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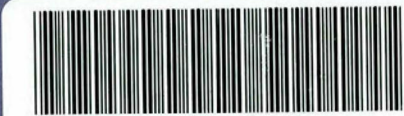

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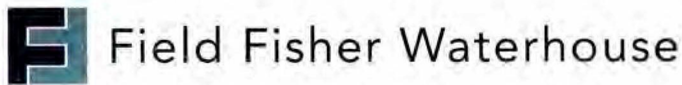

Strictly Private & Confidential

Professor David Black
Dean Director
The KSS Postgraduate Deanery
7 Bermondsey Street
London
SE1 2DD

Our ref: ALW/00492-15579/7597461 v1
Your ref:

Adele Watson
Paralegal
Code A (Direct Dial)
Code A

Also by e-mail: Code A

2 June 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

Geoffrey Packman

This letter is a letter of instruction which should be read in conjunction with the terms and background set out in the letter marked 'General Instructions' dated 19 February 2008.

As you are aware we would like you to revisit your report on the above named patient. You previously prepared a report for the police but we require a report in an appropriate format for the GMC proceedings. We are not anticipating that you will have to do a vast amount of work but we hope that you can briefly review each case to ensure that you have covered all the issues, considered all the evidence (some of which you have not previously been given) and have prepared reports in a consistent style for use at the Fitness to Practise Panel hearing in September.

Geoffrey Packman was a 68 year old male who was admitted to the Queen Alexandra Hospital following a fall at his home. Mr Packman was transferred to the Gosport War Memorial Hospiatl on 23 August 1999 for recuperation and rehabilitation, however he died at the hospital a few weeks later on 3 September 1999.

Papers

I have sent by courier Mr Packman's medical records, the relevant witness statements and a copy of your previous report which should arrive on Tuesday 3 June 2008. There was a degree of confusion in the pagination of records provided by the police as they had records on CD-ROM and hard copy. We have had to re-paginate the records but hope you will still be able to find your way around them. The police numbering still appears above our numbering.

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Field Fisher Waterhouse LLP is a limited liability partnership registered in England and Wales (registered number OC318472) and is regulated by the Law Society.
A list of its members and their professional qualifications is available at its registered office, 35 Vine Street, London EC3N 2AA.
We use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with equivalent standing and qualifications.

The witness statements relating to this patient include the following:

1. Victoria Packman
2. Betty Packman
3. Dr Arumugam Ravindrane *(a copy of which you should already have)*
4. Shirely Hallman – *(a copy of which you should already have)*
5. Gillian Hamblin – *(a copy of which you should already have)*
6. Beverley Turnbull – *(a copy of which you should already have)*
7. Anita Tubbritt – *(to follow as still to be finalised)*
8. Statement made by Dr Barton in relation to Geoffrey Packman
9. Interview of Dr Barton dated 17 November 2005 (at 09:14 hrs)
10. Interview of Dr Barton dated 6 April 2006 (at 09:01 hrs)
11. Interview of Dr Barton dated 6 April 2006 (at 09:42 hrs)
12. Interview of Dr Barton dated 6 April 2006 (at 10:34 hrs)
13. Interview of Dr Barton dated 6 April 2006 (at 11:21 hrs)
14. Interview of Dr Barton dated 6 April 2006 (at 13:11 hrs)
15. Interview of Dr Barton dated 6 April 2006 (at 13:54 hrs)
16. Interview of Dr Barton dated 6 April 2006 (at 13:59 hrs)
17. Interview of Dr Barton dated 6 April 2006 (at 14:53 hrs)
18. Interview of Dr Barton dated 6 April 2006 (at 15:38 hrs)
19. Your statement dated 30 October 2005

20. Your statement dated 17 January 2006

I have also emailed to you a copy of your previous report relating to Geoffrey Packman dated 20 June 2005.

Generic Issues

As I am sure you are already aware, having done additional reports for Field Fisher Waterhouse, Counsel has requested that the following generic issues be addressed in each of your reports:

1. In the 'Summary of Conclusions' section for each patient, any failing identified should be particularised. For example, if there has been a failure to maintain adequate medical records, the matters that should have been recorded should be particularised.

2. In the "Summary of Conclusions' section for each patient, the significance of any failing identified should be set out. For example, if an excessive amount of opioid analgesia has been prescribed, the dangers of such a course of action should be made clear.

3. For each patient please set out in bullet-point format in chronological order the drugs prescribed, written up and administered and by whom it was done in each case.

