take the view that what would assist you at this stage, if you require any more documents, is a more succinct guide to the sources of evidence already given.

As I have said, in conclusion, it is a matter entirely for you but I do finally advise that you should be very cautious indeed about receiving at this stage a complex document of this nature which is not specifically agreed by the defence.

MR KARK: Can I just make one comment about that legal advice? I am afraid I do fundamentally disagree with what is in fact a comment, and not strictly the legal advice, which is that it sounds as if this document is similar to the application made in respect of Professor Ford's statements. It is fundamentally different because you have heard this evidence, you have not heard that, and so there is a fundamental difference between the two applications.

THE LEGAL ASSESSOR: All I say is that I did point out that difference in the advice I have just given.

MR LANGDALE: I do not seek to add anything save a comment on what Mr Kark has just said. Of course they are not the same but the issues as to whether they are appropriately put before you by way of documents which are not evidence are the same.

THE CHAIRMAN: Thank you. There are things that need to be done while the Panel is in camera so we will go into camera to consider that and hope that in due course we will have an answer for you and you will also have some information for us as to the statement that has or has not been signed.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

MR LANGDALE: Dr Barton is not present and we are content, obviously, that the matter proceeds in her absence.

THE CHAIRMAN: That is very kind of you, thank you. I am going to be very brief. The Panel has obviously been fairly brief in making its decision and we have not reduced into writing our decision.

Put bluntly, Mr Kark, I am afraid that on this occasion the skeleton must remain in the cupboard. We appreciate that a great deal of work will have been done by Mr Fitzgerald, but that of course cannot influence us in any way in making our decision. The Panel have taken consideration of the arguments expressed by both counsel and we have also considered very carefully the advice of our Legal Assessor. In particular we have taken on board his advice that it would be unusual in the extreme for a document of this size to go before a jury in a criminal trial, and certainly without the agreement of the defence. Clearly we are not a jury and clearly we are able as a professional panel to do a certain amount of mental gymnastics that it is not fair to expect of a jury, but we do find compelling not so much the size of the document but the absence of agreement that the Legal Assessor has pointed out to us.

He went on to advise us that we could in theory rely on the document as a statement of the GMC's case. But, because it is not admitted, and because by definition it is selective, we would not be able to rely on it as correctly reflecting the full evidential position. He told us that we might think that that would severely limit the use that we could make of it in that it would mean that we can take nothing in it for granted and that, out of fairness to the defence, we would find ourselves having to check any précis against the full record of the relevant evidence, to ensure its accuracy and completeness in so far that anything favourable to Dr Barton was not inadvertently left out.

The Legal Assessor went on then to the pragmatic aspect of the argument and said that,

> "In summary, Mr Kark's document is, you may think, a shortcut, albeit a lengthy shortcut, to the GMC's case, but does not avoid your having to read the evidence in the case. You may think that it will add to, not shorten, the amount of reading which you have to do."

I do not think we took a view as to whether it would not shorten or would add to, but we took the view that in any event there was clearly, in the absence of agreement, going to have to be

a great deal of additional checking that would obviate any value that we might otherwise have gained by the shortcut that Mr Kark outlined.

For those reasons we will not admit that document. That is not to say, of course, that the GMC team cannot put together a different sort of document, maybe something along the lines that was being indicated by Mr Langdale, but that of course is a matter for you.

Finally, I would just like to reiterate that in any event whatever is put before us will be just one more document. We will be looking at all of the evidence in the usual way. Thank you.

MR JENKINS: Sir, so far as the other matter is concerned and the outstanding statements from Gillian Hamblin, I have been reminded there was a composite statement taken by the GMC solicitors from Gillian Hamblin in which she was shown the various statements that the police took. She was given the opportunity to amend those statements and she certainly signed her GMC solicitor's statement. She did not take the opportunity to amend the statements in ways that are relevant and in those circumstances it seems to us it does not matter whether she signed the police statements or not, there is a signed statement from Gillian Hamblin exhibiting the statements that were taken or prepared by the police and in those circumstances I am perfectly content to read those passages that I am asked to do so. There is quite a lot of it – at least 15, perhaps 20, minutes worth of reading. There are numerous references to page numbers of medical records in the case of two patients, firstly Mr Wilson, secondly Elsie Devine. If you wanted to go through the records and actually draw up each page as I refer to matters it may take 25 minutes or half an hour. The alternative position is that you just let me read it into the record and look at the pages at a later time.

THE CHAIRMAN: Exactly. We have the full transcript and we can then work our way through everything at our leisure.

MR JENKINS: It is 15 to 20 minutes, I think, and I am happy to start that now if the Panel would prefer to deal with that and then take an adjournment, or I can deal with it after, whichever you would wish.

THE CHAIRMAN: We seem to be in broad agreement. The Panel are prepared to receive that now. I should indicate there is a final bit of business at the end of that. You may recall that the Legal Assessor has some matters that he would like to bring to your attention before you start to work on your final speeches.

MR JENKINS: I understand. A copy of this will be provided to the stenographers. This first statement has the name G Hamblin on it, it bears the date of 11 June 2005. I am reading extracts from it so as to avoid repetition from matters that I have already read from other statements.

EXTRACTS OF STATEMENTS OF GILLIAN HAMBLIN, read

The statement contains the following passages:

> "Dr Barton would visit at 7:30 each Monday to Friday and see every patient before returning to her own practice.

She would return to the Gosport War Memorial Hospital to check in and arrange to see relatives either that day or later.

On her visits Dr Barton would prescribe the drugs that were required by each patient. This was a new concept to staff at this time. Sister Green, who was in charge at this time, bought syringe drivers to the annexe and explained the system to the nurses and they would have learnt their use from her.

At this time there were no courses in the use of syringe drivers, but these have since been started. I am aware that there had been some concerns in relation to the syringe drivers and diamorphine, but I have not had any doubts myself. The main reason for the use of a syringe driver is to administer drugs to a patient once oral medication has ceased, generally due to the patient's inability to swallow.

I have been asked about the Wessex Protocols. I am unfamiliar with this name but am aware of certain protocols in relation to the setting up and use of syringe drivers. I am unsure if they are one and the same.

I have been asked to detail my involvement in the case of Robert Wilson, date of birth 8 March 1923. I do not remember the patient, Robert Wilson.

I have been shown [she gives a page reference] and I can confirm that I have written up the following entries on the spell summary of the medical notes.

The spell summary is the discharge notes which outline the diagnosis/treatment and follow up if necessary for the patient. This is ultimately sent to medical records at Gosport War Memorial Hospital and then onto clinical coding either at QA or St Mary's Hospital.

The spell summary is typed on the day or day after admission and not only details the patient's personal details, but the diagnosis and the relevant medical codes showing the patient's medical history. It is also based on the transfer letter which accompanies the patient. The transfer letter appears to be missing from Mr Wilson's medical notes.

I have written the following diagnosis:

> Diagnosis
>
> Fracture L humerus = broken left upper arm
> End stage CCF = congestive cardiac failure
> Renal failure
> Liver failure
> Treatment/Recommendation
> Syringe driver 16/10/98"

I will be forgiven if I interject, Mr Wilson was admitted on 14 October 1998.

"This shows the treatment which was administered by (sic) the patient. In this case the commencement of the syringe driver which was on 16 October 1998.

A This diagnosis has been obtained by me as a result of reading the medical records which accompanied the patient.

On referring to the notes of this patient, Robert Wilson, I noted that he had multi-organ failure. The prognosis that I made was that he was being admitted for terminal care at Dryad Ward.

B Treatment/ Recommendation

Syringe driver has been commenced by the medical staff which would have been Dr Barton initially.

The doctors rely on the nursing staff admitting the patient to do the initial assessment. The doctor will then subsequently write up the drug treatment chart for that patient.

C

The final entry on the spell summary that I have written is the date of death of the patient which I have recorded as 18/10/98, 23:40 hours. This entry was signed by me as being entered on 19 October 08 (sic) (which clearly cannot be right).

I have been shown the prescription chart on page 263. I note that 05:15 hours on 17 October 1998 that 20 mg of diamorphine, 600 mcg of hyoscine were administered to the patient by Staff Nurse Jeanette Florio and witnessed by Senior Staff Nurse Maggie Perryman.

D

At 15:50 hours that day I have increased the diamorphine to 40 mg and increased the hyoscine to 800 mcg. I have also added 20 mcg of midazolam.

The previous dose of diamorphine and hyoscine has been destroyed. A record of the controlled drugs destroyed is normally recorded next to the entry showing the original dose administered.

E

It is easier to destroy the dose which is already in situ and then administer the new dosage in a fresh syringe driver.

I can confirm that I have written the following entry on [your page 266]:

F

> 'pm – slow deterioration in already poor condition requiring suction very regularly, copious amounts suctioned, syringe driver renewed at 1550 (=with) diamorphine 40 mg, midazolam 20 mg and hyoscine 800 mcg. Mrs Wilson visited again this evening and is aware that his condition is poorly. She will remain on the ward overnight.'

G This entry is self explanatory. Mr Wilson's condition has continued to deteriorate.

Neither I, nor my staff, have recorded the reason for the increase in diamorphine in the nursing notes. However, it would have been increased due to pain level not being controlled by the previous dose.

I can confirm that I have written the following entry on (your page) 267:

H

A

'18/10/98

Further deterioration in already poor condition. Wife has remained overnight. Seen by Dr X who spoke to Mrs Wilson. Syringe driver renewed at 14:50 with diamorphine 60 mg, midazolam 40 mg, hyoscine 1200 mcg. Continues to require regular suction. His children had also visited.'

B

The diamorphine has been increased from 40 mg to 60 mg. This would have been to control his pain. I must point out that as well as his multi organ failure, Mr Wilson was suffering from a fractured upper left arm.

Midazolam was increased from 20 to 40 mg. This was increased because he was suffering from liver failure and, as a result, the medication would not be working as effectively. Therefore, the dosage was required to be increased.

C

The same applied to the hyoscine which was increased to 1200 mcg.

With reference to the above entry I would have been present when Dr X was called out to see the patient Mr Wilson.

D

The reason Dr X was called out was because in increase in Hyoscine was required. This can only be authorised by a Doctor....

I can confirm that I have written 2 entries on page 262 of the medical notes which is the Prescription chart.

Against the controlled drug Oramorph I have administered the drug at 100 and 1400 hours n 15/10/98 I have initialled both entries.

E

Oramorph was administered to Mr Wilson due to the pain from his fractured arm and also because he was an alcoholic. By this, I mean that his liver was not functioning as well as it should be. He was also suffering from renal and liver failure....

The amount of Diamorphine administered on 17/10/98 was initially 20 mgs; this was doubled to 40 mgs.

F

As I have mentioned this was to control the patient's pain.

The practice for administering Diamorphine to control pain was to double the dosage.

However, other factors had to be taken into account: these would include the weight of the patient plus the diagnosis of the patient.

G

The dosage could only be given up to the maximum that the Doctor had prescribed."

There is a further statement dated 30 September 2005 and I am asked to read extracts. On page 3 of the statement she says:

"Further to my previous statement of 11 June 2005, I have been asked whether I remember having a conversation concerning the usage of Diamorphine with Shirley

H

Hallman who was my senior staff nurse on Dryad Ward at Gosport War Memorial Hospital.

I cannot recollect having a conversation with staff nurse Hallman relating to concerns about the usage of Diamorphine on Dryad Ward whilst she was employed as senior staff nurse.

However, there were concerns when syringe drivers were introduced around 1988 or1989 at the Redclyffe Annexe, The Avenue, Gosport.

I remember a number of staff, in particular the night staff Nurse Sylvia Giffin, being very reluctant to use diamorphine via a syringe driver.

Sister Green, [who] was in charge of the unit at the time, arranged numerous meetings and study session with various palliative care team members from the palliative care ward at the Queen Alexandra Hospital, Portsmouth. All staff at the Redclyffe unit were required to attend. I remember Steve King, a palliative care charge nurse, together with Dr Robert Logan from the Queen Alexandra, attending a number of meetings with staff to allay their fears over the use of Diamorphine via a syringe driver.

They explained the benefit of using a syringe driver and also gave practical demonstrations on how to use/administer Diamorphine via a syringe driver.

I am aware of at least 2 or 3 sessions where Steve King and Dr Logan attended the Redclyffe Annexe. I also remember Dr Bee Wee, a consultant specialist in palliative care, attending at the Dryad Ward who gave a couple of talks relating to the use of syringe drivers, care of the dying and the drugs that could be used in palliative/terminal care.

Trained and untrained staff were present for these sessions.

I have been asked to comment about the increased dosage of Diamorphine I administered on 17/10/98 to the patient Robert Wilson....

I would have assessed the patient's condition and deemed it necessary to increase the Diamorphine to 40 mg and also add in Midazolam 20 mg and increase the Hyoscine to 800 mcg.

This increase was necessary due to the patient's increased pain and anxiety.

However, there is no written record within the nursing notes recording Mr Wilson's pain and anxiety.

The practice of increasing the dosage to alleviate pain and anxiety was not always recorded as it was evident that the patent needed the increase.

A record was always made in the ward drugs register showing the actual amounts of controlled drugs administered to each patient.

A

I would always inform the doctor (normally Dr Barton) of the change in medication given and explain the reason to the doctor.

I would not necessarily inform Dr Barton at the time if the change in circumstances occurred to the patient at night.

I would inform Dr Barton the following day.

B

I was happy to increase the dosage of Diamorphine on a sliding scale, i.e. from a small starting dose initially administered to the patient (a) to alleviate the pain, (b) to monitor its effectiveness.

The drugs such as Diamorphine, Midazolam and Hyoscine normally used in a syringe driver were prescribed by Dr Barton in a range according to the patient's needs as

C

assessed by Dr Barton.

In this case these drugs were prescribed on admission of this patient to Dryad Ward on 14/10/98.

It was policy and the guidelines to double the dosage of Diamorphine as per the Wessex Guideline book (a small green book).

D

The important factor was the assessment of the patient, i.e. if the patient was frail, then the dosage would only be increased a small amount to alleviate the problem.

With regard to this patient Robert Wilson, [he] was a large man who was an alcoholic; it therefore took longer for the drugs to have effect, which is the reason why he needed bigger doses.

E

Mr Wilson had been admitted to Dryad Ward for palliative care as he had multi-organ failure as recorded on the spell summary."

That is the end of that statement. There is another statement dated 30 June 2004, in which Gilliam Hamblin says the following:

F

"Further to my statement dated 2/2/03", and, sir, I break off: that is not a statement that I have read any part of to you.

"I have been asked to detail my involvement in the case and treatment of Elsie Devine. From memory and referral to the entries in her medical notes...."

Your pages 223 and 224 are referred to and she says that –

G

"...is a summary of significant events for the patient Elsie Devine. I have made four entries on this record which I have signed and dated. The entries are not timed as this was not the practice at the time. If a time was included it would appear in the body of the report. Significant events that were recorded [were] anything that was not the norm for the patient, i.e. any medical condition, fits, vomiting, heart attack, visits by consultant, or social workers, if the family had been seen. The care of the patient was

H

recorded on care plans for the patient and these would have been completed on a daily basis. I have recorded on this sheet, pages 223 and 224, see contact record.

This entry was made PM on 3-11-1999 and relates to an entry that I made on Devine's contact record, pages 229 and 230 that I will detail later.

15.11.99 seen by Dr Reid referral made for Dr Luznat continue Thioridazine."

She then refers to another entry and says:

"This entry relates to the fact that Mrs Devine's kidneys were failing. This had been shown by a recent blood test. Mrs Devine had had a long history of renal (kidney) problems and was under Dr Cranfield for this condition. Extremely aggressive this a.m.. Mrs Devine had been throwing the staff into a book case; this was stuff nurse Debbie Barker. During the night had been trying to pull patients out of bed, hitting out at anybody or anything. I can remember that due to her aggression Mrs Devine was given 50 mgs of Chlorpromazine, so that this would calm her down and so that she didn't go on to harm herself or anybody else.

Chlorpromazine is also a sedative but ore powerful than thioridazine. I.M. is intra muscular and means that the drug as injected into the muscle so that it acts quicker. Staff Nurse Barrett injected Mrs Devine. This drug was prescribed on the advice of Dr Barton who I had phoned at her surgery for advice. It would have been given at 0830 hours and I can remember that it was administered in the day room. '2 staff to special' means that 2 staff, Debbie Barker and Liz Bell, sat with her during the morning – 'special' means staying with the patient the whole time. In Mrs Devine's case I can remember that Mrs Devine had hold of their wrists and wouldn't let go. A syringe driver was started at 0925 hours that morning [with] diamorphine 40 mgs. Diamorphine is used for pain relief; it also has a side effect of sedating. Midazolam 40 mgms is used to calm the patients. These quantities of drugs were administered through the syringe driver over a 24-hour period. Mrs Devine's Fentanyl patch was removed. Fentanyl is the same as diamorphine, an opiate, and you don't use both together. Diamorphine is stronger. Dr Barton saw Mr Devine, Elsie's son, at 1300 hours and explained what had gone on and why she had given her the drugs that she had given her i.e. the deterioration of her health due to her kidney problems. The last part of the entry is self-explanatory.

The syringe driver was set up and the diamorphine was administered to Mrs Devine on the advice of Dr Barton. This was because the Chlorpromazine injection had no effect. To fit the syringe driver, Mrs Devine was moved to a bed in a single room. I can't recall if I spoke to Dr Barton but it would have been either me or Lyn Barrett as out of the four trained members of staff two were sat with Mrs Devine. When fitting a syringe driver or renewing the drugs in the driver this is completed by two trained members of staff because of the use of controlled drugs.

20-11-1999: condition remains poor – family have visited and are aware of poorly condition, seen by Pastor Mary.

Mrs Devine's condition was still poor. Mr Devine visited (he and his wife were the only two members of the family that I saw). Pastor Mary was the ward chaplain."

Then there is reference to your pages 229 and 230.

> "....relates to a contact record for Elsie Devine. An entry is made on a contact record when anybody comes into contact with the patient but mainly with staff members.
>
> I have made two entries on this record that are signed and dated.
>
> 3-11-99.... discussion with Mr and Mrs Devine, son, daughter-in-law. Issues discussed safety of Mrs Devine returning home. Both expressed concerns about it. Unable to do stairs and hasn't been able to do so for a while. Mrs Reeves unable to care for Elsie when her husband returns from hospital. Both agree that rest home or dual-registered is the only option.
>
> Referral to be sent to Social Services tomorrow.
>
> This entry relates to a conversation that I had with Mr and Mrs Devine. Elsie had previously been in the QA Hospital and had been transferred to the Gosport War Memorial Hospital. Her daughter, Mrs Reeves, wanted her brother Mr Devine to look after their mother; these were the issues discussed. Mr and Mrs Devine had concerns over Elsie living with them as she was unable to walk up the stairs. Mrs Reeves was unable to care for Elsie as her husband had had a [redacted] Both sides of the family agreed that a rest home (R/H) or dual registered, ie, it could have been a rest home part nursing home was the only option. I asked for a referral to be sent to Social Services. That would have been done by her named nurse (Debbie Barker).
>
> 19-11-99 (19/11/1999) Social Services informed to close the case. Mulberry Ward also informed.At that time due to the deterioration in Elsie's condition, ie, the kidney problem it was not appropriate for Elsie to be transferred. Social Services were told this along with Mulberry Ward, a psychiatric unit that Elsie had been in previously ... Having been shown [your page 281] I can say that I signed on Elsie Devine's prescription chart that I put up, administered the diamorphine 40mgs at 0925 hrs on 19-11-1999 (19/11/1999) and the Midazolam 40mgs at 0925 hrs on 19-11-1999 (19/11/1999).
>
> With regard to [your page 279C] this shows that Dr Barton prescribed the Fentanyl patch on 18-11-1999 (18/11/1999) ..."

That is the end of the statement, sir.

MR LANGDALE: Sir, with that I think I formally close the case for Dr Barton.

THE CHAIRMAN: Thank you very much indeed, Mr Langdale. I think now the Legal Assessor has something.

THE LEGAL ASSESSOR: Thank you, Mr Chairman. I give this short advice on my own initiative. It is not something which the Panel has requested me to do. My purpose in advising the Panel at this stage is to seek to ensure that important

legal issues do not arise for the first time whilst the Panel is in camera. I am keen to ensure that certain matters are ventilated in open hearing before I consider and advise and the Panel thereafter retires. No doubt the issues I am about to mention will at least be touched upon by counsel in their closing speeches and I trust that counsel will not be offended by my anticipating them.