4. Please attribute medical notes of significance to particular doctors where possible.

5. Please set out the nature of Dr Barton's responsibility for each patient and failings attributable to Dr Barton must be clearly identified. Where failings are attributable to persons other than Dr Barton, this must be clearly identified. It must be clear where Dr Barton personally was at fault and where she was not.

6. Please make sure you have commented on the adequacy of the drug chart in each case. Was the drug chart used appropriately? Were any drugs 'written up' but not used? Were any drugs 'written up' but actually prescribed later? Was sufficient guidance given in each case by Dr Barton as to the administration of drugs? Was sufficient guidance given in each case by Dr Barton as to when it would be appropriate to commence a syringe driver?

7. Please comment on the appropriateness of prescribing a <u>range</u> in dose of drugs such as Diamorphine and Midazolam by syringe driver in each case that this practice appears – for example the prescription of Diamorphine 20-200mg/24hr PRN. Is this good practice? Are there any inherent dangers? Does it provide adequate guidance in terms of the dose of the drug actually to be administered? Who decides in such a case what the dose actually to be administered is? In each case, was there any justification for the top range of the dose

prescribed, taking into account the age and personal circumstances of the patient in question?

8. Where appropriate you may wish to cross refer to your very helpful generic report which covers many of the recurring themes.

Patient Specific Issues

In the case of Mr Packman we should also like you to consider the following points:

1. **Date of review by Dr Reid.** This date is given at paragraph 5.12 of the current report as 9/9/99 – should this be 1/9/99?

2. **Blood count results.** Please clarify whether the failure to obtain and act upon the result of Mr Packman's blood count is attributable to Dr Barton. Do the nursing notes reveal anything in this regard?

3. **Medical notes.** Please comment generally on the adequacy of the medical notes relating to Mr Packman's time on Dryad Ward. Please comment in particular on the adequacy of medical notes in relation to the prescription of medication on 26/8/99.

4. **Drug chart.** Please comment on the multiple prescriptions written on 26/8/99 in conjunction with one another. Is this appropriate practice?

5. **'Not for resuscitation.'** Please comment on the significance of the words 'not for resuscitation' in Mr Packman's medical notes. Do they have any significance in relation to the provision of other medical treatment to the patient?

6. **Condition on 26/8/99.** Please explain the conditions which may have accounted for Mr Packman's presentation on 26/8/99. What do the blood test and the drop in haemoglobin levels reveal in this regard? What were the possible appropriate responses at this time, other than a decision to treat the patient symptomatically? Was successful treatment a possibility? Was Dr Barton's conclusion that Mr Packman was too unwell to be moved to an acute unit justified?

7. **Medical assessment.** Please comment on the adequacy of medical assessment after 26/8/99.

8. **Verbal message to administer Diamorphine.** Please comment on the appropriateness of the use of a verbal message to administer Diamorphine, as on 26/8/99.

Format

The style and format of your report is essentially a matter for you. However please refer to our previous correspondence and the general points above as to how the report may best assist the Panel.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

I would be grateful if we could work towards having your final report on Mr Packman prepared by **20 June 2008.** Please confirm that this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Code A

Adele Watson
for **Field Fisher Waterhouse LLP**

General Medical Council

Dr Jane Barton

Statement of Victoria Jane Packman

I, **Victoria Packman**, will say as follows:

1. I am the daughter of Geoffrey Packman.

2. Exhibited to this statement and marked **VP/1** is a copy of my witness statement dated 18 January 2006.

3. I can confirm that I have been given the opportunity to add to or amend this statement but do not wish to do so.

4. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: Code A

Victoria Packman

Dated: 18-5-08

GMC100661-0008

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: PACKMAN, VICTORIA JANE

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: TAXI DRIVER

This statement (consisting of page(s) each 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 anything which I know to be false or do not believe to be true.

Signed: V J PACKMAN Date: 18/01/2006

I am Victoria PACKMAN and everyone refers to me as 'Vicky'. I am the daughter of Geoffrey Michael John PACKMAN, who was known as Mick. My mother is Betty PACKMAN.

My dad was not very tall but he was very big. He ate and drank to excess and was obese as a result. He did not drink alcohol, he used to drink sweet, fizzy drinks.

He used to work in the insurance business but gave that up around 1983 and became a taxi driver. Sometime around 1985 he started up his own taxi business with a friend and I worked as a driver for him.

He carried on the business until around 1988/1989 and then he retired and did not work again.

His weight increased rapidly and for the last few years of his life, he was virtually housebound. His legs and feet were extremely swollen and because of his great size he found it extremely difficult to get around. My dad never spoke to me about any health problems and I never asked him.

During the last two or three years of his life, his legs became so bad that the skin would break open and weep as a result of him suffering from oedema. The district nurse would come to the house two or three times a week to change the dressings on his legs.

In 1999 my mum was diagnosed as suffering from Sensitive and she had to undergo treatment for this. She was due to go into the Queen Alexandra Hospital (QA) in Cosham on 5th

RESTRICTED

August 1999 for a Sensitive .

I left for work in the morning and mum was still at home and dad was upstairs.

When I returned from work I did not see my dad and I assumed that he was in the bathroom, which is on the first floor.

On 6th August 1999 I left for work without seeing my dad and when I returned he was in the bathroom. I spoke with him through the door and he assured me that he was alright.

At this point the district nurse called to change dad's dressings and I explained to her that he was in the toilet and would be out soon.

We waited for some time and he did not appear. I told him that the nurse was waiting and had other appointments and he said that he would not be long.

Eventually the nurse went upstairs to speak to dad. She went into the bathroom and when she came out she told me that dad had to go to hospital.

An ambulance was called and when it arrived the ambulance men were not able to get dad out of the room due to his size and the lack of space in there. In the end, a second ambulance was called and four people were needed to get him up off the toilet and down the stairs.

Dad was taken to the A&E Department at the QA Hospital. I followed the ambulance down to the hospital and I went to collect my mum from her ward. I explained to her that dad had been admitted and I took her to the casualty department to see him.

I was not told the reason for his admission by either the staff or dad.

Dad was taken to Ann Ward and I took mum home.

Mum visited dad every day and if I was not working I went as well.

Dad quickly made good progress, he had injections of antibiotics and soon his legs dried up and he seemed much better. I remember that he looked the best he had for years. He was happy and chatty and keen to go home. He was eating and drinking properly and quite able to do things for himself.

Because of dad's lack of mobility around the house, mum and I were told that he would be going to the Gosport War Memorial Hospital in Gosport (GWMH) for rehabilitation and remobilisation. Whilst he was there, the social service department were going to assess our house in order to put in hand rails to help dad get around.

Everyone seemed very positive.

Dad was in the QA for about two weeks before he was moved to the GWMH. When mum and I visited him there, he was sat up in bed and seemed very cheerful. He was given a room on his own, which was three to four doors away from the nurse's station.

He was eating and drinking properly and was in very good spirits. He never complained of being in pain, nor did he show any signs that he was in pain.

Within three or four days of being in GWMH and without any warning, dad suddenly appeared to be what I would call 'spaced out'. His eyes were glazed and his head would nod about. He was propped up on pillows and I believe he was catheterised.

He appeared very sleepy but was able to talk to us. He was not however, able to hold a cup or pick up anything in order to eat. Mum and I would feed him grapes and hold a cup with a straw in for him to drink from.

The change was dramatic and he became progressively worse. He became a vegetable and just slept. I visited him regularly, if not daily and on Tuesday 31st August 1990 he drifted in and out

of consciousness. On Wednesday 1st September 1999 he was completely 'out of it'. By this I mean that he did not move or stir.

On Thursday 2nd September 1999, I visited him alone as my mum had been admitted for an operation. I sat by his bed for hours and he did not move. No one came into his room to check on him and no one spoke to me about him.

On Friday 3rd September 1999 my dad died. I was at work and my mum had to get word to me through a neighbour.

I contacted my brother Mark and my uncle David, who was the executor of my dads will.

On Monday 6th September 1999 I went to the GWMH with both of them to collect my dad's belongings. We took the death certificate to the town hall where Mark registered dad's death. I know that the cause of death was given as a heart attack.

I was stunned by my dad's death, I didn't know that he was so ill, as he had seemed so well after receiving the treatment for his legs. He was supposed to be in a GWMH for remobilisation but I never saw him out of bed. He certainly did not know that he was dying.

I have been asked if my mum ever told me that she had been told that my dad was dying.

My mum did tell me of the conversation she had with the lady doctor, I believe this was after my dad had died.

She was particularly upset by the manner and tone the doctor used. There was no kindness or consideration shown.

General Medical Council

Dr Jane Barton

Statement of Betty Packman

I, **Betty Packman**, will say as follows:

1. I am the widow of Geoffrey Packman.

2. Exhibited to this statement and marked **BP/1** is a copy of the witness statement dated 17 January 2006 I made in relation to my husband's care.