There are two issues I would like to flag up at this stage. They are as follows: firstly, how is the Panel to deal with the fact that these twelve patients comprise only a proportion of the many patients who were under the care of Dr Barton? Is the Panel to look at the twelve patients in isolation? If not, how is the Panel to deal with any evidence relating to patients other than these twelve and at what stage of its deliberations is such evidence relevant? Secondly, evidence has been adduced that the Gosport War Memorial Hospital and people working there were under some pressure in relation, for example, to staffing levels and patient transfers. At what stage of the Panel's deliberations is that evidence relevant and to what issues does it go?

Although, of course, I independently advise the Panel after closing speeches, the Panel may wish to encourage the parties to seek to come to some consensus as to these matters prior to speeches. One recognises, of course, that that may not be possible.

MR LANGDALE: Thank you for the indication. I am sure Mr Kark and I will have some discussion about it and, hopefully, reach an amicable agreement. I do not think it is going to present a difficulty, quite frankly, but thank you for the indication about the issue.

THE CHAIRMAN: Mr Kark.

MR KARK: I am always hoping to be amicable and I hope we will find an agreement. We will discuss it, no doubt, when you rise.

THE CHAIRMAN: Very well. I take it, although it is prefaced as advice to the Panel, there is not actually anything that is required at this stage for the Panel to do?

THE LEGAL ASSESSOR: No.

THE CHAIRMAN: Very well. Thank you.

MR KARK: Sir, you did not formally indicate your assent to not sitting on Monday to allow us the extra time to prepare our speeches. I wonder if you could consider that.

THE CHAIRMAN: Yes. We were never not going to sit. We understood, prior to the objection being raised, that on Monday we would be presented with a document which we would be asked to read which, certainly, we would have accepted and read along with the numerous other documents that we have to be reading. So we have no difficulty in allowing you time on Monday whilst we continue to read, but, as you know, administratively there are distinctions between non-sitting days, reading days and so on. I am not proposing to take time out from the time that has already been allotted to us. The Panel will be here and we will

read.

MR KARK: Certainly, but you will be content if the barristers in the case are elsewhere working?

THE CHAIRMAN: Absolutely.

MR KARK: I am grateful.

MR LANGDALE: I have nothing to add.

THE CHAIRMAN: Very well then. We will rise now, ladies and gentlemen. As I say, the Panel will be here continuing with independent reading on Monday, should anything arise. Otherwise, we would expect to see you on Tuesday at 9.30. Thank you.

(The Panel adjourned until 9.30 a.m. on Tuesday, 4 August 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 4 August 2009

Regent's Place, 350 Euston Road, London NW1 3JN

GMC Space

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-SEVEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning. Welcome back everybody. Mr Kark and Mr Langdale, the Panel made good use of the time it had yesterday for reading, and I am sure that you both have made good use of your time elsewhere. Are we ready to proceed, Mr Kark?

MR KARK: Yes, sir. Sir, as you know, at this stage your function is to decide, under Rule 27(2), and determine which of any of the remaining facts alleged in the charge and not admitted by the practitioner have been proved to your satisfaction; and that of course is to the criminal standard of proof, so that you are sure – and whether such facts as have been so found proved or admitted would be insufficient to support a finding of serious professional misconduct and you shall then record those findings.

The issues in this case over the many weeks that we have all been sitting here listening to the evidence have become crystallised, and some of the issues which took up many hours of evidence are now so clear that they are hardly worth mentioning. I am not going to even attempt to deal with all 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 and focus on that evidence which, in the view of the General Medical Council, will most assist you, and it is the evidence that goes directly to the heads of charge which is going to do that.

You have heard a great deal of evidence in this case, some of which might now appear to be somewhat extraneous, and it is worth reflecting upon the charges before turning to the evidence, and the nature of the allegations fall broadly into the following heads. First, the lowest doses of diamorphine and midazolam as prescribed by Dr Barton for specific patients was too high; that the dose ranges of diamorphine and midazolam were too wide; and that doses were administered which were excessive to the particular patient's needs.

The GMC case has not set out to prove that such large prescriptions as were written were written with a specific purpose of hastening death, although on some occasions they may have had that effect. This is not a case in which we, on behalf of the GMC, say that all those patients who entered GWMH went in fit as fiddles and some, we have to recognise, were likely to die there. However, in respect of those patients who were likely to die at the GWMH it is still alleged that prescriptions were in general inappropriately high and wide.

So far as the width of the prescriptions is concerned, that head of charge has largely been admitted, although not in respect of Patients A and K, who we will look at in due course. So far as the excessive nature of the prescriptions is concerned, it is not a complete answer to these charges for Dr Barton 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.

The doctor was tackled on this by you, sir, the Chairman, and asked why they did not take the titration approach to find the appropriate level of opiates (Day 31/17), so when one does move on to the syringe driver 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 by Dr Barton that she got the amount of opiates right and that the patient needed these very large amounts, and the assumption that

A they were not overstated. Without an element of titration or some similar approach there was no way of knowing.

The doctor also said this about titration, and this was after Panel questions on Day 32/6,

> "Q Are you saying that under your watch titration was simply not being done throughout these three years?
> B A I am saying that. I was not taught it. I was not familiar with using it and it was not practical".

For any medical practitioner who was regularly prescribing opiates that is a surprising and frankly worrying admission.

The next category of charge is that the total amount of drugs prescribed was excessive to the C patient's needs. Again you will have to consider each individual patient and you will have to take into account not only what is written into the notes of the GWMH, but what was recorded in the notes before the patient arrived there as well as the evidence of the patient's relatives. Dr Barton said this to you, the Chair, at Day 31/18,

> "But if you start from the initial premise that these patients were dying and that that was the process that was going on, then it was perfectly acceptable to give sufficient D 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, in our submission, three central issues. Were all of the patients who Dr Barton thought were dying, actually dying? Secondly, what effect did that approach have on the patient's overall care and treatment? Thirdly, that approach allows for much greater doses to be given than were necessary to govern the patient's pain even applying pretty E liberal standards of prescribing.

It is a fundamental issue in this case that every time a patient was put on a syringe driver that was, for Dr Barton, for the staff and for the patient, the so-called "terminal pathway" started. When that battery got inserted into the machine and the needle inserted into the patient, that was the beginning of that patient's final journey. Hydration, we know, was not going to happen and that patient was inevitably going to deteriorate and die, and everyone knew that. F If Dr Barton's attitude can be summed up in those words - she said this,

> "If you start from the initial premise that these patients are dying";

those are the central words – then you may think it says a great deal about what was happening on Dryad and Daedalus Ward under her management.

G There is a charge that both prescriptions and administration of drugs were inappropriate for the particular patient and not in that patient's best interests. We would ask you to pay careful attention to the wording of those charges; that the administration of drugs was inappropriate for the particular patient and not in that patient's best interests. On occasion, we submit, you do not have to look much further than the quantity of the drugs prescribed and administered to these elderly and generally frail patients. For others you will want to examine the claims made that the patients must have been in considerable pain.

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This, frankly, is a problem for Dr Barton because she made such poor notes that there is nothing on occasion 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 have been noted by somebody at least. Dr Barton's position though is, "Well, if I look at these prescriptions, the only reason I would have allowed them to be administered or I would have written them was if the patient was in great pain". But that ignores the fundamental force behind the GMC's case which is that here is a practitioner who did just use excessive quantities of opiates, either deliberately or through a lack of understanding.

In looking at whether the prescriptions were or were not in a patient's best interests is not the same as looking into Dr Barton's mind to see what she thought was in the patient's best interests. The fact that there has been a lot of evidence directed at establishing that Dr Barton 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.

In relation to Patient H there is a specific charge that she failed to recognise the importance of the previous alcoholism and consequent liver disease when prescribing her standard "one size fits all" doses. The evidence which was read to you of Gill Hamblin on Friday will bear special attention in this regard, because you may think it became clear from her evidence that actually she had no understanding of the effects of liver disease upon the proper dosage of opiates. In Patient H's case that is an added feature which you will want to consider, and whether any account whatever was taken of his alcoholism when Dr Barton wrote out what was in fact her standard prescription.

The next category of charge is that Dr Barton failed to perform an adequate examination either when the patient's condition changed or an adequate examination prior to prescribing opiates – again those words are important. You may think that 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, and the easiest option was, on occasion, taken, and that was the option of providing large amounts of prescribed opiates to deal with the pain itself. If you find that there is force in that suggestion, then you may think that Dr Barton's protestation that she always examined the patient fully may sound rather weak.

One also has to bear in mind what Dr Barton's approach to many of these patients was, because she confessed that she had a very pessimistic view of most of these patient's chances of survival. Very often, as we established during the case, her view was much more pessimistic, in fact, either than the hospital which was transferring the patient to the GWMH, or the view taken by her own consultants who were referring patients to a hospital which they knew. So that you may think will undoubtedly have affected her management of each patient, and perhaps the quality of her assessment.

That leads on to the issue of whether she failed to provide an adequate plan of treatment on occasions. 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, and the effect of her approach to some of these patients can be summed up in her own words, written as we have seen quite often in the notes, "to sort out analgesia".

Finally, there is criticism which is head of charge 44 that Dr Barton did not sufficiently record the drug regime. Dr Barton has made admissions on all the other subheads within that

charge, but not that one. You may think that although Dr Barton wrote up her prescriptions sometimes with dates and sometimes without, and the prescription itself was clear, what she never did was to make any sufficient note as to the circumstances in which those drugs were going to be administered. There was never any note that we have seen that sets out that drugs were only to be used if the patient has been in considerable pain or an analgesia has been tried first; or the syringe driver is only to be used for certain patients when they become, for instance, unable to swallow; or that a syringe driver is only to be used after full discussion with the doctor, or with the patient and/or with their relatives; or the size of the increments that are allowed and of which drugs. There is an assumption always that both drugs are going to be used together, midazolam and diamorphine. Why? None of these things were recorded.

It cannot be said that they did not need to be because of the great depth of knowledge of the nurses because we have heard from a number of nurses that although no doubt well meaning - some of them were very experienced and all of them were caring - some of them, frankly, had a very limited understanding, for instance, of conversion rates.

In respect of all of these charges you will have to consider whether there is evidence that there were certain practices taking place at GWMH which in reality had little to do with the individual needs of patients but, in the words of one of your Panel members – I think 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 the drugs which were prescribed were inappropriate.

Can I say something about Dr Barton's character because you have heard a great deal of good said about Dr Barton from many sources, and I am not going to attempt to undermine or deny that. The GMC does not allege that Dr Barton treated every patient who came under her care in this way, as is alleged in relation to these twelve patients. You know that she is of good character, in the sense that there has been no evidence of any previous finding against her in any disciplinary tribunal, and that helps her. It does not mean that she cannot have acted in the way now alleged; that she may have treated many other hundreds of patients very well. That cannot allow her to escape the consequences of serious malpractice in relation to these patients if you find the evidence supports such malpractice.

If when considering the sufficiency of evidence on the issue of serious professional misconduct, I would say this. Serious misconduct in relation to one patient is still serious misconduct, however many other patients you have treated properly. It may be said, "If she has treated so many other patients well, why would she suddenly have gone off the rails, as it were, with these twelve?" It is important, first of all, to bear in mind that these charges do not just relate to one patient. They relate to twelve. If you find that the failings were serious, then you can find that she has gone off the rails, as it were, in relation to these patients.

These failings are not one-off failings. They are serious failings over a three year period. That is despite the warnings that she had had five years before these events which you are considering.

Many people have told you many good things about Dr Barton: Dr Briggs, Margaret Couchman, Philip Beed, Lynn Barratt, Dr Banks – there is a long list. All said good things about her practice and about her as a caring person.

All of that evidence, though, cannot overcome the plain fact of these prescriptions, of the lack of notes, the lack of assessment as patients deteriorated unexpectedly, the lack of a plan to deal with the source of the pain rather than simply the pain itself, the huge starting doses, the huge width of prescriptions. However caring and compassionate Dr Barton is undoubtedly capable of being, it is clear that there are elements to her contact, 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 of a long 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, despite her good character, that may have proved to be a serious failing.

As I have said, there are certain themes in this case which I am going to have to lack of briefly: the work or overburdening of Dr Barton, for instance, and the change in the nature of patients during the course of the 1990s; the issues which were raised in 1991 and what relevance they had to the charges which Dr Barton now faces; the acceptability generally of anticipatory prescribing and the necessity of providing the dose range and the acceptability of the ranges prescribed by Dr Barton; the autonomy of the nurses and whether or not they were able to start and increase doses by syringe drivers; the use or lack thereof of rehydration. All of these issues will need to be examined by you and some, frankly, will take you less time than others.

You have to bear in mind whatever those surrounding issues are, that the most important document you have in this case at this stage is the heads of charge. That is the cornerstone of the case and it is a document to which you will need to revert repeatedly.

Can I deal very quickly with the issue of hydration. It will not take me long because there was not any in relation to any of these twelve patients once the syringe driver had started. These patients were all on the terminal pathway once that needle was inserted. Had there been any hydration by way of subcutaneous infusion, it would have been written up. We know that there was no capability of intravenous hydration at the GWMH. There is no note of subcutaneous hydration having happened. Without hydration, the patients are inevitably going to deteriorate, lose consciousness and die. That is perhaps all I need to say about that particular issue. It follows that realistically, therefore, the use of a syringe driver was always ultimately going to lead to the death of the patient.

Let me deal very briefly with the issue of poor note-making. Dr Barton has accepted significant failings in her note-making. She says, however, 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 the patients themselves.

The GMC simply does not accept that as a proposition. She accepted in evidence the importance of making a note of assessment and the diagnosis of a plan of treatment. She told you that in terms of new patients, she would attend at lunch time specifically in order to clerk the new patient in. If that is right, then it is surprising that she claims not to have had time to make notes in those circumstances which surely would have taken just a few minutes to write up.

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 Panel questions. This was Day 32/4. She said this:

A

> "...we did not write out a formal plan at the 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 was true in explaining why the initial plans of treatment were poor or non-existent, which we I am afraid suggest is not true, it is surprising that Dr Barton felt the need to have a few days before writing up an appropriate plan of treatment but did not need a few
B days to get to know the patient before writing up these enormous variable doses of opiates.

As significant is the time when Dr Barton made changes in the patient's drug regime, that there is nothing in the notes to demonstrate why that was taking place. Also significant were those occasions when Dr Barton set the patient off on what we have decided to call the "terminal pathway". Still there is no note very often being made about that at all.

C I am going to turn briefly to Professor Ford's evidence about note-keeping. What I am going to do on each occasion is to try to give you the day and the page. I am not going to ask you on any occasion to turn up the transcript. You will in due course, like it or not, have a transcript of my speech and you will therefore be able to find the references in due course if you want to check them. This was Day 20/8. I asked Professor Ford:

> "Q We know that Dr Barton was practising not only as a clinical assistant at the
D hospital, going in every morning, but also acting as a GP and treating patients, presumably during her daily practice, but she was going into the hospital on an almost daily basis. Does that in any way lessen or increase the necessity to make notes about the patients that she was caring for?
> A I cannot see the frequency of contact is the issue. Other doctors were still being involved in the management of patients in the care of Dr Barton and the responsible consultant. I think the other reason to make notes is for your own records.
E To carry around in your memory when you have a very large number of patients under your care, exactly what you did and why you did it, is very difficult. One often has the experience of looking back over a set of notes of a patient you managed six or twelve months ago and you find it is often not what your memory was. Because we are so busy and see so many patients, the medical records act as the basis of what you did. There is an aphorism that we tell our junior doctors, that if you did not write down what you did, there may be the assumption that you did not do it. It does not
F mean that you did not do it, but if you did not write it down, it is very difficult to remember exactly what you did do."

Then, Day 20/33, he dealt with the relevant examination on assessment. He said this:

> "You would summarise what their main problems were, what the plan for their admission to that hospital ward was and check that their drug therapy was appropriate
G because that has to be prescribed anyway. That process would take, it depends on the patient and it depends on the experience of the doctor involved, but 20 to 30 minutes would be a reasonable amount of time for most patients. Clearly, if the patient was not straight forward, it would take longer than that."

Dr Barton herself accepted how important it would be to make a note if she was deciding that the patient was entering the palliative care pathway – Day 29/3. She has accepted repeatedly
H that no such note was made by her. Sometimes the only note that we see from Dr Barton to

give us a clue as to what is to happen to patients are phrases such as, "Please make comfortable"; "Sort out analgesia"; "Happy for nursing staff to confirm death".

Finally on notes, I ought to say something about the nurses' notes. I suggest that caution is needed. I am not going to suggest that nurses have not written down what they genuinely believe, or that notes had 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 a patient is agitated or distressed, and that has been interpreted repeatedly as meaning, either by nurses or by Dr Barton now, as meaning that that patient was in pain. One has to be cautious about that. Agitation and distress may be caused by a number of things we have heard. In the case of Gladys Richards, it may be that she needed to go to the lavatory. In the case of Elsie Devine, it may be because of her dementia rather than pain. So when a nurse has interpreted a note as meaning that the patient was in pain, unless the note specifically says so, you may want to exercise caution before automatically accepting that agitation and distress, by way of example, was caused by pain.

Let me say something about the change in the nature of the patients during the course of the 1990s. It is well established by evidence, you may all think, that there was a change in the nature of the patients this hospital received in the mid- to late-nineties. The hospital was apparently not unique in that happening. How much does that matter, and what difference does that or should that make to your consideration of the evidence? The question is whether the change in fact affected the patients' standard of care and did it affect Dr Barton' approach to her patients. You may find the answer to those questions in the answers that she gave you. If Dr Barton was so overburdened by work in the late 1990s that she could not properly care for her patients – and I am not seeking to escape from the fact that there was clearly such a change – but if it was such that she could not properly care for her patients, then it was her duty to bring that formally to the notice of the Trust.

That, though actually is not her case. Dr Barton has not said to you at any stage either that she could not perform her duties properly or that patients were suffering as 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, in fact, "There is nothing wrong with anything that I did in relation to these patients which I have not admitted."

Dr Barton was asked about this during the course of Panel questions by Ms Julien – Day 31/2. You may think she was given every opportunity that could be given to her to say, "Well, on reflection, now that I look at the pressure that I was under, I do wish that I had done things differently." What she was asked was this:

> "Q ... In retrospect, would that still be your answer in terms of all the cases? Would there be anything you would do differently?
> A In the case of those 12 patients?
>
> Q Yes.
> A In the days and hours of their dying, I would have done nothing differently.
>
> ...

Q So you would not have adjusted any prescription, you would not have referred a patient or asked for a second opinion.
A No.

Q In none of those 12 cases.
A No.

...

Q Okay, putting aside Professor Ford ... is there anything now you have been going over these cases where you think, "Oh, well, maybe I should not have quite done that like that"? Is there anything?
A Nothing at all."

Those answers reveal a woman of absolute conviction, not a woman worn down by the pressures of her job or the exigencies of the situation in which she found herself. She is certain of her decisions. The letter which she wrote to Dr Reid, which you now have as Exhibit D6, and the exhibits thereafter – I am not going to turn them up – you have to bear in mind that that was note written, and that string of correspondence was not started, until January 2000 when there was apparently already a police investigation into attempted murder. This may look as if Dr Barton is trying to shut the stable door well after the horse has bolted. Why were there no letters like that prior to 1999? Why did it take a police investigation to bring about this period of soul-searching and formal concern?

When issues were raised by nurses about the practices of GWMH in 1991, they were not met then with any soul-searching. They were met, as one told you, by a brick wall. 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 – this is Day 33/26:

"A ... I must point out I had an excellent team of nurses. ... but I never found that the extra workload affected my nurses' care in any way at all."

As you know, and Professor Sikora confirmed this, Day 34/22, the changes in the style of the patients or the ailments of the patients coming to GWMH were not actually unique to Gosport in the late nineties. They were happening up and down the country. Clinical assistants in Dr Barton's role were having to deal with these problems across the UK. Dr Barton was asked about this issue, Day 28/64. I think this was in cross-examination.

"Q What you are telling this Panel is 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.

...

A

Q Yes. If you had had more time ... would it have affected your management of any of these 12 patients?
A No. ..."

Then at Day 28/83:

"Q Are you saying in relation to any of our 12 patients that you started them on
B opiates or you prescribed opiates earlier because of inadequate staffing?
A No."

Day 28/83. What about the transfers from other hospitals? We have heard much evidence about patients being described as being in one state – and I am going to use the acronyms, if I may – at the RHH and QAH and being in a worst state on arrival at the GWMH. You will have to consider that issue first of all of whether other hospitals were transferring patients
C before the patient was ready. Rear Admiral Farquharson-Roberts denied it on behalf of the Royal Haslar Hospital, the RHH, but said that it might be happening at the QAH. Mrs Mansell picked up the point that, if a patient was too ill for rehabilitation and they needed palliative care, why not simply say so. If that was happening however – and we do have examples in this case where it seems to have happened – you may think that it makes the assessment and the treatment of the patient even more important, not less so. If a patient is arriving in a different state to that which they ought to be arriving in, then an assessment is
D crucial and it is not a passport, you may accept to higher prescriptions.

There were many sources of evidence who spoke about the difference in the state of the patient from one hospital to the other but, at the end of the day of course, you have to focus on these 12 patients and to see what evidence there is in respect of each of them of that happening and, if that did happen, what effect it would have in this case. As I say, if the staff at GWMH found that the pre-transfer assessment was unrealistic, then there must be a duty to
E re-evaluate, to note it and to re-plan. It may be that that patient has simply been affected by the transfer itself; not necessarily an over-optimistic view at the first hospital but, as we heard, the transfer itself, can have an effect and the patient may just need a day or two to recuperate. Dr Barton herself spoke about this and said this was one of the reasons for not doing an assessment immediately and I will just repeat her phrase, Day 32/4:

F "We did not write out a formal plan at the time of arrival because we needed a few days to get to know the patient and the patient to get to know us, to meet the relatives and find out what their expectations and aspirations were".

You will have to ask yourselves, were patients being given the opportunity of demonstrating what their true condition was or were they in reality being pigeonholed almost as soon as they arrived? For each patient for whom a syringe driver was written up on arrival, you may think that their initial assessment set the course for their treatment thereafter and Dr Banks told
G you, Day 15/68, that one must build in a safety margin from the transfer in making an assessment and that whatever course of treatment must be well worked out. You have to ask yourselves in relation to these cases, was that in fact happening?

May I deal with the issue of 1991. Whatever attack or criticism is levelled at the nurses who gave evidence about those issues – and we will look at their evidence briefly in a moment – the fact remains that those issues which are set out in your panel bundle 1 at tab 6, page 2 –
H and I am not going to ask you to turn it up again; I do feel (and I hope I am right) that we all

know quite a lot of this documentation so well. The fact remains that those issues, which were raised five years before 1996, when the first of the patients you are considering were treated at the GWMH, mirrors much of the problem we are now dealing with.

The reality is that there is no evidence from any source that practice has actually changed as a result and whatever can legitimately be said to denigrate the evidence of Nurse Hallman or Giffin or whoever, the fact is that those nurses were raising concerns about very similar issues to those which you are now considering and those concerns were never resolved. Dr Barton told you, Day 29.5, when asked:

> "Q The practice did not change one jot, did it?
> A No."

Let me turn up a little bit of evidence. Sylvia Giffin, Day 13/88-89, said that Sister Hamblin encouraged the use of syringe drivers and that, prior to her coming to the unit, we rarely used them and, after that, they escalated. Most patients were going on them even when not in pain. They were used as a matter of course, not need. The decision to place patients on them was Dr Barton's. She said that the dosage of diamorphine would increase automatically and she said, "Eventually, I gave up complaining".

Beverley Turnbull, who gave evidence on Day 14, remembered the disturbance in the staff about syringe drivers in the early 1990s. She said, "I shared those concerns". She attended the meetings in October 1991. She said, "Steve Barnes, the RCN officer, became involved because we felt that we were not getting anywhere. We were labelled trouble makers. No protocol was devised as a result. No one at the meeting put their hand up to say, 'hang on'" and that was in relation to questioning the amounts of diamorphine. "We were banging our heads against a brick wall". She accepted that all staff had great respect for Dr Barton and she said, "I am still of that view". She said,
"I shared the fear that it was becoming routine to prescribe diamorphine to patients who were dying regardless of their symptoms. I did not tell Sister Hamblin of concerns because I felt she would not listen to us".

Beverley Turnbull told us that, after Dr Barton left, doses of syringe drivers changed. Patients would have intramuscular morphine and were then reviewed. The parameters of the syringe driver would be set up; doses are much lower now. In 1991, there was a difference of opinion between the day and the night staff re syringe drivers and, by 1996, all the earlier concerns had been dealt with. She said that it was possible that patients were comfortable at night but not comfortable during the day. She said, "After 1991, I think I just accepted what was happening. I think that the process of complaining was threatening to some of the staff. I think that things did get better afterwards and other nurses accepted the situation".

Anita Tubritt also told you that she shared concerns in 1991 about diamorphine being prescribed indiscriminately; this is Day 15 of the evidence. She said that concerns from 1991 had been resolved by 1996. Initially she said that her training was not adequate. I was being asked to deal with complicated patients with syringe drivers and no training. I thought then that diamorphine should only be used for pain but Dr Logan explained that it can be used in other circumstances.

Beverley Turnbull, Day 14. She was the nurse who specifically made the comment about the feeling that they were banging their heads against a brick wall.

The issues in 1991 are important, we suggest, in the following ways. First, to demonstrate that the practice adopted at GWMH by Dr Barton of anticipatory prescribing was unusual enough for experienced nurses to be very concerned. Secondly, that the practices were recognised by some to be wrong at a relatively early stage. Third, that concerns were raised not just with management but with Dr Barton herself. Fourth, that the practices were so entrenched and, despite being challenged and ultimately accepted by the nurses, it did not lead to any internal review and it did not in fact lead to any real change. It led to a change in the nurses' perception but it does not appear to have led to a change in the reality of what was happening. You may think that here was a perfect time to reflect upon the practices that Dr Barton had by then adopted. It was a perfect opportunity to resolve to speak to someone outside this small hospital to ask for advice, but the only people who received any extra training appeared to have been the nurses themselves. Dr Barton herself did not receive any further training and no one reviewed her practice. Dr Logan of course was part of the system.

When the defence thereafter put to nurse after nurse, "You would not have administered these drugs unless content that they were appropriate", and more often than not, in fact I think on every occasion, the nurse accepted that is to ignore the plain fact that, when the practice actually was challenged by the nurses, it had no affect whatever and things went on as before, and drugs were administered in circumstances where all of the guidelines, the *BNF* and the Palliative Care Handbook, were in fact being fundamentally breached, but no one from the consultants to the pharmacist to the nurses did anything about it after 1991. Whether or not the nurses retained their concerns or whether those concerns were resolved you may think does not matter a great deal.

Professor Ford on Day 24 was answering, I think, Panel questions and he said this about the broader institutional responsibility. He said:

> "I have not been asked to do a review, as Mr Langdale pointed out, an inquiry into what happened, but in my opinion there is a broader institutional responsibility for what was happening and where you place that is a judgment. I think in my opinion – and I am trying to be very balanced about this – to say Dr Barton wrote the prescription and therefore that is the end of the matter in terms of responsibility is somewhat of a narrow perspective on the care of patients over a number of years. There were clearly other people that were aware of this prescribing practice. Senior nurses were and a consultant was in at least one case".

That must have been Dr Reid,

> "Pharmacists would have been reviewing the use of diamorphine and midazolam. I think it is worth pointing out that this prescribing – I have never come across such wide and high prescribing of opiates and from talking to other people, I am not aware of it happening anywhere else. So it is not at all a usual practice and you could argue from that that it should have triggered someone to question it".

The difficulty is that, in 1991 when the practice was questioned, the questions came to nothing. Dr Barton, in her evidence, Day 29/3, explained it in this way:

> "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 care of patients at the

A end of their lives".

The reality, you may think, is that the issues were in fact almost the same: (1) patients being diamorphine who were not in pain; (2) no other forms of analgesia being considered; (3) the sliding scale not being used appropriately or at all; (4) each patients' needs not being considered and the drugs being used indiscriminately – how close to one-size-fits-all is that? – (5) patients' deaths being hastened unnecessary; (6) no titration or adjustment of doses to
B suit patient needs; (7) too high a degree of unresponsiveness sought from patients.

You may think that all of those issues were in reality mirror images of those which you are examining now and it really is something of an indictment of the system that these specific worries having been raised in 1991 and the practices which led to them were in fact allowed to continue until 2000 when Dr Barton resigned following the complaints and the police investigation.

C

Let me turn to the issue of the acceptability of anticipating prescribing and the necessity of providing a dose range. First of all, unless there is any doubt about it, no one challenges the necessity and pragmatism of anticipatory prescribing generally. It is apparently widely practised and it is 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.

D Professor Ford said this, Day 20/9:

> "... what about anticipatory prescribing with opiates? Professor, is that something you would do in your own practice or have done in your own practice, or not?
> A There are two issues. There is the need to prescribe variable doses of morphine to people who require opiate analgesia. So you would put a range of morphine, for example, or another opioid analgesia to be prescribed within, usually, a not-too-wide
> E dose range, and there is the issue of patients who are expected to require opioid analgesia where there may not be a doctor available to write the patient up for that. Clearly, in most acute hospitals, or any hospital with a resident doctor, this is not an issue ... The issue of anticipatory prescribing in other settings really depends on the consideration of the risks and benefits, and the problem with anticipatory prescribing for opiates, in terms of in a non-acute hospital setting, is that there would have to be expected deterioration in a patient that was going to require opiate analgesia. It would
> F be in that context. This would typically be somebody who was already on moderate analgesia and you might reasonably prescribe PRN as required morphine – that would be the standard oral drug to use – in a narrow dose range, but I think I had never come across before anticipatory prescribing of wide ranges of subcutaneously infused drugs. Even in palliative care settings, my understanding, through talking to palliative care specialists, is it is not at all standard practice for palliative care units to have anticipatory prescribing with wide ranges of opiate and sedative drugs".

G

Mr Payne asked Dr Barton about this issue of anticipatory prescribing on Day 31/4:

> "... there were times when you wrote the anticipatory prescription on the day [of arrival]".

H

A

> A Because it was obvious that they were not going to be ... rehabilitated. They were really very seriously ill even when they arrived, and I was looking at them at some stage in the future needing palliative and terminal care".

Dr Barton claimed that these patients were out of the ordinary. She said, "They were out of the run of work we did on the ward", Day 31/4, which is why effectively she said she managed them in this way but, quite frankly, that was not a true claim. First, there was
B nothing which stands out about these particular patients and their variety of ailments, some serious and some less so. She accepted, when I re-examined her after Panel questions, that these were not by any means the only occasions on which she had written up these type of prescriptions. When you look at this broad range of patients which you have before you and then you realise that Dr Barton wrote up very nearly the same anticipatory dose for each one, not quite but almost, 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
C approach.

Sister Joines told you that in her view syringe drivers were never inappropriately prescribed, nor was diamorphine (Day 33/19). You may think that there were a number of nurses who were extremely loyal to Dr Barton and who worked within the system with which they either wholeheartedly approved or, frankly, had become inured to over time. Sister Joines also repeated the evidence that others had given that some other doctors were not prepared to
D prescribe stronger analgesics (Day 33/21) in the way that Dr Barton was willing to prescribe them, although later she told Mr Payne, (Day 33/34) that no doctor ever refused to come in and give what was necessary when it was necessary.

You may think that it is unfortunate, perhaps, that more heed was not paid to those doctors' views who were unwilling to dole out heavy analgesia in the same manner. It seems therefore that Dr Barton felt it necessary to ensure that there could be circumvention by the
E nurses of the wishes of other doctors and, to that end, she did to a certain extent hand control of the syringe and its contents to the nurses who she knew and trusted.

Sister Joines again, Day 33/23,

> "We would never start a patient on a syringe driver without a relative's consent".

F Well that, quite frankly, is obviously not right. She went on,

> "Obviously the outcome inevitably was death".

She said,

> "It was Dr Barton's assessment which always set the tone for a patient's treatment".

G

You may think it is very noticeable that whatever Professor Sikora was able to say on Dr Barton's behalf, the defence have not called before you any expert who has examined these notes and these prescriptions and is able to say that in his or her view they represent an acceptable practice. You may think that if there were such an expert who could be found, they would have been called.

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

How safe were these prescriptions in the hands of these nurses? That may depend on their attitude and what they felt was the purpose of their wards. Lynn Barrett told you (Day 10/75-6) that they seemed to get the patients that no one else wanted. They would, in her words, have been "dumped" – and those are words that have come back into play on a number of occasions.

Anita Tubritt, Day 15, said,

> "It felt that we were taking patients that other hospitals did not want. Some were in very poor condition when they arrived and some very close to the end of their lives".

Dr Tandy told you, Day 18/30,

> "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".

What about the issue of nurses effectively being delegated the responsibility of starting the syringe driver, which in at least one case – the case of Mr Cunningham and the syringe driver being started at 10 past 11 at night – we know really must have been a nurse decision.

Professor Ford said this about that practice, Day 20/37,

> "We have already talked about the fact that nurses need discretion to adjust the dose of opiates when you are giving morphine. The issue is well accepted that nursing staff had discretion about the use of opiate drugs. That is a principle you would find throughout most practice in the NHS. However, the issue around delegating the decision to commence subcutaneous infused potent drugs, such as morphine and midazolam, I think is very different. Most people would not think it desirable to delegate that in the first instance. If one was going to, one would need a clear protocol that it was absolutely clear that nurses understood when they should move to giving subcutaneous drugs and what doses they should use if you have a dose range".

Of the decision to start a syringe driver, he said,

> "I would say that should be a medical decision by the responsible doctor".

He was asked this, Day 20/38,

> "What if the suggestion is: "Well, we had to leave that decision on occasions open – the decision to start the syringe driver – because the patient might suddenly find themselves in pain and they would need immediate relief, and Dr Barton might not be there over a weekend", or something of that nature? Does a syringe driver necessarily deal with that situation?
> A To me that is not a very strong or sound argument because, as I indicated earlier, when you give a syringe driver, you are giving a continuous infusion and it takes a while before the effect of that has come to what we call a steady state, because it takes

A

> a while for it to build up, if you made a change in the equivalent dose. I can see the situation of somebody at a stage due a dose of oral morphine, they now can no longer swallow and you can see they are not going to have any opiates, that it would be appropriate to give some opiate to ensure they remained pain-free. I think we would all recognise the importance of that. But that opiate could be a single subcutaneous injection, which would last for four hours, and I think, from my understanding of the cover at the Gosport War Memorial Hospital, it would not be unreasonable to expect a
B doctor, at any time of the day or night, to be able to respond within four hours. So I do not see the very strong logic for needing to move to subcutaneous infusions as opposed to giving drugs by a subcutaneous route".

That is all I wish to say about anticipatory prescribing. I am turning to a new topic, unless you wish to take your break now.

C THE CHAIRMAN: How long will the new topic take?

MR KARK: Around four minutes. I shall endeavour to speed up a bit. It relates to the *BNF* and the Wessex Protocol. I can say I am going to be very short with this because I am not going to take you to them, and frankly I am not going to insult your intelligence by taking you through once again the *BNF* and Wessex protocol. You know them so well by now. I did it when I opened the case. We have looked at it with many of the witnesses and we
D went through it with Professor Ford. Suffice to say we have not found a word of support for Dr Barton's practice, and she has not been able to point out any single guidelines ever written which support her prescribing practice.

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

The reality is that whatever the guidelines say, it was not going to affect Dr Barton's management of these patients or her prescribing policy. We know that she kept a copy of the *Palliative Care Guidelines* apparently in her pocket, but the fact is that despite her relative lack of training, she made a positive decision not to apply the guidelines contained therein.
F With small fluctuation on one occasion, she gave pretty much the same to all, whether the patient was old, young – or younger – fat, frankly, thin, alcoholic: these patients all got opiates with a wide range and, we suggest, potentially dangerous doses with no special instructions to any of the nurses in any of the cases. So I am not now going to spend time going through the guidelines. I am going to take it that in general terms you know the principles.

G For reference can I tell you this? I went through the guidelines with Dr Barton at Day 28/71. She said this,

> "My philosophy in those days, working as a general practitioner and visiting a community hospital, was that I would go in at a higher dose in order to give adequate pain control sooner and then reassess the dosage".

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Dr Barton accepted that she was well aware of the guidelines, and accepted, Day 28/73, that the danger was that if you went outside the guidelines you would end up over-sedating the patients. Importantly she was also aware, apparently, that mental confusion was a recognised adverse reaction to opiates (Day 28/78). That was also spoken about by Professor Ford. Let me just turn that up very briefly. It is Day 20/18. He was asked this:

> "Q This is an important point, and I think Dr Payne [I do not know if that is a promotion or not] raised this with Dr Reid last week, which is the question of the potential side effects of opiates and the point about whether more opiates cause more side effects. What do you have to say about that?
> A The first thing I say is that opiates are not a treatment for restlessness or confusion. The *BNF* says that, the Wessex Protocols will no doubt clearly state that. Opiates are a treatment for pain and may help restlessness where it is the context of pain. They are not a treatment for confusion per se. If you have a patient who has opiate induced confusion or restlessness, clearly if you give them more opiate that is not going to help the problem, it is, if anything, going to exacerbate it".

That was one of the adverse reactions quoted in the *BNF*. When I asked Dr Barton about the principle of reducing the dosage, for instance by 50 per cent of the adult dose for elderly patients, she gave a surprising answer at Day 28/79.

> "Q ... again is that a principle which you applied in your practice?
> A No.
>
> Q Why not?
> A I applied the principle of what I felt was an acceptable starting dose for the drugs that I was familiar with in this very specialised corner of prescribing".

We will look in due course at the occasions when I suggest that she had effectively ignored the *BNF* within the ranges, but it was at times as if she felt that her particular corner of the Gosport Memorial fell outside the run of the mill and that the guidelines did not apply to her because somehow either she or her patients were an exception. We submit that they were not.

I am going to get on next to the role of the consultants and perhaps that would be a convenient moment to break.

THE CHAIRMAN: Very well. We will return at five minutes past eleven.

(Adjourned for a short time)

THE CHAIRMAN: Mr Kark?

MR KARK: Sir, first I was asked to correct one matter relating to Sister Joines making the comment that they always got a relative's consent. In fact it was pointed out in the nursing notes that they do reveal that on Daedalus Ward there is a note that consent was obtained from relatives, although in fact you will remember that in respect of both the Stevens and Mrs Richards, the relatives themselves said that they had not been spoken to about the syringe driver before it was started. Mr Langdale properly points out that where there is a

A comment in the nursing notes my comment in relation to Sister Joines was perhaps going too far.

In my desperation to finish my last comments with my colleague having his stop watch out I did not say one thing in relation to Professor Ford. This was Day 20/6 in relation to the *BNF*. He said,

B

> "The *BNF* is, I think, probably one of the most used books by any practising doctor. It is a very valuable source of information about drugs, what their indications are, what the potential side effects of drugs are, what the appropriate doses that should be used are and it is laid out into sections about different groups of drugs with some general sections on prescribing in certain settings, such as children, the elderly, palliative care and the like.

C

> Q One of the pieces of evidence that this Panel heard, I think it was from a doctor who we will be referring to as Dr X, was guidelines for narrow minded people. First of all, *BNF* is a protocol or a guideline?
> A It is certainly not a protocol. It is a source of information which gives you guidance about the use of drugs. In a way it is not a guideline because guidelines are generally considered to be documents that outline general management of specific conditions. I have during my professional career had quite an involvement in the

D

> development of guidelines. I was a member of NICE and the British Hypertension Society Guideline on Hypertension, I have also been on a number of stroke guideline groups at both national and European level, so I am aware of the difficulty in crafting good guidelines. An important principle is that guidelines do not apply to every patient. What they do is they provide a framework of care based on evidence which should be looked at by doctors as the basis to underpin their practice".

E He went on to say that patients do not always neatly fit into the guidelines. I will turn also to what Professor Sikora said about that in due course. I was now going to turn, again I hope briefly, to the role of consultants, Messrs Reid, Lord and Tandy. You may think that certainly Messrs Reid and Lord must have known that there was anticipatory prescribing going on and that the prescriptions were sometimes wide ones. Both, you may think, certainly Dr Reid, must take a degree of responsibility for failing to control it or to put a stop to the very wide ranges.