3. I can confirm that I have been given the opportunity to add to or amend this statement and wish to state that at the top of page 7 it should read 'Elliott' Beresford, rather than 'Ernest' Beresford.

4. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true

Signed: Code A

Betty Packman

Dated: 2/1/08

General Medical Council

Dr. Jane Barton

Exhibit BP1

This is the Exhibit marked “BP1” referred to in the statement of Betty Packman:-

- Statement dated 17 January 2006(regarding Geoffrey Packman)

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: PACKMAN, BETTY

Age if under 18: O18 (if over 18 insert 'over 18') Occupation: RETIRED

This statement (consisting of 8 page(s) each 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 anything which I know to be false or do not believe to be true.

Signed: B. Packman Date: 17/01/2006

I am Betty PACKMAN and I am the widow of Geoffrey Michael John PACKMAN, who I called Michael and everyone else knew as Mick.

In August 1999 Michael was admitted to the Gosport War Memorial Hospital, Bury Road, Gosport, Hampshire. On Friday 3rd September 1999 (03/09/1999) he died there. This statement is about what happened to him.

Michael was born in Shirebrook in Derbyshire on Code A (Code A). His parents were George and Ethel PACKMAN. Michael had three sisters who are still alive, his parents are both dead. I know that his father died from a stroke, I don't know the reason for his mother's death, but she was in her eighties when she died. The family were all well built, by this I mean that they all enjoyed eating their mother's cooking and as a result were all on the plump side.

Michael always worked in what I would describe as office jobs. We met when we both worked in local government in Derbyshire.

Michael carried out his National Service when he was 18 years old and got a job in insurance in Nottingham when he finished at the age of 20.

We were married in July 1956 in Chesterfield and stayed in the area until Michael got a job working in Zurich Insurance in London.

In 1964 we adopted our son, Mark, and in 1967 we adopted our daughter, Victoria, who is

Signed: B. Packman Signature Witnessed by:

2004(1)

known as "Vicky".

In 1969, Michael moved to work in the Portsmouth Branch of Zurich Insurance and the family moved from London to live in Emsworth.

At this point Michael was fit and healthy, he played table tennis, and he enjoyed walking. He was a sideman in the local church and he was heavily involved in the Nautical Training School in Emsworth. This was like the naval cadets and was run for the local children. They had a band and both of our children played in it. Michael would take the troop away to camp and it was whilst on one of these camps that he fell and twisted his knee and as a result became less mobile.

Around 1983 Michael had a falling out at work and left the company. He became a taxi driver working for a local taxi firm. He had to have a medical in order to do so and at this stage was found to have high blood pressure and I think he weighed 17/18 stone. When he became a taxi driver his weight began to pile on.

In 1985 he set up his own taxi firm with a friend. After 2 or 3 years the business collapsed. I think this would be around 1988/89 and Michael decided to retire, he was 57 years old. He continued to put weight on and his legs would swell up, his feet would swell to the point where he couldn't get his shoes on and he would have to visit the Doctor in his socks. I would drive him to the front of the surgery and he would walk the short distance inside in his stocking feet.

Around this time Michael had a very severe nose bleed and was taken to the A & E Department at the Queen Alexandra Hospital, Cosham (Q.A.). They had to pack his nose in order to stop it bleeding. I know that he was warned about his weight and they were going to refer him to a dietician.

Michael continued to put on weight, his legs were a constant problem to him. They would weep fluid and were never dry. It used to make the bottom of his trousers wet through.

It reached the stage where he couldn't walk properly so he didn't go out. He used to lean on the furniture and walls in order to get around the house. He spent most of his time just sitting down. He didn't drink alcohol very often but would drink huge amounts of sweet, fizzy drinks.

For the last two to three years of his life he had the district nurse come in two or three times a week to change the dressings on his legs.

Despite his condition he never complained or moaned about his health and as far as I am aware, he never had to take any medication for pain relief.

Michael never discussed his health with me, he never told me why he was going to the Doctors, of what treatment he was receiving. Our relationship was such that we didn't communicate particularly well.

During the summer of 1999 I was diagnosed with Sensitive and I had to undergo treatment for it.

On 5th August 1999 (05/08/1999) I had to go into Q.A. Hospital for a Sensitive. I was due to be admitted for an overnight stay and I needed to get ready to go. I needed to have a shower but Michael was in the bathroom. I kept asking him when he would be coming out and he kept telling me that it would be 'soon' and that he was 'alright'.

Eventually I had to use the shower whilst he was still in the bathroom.