F

Dr Reid, it appears, even had a hand in the protocol or the draft protocol, which looked at one time, in 1999, as if it was going to give Dr Barton effectively carte blanche to write these wide prescriptions of the type that we have seen. Dr Reid himself denied that that ever came into existence. That was Exhibit D5.

There was a protocol which speaks of a starting range of between 10 and 40mg. That is

G within D5. It is not from 20 to 200 mg. You will have to consider that. Barbara Robinson was plainly fairly sure that Dr Reid did know about the so-called agreed protocol which speaks in D4 of Dr Barton regularly using a 20 to 200 range. You may think it is safest to assume that he, Dr Reid, did know about that. The fact that he did not challenge what was plainly inappropriate does not, in our submission, make it appropriate. That they were plainly inappropriate prescriptions is clear because they are, frankly, potentially dangerous and that has been admitted. Dr Reid should undoubtedly have said so.

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It sounds, you may think, as if the relationship were not the usual one between a consultant and a junior doctor. As Dr Reid readily conceded, Dr Barton had greater experience in this field of palliative care than he did. Equally, the pharmacist who we are told looked at the prescriptions, did nothing. That does not make these prescriptions any safer or better. It may simply demonstrate that there were failures across the board at this particular hospital, but at the end of the day Dr Barton cannot, with respect to her, escape responsibility by pointing to the failure of others to correct them. These were her prescriptions. She was an experienced doctor. She was effectively, we say, ignoring well known guidelines and her attitude was that this was her hospital, her wards, her nurses and her patients.

I turn to the issue of the police statements that you have. I described those previously as self-serving and carefully crafted. You will have to consider what is the relevance of them now.

Dr Barton does not now have a recollection of these individual patients in general, but she does seek 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 abut what she could actually remember of these patients. When she was interviewed, at first she chose to answer no questions and instead she responded with the statements that you have got. If you look at those again you will find her phrase, "I anticipate that", throughout those statements.

What in fact Dr Barton is saying is that, because the prescriptions and the administration of these 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 in fact bear that suggestion out, nor in many cases does the lead-up to the administration of those drugs, either at the previous hospital or at the GWMH, nor in many cases does the recollection of those nearest and dearest to those patients bear that out. We would ask you to examine those claims now made by Dr Barton about any specific recollection that she does have about patients being in great pain with great care before you accept them.

As Dr Barton told you, at Day 29/7, she would not and did not leave anything significant out of those statements which she could then remember. There is no reason to mention that her memory now is any better.

And so when you read in the transcript Dr Barton claiming that a patient was in great pain, what she is really saying – you may think and it is a matter for you – is, "I cannot justify these prescriptions in any other way, other than saying this patient was in great pain because otherwise I should not have done what I am alleged to have done."

Can I turn to the expert witnesses. I have just a word or two about those before I turn to the individual patients. It may be suggested to you – I do not know –that Professor Ford approached these issues as an academic looking down upon these proceedings and those administrations of drugs from some sort of ivory tower. That is not, we submit, the case because Professor Ford is a clinician with a current clinical practice. He dealt with his won experience at Day 20/3 at the beginning of his evidence in chief.

> "A Following my training in general medicine and geriatric medicine, I was a senior registrar in geriatric medicine and general medicine from 1989 till 1992."

Then he was appointed as senior lecturer in clinical pharmacology and geriatric medicine. He was at the time at the Freeman Hospital in Newcastle. He said:

> "My practice at that point was, like many geriatricians, even though I was an academic, quite busy. I did acute medical takes on a one in nine basis, a rota through most of the early 1990s. I was responsible for half of an acute geriatric rehab unit on the Freeman Hospital site and I had responsibilities for what became a rehabilitation ward and a continuing care ward on what was the Walkergate Hospital, which still exists. This, I think, can be described as being very similar to Gosport War Memorial Hospital."
>
> ...
>
> A ... In terms of the number of patients, it varied a lot, but I do remember at one point having over 120 patients under my care which, again, you would not see now, but it was not uncommon for geriatricians to have very large numbers of patients with different medical needs under their care in the 1990s."

At Day 20/6, we see:

> "A I realise there are academics around, particularly in London and elsewhere, who may have very little clinical practice, but that is not the way I have ever practised as an academic. My academic work has been very based around my clinical practice throughout my working career."

He had, before he came along here to give evidence to you five, given evidence that he had read all of the evidence, all of the relevant statements, all of the patient notes; he had equipped himself with material to give him a proper foundation from which he could give his expert opinion.

Professor Sikora is, as I have already said, extremely eminent in his field, which is as an oncological physician. He did not have the advantage of having looked at the patient notes or reading the relative statements, or hearing or reading their evidence. He was not asked to comment on each individual case. He gave general evidence, which I will examine briefly. He gave evidence on Day 34, and it quickly became apparent that his opinion was based on a wholesale acceptance of the material put forward in Dr Barton's statements, as if they were fact. He was not what you need to be: cautious about that. He was asked by Mr Langdale to describe how it was possible to judge accurately what a patient's analgesic needs are. You may think – perhaps this is guesswork – that the purpose of that question was to elicit from him his evidence that you have to have the patient in front of you. This has been a constant theme and a legitimate one throughout the defence case. They say that no one other than the doctor looking after the patient is in a better position.

The way that he started his answer to that question was interesting. This is Day 34/6.

> "A The only way is to be with the patient and see what happens after a given dose of an analgesic that is given."

That may well be right. If it is, then Dr Barton broke that first rule because she prescribed large doses in advance of the patient ever needing analgesia. She did so because, frankly, she

A appears to have been gazing into a crystal ball to assess what pain relief a patient might need in the future. There was with her no administration very often of a first dose, and then checking the effect before the patient was given more.

Professor 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: Day 34/23. Particularly important, he agreed, was the decision to enter into the non-curative palliative care pathway. B He said, when answering questions from Ms Julien, that note-making was an integral part of good medical practice: Day 34/40. In his opinion a range of between 10 and 20 mg was reasonable provided that the patient was already in pain, or very soon to be visited by some serious pain. That is Day 34/24. A "one size fits all" approach would, he said, be wholly inappropriate.

We also established with him the importance of the *BNF* and the Palliative Care Handbook in C the treatment of real patients, not just as an academic exercise. It put to him (Day 34/25) that you do not throw these guidelines out of the window as soon as you are confronted with a patient. He said, "Exactly". He was also an advocate, of course, of titration. To use oral morphine or long-acting morphine and work out over two to three days what the dose is, then use that in a syringe driver – what the dose is required to control the pain. That is Day 34/27.

> "Q Because unless you do that there is a serious danger that you are either going D to start too low or too high.
> A That is the case.
>
> Q With your syringe driver.
> A Exactly."

And he told us that titration does not mean having to have a nurse hover over the patient E every minute, but checking every hour or so, and making a note every four hours. That would not have been beyond the capability of these nurses on Dryad and Daedalus Wards. He confirmed the great caution required when adding midazolam to the mix – Day 34/29. And he also confirmed – and this is of particular importance to rebut one of the assertions made by Dr Barton – that simply because a patient is on so-called terminal pathway, in other words as we might put it more commonly, dying, does not obviate the necessity for using the analgesic ladder and the guidelines. Guidelines do not go out of the window as soon as the F patient is on the terminal path.

So far as going outside the guidelines, Professor Sikora confirmed that he had done that himself. He said that in his cases, his patient had had cancer. they were all patients in really severe pain. In one case there was distress and agitation that was really distressing to the family. He said he was on the spot on those occasions and he said it was very unusual. This is the defence expert. The difference was that from what we see in these twelve cases it was G not at all unusual for Dr Barton to ignore the guidelines. When he spoke about the practice of titrating using a syringe driver, he spoke about how that required considerable monitoring because he said the plateau is reached after about ten hours. If you have started with too high a dose, it will only become apparent after that period of time. You will recall that schedule that was put in, very helpfully, by the defence. I think it was D7. It was D7b which is most relevant to our elderly patients. I asked him:

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"Q And so does it follow from that, that your responsibility for monitoring the patient is obviously that much greater?"

He said:

"A It is."

B That is Day 34/54. He said that for a doctor in the position of Dr Barton, without particular specialist training, he agreed that guidelines such as the *BNF*, the Palliative Care Handbook took on a particular significance – Day 34/55.

I am going to turn now to deal with the patients in turn. Again, I am going to assume – I hope not wrongly – a certain degree of knowledge about these patients. We are in our eighth week looking at these various issues. I am not on any occasion going to take you to
C patient notes. I am going to rely, if I may, upon the chronologies that we have, and I am also going to refer you on occasion to evidence given specifically about the patients. Can we look at Patient A. I will leave it to you, as it were, if you want to get out the chronology on each occasion but I am going to give a very, very brief run-through in respect of each patient in any event.

Leslie Pittock, you will recall, had long-term chronic depression. He had been admitted in
D September, I think it was, of 1995, to Mulberry Ward under Dr Banks and he had returned to the Hazledene Rest Home. Then he was readmitted to Mulberry Ward in December 1995. You will remember that rather sad comment in the notes, that he revealed that his thinking that everything was horrible. He was then noted to have a sacral sore. His Barthel was zero and on 5 January he was admitted to Dryad Ward. He had depression and sores. He had a broken sacrum and sores on his buttocks. His overall prognosis by Dr Lord had been described as poor, but it had been suggested that he should have high protein drinks and
E bladder wash-outs. Dr Lord was happy for him to be taken to the GWMH. So here was a patient being referred by the consultant in charge, who must have known GWMH well.

As we know he was prescribed, on 10 January, Oramorph, 30 mg per day, and diamorphine at 40-80 and midazolam at 20-40 mg. This was after he, of course, had been given Arthrotec.

Those ranges are, of course, much lower than the ranges that we later see. I will come back
F to that when we look at the charges with him in due course.

On 15th he had been given Oramorph at 30 mg daily since 11 January. But then, on 15 January, in fact he was given diamorphine for the first time. By then you will recall that the prescription had already been changed so it is first prescribed on 10 January at that limited dose range. Then, the very next day, before anything in fact has happened, Dr Barton has re-prescribed, and this time she has prescribed 80 to 120 mg of diamorphine and 40 to
G 80 mg of midazolam. On the 15 January he is started on diamorphine at 80 mg. That was effectively an increase from, at that time, 30 mg orally to 80 mg subcutaneously. It is an equivalent increase of eightfold, because – again I am not going to spend time on the maths – we know the equivalent rate would be one-third, an increase would be a half of the oral dose. Onto that was added 60 mg of midazolam.

Can I just remind you of some of the evidence that was given about Mr Leslie Pittock. Linda
H Wiles gave evidence about him. She was his daughter. She spoke about his depression

throughout his life. When he was transferred to Dryad Ward, the relatives had understood he was for terminal care although no one had said it to her. This is Day, pages 25-27. They had expected him to die there and he was not eating or drinking. She said they were kept fully informed about his condition by nursing staff.

Dr Jane Tandy spoke about him, and her note on 10 January that he had chronic depression, and she had written "For tender loving care".

We have to be absolutely realistic about this patient. This was a very ill patient who a consultant had recognised was on the terminal care pathway realistically. Dr Tandy said:

> "A ... I suggested a small dose of opiates to see how he was if we took the edge of his pain and then review."

This was Day 18. She said, "I was not aware of the syringe driver prescription. I might also have used a variable dose range but I would have used a lower starting dose. I would not have written that prescription in relation to the 80-120 prescription." She said: "It is a high dose of midazolam." She said though, "It is a reasonable thing to do in a functioning unit where you trust the nursing staff."

You will have to consider that prescription and whether it is so far outside any guidelines, as we submit to you that it was; that it really is unjustifiable.

Professor Ford gave evidence on Day 20 at page 46 about this patient.

> " ... The picture one obtains from the notes is a very frail, older man with severe depression who is deteriorating, has bedsores. I think nearly everybody who saw him as a geriatrician would recognise this man was nearing the end of his life."

So Professor Ford was also realistic about this patient. He then said this at Day 20/48, when he was asked about the variable prescription of between 80 and 120 mg of diamorphine:

> "A ... I cannot, from the information I have seen in the notes, understand why there was such a large increase in the equivalent opiate prescribed for Patient A, which is, using the [WHO] one-third conversion it is an 8-fold increase, at the lower dose of the range, 12-fold [at the higher]."

He was asked:

> "Q Is it consistent with any medical practice you have come across?
> A No, not a magnitude of this increase."

A little later on, the following page, page 49, he was asked about the midazolam. He said:

> "A The problems are, first, it is unlikely he will remain alert. He is going to have a very depressed conscious level, as happened. Secondly, you will bring about respiratory depression and death at an earlier point. This man is dying, I think everybody recognises that. I think there is little disagreement by any of the experts about that or the clinicians involved, but the treatment he is receiving as a dying man should still be appropriate to his needs."

You may think that also reflects the evidence of Professor Sikora. You do not throw the *Palliative Care Guidelines* or the *BNF* out of the window because a patient is dying. The care should still be appropriate.

Then he was asked about the increase in the drugs because the patient was started off on 15 January at 80 mg diamorphine and 60 mg midazolam. That continues. Then, on 17 January, the dosage now becomes 120 mg of diamorphine and the 60 mg of midazolam goes up to 80 mg of midazolam. Haloperidol is added. Then, we know that Nozinan is added to the mix on 19 January and Professor Ford, Day 20/54, was asked, "If we go to page 20 of the chronology, we can see that the diamorphine was continued at 120, the hyoscine was increased and the midazolam continues at 80 mg on the 19th, haloperidol is being administered now we have Nozinan added at 50 mg. Do each of those drugs have a sedating effect?" and he said,

> "A Yes. Not the hyoscine – it does not have major sedating effects".

He said:

> "Q ... I think the major drugs causing sedation here, at this point, would have been midazolam and the Nozinan. To a lesser extent the diamorphine and haloperidol".

He was asked about Dr Briggs discontinuing the haloperidol but increasing the Nozinan and he said:

> "A That would mean more sedation".

I would like to turn to the issue of the width of the initial prescription, Day 20/55 and this is the initial prescription. He said:

> "A The width is within the two-fold I said might be desirable, but the problem here is the starting dose for both drugs is excessively high and was likely to produce significant adverse effects ..."

In the light of that answer, despite the answers that were later given by Dr Barton and then in fact withdrawn, you may think that so far as head of charge 2(b)(ii) is concerned in relation to this patient – and that is the width of the dose – that Professor Ford does not any longer support that head of charge.

He was asked about the notes that were made about the patient remaining tense and agitated once he had been on 80 mg of diamorphine, so once the syringe driver had started, and he was asked whether that was something for a doctor to consider in terms of increasing the analgesia to do something about that and he said, "The difficulty is that the opiates could be indeed contributing to the agitation or it could be that he has uncontrolled pain. It is very difficult to be certain as to the cause of the agitation but that obviously one of the issues is that the opiates could be in part contributing or it could be his underlying problems of depression and agitation from that". This is Day 22/56. He was asked about Dr Briggs having made the visit on 21st January and the slow breathing rate and he said:

"A I find it difficult to accept with a respiratory rate of 6 per minute that any doctor would claim he has not got respiratory depression. I am not saying he did not need at this point necessarily the drugs to achieve symptom control, but he has respiratory depression".

A respiratory rate of six per minute is not normal. When Dr Barton gave evidence about this patient, first of all her justification for her prescription is worth looking at. It is Day 29 and I am just going to read it out to you but in due course you may want to check it yourselves. Dr Barton dealt with this patient at Day 29/12 and I put to her – and I am going to read quite a chunk of this I am afraid but I think it is the only occasion that I am going to do so:

"Q ... before he had even started his first syringe driver of a minimum dose of 40 to 80, you doubled the minimum dose.
A Yes.

Q In evidence you told the Panel that you did so, as I understand it, because of the intensity and depth of his pain, his rigidity and discomfort.
A And mental distress.

Q Do you now remember that?
A I have told you that I do not actually remember the case, but that is what I would have done faced with that situation with that man dying.

Q What you actually said in your police statement at paragraph 23 was this:

'I would have been concerned, although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly'.

A Yes.

Q 'And that appropriate medication should be available to relieve this if necessary'. Yes?
A Yes.

Q There is no indication there that his pain, anxiety and distress had in fact increased; it was simply a feeling by you that it might.
A It was.

Q That is not the same as saying that you did that because of the intensity and depth of his pain, his rigidity and discomfort is it?
A It is anticipating these symptoms.

Q So you were anticipating the depth of his pain, his rigidity and discomfort?
A Yes.

Q You thought those things might happen, but actually they had not?
A They had not at that moment in time, no".

A We would ask you in due course to review those answers because they are not just relevant, you may think, to this patient but they are relevant to her attitude as a whole. Asked:

> "Q If, in fact, he was not displaying pain rigidity and discomfort, why would you feel the need to double the dose? Nothing had happened",

She said, "Yet". That is her answer to all of these, "I was anticipating that this was going to B happen".

I asked her why she had put in the increase when the man was on 30 mg of Oramorph. I put to her,

> "Q This now before he started the syringe driver at all is an eight-fold increase is it not?
> C A Yes.
>
> Q Have you read anywhere that that sort of increase is in fact appropriate and justified?
> A No. ... I have never seen it written down how somebody not standing at the patient's bedside can make an assessment of what level of analgesia and anxiolytic treatment they are going to need as they approach death. Guidelines are fine".

D I asked her:

> "Q Do you think that the editors of the *BNF* and those who wrote the *Wessex Guidelines* had never stood at a patient's bedside?"

and she answered revealingly, "I sometimes wondered".

E That is her attitude to the *BNF* and the Palliative Care Handbook.

She said at Day 29/14 that the *Wessex Guidelines* were:

> A Very appropriate in palliative care, not always appropriate when dealing with an individual patient requiring terminal care, dying".

F Neither her own expert, Professor Sikora, agrees with her nor does Professor Ford.

The heads of charge in relation to this patient – and I have dealt with them globally and I am not going to deal with them in any length now – allege that the lowest dose that Dr Barton prescribed of diamorphine and midazolam was too high. In the first prescription of 40 to 80 diamorphine and the second prescription of 80 to 120 mg of diamorphine and 40 to 80 of G midazolam and that is based on Professor Ford's evidence. You may think that it is also based on the Palliative Care Handbook and the *BNF*. What is alleged is that doses were administered which were excessive to the patient's needs, that the prescriptions in combination with other drugs were excessive to his needs and that the drugs were inappropriate and not in the best interests of Patient A. Whether or not Dr Barton had in her heart the best interests of Patient A is not the issue here and I will say this just once more. We are not seeking to look into the mind of Dr Barton, but what you have to consider is H

whether, as a matter of fact, these prescriptions and these administrations were in that patient's best interests and Dr Barton is entirely unsupported by expert opinion in this regard.

Can I turn then to Patient B. Elsie Lavender had either a stroke or a fractured neck depending on which way you looked at it. She was put on a very high dose of diamorphine after two weeks at the GWMH and the next day she was dead. She had been admitted on 5 February 1996 to the Royal Haslar after a fall. There she was dealt with in general terms by means of co-proxamol and dihydrocodeine. She was transferred to Daedalus Ward on 22 February 1996. Then DHC was prescribed. Two days later, MST was prescribed and administered, 20 mg. Then, on 26 February, so four days after her admission – and I am dealing with this very briefly – Dr Barton wrote out her prescription for 80 to 160 mg of diamorphine and 40 go 80 mg of midazolam. At the same time, the MST was increased to 40 mg daily. Then, on 4 March I think it was, MST was increased eventually to 60 mg daily and then finally, on 5 March, diamorphine was started.

You will recall in relation to this patient that first of all she was clearly unwell but Professor Ford told us – and we will look at his evidence in a moment – that it was too early to say that her chances of recovery were small. She had a reasonable chance. She was on MST for a long time but, when you look at the conversion which took place on 26 February 1996 from MST to the prescription that was written out by Dr Barton of 80 to 160 mg of diamorphine, that was a huge increase. Again, it was an increase outside all of the guidelines, no matter which book you care to look at.

She is described on 5 March as being in some pain. Therefore, "start subcutaneous analgesia". There was no evaluation of the cause of the pain or the reason for this patient's deterioration. This was a lady who had no progressive illness as Professor Ford told you, so it would have been important to identify the underlying diagnosis. When she was eventually started on diamorphine, she was started at a rate of 100 mg over a 240-hour period. Up until that point, she had been on a total of 60 mg orally. So, this again is a five-fold increase from the one-third normal reduction to which of course was added a hefty dose of midazolam of 40 mg.