When I left for hospital he was still in there, still assuring me that he was alright and that he would be out shortly. He was alone in the house at this point as Mark had left home many years previously and Vicky was out at work.

On 6th August 1999 (06/08/1999) I was collected from the hospital by Vicky. She told me that Michael had just been admitted to the same hospital and that he was in the Accident &

Emergency Department.

We went straight to see him and I now know that he had a rash on his groin. I'm not sure that I was aware of this at the time. I remember that I thought something had happened to him whilst he was in the toilet. Michael was taken to ANN Ward in the Q.A. Hospital where he was treated with penicillin for his legs. I remember that he had injections in his stomach. He was initially given tablets but they made him sick and gave him diarrhoea.

Michael made a really good recovery whilst in the Q.A. His legs stopped weeping and dried up, his feet improved, he was eating and drinking properly. He was cheerful and he looked so much better than he had in recent years. I visited him daily and Vicky visited when she wasn't working.

We were told that the Social Services would be coming to assess our home in order to arrange some hand rails to help Michael get around the house more easily. We were also told that Michael was to be transferred to the Gosport War Memorial Hospital (GWMH) for recuperation and rehabilitation. They wanted to get Michael walking again. We didn't know when he would be moved, I think that they were waiting for a bed to become available.

Michael was in the Q.A. for around two to three weeks before he was taken to the GWMH. He was admitted onto Dryad and was put in a room by himself. The room was three to four doors away from the nurses' station.

I visited him daily and initially he was fine. He was eating and drinking well and didn't need any assistance in order to do so. He had his own supply of drinks next to his bed and could help himself.

As I said, I would visit him daily and I always seemed to arrive just as he was having his dressings changed. He never complained of being in any pain whilst this was happening. In fact he never complained of any pain at any point nor did he seem to be in any pain.

A couple of days after Michael was admitted to GWMH, I visited him with Dorothy and Elliott BERESFORD, our closest friends.

We were stood in Michael's room chatting to him and he was laughing and joking in his normal fashion when a lady doctor came into the room and said to me, "I'd like a word with you" and she turned and walked out.

I followed her and we went into a little office nearby. As I walked into the room, I could see that there were a couple of nurses already in there.

I stood waiting for the doctor to speak to me, I wasn't asked to sit down and I was not prepared in any way for what happened next.

The doctor said in a very abrupt manner, "Your husband is going to die and you have to look after yourself now". She didn't explain why or when this would happen, she just told me that she 'liked my coat' and that was the end of the conversation.
I was stunned. I had no idea that Michael was so ill, he looked so well. I walked back into his room in a daze. He said to me, "What did she want?"

He clearly had no idea of what his prognosis was. I didn't know what to say to him, I couldn't tell him what the doctor had actually said to me, so I told him that she had told me about his treatment and that she liked my coat. I did a little twirl to show my coat off.

At some point around this period I received a telephone call from the hospital telling me that Michael had suffered a heart attack. I went in to visit him and he seemed fine. He told me that he hadn't had a heart attack, he was suffering from indigestion. Michael had always suffered from this, he never took pain killers, just Rennie indigestion tablets by the bucket full.

Within two or three days Michael became progressively worse. He looked 'spaced out'. His eyes were glazed over and he spent long periods asleep. When he was awake he could still talk

to us but became unable to feed himself or to hold a cup. Either I or Vicky had to hold a cup with a straw for him to drink. We would feed him grapes and he would suck the juice from them, he seemed very thirsty.

He was catheterised and I believe that a nurse told me that he was put on diamorphine. There was something behind the head of his bed that the diamorphine was in.

I didn't understand why he was put on diamorphine and no one explained the reasons to me.

I last saw Michael on Wednesday 1st September 1999 (01/09/1999). He was asleep and 'out of it'. He didn't wake for the whole time I stayed with him. I believe that he was dying just as the doctor had told me.

The following day I was admitted to hospital for a major operation in relation to my Sensiti and I was unable to visit him.

On Friday 3rd September 1999 (03/09/1999) in the early afternoon, I was visited by Margaret SHERWIN who was the Curate at our local church. She told me that she had visited Michael that day and I believe that she was with him when he died.
I could not get in contact with Vicky as she was working so I left a message with our neighbour to tell her. I remained in hospital for the next four or five days and my brother, David LATHAM, came with my son, Mark, to help Vicky with arrangements.

I have been asked if I know what Michael died from. I have seen his death certificate and his cause of death is given as a heart attack. I know that the certificate was signed by Dr BARTON and I believe that this was the name of the doctor who told me that Michael was dying.