Alan Lavender gave evidence about his mother. In fact, his statement was read on Day 3/1. He told us that his mum had otherwise been healthy, strong and independent. He was told that she had had a brain stem stroke. She had had physiotherapy whilst she was looked after at the Haslar. She had made excellent progress. She was speaking coherently and checking that they had fed the cat. She had learnt to walk with a walking frame. She was told she was going to GWMH for rehabilitation. He said, "I met with Dr Barton after two to three days and she said, 'You can get rid of the cat. You do know that your mother has come here to die'". He said that she deteriorated very quickly.

Alan Lavender, Day 4/3, said, "I did indicate I was keen that she should be pain free. We did not want to accelerate her death either. A conversation about the syringe driver took place after it was installed. Before that, I knew they were going to manage her pain but you can do that with tablets as she was being fed at the time".

Margaret Couchman gave evidence about this patient on Day 7. She said of 5 March that the pain was uncontrolled and the patient was distressed. The syringe driver was commenced. She said this, "I think I remember from my interview that I was told by the night staff how distressed she was, so the note I made was based on what I was told by someone and, if I had

spoken to the patient and she had told me that she was in pain, I would have noted it. It was my decision to begin the syringe driver but not mine alone. It requires two nurses. Dr Barton would have come in and I would have told her how distressed the patient was. I administered the syringe driver. I started at 100 mg because in my opinion it was enough medication. We decided, (me and Beed as it were) decided to give the lowest dose and that is part of the criticism here. This was the lowest dose that these nurses could give and it was frankly simply a great big whack for this patient who had been on oral morphine up to that time.

Professor Ford at Day 21/4 first of all spoke about the initial assessment.

> "... what if any view do you have of the initial assessment and the plan provided for this patient?
> A I think it was reasonable. I would not have expected Dr Barton to question the diagnosis that had been made by Dr Tandy".

You may think that that goes directly to head of charge 3(d)(i). In fact, out of interest, we know from Dr Barton that she did not agree with the diagnosis or the assessment made by Dr Tandy. So, you will have to take a view as to what note she made of it.

Moving on to morphine, he said:

> "I think the use of morphine may have been appropriate but I am critical that there was no assessment of the location of the pain or which might have led to using other strategies such as non-steroidal anti-inflammatory drugs or further investigation".

He said:

> ... using morphine may have been appropriate, but there is not a clear and strong justification, or assessment of the cause of the pain".

He was asked:

> "Q What do you say about the prescription that allows for between 80-160 mg of diamorphine to be given and 40-80 mg of midazolam?
> A It is not indicated or justified, and it is a very high dose".

That is Day 21/5. He said, "It is a four to five or six-fold increase, and if that had been commenced it would be highly likely to cause major adverse effects which is respiratory depression and coma, particularly with the co-prescription of midazolam at the dose range prescribed.

Q Does that apply to the lowest dose?
A It applies to the lowest dose of 80 mg".

He said,

> "Just to discuss the deterioration first, the first issue is why is this lady deteriorating at this stage. It should not be related to her stroke per se. It is possible it was an adverse effect of the opiates. It is difficult to tell from the information in the medical and nursing notes, but it is not clear to me why this lady at this point is not eating or

> drinking, but that could be related to her opiates...she is taking 60 mg of oral morphine, which is the equivalent of 20 mg prescription of subcutaneous infusion of 100 mg, is five times higher than the current equivalent she is taking".

He said that is not justified.

> "Again, I would judge that prescription to be very risky and likely to lead to, as the first prescription if it had been administered, adverse effects, with particular concerns about depression of respiration and conscious level".

He was asked by Mr Langdale,

> "If it were a stroke, what about the use of opiates?
> A There should not be the sort of pain. If it is post-stroke pain, it is the wrong approach to use opioids".

Dr Barton accepted that when she wrote up these prescriptions for this patient, Elsie Lavender, she would not have done so either by reference to the *BNF* or the handbook (Day 29/26). She accepted that there was no note of any re-evaluation of a patient, and you have to ask whether there was any re-evaluation taking place at all. Is the reality that once this anticipatory syringe driver had been written up, her destiny had been decided? There is a total dearth of notes and a lack of assessment in this case.

The doctor directed that the patient should receive on conversion many many times what she had previously been receiving of oral opiates. Our case is that 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 prescription that it may have potentially fatal consequences for her patient (Day 29/28). That is all very well and what she was accepting really was the principle of double effect, but the dose was outside all medical guidance. She in turn was relying for the beginning of that infusion of the syringe driver on what she had been told by the night staff.

Yvonne Astridge was called by the defence in respect of this patient on Day 30. She could not in fact add to her notes and could not remember the patient specifically, but she was asked specifically about this patient moving to the terminal care route and what note is made when that happens. This was by Mrs Mansell, Day 30/80. She could not point to any note of any assessment where that crucial decision was made for this patient. She also told you that the nurses would always seek specific authority for starting a syringe driver, but unfortunately the reality in fact is that that did not always happen, and that illustrates the danger of these prescriptions.

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. She went on that in essence she would leave that sort of thing up to the doctor. In this case, of course, the doctor had the attitude, you may think, to control the symptoms because they were not going to be able to do anything about the pain.

Dr Barton may have been right about that. She might have been right that they were not going to be able to do anything about this patient's pain. The concern is that there was no assessment as to whether or not that was a possibility. So far as this patient is concerned, again the criticism is based around the lowest commencing dose of diamorphine and

midazolam being too high, and therefore her prescriptions, as you will see, being inappropriate and not in her best interests.

Specifically there are allegations in relation to Dr Barton's management of the patient; that she did not perform an appropriate examination and assessment of Patient B on admission. I have revealed to you and reminded you of what Professor Ford said about that and you may think there is not much support for that head of charge. But also she did not conduct an adequate assessment as Patient B's condition deteriorated. You may think there is good support for that. She did not provide a plan for treatment and her actions and omissions in respect of this patient were inadequate and not in the best interests of Patient B. If she was doing nothing other than controlling her pain, and controlling her pain with huge doses of opiates which were not justified, then in our submission that cannot be in the best interests of this patient.

I turn then please to Patient C. Sir, I do not know if you were thinking of taking another break or breaking early, just so I can get a sense of where we are.

THE CHAIRMAN: It is quite helpful if we take the breaks in these bite-size chunks so we get some reflection for absorption.

MR KARK: If I were to go on until 20 past, and then we take a short break.

THE CHAIRMAN: Do the next patient and we will see where that ends rather than break in the middle of a patient.

MR KARK: Eva Page did not have any patient relatives who came along to speak to you, and the reality is that this patient was for palliative care. She had a cancer of the bronchus and it appears that she was not generally complaining of pain, but she was understandably frightened. She was opiate naïve before her arrival at the GWMH on 27 February 1998 when Dr Barton wrote her up for Oramorph. In the particular circumstances of this case, Professor Ford thought that was appropriate. There is no complaint in the charges about that initial prescription.

She was, as you will recall, eating and drinking up to the point at which she was transferred, but the opiates were commenced on the first day as well as thioridazine. She was said to be distressed on the second day of her admission, on the Saturday, calling for help and saying that she was frightened. Oramorph did not, apparently, help her.

Then on 2 March we have this note,

> "No improvement on major tranquiliser. I suggest adequate opiates to control fear and pain. Some to be seen by Dr Lord today".

On that day the fentanyl patch was started, in addition to which she was given 10 mg of diamorphine intramuscularly. After that, that patch, we have to recall, was administered at 8 o'clock in the morning. The drug charts indicate that on the following day diamorphine was started at 20 mg and 20 mg of midazolam. Those are the lowest doses prescribed.

I think it is worth mentioning and I will only do it once, that we have become in this case rather inured to the 20 mg dose. There is a danger that we view that as a low dose of

diamorphine. It is not a low dose of diamorphine and one has to recognise that this is the use of a heavy opiate.

Professor Ford spoke about this. Again he had no criticism of the initial use of opiates and in relation to the fentanyl, Day 21/13, he did not think that was an unreasonable thing to do.

> "I think it is quite a high dose of opiate that one is administering".

Then we turn to 2 March when Dr Barton wrote out her prescription for between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. He said first of all,

> "I could not find any indication in the notes that the fentanyl patch had been removed".

He assumed therefore that it was left on. He was asked if the effect of the fentanyl patch would continue after it had been removed, and he said it would. He said,

> "If we recollect, we looked at the British National Formulary yesterday which talked about 17 hours before the concentration would have halved".

He said,

> "I cannot understand the rationale for starting in addition to that a diamorphine infusion".

Obviously, in broad terms, what she is now receiving from the combined prescription, we understand she still has the fentanyl patch on, she has 90 mgs over 24 hours from the fentanyl patch and 60 mgs equivalent of the diamorphine so she is having 150 mgs morphine equivalent over 24 hours at this point which is obviously a very high dose.

> "Q In your view is that consistent with *Good Medical Practice* or not?
> A Only if there was a clear indication that she had pain and required further opiate treatment, but it is a very, very rapid escalation, the introduction of opiates in a patient who was opiate naïve until when she was she receiving oral morphine, a much lower dose of oral morphine, so it is a very large increase".

First of all, Dr Lord approved of this patient having a fentanyl patch and Professor Ford is not over critical of that management. But it was important that nothing else was added, you may think. Dr Barton said on Day 29/33,

> "I would ensure that the patch was taken off, otherwise the patient would receive a higher dose than he would want and that could lead to over-sedation".

But there is no note of this patch being removed, and in the latter case of Elsie Devine, it was noted when the patch was taken off. We know in this case that as soon as the syringe driver was started – almost as soon as syringe driver was started – there was a rapid change in the patient's condition. In relation to this patent it is worth bearing in mind that the charges relate to the prescriptions for diamorphine and midazolam and that they create a situation which allowed for the drugs to be prescribed to Eva Page which were excessive to her needs. It was inappropriate and not in her best interests. You may think that is the case, frankly,

irrespective of the use of the fentanyl patch and whether or not it came off at the time, because the fentanyl was going to continue.

The failure to make any record here of the circumstances in which the diamorphine and the midazolam should be deployed and their administration apparently when the fentanyl patch was still in place is, we submit, a good example of the dangers inherent in Dr Barton's practice.

Only two charges remain in relation to this patient, and that is Dr Barton's wide prescription of diamorphine and midazolam on 3 March when the patient still at that time had the fentanyl patch on her body, which we say was inappropriate and not in her best interest. As you know, the patient died in fact on the same day as the diamorphine and midazolam were administered with, we submit, the fentanyl patch still present.

Can I turn to Patient D, if you are up to dealing with another patient? I am dealing with these very briefly indeed. Patient D, Alice Wilkie, was 81 years old. She had an unresolved urinary tract infection. She had been to the Queen Alexandra Hospital for treatment. She is described as a demented lady and as a lady with advanced dementia. She had had some haloperidol while still at the QAH but she had not had any opiates in the form of diamorphine or Oramorph at all.

Dr Barton says that this patient's care may have been affected effectively by the rumpus made by the relatives of Gladys Richards. She made that clear at Day 29/36. 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 any of the other 11 patients or whether again it was the standard prescription and standard treatment.

Right up until the 20th, this patient having transferred on 6 August and she remained in the hospital for some time, you will remember, but right up until the 20th, the day the syringe driver was started, the patient was in fact opiate naïve. Page 8 of the chronology recalls that on 17 August 1998 the patient's condition had generally deteriorated over the weekend. That is a nurse note. There is no note made by Dr Barton. There is no mention of any pain or agitation or restlessness. In fact the last mention of pain was 11 days before, back on 6 August 1998.

On 17 August Dr Barton, on the basis of this deterioration over the weekend, prescribes her usual prescription, 20 to 200 mg of diamorphine, and this says 20 to 80 mg of midazolam. It is interesting to note the basis upon which apparently the syringe driver was started. Marilyn Jackson gave evidence about her mother, Alice Wilkie. She said that she had been in a residential care home. She had been admitted to the QA where she had responded very well to treatment. She was eating and drinking. She was transferred to the GWMH for rehabilitation and she said, "I visited her there".

> "A When I first went to visit for the first few days she was eating and she was drinking and then I started to go in every day so I saw a gradual decline in her health."

She said that Philip Beed told her that he did not think her mother would get better and he would die there. "I said to him, I did not want her to suffer. I went in one lunch time and mum was really very sleepy. She was flinching in the face."

A This is before any opiates had started. "She was flinching in the face and I asked her if she had a pain. She said yes. I told a nurse. Philip Beed eventually came and said, 'We did not know your mother was in any pain. We'll give her something to relieve her. You may find that when you come in this evening your mother will be sleepy." She said, "I went back at about eight o'clock and she was unconscious. I tried to rouse her but she never regained consciousness. She died the following evening. Why did they use a high dose of diamorphine in a syringe driver? The syringe driver was never mentioned to me. No one B knew she was in any pain at all before 20 August. The only time I saw Dr Barton was in the morning. She walked round, looked at my mum and said, 'It won't be long now', and walked back out. When she came to the GWMH mum was sitting up having a cup of tea and eating a biscuit. Her deterioration over the first few days was that she was very weak and very sleepy, and then she was unresponsive. I do not think the transfer was responsible. Philip Beed told you he had no recollection of this patient, but it was he who started her on 30 mg of diamorphine, this opiate naïve elderly frail lady. He said 30 mg of diamorphine would have C been based on the level of pain the patient was experiencing. There had been no other reason for giving diamorphine."

Well, he had not witnessed any pain. He was basing it on what the daughter had told him. I am not suggesting for a moment that this patient was not in pain. The question is the amount of opiate that was used, and the fact that they were allowed to be used because of Dr Barton's prescription.

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Professor Ford told you this on Day 21/20:

> "A ... would be critical of going straight to opiates, to strong opiates. I think one could have tried mild opiates, paracetamol and codeine or non-steroidal anti-inflammatory drugs if she was able to swallow."

E She said, "If having assessed the patient it was still not clear what the cause of her pain was, and there was no treatable cause in the terms of another intervention which one could take, a reasonable approach would have been to start mid-way or half way up the analgesic ladder.

> "A Say with paracetamol and codeine, for example, if she was able to swallow at this point. Failing that, if the pain was thought to be very severe – and we do not have any assessments which give a clear indication in the notes of how this lady was – F again I think a reasonable approach might have been to consider a one off oral dose or a small subcutaneous dose of morphine orally or morphine subcutaneously, but I think to start with such a high dose of a powerful opioid in an opioid naïve patient without a clearer justification is not good practice.
>
> ...
>
> G Q The equivalent of the dose that this patient was started on was 90 mg?"

What I think I meant was, the equivalent of the oral dose, the patient was started on 90 mg.

> "A 90 mg every 24 hours, yes, and that is a very high dose and in an opioid naïve, frail older patient one would expect there would be a high probability of adverse effects occurring ...

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A

Q ...
A ... respiratory depression, depression of conscious level and that is why one would want to start cautiously with a small dose.

Q The lowest dose that we have seen Dr Barton prescribe for a syringe driver anywhere, I think, in these records is 20 mg. Is it possible to give less than 20 mg?
A Yes. You very definitely can give less than that, and it is often given."

B

They are talking about the coupling of morphine and midazolam.

"A They both potentially have profound depressant effects on conscious level and respiration and I think you would be surprised not to see such effects using this dose of diamorphine and midazolam in a patient like this."

C

He said, "It is not the prescription for analgesia which is being crystallised; it is the very high starting doses and the wide range."

He said this – this is Day 23/6 and it is worth just pausing for a moment because, again, in this whole case we have been surrounded by the atmosphere on Dryad and Daedalus Wards and the practices that were regular within that hospital. But Professor Ford said this:

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"A Yes, but I think the problem I have with that [in] clinical practice, you have very few patients who go to this level."

This is just talking about these relatively low doses. This is Day 23/6.

"I mean, after you had asked me the question last week, at the weekend I went and looked at all the diamorphine prescribing on three wards – continuing care ward,

E

Walkergate Hospital rehabilitation ward and the stroke unit – and I looked at the 59 patients who had died in the previous eight months, and 19 had received opiates, which was about a third, which accorded with what my anecdotal impression was, and of those 19 only 4 had received doses more than 5 mg over a 24 hour period, and the highest dose was 20 mg over 24 hours, so this is a very high dose that you would not normally require to achieve pain control in terms of usual clinical practice.

F

Q ...
A ... I cannot conclude that this lady definitely would not have required 30 mg every 24 hours of diamorphine if it had been titrated up to that, but my view would be it would be very unusual for a patient like this to require that amount to achieve symptom control, and I think there still remains the issue of the midazolam and the lack of clear indication for that if she did not have terminal restlessness."

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This dose is only appropriate, you may think, if it was the lowest dose which would control this patient's pain, and there is simply nothing to support that contention, because there is no attempt at titration here. Neither Dr Barton nor Philip Beed nor Professor Sikora can possibly say that it was justified. The lack of notes about decision-making in this case frankly is pretty appalling. This patient was transferred to Daedalus on 6 August from QAH. Dr X made an extremely brief note on clerking her in. Four days later there is a clinical note by Dr Lord which says that the patient was eating and drinking better, and the only clinical note made by

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Dr Barton in the records was on 21 August, the day before syringe driver was started, and the

day after the patient died. I am sorry – the only note she made was on 21 August, the day after the syringe driver was started. So Dr Barton only makes a note on the day this patient died in her hospital.

The allegations are restricted to the width of the prescription which was, we submit, for this patient inappropriate, not in her best interests and was, frankly, the standard "one size fits all frail old ladies". If one asks oneself what was it about this lady's presentation or her symptoms at the time that Dr Barton wrote that prescription out, which justifies it, it is impossible frankly to see any justification for it whatever.

I am going to turn now to Patient E. You may need another break, I expect. Sir, I do.

THE CHAIRMAN: We will come back at twenty twelve, please, ladies and gentlemen.

(After a short adjournment)

THE CHAIRMAN: Yes, Mr Kark.

MR KARK: The best I can say is that we are getting through it. We are now on Patient E, Gladys Richards. We have spent, in fact, a great deal of time during the course of the proceedings reviewing issues around Mrs Richards' care, but it is worth reminding ourselves that the heads of charge in relation to her are almost more limited than in respect of any other patient. They are that the initial doses prescribed on her admission on 11 August were inappropriate and not in her best interests. Although there were two admissions for this patient, of course, because of the dislocation which we all remember, in fact all the charges go back to those initial prescriptions. I am not going to spend a great deal of time on this case although of course I hope to do it justice.

At her pre-transfer hospital, she was described, after her neck of femur fracture on 29 July, as fully weight bearing. She was cared for not at the Queen Alexandra Hospital, but at the Royal Hospital Haslar. You will remember the evidence of Rear Admiral Farquharson-Roberts, called by the defence on Day 33, when he said at page 62, that he dismissed the suggestion made by Yvonne Astridge (Day 30/74) in effect that his nurses were a bunch of beefy sailors who would not know the difference between a patient being able to take their own weight and not. He did not like that suggestion very much and he described the expertise of his nurses and his physiotherapists.

It is worth also bearing in mind, of course, that again this is another patient who, on the day of her transfer, was opiate naïve. Just looking briefly at her summary, she is transferred to Daedalus Ward on 11 August. She had previously had haloperidol but nothing else apart from when she was actually first operated on. This was the lady for whom there was the note: "When she becomes fidgety and agitated, it means she wants the toilet." Although that is not particularly relevant in her case, because that was not the reason for the start of the syringe driver, it is just worth bearing that evidence in mind in relation to others, and when you look at nurses' notes to support the start of a syringe driver on the basis of a patient becoming agitated or upset. In her case, when she became fidgety or agitated, she wanted the toilet.

She was transferred to Daedalus and reviewed by Dr Barton. It is interesting to compare the referral letter with Dr Barton's assessment. Her referral letter says this:

A

> "Now fully weight bearing. Walking with the aid of two nurses and a zimmer frame. Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. She is continent. When she becomes fidgety and agitated she wants the toilet. Occasionally incontinent at night. Occasionally says recognisable words. Wounds healed clean and dry. Pressure areas all in tact."

B Wounds healed clean and dry. Then she is transferred and Dr Barton's clinical notes reveal this:

> "Frail demented lady, not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL. Barthel 2. Happy for nursing staff to confirm. Deaf."

C On that day she – Dr Barton – wrote out prescriptions for Oramorph, which were administered the same day twice – 10 mg twice; diamorphine, the usual prescription, 20 to 200; midazolam, the usual prescription, 20 to 80.

Lesley O'Brien gave evidence about her mum. She was a former registered general nurse. She said of the Haslar that she was in pain there, and she was given morphine and haloperidol, but thereafter her recovery was "remarkable". Within two to three days she could be –

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> "...stood up with a zimmer frame and walk a few steps. She was lucid, she was off all her medication, she was able to hold good conversations with us, she was having three meals a day, she was completely hydrated and getting better every day. Her wound site was absolutely perfect."

E She had needed analgesia after the operation, but after that she was pain free. On the day of her transfer she had porridge and orange juice for breakfast. "I was there when she arrived. She was sitting in an ambulance. She was there for rehabilitation." She spoke about the following day, 12 August, her mother being unrousable and totally out of it. "I tried to rouse her but couldn't. She wasn't having any food or drink. She had not appeared to be in significant pain before this time."

F It is right to point out that although she was given Oramorph on the day of her admission, she was given it the day after on the 12th, which is this day that Lesley O'Brien was talking about, at 6.15 in the morning, but not thereafter but she was, as we understand it, on haloperidol. In the evening of that day she was not given medication because she was said to be too drowsy.

G "In the late evening she became rousable," said Lesley O'Brien, "and I gave her a bottle of fruit-flavoured drink, which she had in full." Then we move on to the time when she had a fall and she is discovered on the fall, and that fall has dislocated her new hip which undoubtedly must have been painful and required reduction. So she went back to her hospital. Lesley O'Brien told us, "Within 24 hours she was standing up and weight-bearing again – back to how she was before. Then, on 17th, she was transferred back to Daedalus. When I arrived at 12.15 she was screaming in pain, lying in a terrible position. She said to me, 'Don't just stand there, do something, pain, pain'. Her hip was in an awful position. With the nurse we repositioned her, and that nurse, you will recall, was Nurse Couchman."

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Then she said, "Dr Barton spoke to me and said it was not appropriate for a 92-year old to go back for a further procedure. Mum was given Oramorph for the pain, and I was happy for her to have something to stop the screaming. She said she was given four doses in seven hours, including two injections. She never then regained consciousness thereafter."

Philip Beed said she had a massive haematoma. The daughter said this, and it is relevant to evidence we have had form other relatives. "I wanted her to be pain free, but it doesn't mean she had to be unconscious for the rest of her life until she died. She was not hydrated. On the 18th, Dr Barton came into the doorway, folded her arms, lent on the wall and said, 'The next thing will be a chest infection.' On the 18th she was not conscious. She was not screaming or moving or doing anything at all. The syringe driver was already in situ."

As I say, Nurse Couchman spoke about this re-admission, about the patient being in a lot of pain and distress.

Can we look at what Professor Ford said focusing on those initial prescriptions. Day 21/26:

> "Focusing first on the Oramorph for this patient, do you have any commendation or criticism of first of all the prescription and secondly the administration of that drug?
> A On the information available in the medical and nursing notes, there is no rationale presented for prescribing morphine at this point. This lady was mobilising a few days before at the Royal Hospital Haslar and taking regular co-codamol. So that would be the appropriate analgesic to continue, unless there had been a major change in her situation. In fact, I am not sure whether we know she was still taking co-codamol after 7 August, between the 7th and the 11th, but even if she had stopped it or was still taking it, the appropriate prescription for analgesia would be to continue the co-codamol in my view. That could have been written up either as a prn or a regular prescription. ... But to move to prescribing morphine, when obviously there is the potential for significant adverse effects, without a clear description of there being a change in the pain severity or lack of control on other painkillers, means the prescription has no justification".

My question:

> "Prescribing diamorphine for this patient on the day of her admission, starting at 20 mg with a variable dose going up to 200, with midazolam. What view, if any, do you have about that?
> A I cannot find any information in the medical and nursing notes that would provide any justification for that prescription. This is a lady who, having had a major change in her level of function, against a background of slow deterioration, is now improving from a major surgical procedure. She has been referred for further rehabilitation in an attempt to improve her mobility, with a recognition that that may not be possible, to get her back to her previous level of functioning. So there is no information which would justify why this patient would potentially need nursing staff to commence infusions of diamorphine and midazolam. The notes do not say at this point that this patient is deteriorating and has symptoms which require those drugs.
>
> [They are] ... are high starting doses in what is at this point essentially an opiate naïve patient. ... there is a high risk of serious adverse events again".

When the patient returned after her reduction, we know that she was in pain. We know that there was this unfortunate event when she was transferred on a sheet. It seems a long time since we heard all of that evidence but you will recall it, I am sure. We also know that she had demonstrated that she had been particularly sensitive to midazolam after the operation and there was that note about that. Professor Ford said:

> "A Given we know she is very sensitive to a single 2 mg dose she has had, the 20 mg – which is as we have said before a high dose to start with in an older person – would be, again, very likely to produce adverse effects when it is started at the same time as a significant increase in the opiates.
>
> Q It is the combination again?
> A It is the combination, but even without the opiates, that dose of midazolam on the basis of her prolonged sedation after the 2 mg, might be expected to produce profound depression of conscious level".

So, when she comes back on 17 August and the syringe driver is started on the 18th with 40 mg of diamorphine, which was high but not unreasonably so given her pain, in addition to that she received 20 mg of midazolam and that administration was unjustified but remember in the charges you go back to what was her presenting condition then. The fact is that those prescriptions on the first day of her admission allowed for the later administration of that high dose of diamorphine and midazolam together.

It is also worth reminding ourselves – and it is worth doing this on more than this one occasion – to compare the medication that she received at the Royal Hospital Haslar with the medication that she received at the GWMH. At the Royal Hospital Haslar, she broke her hip, having broken her hip on 29 July 1998. On 8 August, there is a note in the chronology that she was agitated. She had a single dose of haloperidol to deal with that and that seems to have helped her but at the same time keeping her alert and conscious so that she was able to eat and drink. Well, that of course was not the case once she got back in due course to the GWMH.

As I say, although you have had a huge amount of evidence about this particular patient, I have to and you have to focus on the specific charges that you now have to deal with and that is all that I say about them.

Can I turn to Patient F, Ruby Lake. Again, the charges are very limited in relation to Ruby Lake. They relate to the first prescription for Oramorph on 18 August, the standard diamorphine and midazolam prescriptions of the same date, and the allegations being that those prescriptions were inappropriate and not in her best interests. As with all patients, there is the additional allegation at paragraph 15 that Dr Barton failed properly to assess the patient before prescribing opiates and that charge, which you will be asked to consider in due course, is different to some of the patients where we have specifically charged failing to assess on admission or failing to assess when there is deterioration. It is a charge which is directed specifically to the issue of an assessment before prescribing opiates. In other words, what was the foundation of the prescription of opiates. If you find that actually Dr Barton was simply prescribing opiates without making an assessment that justified them, then, in our submission, head of charge 15 is well made out.

This lady of course had a fractured neck of femur following a fall at home. Of course, we accept that that is capable of being and is sadly very often a terminal event in an old person's life, but, on 14 August 1998, so eight days or so after her operation, she is described in the notes as being frail and unwell but standing with frame and moving with physio assistance. She is given paracetamol with good effect and, on 18 August, she is described as being well, comfortable and happy. She had had a spike of temperature the day before but then her temperature was normal on the say of her transfer. There is a transfer letter that you have revealed in the chronology at page 14 at page 23 of your bundle speaking about

> "[This patient] had had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload ... now resolved, it appears.
>
> Presently ... slowly mobile with a Zimmer frame and supervision. She is able to wash her top half ... [She had] bilateral leg ulcers and a broken area on her left buck and in the cleft ..."

which was improving. She had a small appetite but her hearing aid unfortunately had gone missing.

When she got to Dryad Ward, her past medical history is set out by Dr Barton and the plan for her, "Needs some help with ADL. Barthel of 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death". She is immediately prescribed oral morphine, she is immediately prescribed diamorphine and midazolam in the usual amounts and she is given Oramorph the same night. This was the patient – I expect we may all remember it – who, on the night of her transfer woke up at night and she was distressed and she was anxious. She was obviously in a new environment and she was not very well. She was given Oramorph to deal with that. Dr Barton told you that when she wrote out her note about gentle rehabilitation, that was slightly tongue in cheek, Day 29/54. This was potentially a very ill elderly lady. That does reveal, you may think, an extraordinarily pessimistic attitude, not that this lady was well, as it were, I am not going to suggest again that this lady was going to be up and about within a few days, but to say that the comment "gentle rehabilitation" was slightly tongue in check is frankly quite depressing.

Until her transfer, this patient and her pain had been controlled by paracetamol; she was totally opiate naïve. Dr Barton accepted when she wrote out her prescription on admission that she was ignoring – and that is my word and you can check what she actually said about this at Day 29/55 – both the Palliative Care Handbook and the *BNF*. That night, instead of having someone to sit with her and as a direct result of the prescription that Dr Barton had written out, a nurse gave her not paracetamol and not temazepam but morphine and Dr Barton accepted, Day 29/56, that, with a confused patient, Oramorph was not necessarily going to help them. It might help congestive heart failure, but there is no evidence that that night that is what the patient was suffering from. She was simply anxious and distressed at her new environment.

Of her prescription for the variable dose, Day 29/57, I put to Dr Barton that, if nurses had given even half of that full amount that might well have killed her and the answer was "yes".

By four o'clock the next day, this lady was put on the terminal pathway. Diane Mussell, her daughter, gave evidence and she told you frankly that there was nothing that struck them as

being out of the ordinary with her care. She was in the GWMH, a private room, and able to talk. She said, "I can't recall any real concerns. Nobody actually spoke to us about a syringe driver". Pauline Robinson said, "I visited her at the Haslar after her fall. She did not want a nurse at first but I saw her a week later and she wanted to be taken out around the grounds. We took her on to the seafront. She seemed quite bright. She was in a wheelchair. When I saw her on the 20th – and that is two days after admission – she was unconscious and did not know we were there. She did not speak back to us at all. I think we were aware that she was on a syringe driver".

Timothy Coltman gave evidence about this patient and, if you want to look at his evidence, it is at Day 4 starting on page 14 and he talks about how, on 18 August, it was he who had recorded that the patient was well, comfortable and happy and mobilising well. "She did not seem to be in any distress and she did not seem to be in any pain. She seemed fairly normal for a patient of her age who had gone through a fractured hip and that operation. If she had been exhibiting pain, I would have made a note of it. She had been prescribed analgesia but she was not taking any" and then he spoke about the associated mortality with patients with this sort of fracture.

You heard from a number of nurses about this patient; I am not going to go through them all. You heard from Shirley Hallman, Beverley Turnbull and Anita Tubritt. They spoke about the syringe driver being started after the Oramorph had been given and Shirley Hallman said, "The diamorphine was started at 20 mg. Possibly I would have done that as the Oramorph was not enough and she was still in pain. I clearly was not happy with the dose" meaning of Oramorph "as I gave it". As we know, the dose was also increased by Nurse Hallman.

Again, the start of the syringe driver and these increases were all allowed for by the initial prescription by Dr Barton. Started on 19 August at 20 mg, doubled the following day to 40 mg and then increased to 60 mg the day thereafter.

At the start there is of course a huge increase on the few milligrams of Oramorph that she had had up until then.

So again, if we came back to the heads of charge for this particular patient, they are again relatively limited. Again, the dose ranges were of course too wide, etc., and particularly that the action in prescribing the drugs, 7(a)(ii) and (iii) which is the Oramorph and the diamorphine, were inappropriate and not in the best interests of the patient.

Again I come back to the point, if I may very briefly, to the question: what was there about this lady's representation which conceivably justified those doses? The analgesic ladder has gone out of the window. The Palliative Care Handbook has gone out of the window; the *BNF* has gone out of the window. There is nothing in this lady's presentation, in our submission, which justified those particular doses.

Professor Ford – I can deal with this quite briefly, I hope – gave evidence on Day 21/43 about this. He was asked specifically about the first night when the patient woke up just after midnight and was anxious. He was asked,

> "If that were the basis for giving this lady Oramorph, what do you say about it?
> A I think it can be criticised. The patient is anxious, they have come to a new environment, they have been quite unwell, they are saying they want someone to sit

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> with them. The first response would be for a nurse to sit with the patient. Nurses would not necessarily be able to sit with her all night, but you would expect, unless there were major staffing problems or other problems on that unit, a nurse to be able to sit with the patient for 20 or 30 minutes. If they were no better at the end of that, I think it would be perfectly reasonable to give either a hypnotic, temazepam, which I think she was written up for, or an antipsychotic drug such as thioridazine or haloperidol, but not morphine".

B

He said,

> "I think it did raise to me concerns that the nurses had interpreted that prescription of morphine to be used to treat anxiety or agitation in older people, in the absence of pain. I think most nurses would look at morphine being used to treat pain. So I thought that was potentially a confusion or maybe that was the general

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> understanding of nurses",

And that appears to be what happened here. He is then asked about the increases on 20th and 21 August. He said,

> "One would want to see clear rationale for these large increases. The increases are greater than those which are recommended in the Wessex protocols and other

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> guidelines, which would be a 50 per cent increase".

He also said – Day 21/45 –

> "One would generally increase one drug at a time to treat a specific symptom, but the escalation of doses over that period in an older patient like this would be expected to cause very marked sedation...I was of the view that the doses administered over the

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> period would very likely contribute to her death, yes, but again, because she had a lot of other medical problems, you cannot conclude that the drugs were the cause of her death".

Again, pausing there for a moment, it is the two drugs together. It is the assumption that seems to be made that when one is given the other should be given. There does not seem to be any particular approach as to what the midazolam is there for and what the diamorphine is

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there for separately, and they are not necessarily there to treat the same condition. When one goes up, we see regularly that the other goes up and you have to ask yourselves whether that is an appropriate or inappropriate approach.

That might be a good time for us all to take some lunch, sir.

THE CHAIRMAN: We will return at 2.15 ladies and gentlemen.

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(Luncheon adjournment)

THE CHAIRMAN: Thank you, Mr Kark.

MR KARK: Sir, I was going to move on now to the case of Arthur Cunningham, Patient G. Again it is worth going back to the heads of charge, which once again are fairly limited. This

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patient was admitted for treatment to his very bad sacral ulcer. He was admitted from the

Dolphin Day Hospital by Dr Lord, who well knew the abilities of GWMH and he had also, of course, been reviewed by Dr Barton herself. Dr Lord cannot surely be accused of an over-optimistic approach.

The heads of charge, so far as this patient is concerned, start at paragraph 8 and are specifically in relation again to the doses for diamorphine and midazolam on two occasions, 21 September and 25 September, and failing to obtain the advice of a colleague, or not obtaining the advice of a colleague when the patient's condition deteriorated.

As I say, the charges are very confined. There is also, of course, a lack of assessment before prescribing opiates and the additional charge that Dr Barton did not obtain the advice of a colleague is put simply in this respect. That is a fact which has been admitted and in due course you will have to decide whether that contributes in any way to an allegation of serious professional misconduct.

So far as the patient's progress is concerned, he was seen at the Dolphin Day Hospital on 21 September and reviewed by Dr Lord. He had a large necrotic sacral ulcer, which was described as "extremely offensive". He was being admitted with a view to more aggressive treatment of the sacral ulcer, and that was going to need this unpleasant chemical, apparently, called acerbine. But his social worker was to keep open his place at the Thalassa Nursing Home.

He was noted on 21st to have had tablets still in his mouth, although later on in fact we know he was able to drink some milk, so he was not unable to swallow anything. The plan from Dr Lord was that he should have acerbine for his sacral ulcer; he should be nursed on his side and he should have a high protein diet. Dr Barton saw him in the Dolphin Day Hospital and then he was literally wheeled, as we understand it, down the corridor to Dryad Ward.

The reality is that as soon as that patient was wheeled from one ward to another, he was almost literally on the terminal pathway because that is how we suggest this doctor approached his treatment. In her view it was not even practical to try to give him a high protein diet, as directed by Dr Lord – Dr Barton's evidence Day 29/62. Whatever the nurses were going to try to do for this patient, Dr Barton agreed with me that she would have spoken to the nurses and given her opinion that the best that could be done for this patient was to make him comfortable (Day 29/64).

That is quite important. The approach is governed from the top and in this case, on this ward, Dr Barton was the top. You will all recall that on the night of 21 September, on the day in fact of his admission, he has a period of agitation and frankly of behaving badly. Oramorph is given to him at 8.20. Ten minutes later he is described as no longer being agitated. Two and a half hours later the night staff appear to have thought it right to put this man on a syringe driver prescribed by Dr Barton. It is noted that that is "as requested" and nobody seems to know who made that request.

Pausing for a moment, and going back and stepping away from this for a moment, we all know now because it has been agreed by a number of witnesses, that the starting of a syringe driver for any patient is the terminal pathway. So when this patient is wheeled from one ward to another and that same night he has got a syringe driver set up for him, that quite frankly was the end of any idea of treating his sacral sore, of rehabilitation or anything else.

A You heard from his stepson, Charles Stewart-Farthing, who described his step father as being, "Can be difficult. Had strong opinions". In summary he said, "When I first saw him on Dryad Ward he was perfectly normal. He said he had a sore butt. They said they decided to take him in for aggressive treatment so he knew what he was there for. He was quite frail and he had lost a fair bit of weight. He could not walk on his own but he could get in and out of a wheelchair himself. Nurse Hamblin said it was one of the worst sores she had ever seen".

B He said, "The following day I telephoned the ward and was told he had become aggressive to the staff. They had given him something to calm him down. I said I would be in the next day and would have strong words with him. On 23rd I went to the ward. He was unconscious, unrousable. He was totally different. He had gone from a normal person to someone who was totally comatosed. On 23rd I discovered the syringe driver and asked for it to be removed".

C This was first of all to Nurse Hamblin. "She said she couldn't. It was only the doctor who could authorise that. We came back the next day and Dr Barton did not come until the 24th at around 5 pm. He had not been conscious all day. Dr Barton told me bluntly that he was dying from the poisons emanating from his bed sores and she refused to remove the syringe driver due to the pain he would experience. I accused her or murdering him. The interview terminated rather quickly".

D That was Day 6, pages 2 to 23, where you will find his evidence. You will have to consider that. You have had a lot of evidence about the appropriateness or otherwise of reducing a dose so that a patient can at least speak. But let us go right back to the charges. What happens as this patient is wheeled from one ward to another? Dr Barton first of all prescribes him Oramorph. She then prescribes him diamorphine at the usual prescription and midazolam between 20 and 80 mg. We know that that night he had this episode of either acute bad behaviour on one view or acute distress on another. But the initiation of the
E syringe driver was some hours after that had happened and some hours after apparently this patient was no longer being agitated or aggressive.

Can I just remind you of the evidence of the nurses? Ingrid Lloyd told you at Day 15, page 84, that she had agreed that a syringe driver would commence in order that he remain in a pain-free and peaceful state. She said, summarising, "Although he was peaceful at 8.30 pm, it was not certain that he would remain so, and the syringe driver was commenced at 23.10.
F The drugs were prescribed to be given at our discretion".

That is a worrying circumstance, you may think, in which this gentleman who had been admitted to that ward on the same day for treatment of the sacral sore, is put by nurses on to the terminal pathway.

Professor Ford gave evidence about this patient on Day 21/50. He said in terms of the
G assessment and plan,

> "I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated",

So far as his plan is concerned. Then he was asked about the diamorphine and midazolam, and he said this:

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"It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?
A He is taking Oramorph, so he is getting morphine to control the pain, so there is no need to change that unless he is refusing to take medication, which this note
B does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness".

He was asked,

"First, if the nurses had started diamorphine and midazolam inappropriately and the
C doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving".

He said,

D

"That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent".

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...
A ... You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care."

Just pausing for a moment, if the nurses had that night inappropriately put this patient on a syringe driver, the doctor needs to review that – needs to review the reason for that – the next
F day. In this case, the doctor had every reason for reviewing it because Mr Stewart-Farthing was asking her to do so. Dr Barton agreed when she gave evidence. We will go back to what happened with the doses of midazolam which in fact were tripled. Dr Barton agreed that Charles Stewart-Farthing was clearly a caring and loving relative, but she described as inhumane and abhorrent the suggestion that the patient's infusion should be stopped or reduced – Day 26/69 and Day 31/11.