My recollection of this time is somewhat vague as I was under a great deal of stress due to my own ill health.

I have been asked if I told anyone about my conversation with the doctor. Apart from my

friends, Dorothy and Ernest BERESFORD, who were with me at the time, I did not tell anyone at first as I did not want to upset my children.

I subsequently told Vicky about it as I was upset by her tone and the insensitive manner in which she told me of my husband's forthcoming death.

Statement taken by DC Code A ROBINSON

Copy JB/PS/11

STATEMENT OF DR JANE BARTON

RE: GEOFFREY PACKMAN

1. I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport, Hampshire. As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole clinical assistant at the Gosport War Memorial Hospital (GWMH).

2. I understand you are concerned to interview me in relation to a patient at the GWMH, Mr Geoffrey Packman. Unfortunately, at this remove of time I have no recollection at all of Mr Packman. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General Practitioner and as the clinical assistant at the GWMH. I adopt that statement now in relation to general issues insofar as they relate to Mr Packman.

3. In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores, and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr Packman.

4. Mr Geoffrey Packman was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound measurement of the pressure in the veins of the legs. Mr Packman's GP appears to have referred him to Consultant Urologist Mr Chiverton at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr Packman had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostate, had been virtually impossible because of Mr Packman's huge size and inability to lie properly on his side. The GP noted that Mr Packman was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146 kg - in excess of 23 stone.

5. Mr Packman was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.

6. At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr Code A in relation to Mr Packman's leg ulceration. Mr Packman had apparently been attending the District Nurse's leg ulcer clinic for many months, and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Keohane's advice was requested. At this stage it seems that Mr Packman was being visited by the District Nurse 3 times a week in order

to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr Packman was seen in the dermatology clinic on 30th June 1999, the Senior House Officer reporting back that Mr Packman had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr Packman was to be brought in for further Doppler's testing.

7. On 6th August 1999 Mr Packman was then admitted to the Queen Alexandra Hospital having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr Packman at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity, and it was noted that he was simply not coping.

8. In the course of clerking-in on 6th August, it appears that Mr Packman was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at a rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31, and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics, and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985, and arthritis.

9. It appears that about the time of admission Mr Packman was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

10. Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility, morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter, and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr Packman was commenced on Clexane 40mgs twice daily.

11. At this stage Mr Packman's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.

12. It was also noted on 6th August that "in view of pre-morbid state + multiple medical problems [Mr Packman was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5th August (presumably 6th August in error) was recorded as zero, indicating that Mr Packman was completely dependant.

13. Mr Packman was reviewed by the Specialist Registrar the following day, 7th August, who agreed, presumably on the basis of what was felt to be Mr Packman's poor condition at that stage, that he was not be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema, and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr Packman was given Flucloxacillin 500 mgs 4 times daily, supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

14. Although steps were apparently taken to prevent the development of pressure sores, on 8th August Mr Packman was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.

15. Over the next few days it appears that Mr Packman's cellulitis improved, but the overall assessment of his suitability of resuscitation did not change - on 11th and again on 13th August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".

16. On 13th August Mr Packman was reviewed by a Consultant Geriatrician Dr Jane Tandy. She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the left buttock and right lower buttock and thigh were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr Packman had developed significant pressure sores.

17. A Barthel score measured on 14th August again recorded a score of zero indicating his complete dependence.

18. It appears that by 15th August a decision had been made that Mr Packman should be transferred to the Dryad Ward at the GWMH. A note in the nursing records indicates that Staff Nurse Hallman at GWMH had indicted that we were not in a position to take Mr Packman at that time. This is likely to have been an indication that there were no beds available, and that we would have been under considerable pressure in consequence of the high bed occupancy.

19. An entry in Mr Packman's records for 20th August by the Specialist Registrar indicates that Mr Packman was due for transfer to the GWMH on 23rd August. The Specialist Registrar also noted that Mr Packman remained not for resuscitation. A Barthel score measured on 21st August again recorded a score of zero indicating his complete dependence.

20. Mr Packman was then admitted to the GWMH on 23rd August 1999. There is a clerking-in noted contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr Packman also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs once a day as a diuretic for Mr Packman's oedema, Clexane 40 mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

21. On this occasion, a Barthel score of 6 was recorded for 23rd August, suggesting that, although Mr Packman might have improved to a degree, he was still significantly dependent.

22. I anticipate that I would have reviewed Mr Packman the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical

records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr Packman on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24th August, with a night nursing record then indicating that he slept for long periods.