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This patient, two days earlier, when Charles Stewart-Farthing had seen him, had been sitting up in bed asking for chocolate. You may think it 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. You will recall – and I am sorry I do not have the reference for this – that Dr Barton eventually agreed that if the patient says to her, "Please, take that thing out. I am not consenting to have a syringe driver," she would have to follow that instruction. One wonders what would have happened in this case if that conversation had taken place. Dr Barton's comment to me, Day

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29/72: "...your idea of withholding analgesia from somebody who was dying was just abhorrent to me."

As you know, he was started on the syringe driver that night, and it continued. It continued throughout the next day and then, on 23 September, there is a comment that he became a little agitated again at night, and the following day the diamorphine continues, but the midazolam is tripled up to 60 mg.

Professor Ford said this, Day 21/53:

> "A ... One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be."

This was a very large dose. This is page 53 again – "this was a very large dose, a very large increase" in relation to the midazolam. There was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point and see what happened. He was variable in his agitation. We had the problem that it was possible that it was the diamorphine and its metabolites that might be worsening his agitation. If you have somebody who is over-sedated, it is best to stop for a few hours and then see what happens to the patient, and re-start the infusion at a lower rate. He said:

> "A ... I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death."

Finally this, in relation to 24 September, which was the day when the diamorphine was first of all doubled to 40 mg, and then the same day increased again to 60 mg, the midazolam then went up to 80 mg, there was this CPN note: "Physical decline. Pressures sores development. Admitted to Dryad Ward, terminally ill. Not expected to live past the week-end." That is referring to a staff report on 24 and 25 September, the 24th being the day when these drugs were increased, as I have just indicated. Professor Ford said, "It is unclear what they are observing in their response to pain. This is a man who was, as far as we can see, not complaining of major pain. He was obviously thought to have some discomfort when he was seen at the Dolphin Day Hospital. Then he has escalated within a very short period to a very high dose of diamorphine. It is a very dramatic change. At the same time, he has also been escalated to a very high dose of midazolam. I find it very difficult to know what signs the nurses were interpreting, as to whether this man was in pain or not." That is Day 23/25.

So we submit that there is substantial support for the contention that the drugs which were prescribed on his admission, and then increased on 25 September, were inappropriate and not in his best interests for this particular patient.

Can I turn then, please, to the next patient, Patient H, Mr Robert Wilson. This gentleman, again, we no doubt all recall. We had pretty graphic evidence about this gentleman's drinking habits. He was a heavy drinker. To say he enjoyed a drink I think is probably putting it too low. He had as a result, it would seem, alcohol liver disease. Then, in

September, he fell, breaking his left humerus. He was admitted to QAH. He did not want to have the fracture fixed, and that undoubtedly caused him considerable pain whenever he knocked it or tried to move it. He was given morphine at first and then codeine phosphate and paracetamol. Prior to transfer, he was on a mixture of codeine, paracetamol and occasionally small doses – I think 5 mg doses – of intramuscular morphine. Then, on 14 October he was transferred to Dryad Ward.

The fact that this patient was known to have alcohol liver disease was also well known to Dr Barton. Indeed, her clinical notes on 14 October revealed past medical history "alcohol problems". There is no suggestion that people did not know generally about that issue with him.

Can I just remind you of something that Professor Ford said in a general way about those with alcohol problems. This was Day 20/27, and he was again dealing with *BNF*. He said the guidance is about careful monitoring.

> "If you have somebody with significant liver disease who is in severe pain, you are not going to want to deny them opiate analgesia and you would give a lower dose and monitor carefully. It is important to emphasise it is not saying these patients should not receive morphine or other opiates. In renal impairment, the problem is, again, more sensitive and there is this risk, because of the accumulation of metabolites, of a greater likelihood of getting confusion and agitation but I think now their recommendation is to use alternative opiates to morphine in renal impairment. I think however at this time you would still use opiates. You would just use them more carefully."

Then we heard from Sister Hamblin, whose statement was read to you on Friday last. She told us, at Day 36/55 when her statement was read, one of the reasons for increasing the diamorphine.

> "The diamorphine has been increased from 40 mg to 60 mg."

We will go through the chronology in a moment.

> "This would have been to control his pain. I must point out that as well as his multi organ failure, Mr Wilson was suffering from a fractured upper left arm.
>
> Midazolam was increased from 20 to 40 mg. This was increased because he was suffering from liver failure and, as a result, the medication would not be working as effectively. Therefore, the dosage was required to be increased.
>
> ...
>
> Oramorph was administered to Mr Wilson due to the pain from his fractured arm and also because he was an alcoholic. By this, I mean that his liver was not functioning as well as it should be. He was also suffering from renal and liver failure."

That is a slightly worrying admission, you may think. Sister Hamblin was extremely experienced, obviously. We have heard a great deal about her. Unfortunately we have not heard from her. If that was her understanding, then it rather belies Dr Barton's evidence that

she was entitled to rely on the experience of her nurses, because this was her most experienced nurse. She may, it appears, have been getting this wrong.

The prescription written on the day of his admission, as we know, is the usual one, if I may call it that, including Oramorph. It is exactly the same prescription that we have seen throughout. Forget his liver disease. Forget his alcohol problems. This is – and I am sorry to use the expression again – the "one size fits all dose". No special instructions to the nurses warning, "This man is an alcoholic. Be careful how you use these." It is just the same dose as before. Up until this point, he is in our submission effectively to be regarded as opiate naïve, although he had had some small amounts of diamorphine previously.

He is commenced on 15 October on 40 mg a day of Oramorph. He deteriorates. The condition deteriorated overnight on 15 October, and he is described as being "very chesty", and he becomes, it would appear, incontinent. Then the Oramorph seems to go up. He is given 50 mg. Then he is described on the 16th as unresponsive to spoken orders, suffering from shortness of breath and on the Friday, the 16th, the syringe driver is commenced with 20 mg of diamorphine. On this occasion, there is no midazolam.

Thereafter, on the following day, on the 17th, the diamorphine is doubled and the midazolam is started. The day after that, the diamorphine goes up again. The midazolam is doubled and the patient dies eight hours later.

This is a patient whose pain hitherto had mostly been controlled by codeine. His deterioration mirrors the increase in his opiate dosage. His deterioration did not cause Dr Barton to consult with any senior colleagues. Dr Knapman saw him on his second day and Dr Barton appeared at one stage to suggest that it must have been Dr Knapman who authorised the syringe driver but you will recall, and it was pointed out, that Dr Knapman saw the patient in the morning, and increased his frusemide, saying nothing about a syringe driver. It was not until that afternoon that the syringe driver was started, and Dr Barton accepted that it would have been very surprising if Dr Knapman, at least, had not made a note about that decision.

Professor Ford gave evidence about this on Day 22/3, and he commented on the fact that the patient had been getting at most paracetamol and codeine. He said:

> "A ... I think it would have been most appropriate to continue paracetamol regularly and increase the dose of codeine to say 60 mg four times a day. He had not had that level of regular moderate opioid dosing prior to his admission to Dryad Ward as far as I could tell. The dose is a large increase on what he had been having before of intermittent doses of 2.5, so I think it would have been reasonable, if one had decided he was unlikely to be controlled or had not been controlled on the moderate opioid, to start with a more cautious dose of 2.5 to 5 mg, given his liver disease...".

This is speaking of his first dose of diamorphine.

> "So I think the 10 mg is in my view an excessive dose, given his age and liver disease."

Gillian Kimbley had travelled with him to the hospital, of course. She described him as being "not too bad and able to hold a conversation, but he was exhausted. Dr Barton had said, 'Get

straight into bed and I will give you something to calm you down'. That is not a criticism of Dr Barton at all, but in less than 24 hours she said there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense and he was semi-conscious. I spoke to a sister, and she said, 'Your husband is dying. He will be dead with a week.' I could not believe it. From the 16th he was unconscious. He did not indicate that he was in pain."

Shirley Hallmann gave evidence about this patient on Day 13. She told you that she did not know who made the decision to start at 10 mg of diamorphine prior to the syringe driver and she could not say who started the syringe driver, but she accepted that Dr Barton appeared not to be there that day. She said it could well have been a nursing decision. "It could have been my decision. There were occasions where we decided to start the driver without consulting the doctor to stop the patient being in unnecessary pain. I did not think the doses were excessive."

Professor Ford, of course, said that you need to reduce the dose because of the damage to the liver.

You may take the view, again, I am afraid, with this patient, that there was no particular care taken to ensure that the particular dose was appropriate to the particular patient.

Ian Wilson told you that he had been along to see his father and his father had complained that the staff were killing him, and those were the last words that his father said to him. That may no doubt have been the unintended consequence of the nurses' actions, but it may appear to you to be one of the consequences nevertheless because of too large doses for a man with this sort of liver.

I should mention that there is a specific set of charges in relation to Mr Wilson which you will find at 9(b) all of which refer to the fact that, in the light of a patient's history of alcoholism and liver disease, the decision to give him Oramorph was inappropriate and potentially hazardous, and also the prescription for diamorphine at a dose range of 20 to 200 is also said to be hazardous and likely to lead to harmful consequences and not in his best interests.

Can I turn then to Patient I, Enid Spurgin. Again, in relation to Patient I, the charges are limited. They focus on the prescriptions for diamorphine and midazolam and the assessment for this patient was inadequate and not in her best interests and the doses prescribed were inappropriate again and not in her best interests as were those which were in fact administered to her. This was a 92 year old lady who was pulled over by her dog which unfortunately broke her hip, again a potentially terminal even for any old person. The charges in relation to this patient do need perhaps more careful consideration. The assessment on admission is criticised. The usual dose range is criticised as being inappropriate, the administration of the syringe driver and the dose of 80 mg of diamorphine and 20 mg of midazolam – you will remember Dr Reid later intervened and ordered a reduction – is particularly attacked as being inappropriate and potentially hazardous. None of those allegations have of course been admitted.

At the time that this patient was transferred to Dryad Ward, she had last had any morphine five days earlier and she had received five days earlier 5 mg. Again, we think legitimately make the point that, when you compare the sort of doses of these patients at the previous

hospital with the doses that they were subsequently to receive on transfer, there really is no comparison at all. On the day of her arrival, which was 26 March, this patient received some 25 mg of Oramorph, 30 mg having been prescribed. Up until then, she had been on a regular dose of 1 gm of paracetamol a day. My understanding is – and I got it from looking at a box of paracetamol that I have at home – that the standard paracetamol is 500 mg, so this is two paracetamol provided by any chemist a day and that, up until that stage, had been controlling this patient's pain, so it would appear or at least the doctors thought so. So, for her to start on 25 mg on 26 March, you may think that the analgesic ladder has gone out of the window, as has the *BNF* and as has the little green Palliative Care Handbook.

Carl Jewel whose evidence you heard on Day 8, the nephew of Mrs Spurgin, said that she was sat up in the bed back at the Haslar. She was transferred to the GWMH, he visited her four to five times, initially speaking happily. The staff said she was too uncomfortable to be moved. Then there was a phone conversation, "I said she is an old lady, please, make her as comfortable as you can" and then, on the 12th, she was found to be unconscious and unrousable.

Let us look briefly at what happened to this lady from her admission. On 26 March, she is transferred. She was complaining of pain and she is given Oramorph. You will remember that Professor Ford was critical of the lack of further assessment because this patient should not have been suffering from pain for this long period after the operation itself. She continues on Oramorph. On day two of her admission, she now finds herself on 40 mg of oral morphine. That is on Saturday 27 March. She then on the Sunday is vomiting the Oramorph and so that is stopped and she is put on to co-dydramol. Then, on the Wednesday of the following week, she is put on to MST. So, long-acting morphine. Her wound is noted on Thursday 1 April to be oozing large amounts of serous fluid. That was not swabbed that day and indeed it was not swabbed until some four days later. She was reviewed by Dr Barton on 6 April, although there is no note about Dr Barton herself about that, and swabs are then taken.

Then, on 7 April, so the day after this review by Dr Barton, she is seen by Dr Reid and he notices that this patient's right leg is two inches shorter than the left. You may ask yourselves, why on earth, if proper assessments were being made by Dr Barton, is that something that was not noted by her? He ordered that an X-ray be taken. Then the MST is continued, but nothing apparently is going to happen until Dr Reid sees the X-ray. Dr Reid gave evidence at Day 16/38. He was concerned that the head of femur may have collapsed. He said that Dr Barton could have ordered an X-ray. He was asked about the 20 to 200 mg prescription and he said, "I do not think that is acceptable". As I have said, according to Professor Ford, this patient should not have continued to be in pain for so long without action being taken. Dr Reid having ordered an X-ray, Dr Barton told you this on Day 29/89, "I would not have looked at the X-ray because it would not have altered my management". You have to ask yourselves why it is that Dr Barton is not going to react to an X-ray? Why is she not, at least potentially, going to go through that thought process of sending this patient back to the orthopaedic department? By the weekend of course, this patient deteriorates very markedly. The X-ray has been ordered but nothing has happened and, on the Monday morning, Dr Barton, before the X-ray apparently comes back, starts the patient on 80 mg of diamorphine. Up until that point, she had been on 40 mg MST and 5 mg of Oramorph. So this is – and again I am going to use the word – a massive jump. It is the equivalent of giving her from 45 mg orally 240 mg orally over a 24-hour period and the day before that infusion was started, she was described as being very drowsy and unrousable at times.

Dr Barton readily accepted that she had not been consulting the guidelines when she administered that dose and even Dr Reid, who you may think was not exactly quick to take any supervisory role, thought it was too high and halved it. A nurse apparently then, either deliberately or otherwise, doubled the dose of midazolam which Dr Reid thought was an astonishing thing to do in the light of his reduction of the diamorphine. However you look at that increase in the midazolam, it is extremely unfortunate. Whether it was a mistake or whether it was done deliberately, again it is one of those pieces of evidence that does undermine Dr Barton's trust in the nurses.

Daniel Redfern, the consultation orthopaedic surgeon, gave evidence of a general nature about this patient on Day 16. He told you that it sounded very much as if the implant ... I am sorry, I should not put it that high. He said that a shortening of the leg would raise concern that the implant had failed. A sound fixation without other complications would expect analgesic requirement to diminish the ability to mobilise would improve. At no time at the GWMH did the pain improve and that would worry him. He said that the shortening of the leg by 5 cm is a long way short. To be requiring morphine still two weeks after the operation is very uncommon. He said that the correct thing to do would be to take an X-ray and check the fixation was sound and "we would expect non-orthopaedic, non-surgical doctors of one or two years post qualification to exercise that course of action. He said that the bar for re-surgery would be set fairly low.

Professor Ford spoke about this patient's first administration of Oramorph as a high dose to start with. "She is very elderly and one would start with 2.5 to 5 mg". So, either a tenth or a fifth of what she was actually started with. He said, "I think the key issue with this lady for instance on 3 April was that one would not expect her to have severe pain after the surgery at this point in time. This should have led to an evaluation".

He said – and this is at Day 22/15:

> "But one would want to be particularly cautious about increasing the opiates. So one would want to only do the 30 to 50 per cent increase and hope tolerance came to the drowsiness in a patient who is experiencing the probable adverse effects and the opiates are the most likely cause. ... So if one increases that by a third or a half, on the basis she has some pain, one would reasonably give 20 to maybe 25 mg of diamorphine over 24 hours. So the commencement of 80 mg is clearly much, much greater than one would administer if one were going by the guidelines. In this patient, because she has evidence of adverse effects already, I think one would have to have very good reason not to follow the generally accepted guidelines of a 30 to 50 per cent increase.
>
> Q You mean you would go less?
> A Certainly less. As I say, a reasonably appropriate dose to give to control [the pain] would be somewhere between 20 and 25 mg of diamorphine ...
>
> Q What would be the likely effect of this, which is I think a four to five-fold increase?
> A That she would become very drowsy and it could suppress respiratory function".

A He said of the reduction by Dr Reid:

> "My view was that that reduction probably was not sufficient to prevent the toxicity she was experiencing at this point in terms of having a depressed conscious level",

So far as the increase in midazolam was concerned which was allowed for by Mr Barton's prescription and it was put to him:

B

> "Q Dr Reid described that increase as "astonishing".
> A Well, it is. It is a huge dose for an older person. It will induce deep sedation and coma".

On Day 22/17, he said:

C

> A I think it is very difficult to conclude that that combination of the diamorphine and midazolam did not contribute to her death through sedation and respiratory depression".

When he was cross-examined by Mr Langdale, he gave this answer, "We seem to always be trying to conclude that the drugs which we know cause drowsiness are not the cause of a patient's drowsiness that we are looking at". He said, "I would say about that there was no D clear evidence presented in the notes that she was septicaemia in terms of having an elevated blood pressure". In other words, the other possibilities for making her so drowsy.

Her cause of death in this case was given by Dr Barton as being a CVA for which you may think there was precious little basis.

I am going to move on to Mr Packman if the Panel are alert enough to bear with me for E another patient. I can tell that there is not huge enthusiasm but it would be better to get on nevertheless.

THE CHAIRMAN: We will get on to Mr Geoffrey Packman.

MR KARK: Mr Packman. Again, I expect that we will all remember always hereafter this case the reason for this poor man's admission to hospital having had this accident in this F bathroom and unable to get out. He was terribly obese and he had serious sores. He had been on Clexane at the QAH since ... Well, he was admitted on 6 August and he was put on Clexane shortly after that to make sure that he did not have DVD and then, on 18 August, there is the comment that he had a black stool overnight.

He was admitted to Dryad on 23 August and reviewed on the ward by Dr Ravindrane. Doctor Ravindrane made quite a good note, you may think, of his admission and his findings G on admission. He had a very good mental test score. He had lower leg oedema. He was still being prescribed clexane, but that was stopped quite shortly after that on 25 August. There was an order to withhold the clexane and review with Dr Barton mane, because he had been found to be passing fresh blood per rectum. It was described by Dr Ravindrane, I think as, "This could be something serious".

Thereafter he is seen by Dr Barton on 26 August 1999 and he is described as, "clammy, H unwell". There was concern that he might have had a myocardial infarction. An alternative

possibility was a GI bleed. That, it appears, is what actually did for this old man. On that day of that review, Dr Barton writes out her prescription for diamorphine, 10 mg stat; Oramorph up to 60 mg a day. Rather strangely here there are two prescriptions for Oramorph, one up to 60 mg a day and another up to 100 mg a day, and on the same day diamorphine was also prescribed, between 40 and 200 mg, and midazolam between 20 and 80 mg. So suddenly this rather large cocktail, frankly, of drugs is prescribed all on the same day without any specific instruction about how any of these prescriptions are meant to be used, presumably all down to the discretion of the nurses.

We know that the Oramorph was administered and he was given, from 28 August onwards, 60 mg a day. That is on the Saturday and Sunday. On the Monday he is complaining of left abdominal pain. His condition remains poor and at 14.45 – this was a Bank Holiday Monday, 30 August – the syringe driver was started, 40 mg the minimum dose allowed on the prescription and 20 mg of midazolam.

That is 30 August. Betty Packman, his wife, told us on Day 8/5-15, that he was very heavy; he had reached 23 stone. He did not complain of being in pain. He was transferred to GWMH for rest and rehabilitation. She visited every day there and on 26 August Dr Barton asked her to come to another room. She told her that his organs were not working properly and "he was going to die". "I was shattered".

Summarising, she said, "When I went back into his room he asked me what she had said and I did not tell him. At the time he did not complain of pain. I continued to visit. He got weaker and I could not converse with him easily. Eventually he was completely out of it. I did not know he was given Oramorph, but I was later aware he had a syringe driver".

Victoria Packman, his daughter, describes him at QAH as being in a "sorry state", but at GWMH, "When he first got there he was cheerful. He looked the best I have seen him in years. If anything the transfer had benefited him. He was fine for the first three days. Then we got a call saying he had had a heart attack". That may well be a reference to the myocardial infarction that Dr Barton speaks about. "We went down. He said to mum that he had had a bad case of indigestion. Two days later he was away with the fairies. He was drowsy. He could not feed himself or drink. It was shocking. He went downhill from there".

Dr Reid explained that when he saw the patient, I think on 1 September, by then the patient was terminally ill because he had had, or was having, a very significant GI bleed. At Day 16/50-60, he said, "Had the problem been recognised earlier, it is possible something could have been done for him, but his pre-existing problems would remain". He thought giving this patient diamorphine was an appropriate measure. He said, "I would not have written prescriptions for diamorphine between 40 and 200 mg or midazolam between 20 and 80 because the range was too great".