23. I anticipate that I would have reviewed Mr Packman the following day, 25th August, though again I did not have an opportunity to make an entry in his records. It appears that Mr Packman then was noted to have passed blood per rectum, and Dr Beasley was contacted, Dr Beasley presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr Beasley also appears to have prescribed Metoclopramide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55 pm with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

24. I do not know if I reviewed Mr Packman on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister Hamblin has recorded that Dr Code A locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr Packman was noted to be "not for resuscitation". Sister Hamblin may have contacted Dr Ravi if I was unavailable that morning. The nursing record goes on to indicate that Mr Packman then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as follows.

"26-8-99 Called to see pale clammy unwell
suggest ? MI. treat stat diamorph

and oramorph overnight
Alternative possibility GI bleed but no
haematemisis
not well enough to transfer to acute unit
keep comfortable
I am happy for nursing staff to confirm death."

As my note indicates, I was concerned that Mr Packman might have suffered a myocardial infarction, and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction, at a dose of 10 mgs intramuscularly. In addition, I would have been conscious that he had large pressure sore areas on his sacrum and thighs which would have been causing him significant pain and discomfort. I prescribed 10 mgs Diamorphine intramuscularly to be given immediately, which is recorded on the drug chart as a verbal instruction. An alternative diagnosis which I recorded was that Mr Packman had had a gastro intestinal bleed.

25. My impression when I assessed Mr Packman on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.

26. The nursing note for 26th August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr Packman complaining of indigestion and a pain in his throat, which was not radiating.

27. The blood count taken on 26th August subsequently showed that Mr Packman's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.

28. It appears that I re-attended to see Mr Packman at 7.00 pm on 26th August. Concerned that he should have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00 pm.

29. I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr Packman's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr Packman's wife, explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs Packman that her husband was very ill indeed, and in all probability that he was likely to die.

30. I would have reviewed Mr Packman again the following morning, and indeed the nursing record confirms that I attended to see him then. Sister Hamblin has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr Packman apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr Packman was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs

at night as prescribed, so that Mr Packman received a total of 60 mgs that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night.

31. I reviewed Mr Packman again the following morning, and on this occasion I made a note in his records which reads as follows:

"28-8-99 Remains poorly but comfortable
please continue opiates over weekend."

32. The nursing record indicates that Mr Packman remained very poorly with no appetite. However, the Oramorph again appears to have been successful in keeping Mr Packman comfortable at night.

33. I do not believe I would have seen Mr Packman on Sunday 29th August. The nursing record indicates that he slept for long periods, but that he also complained of pain in his abdomen. The sacral wounds were said to be leaking a lot of offensive exudate.

34. I do not know if I would have seen Mr Packman again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr Packman's condition remained poor, and later that day - at 2.45 pm the syringe driver was set up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr Packman would have continued to experience pain, and clearly in view of the significant sacral

sores, it was highly likely that he would have been experiencing further significant discomfort.

35. In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr Packman had received 60 mgs of Oramorph daily over the preceding 3 days, and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr Packman would have started to have become inured to the opiate medication, and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr Packman was able to take a small amount of food.

36. I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazalam and that this would have been set up on my instruction, directly if I had been at the Hospital, or otherwise by phone.

37. On the morning of 31st August Mr Packman was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.

38. I believe I would have seen Mr Packman again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered, and that he would have remained comfortable. Similarly, I would probably have seen Mr Packman again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again

unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

39. Mr Packman was reviewed the same day by Consultant Geriatrician Dr Reid. Dr Reid noted that Mr Packman was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft, and Dr Reid also recorded the presence of the pressure sores over the buttocks and across the posterior aspects of both thighs. He noted that Mr Packman remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued, and Mr Packman's wife was said to be aware of his poor prognosis.

40. The entry by Dr Reid that Mr Packman was to have "TLC" - tender loving care - was clearly an indication that Dr Reid also considered Mr Packman to be terminally ill. Dr Reid had the opportunity to review the medication which Mr Packman was receiving at the time, and clearly felt it appropriate.

41. Sister Hamblin recorded later in the nursing records that the syringe driver was renewed at 7.15 pm with 60 mgs of Diamorphine and 60 mgs of Midazalam subcutaneously as the previous dose was not controlling Mr Packman's symptoms. It appears therefore that Mr Packman was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

42. That night, Mr Packman was noted to be incontinent of black tarry faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.