Professor Ford talks about the review by Dr Barton where she makes the comment about the myocardial infarction on 26 August. He said,

> "I would have expected some other observations in this context, certainly a blood pressure and heart rate recorded by nursing staff".

This is Day 22/20:

> "given he is clearly unwell and at this stage there is no suggestion in the notes from what is recorded that he is for end of life care, certainly I would have expected the appropriate response was to contact the acute hospital, either the on-call medical doctor depending on the structure, medical registrar or the coronary care unit".

He was asked about the note which was made by Dr Barton, "Not well enough to transfer to an acute unit". He said,

> "I cannot really follow the logic of that. It indicates he is very unwell and that is even more of a reason why he needs to be in an acute hospital".

He was asked about the 10 mg that was given to the patient intramuscularly, and he said,

> "Yes, one would normally give it to people complaining of chest pain with myocardial infarction but I think if that is the working clinical diagnosis, although the absence of an ECG, if that could have been obtained, there is some question over it, I would not consider that is unreasonable".

Sir, can I just ask you please to turn up head of charge 11(c)? It is rather complex, I am afraid,

> "Your actions in prescribing the drug described in paragraphs 11(a)(ii) and or (v)",

Head of charge 11(a)(ii) refers to the verbal permission for 10 mg of diamorphine to be administered to Patient J, and the criticism is that that was inappropriate, and in the light of Professor Ford's concession, just to give you the reference again it is Day 22/21, you may think that in respect of that particular prescription, and also in relation to 11(c)(iii), that it was not in the patient's best interests, that the criticisms in relation to that 10 mg dose fall at this stage.

However, when he looks at the rest of the prescription, he was less complimentary. He said,

> "he is a big man, although weight does not have necessarily a large impact on the dose required. Again, one would want to start with the usual suggested dose of I would have thought 10 mgs but not 20 mgs and observe the response, but I am not clear from the notes what the opiates are treating because he is not being described as being in pain at this point".

In relation to the 40 mg start of diamorphine, he says,

> "Yes, Yes, it is very high and, again, there is no - he has got abdominal pain, he seems to have been placed on an end-of-life care pathway, if one wants to use that phrase at this stage. His abdominal pain is being treated with high doses of opiates".

The fundamental issue here is that there has not been an approach for assessment to try and treat the underlying problem. There is not a clear justification for prescription or the subsequent doses administered of diamorphine and midazolam.

Then,

> "He should be transferred back, or at the very minimum a discussion had with the on-call medical team to accept him for management that cannot be provided and interventions on the Dryad Ward site".

He said,

> "I think the vast majority of rehabilitation teams would have attempted to mobilise this patient, recognising that it could take a very long time".

That is Day 23/48. Asked again about the decision not to refer him back to the acute unit – Day 23/49 when he is being cross-examined by Mr Langdale – he said,

> "I do not think that decision should have been made by the clinical assistant without discussion with the on-call acute physician or on-call geriatrician. I find this statement, 'not well enough to transfer to acute unit', difficult to understand. He is clearly very unwell. In my view that argued even more strongly for the case to transfer him to an acute unit for treatment. His prognosis is extremely poor without treatment as we have seen. I do not think the situation for this man was completely hopeless. In my view I do not think he was destined to die".

With those words, I have just one other comment to make about this patient. It is worth remembering that the first prescription for this patient by Dr Barton was an anticipatory prescription and that means, of course, that she was apparently foreseeing not only that the patient would need opiates in due course, but somewhat surprisingly that he would need no less than 40 mg of diamorphine, and we say that that was unjustifiable in these circumstances.

That is all I say about that patient. There are two more to go, but it may well be that you could all do with a break.

THE CHAIRMAN: We will return at 20 minutes to four.

(Adjourned for a short time)

THE CHAIRMAN: Mr Kark?

MR KARK: I move on to Patient K and the final furlong, as it were. This is Elsie Devine who had nephritic syndrome or kidney failure, but apparently fortunately, no multiple myeloma. You will have seen that she had been under the care of Dr Cranfield. She had worsening creatinine levels at the time she was in QAH and then on Dryad Ward, but her mental test score was in keeping with severe dementia but she was described as a very pleasant lady. You will recall her daughter, Ann Reeves, gave evidence on Day 5, pp 1 to 19, and she described how this had all come about because her husband had been unfortunately diagnosed himself with [redacted] and was being treated.

She described her mum as being, "like a rock". Then on 9 October she came down to find that mum had decided to have a tea party which sadly nobody had attended, and she realised that things were not quite right. That is what had caused her admission to QAH.

A She was treated there, having been admitted also with a history of UTI, but actually no pain for this patient, and that may be significant in terms of later events. On 21 October she was said to be suitable for a rehabilitation programme. She was transferred to GWMH and reviewed by Dr Barton, who on this occasion said that she had a Barthel of 8. The plan was, "get to know". Assess rehabilitation potential. Probably for rest home in due course, and she had a very low mental test score of nine out of 30, which Professor Ford thought was in keeping with severe dementia.

B She is then reviewed. She is described as being confused on occasion, and disorientated. From around 11 November she is put on thioridazine, which is a major tranquiliser, to try to make her less agitated because she was at times agitated, and she stayed on the thioridazine. On 15 November she is being described as "very aggressive at times".

C She is reviewed on 18 November by Dr Taylor and at that stage, unfortunately, the patient was refusing medication, not eating well and was at times more restless and aggressive again. Dr Taylor was going to arrange for her to go on the waiting list for Mulberry Ward, and Dr Joanna Taylor gave evidence to you on Day 5/22. She described that letter of hers on 18 November. She said,

> "I got the impression that she was happy and had no complaints. She told me that the tablets she was taking made her mouth sore. I recorded my plan to transfer to
D Mulberry Ward when a bed was available. By 'deteriorated' I meant that her mental health had deteriorated and she was now more aggressive, more restless and refusing medication".

So obviously this patient was unwell. What happened thereafter, after that review by Dr Taylor however was that this patient had suffered a deterioration. First of all, she is put on a fentanyl patch the same day as that review by Dr Taylor. That fentanyl patch was described
E by Dr Barton. It is a 25 mcg patch which, at the time was the lowest that could be given, and it was given at 9.15 in the morning of 18 November. That may be prior to her review by Dr Taylor.

Then, the following morning, she has this very aggressive incident. Dr Barton apparently was in attendance. She is given chlorpromazine, which is a major tranquiliser, but which Professor Ford regarded as a reasonable response to that serious disturbance, but then an hour
F after the chlorpromazine was given the patient was put on a syringe driver at 09.25. Again, just to remind you, if you need reminding – I am sure you do not – it does not look as though the fentanyl patch was removed until three hours later at 12.30. On 19 November this patient is on fentanyl, chlorpromazine and diamorphine and midazolam. The lowest rate prescribed by Dr Barton for this totally opiate-naïve patient was 40 to 80 mg. So the lowest dose 40 mg, and midazolam 40 mg, which Professor Ford, as we will see, describes as extremely excessive.

G Dr Reid was asked about this. He said: "I would expect a note to have been made as to why the fentanyl had been started. Dr Barton on the 19th wrote, 'Confused and aggressive'. I would have been more cautious, he said, in my use of diamorphine and midazolam. I would have had reference to the *BNF* and followed guidance. I did not see the prescription." Then he said, "I must have done but I don't recollect it." He then said, "I should have done
H something about it." This is Day 16/60-66.

A Professor Ford was first asked about the morphine solution, the Oramorph solution, which was prescribed on Patient K's admission on 21 October. She was prescribed on the day of her admission thyroxine, frusemide, temazepam and Oramorph between 5 and 10 mg. That is long before, of course, the syringe driver started. He was asked:

> "Q ... At this stage, is there any basis for that prescription?"

B And Professor Ford said:

> "A I could see no basis for the prescription on the information in the notes."

This is directly relevant to head of charge 12(a)(ii), the criticisms of this prescription. He said:

C

> "A ... She is not in pain. Certainly if one has agitation and confusion in a patient with dementia, in the vast majority of cases it is not due to pain. It is a common problem that one sees in patients with dementia.
>
> Q Is Oramorph a suitable medication for confusion or dementia?
> A It is not at all a suitable medication."

D He was asked on the following page:

> "Q ... Help us, please, with your view on fentanyl. ...
> A Again, the medical and nursing notes do not indicate that the patient is complaining of pain. ..... There are two issues about the fentanyl prescription in my view. One is that there is no indication, appropriate indication, recorded in the notes. If she was in pain, there is no indication that it would not have been feasible or
E appropriate to give either an oral or subcutaneous small dose of opiates, but I could not find any evidence she was in pain. Secondly, the use of a fentanyl patch, because of the very high dose in an elderly patient with moderate renal failure, was highly likely to result in adverse effects."

You should bear in mind, and I respectfully remind you of it, that so far as the fentanyl is concerned, there is no specific criticism in fact in the heads of charge, although it stated that
F it was given. The criticism is in relation to the first prescription of oral morphine and then 12(a)(iv), which is the diamorphine and the midazolam. Of course, however, those prescriptions were written by Dr Barton on 19 November when she knew that this patient was already on fentanyl. That is the relevance of the attack, as it were, in relation to that particular prescription.

Professor Ford said, "If you give a dose that renders the patient unconscious, that will stop
G them wondering round, but that is unacceptable, and a dose of opiate does not produce that. It is actually just as likely to make the confusion worse. So opioid is not an appropriate treatment for behavioural disturbance in patients with dementia."

When he was asked about the administration of 40 mg of diamorphine and midazolam, he said at Day 22/28:

H

A

"A Well, again, the approach appears to being taken to increase the opiate dose to deal with her symptoms of agitation, behavioural disturbance, and I say that is not appropriate and is not an indication for opiates. There may have been a lack of appreciation about the extent to which the fentanyl effects would continue, so you have got the background fentanyl effect which is going to be there for quite some hours, and then you are adding in another 120mg equivalent of morphine."

B Professor Ford said this:

"I mean, this is a very, very large opiate dose in an elderly lady with renal failure. Then, looking at the use of midazolam, so going back for the treatment of terminal restlessness, well, she is certainly restless, we know that, that is part of the problems with her dementia. Is she terminal? Well, a decision seems to have been taken that she is now having terminal care, but even if one were to accept that that decision was C appropriate and therefore she had a terminal restlessness, the dose used is extremely excessive, in that, you know, the recommendations are to start with 10mg for 24 hours in an elderly person, and this will result in profound sedation. There has been no titration up to that to see if it was appropriate, and I do not believe it was appropriate. To start at 40mg over 24 hours was a very high, excessive dose."

He said:

D

"... I think it is difficult to conclude they did not contribute to her deterioration and death."

Those are really our criticisms of the prescriptions administered to Patient K. Again, we come back to the issue of no titration at all. The handbook has gone out of the window, quite frankly. The *BNF* has gone out of the window.

E

When Professor Sikora was giving evidence and I said to him that Dr Barton had accepted that she had ignored the *BNF*, Mr Langdale took up the cudgels, as it were, on Dr Barton's behalf. Can I just remind you, and this is just a smattering of what Dr Barton said about the *BNF* (I am going to move on to Patient L in any event, but just to interject. This was in relation to Patient A, and the first prescription. I asked her at Day 29/14:

F

"Q Can we take it that if you had the palliative care hand book in your pocket at the time that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

G

Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you were not looking at those were you?

H

A "A Not on this particular occasion, no."

In relation to Patient B, Day 29/26:

"Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?
A Yes."

B This was the 40 mg dose.

"Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?
A Yes."

C Patient F. This is Day 29/55.

"Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

D Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the *BNF* of course.
A Of course."

E If you have any doubt that Dr Barton had frankly given those guidelines a miss, then you may wish to remind yourselves of her specific evidence about it.

Can I turn then finally to the case of Jean Stevens and Patient L, who had had the misfortunate on 26 April 1999 to collapse at home with a right handed stroke. In relation to this patient, all of the opiate prescribing by Dr Barton is criticised, including the Oramorph, and it is alleged that there was, even though the patient was ill and may not have recovered F from her stroke, insufficient clinical justification for her prescriptions. This was the patient, you may remember, when she had been at the QAH, who had her problems with the nasogastric tube, which might or might not have caused her later broncho-pneumonia problems. She had at the QAH occasionally been given diamorphine. She was transferred on 20 May to Daedalus Ward. The last time that she had been given diamorphine was on 15 May, when she had been given 5 mg subcutaneously.

G There was from the QAH, when she was reviewed on 18 May, liaison with the GWMH who were said to be happy to take her with the blood results that they then had. The patient seemed then to have recovered from her aspiration pneumonitis. There had been a slow improvement in her orientation, her speech and her strength, but she was still faecally incontinent and required a catheter. She was transferred to Daedalus Ward on 20 May. Diagnosis and treatment in hospital – stroke; for rehabilitation. Her aspiration pneumonia was said to be resolved. She was reviewed by Dr Barton on 20 May, on the day of her H transfer. She was said to be for slow stream/rehabilitation as she needed help with all daily

living activities, catheterised, her Barthel was zero. There is no real reference to any plan there and she was prescribed on the day of her admission with Oramorph, 5 to 10 mg, of which she received 15 mg that day as soon as she got there at 2.30 in the afternoon, and then at 6.30 at night and 10.45. She was also prescribed the usual diamorphine and midazolam.

One has to ask, on what clinical basis were those prescriptions written. She had been at the Haslar for a month with a minimal amount of diamorphine and that was irregularly. By the day after her admission, on 21 May, she is given 60 mg of Oramorph. This is to a lady who is suffering from a stroke. She is said to be uncomfortable through the afternoon. She is seen by her husband, Ernest. He said at Day 9: "I did not see Dr Barton at all at the GWMH. I was by the bedside of my wife the whole time. She was not in any sort of pain. She did not show any sign of pain or distress. She was not administered with any fluids. She had had previous pain from her bowel." He said that when she was transferred, "... she had development sufficient swallow for transfer and she was in good spirits. She was transferred on 20 May. When I visited her she was lying in bed in a coma. I did not know why she had deteriorated so quickly. A nurse called Philip said she was in a lot of pain and he wanted permission to double her morphine. He said he would phone Dr Barton for permission to increase the dose. At the GWMH she never made any sound, never gave any indication of pain or discomfort. Her daughter, June Bailey, told you that she had visited her mum at the Haslar, but when she had seen her there after the stroke, she was propped up in bed chatting. She had lost the use of her left arm and leg but she still had all her faculties. I visited her on the evening before transfer. She was in good spirits and they were planning a party for her return home. I visited her at the GWMH the following day. She was asleep and unrecognisable. She never made a sound or gave any indication that she was in pain, and on the 21st there was no response."

Professor Ford gave evidence about this patient, Day 22/32. He says:

> "A The notes do not record there was a physical examination."

He said:

> "A ... I think the issue is around if this lady was complaining of pain should she have been examined, and particularly around the issue of the abdominal pain, which is referred to...
>
> ...
>
> A ... you would not treat chronic abdominal pain with opiates?
>
> Q Why not?
> A Because with chronic pain, opiates you try to avoid because they are not particularly effective, and you do get problems of dependency and difficulty getting people off opiates for non-malignant chronic pain...
>
> Q Being realistic with this lady, the question of getting her off opiates probably is not going to be a significant issue, is it?
> A No, but it is a lady you are intending to rehabilitate, you want to avoid the adverse effects of opiates as well. Just because she has a severe level of disability from her stroke is not an indication, or lessens the issue of giving her opiates. We

A would not in any circumstances start approaching this sort of problem in a patient with a severe stroke who is complaining of abdominal pain by prescribing opiates."

"Not in any circumstances", was his view.

> "Q ... We can see that she prescribed 20-200 mg, midazolam 20-80 mg by syringe driver. Again, I am not going to take up time, you have commented
B extensively on these sorts of prescriptions, in your view appropriate or inappropriate?
> A Inappropriate, because this lady has been transferred because it was thought she was medically stable, she has got a stroke, she is coming for rehabilitation, her outlook, as I describe in my report, is poor. I mean, this is a lady who is going to require care either in a nursing home or with considerable care package from her family and other carers if she were to be able to return home after what would likely be a very prolonged period of rehabilitation, but she is not in any way expected to be
C dying within the near future, from the information presented in the notes.
>
> ...
>
> A ... A Well, I have already commented that I, from reviewing the notes, was not of the opinion that the opiates were indicated..."

D and then he talks about, if they were going to be used, the diamorphine equivalent would have been slightly less than in fact they were.

> "Q In your view, is the diamorphine and the midazolam likely to have had any significant effect upon her?
> A Again, this was a lady with a severe stroke. She could have died suddenly from a pulmonary embolus or other problems, but the timing is very suggestive that
E the drugs contributed to her death"

and,

> "... opiates are not good in terms of patients engaging and effectively recovering rehabilitation".

F Day 23/63. So, this lady who is effectively opiate naïve apart from her co-dydramol when she arrived at the GWMH, on her first day she receives opiates and on the next day she is put on a syringe driver at what we have come to regard, as I say again, a low dose but, for this elderly, frail lady, perhaps it was not and it was, according to Professor Ford, wholly inappropriate.

G It was Dr Beasley, we know, who increased the hyoscine on the second day on 22 May, but Dr Barton was not, I think, suggesting that it was he who ordered the syringe driver to start and she accepted, Day 30/40, that it looks as though the syringe driver was started by nurses and it was started because her own prescription allowed it, again with no indication to the nurses of how it was to be used and the patient died the day after that syringe driver was started. Professor Ford's view was that that lady should never have been treated with opiates, full stop.

H

That is all that I say about the individual patients and I have one or two concluding comments. You may think that one of the central problems here is that no one from the outside medical world looked in and examined what the customs and practices were which had built up over a period of time at the GWMH. Consultants appear to have accepted in part what was happening even when they must have been looking at prescriptions way outside the norm. One of the most startling pieces of evidence that I expect you have heard in the last eight-or-so weeks was when Dr Barton told Mr Langdale that the criticisms of Professor Ford did not give her cause to question her judgment and I asked her again about that on Day 29/61:

> "Q Do you mean that? That they do not even give you pause for thought about your judgment?
> A I do".

When you consider the evidence and consider whose evidence to accept and whose to reject that if it comes to that in relation to any particular issue, it may be worth coming back to that reply because it reveals a doctor frankly who is absolutely convinced of the infallibility of her own judgment and who will stand before you and justify what we submit to you is frankly unjustifiable. When Dr Barton was asked whether she felt it mattered whether or not a patient who was dying was overdosed, her reply was revealing. Day 31/8 and it was the Panel questions, I think from Mrs Mansell;

> "That is a very good question, is it not? If you believe that and you think that is true, why am I here?"

She said that she thought that probably overdosing with anything was wrong, incorrect and unprofessional. She also said later when I questioned again, Day 32/4,

> " ... I think that if I was accused of over analgesia or sedation rather than under analgesia or sedation, I know which direction I would wish to err".

Luckily, you do not have to consider the very wide issues that this case might be thought to throw up. You have to consider the specific evidence in this case at the specific charges. We ask doctors to abide by *Good Medical Practice* and have regard to the guidelines for prescribing opiates. When Dr Barton says, as we submit that she did, that she ignored the *BNF* and the *Wessex Protocols* time and time again, when that same doctor makes no note about what she is doing or why she is doing it and when she delegates responsibility to nurses for deciding quite often how much to give and on occasion when to start the terminal path, then you have to consider whether those actions could ever be in the best interests of her patients and although there are many other people who might be looked at and upon whom the shadow of blame can be cast, in terms of ultimate responsibility, this was, in Dr Barton's own words, Day 31/9, "my wards, my patients, my nurses" and the responsibility, we submit, ultimately is hers.

Sir, those are my submissions.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Mr Langdale, I do not suppose that you want to start today?

MR LANGDALE: I could but I would not want to be accused of sadism or indeed

masochism!

THE CHAIRMAN: I think you would suffer from both accusations!

MR LANGDALE: Really, it would make much more sense from everybody's point of view if I start tomorrow.

THE CHAIRMAN: Yes. Do you have any sense of the time that you will be taking? I imagine that it will be certainly no less than Mr Kark.

MR LANGDALE: I certainly will not be less. I shall certainly take all of tomorrow and I may spill over into Thursday.

THE CHAIRMAN: That is very helpful. We will rise now, ladies and gentlemen, and reconvene tomorrow morning at 9.30.

(The Panel adjourned until Wednesday 5 August 2009 at 9.30 a.m.)