43. I believe I would have reviewed Mr Packman again the following day, 2nd September. The nursing records show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr Packman would have been experiencing pain and distress, and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr Packman was said to remain ill, but was comfortable and the syringe driver was satisfactory.

44. Sadly, Mr Packman passed away on 3rd September 1999 at 1.50 pm. My belief was that death would have been consequent on the myocardial infarction.

45. The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr Packman's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr Packman's demise.

RESTRICTED

DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AQ

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1538 Time concluded: 1605

Duration of interview: 27 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This is a continuation of the interview with Doctor Jane BARTON. The time is 1538 hours and the date is the 6th of April 2006 (06/04/2006). Doctor can you just confirm that it's the same people present in the room please?
BARTON	It is.
DC Code A	And has there been any conversation about this matter while the tapes have been off?

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BARTON None at all.

DC Code A Okay. Just so that we can (pause – clears throat) re-cap on this, we were discussing Paragraph (41) and who actually authorised this increase in the medication. (Pause) So where was it recorded in the records that Mr PACKMAN was in pain?

BARTON No comment.

DC Code A And where was it in the records who authorised this?

BARTON No comment.

DC Code A Am I right in thinking had it been a telephone authorisation that two nurses would have signed the records?

BARTON No comment.

DC Code A Am I right in thinking that had you been at the hospital you would have signed the prescription sheet?

BARTON No comment.

DC Code A Geoff.

DC No not at the moment.

DC Code A No. Paragraphs (42) and (43) then. 'That night Mr PACKMAN was noted to be incontinent of black tarry

faeces, but otherwise he had a peaceful night and the syringe driver was said to be satisfactory. I believe I would have reviewed Mr PACKMAN again the following day, the 2nd of September. The nursing records show that his medication was again increased, the Diamorphine to 90 milligrams and the Midazolam to 80 milligrams subcutaneously. I anticipate again that Mr PACKMAN would have been experiencing pain and distress and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night Mr PACKMAN was said to remain ill, but comfortable and the syringe driver was satisfactory'. So Mr PACKMAN was noted to have had a peaceful night, however Diamorphine was increased to 90 milligrams over a twenty-four period from 60 and the Midazolam to 80 from 60 and that was at 1840 hours on the 2nd of September. Why was this doctor?

BARTON — No comment.

DC Code A — However there is no mention of pain and distress from the nursing or medical notes. Who authorised this increase?

BARTON — No comment.

DC Code A — Did you authorise it?

BARTON — No comment.

DC Code A — Personally?

BARTON No comment.

DC Code A Or by phone?

BARTON No comment.

DC Code A Or was it unauthorised?

BARTON No comment.

DC Code A (Pause) Also it's mentioned in Paragraph (42) – 'That night Mr PACKMAN was noted to be incontinent of black tarry faeces otherwise he had a peaceful night'. What is that significant to?

BARTON No comment.

DC Code A So we've gone from the 26th of August where you've query a GI bleed and you queried a heart attack. Well we are now on, I believe, the 1st of September (pause), overnight on the 1st of September I believe. So four or five days and you have quite a few pointers now as to what might be wrong with Mr PACKMAN haven't you?

BARTON No comment.

DC Code A (Clears throat) And this last one 'the black tarry faeces', am I right in thinking that that is indicative of a GI bleed?

BARTON No comment.

DC Code A Albeit it could be indicative of a lot of things I'm sure, but you suspected a GI bleed, and why did you suspect a GI bleed doctor?

BARTON No comment.

DC Code A And not only did you suspect a GI bleed on the 26th of August you, at some stage, had seen that Lab Report and you'd seen the drop in the haemoglobin. You must be pretty damn sure now that he was suffering from a GI bleed.

BARTON No comment.

DC Code A So what did you do about it?

BARTON No comment.

DC Code A (Pause) Code A

DC Was it too late to do anything about it?

BARTON No comment.

DC Code A Well we're now up to, what was that Chapter what, Paragraph what Christopher was it?

DC Code A — That was Paragraph, well that main bit with the faeces was Paragraph (42), but we're doing (42) and (43).

BARTON — No comment.

DC Code A — Okay. So we've got Paragraph (39) 'passing melaena stools'. The end of Paragraph (39) 'poor prognosis'. Paragraph (40) 'terminally ill'. (Pause) Paragraph (42) 'incontinent of black tarry faeces'. (43) end of that sentence 'pain and distress as he died'. 'Mr PACKMAN was said to remain ill'. So several mentions to the things that were happening to Mr PACKMAN the stools, terminally ill, ill, pain and distress as he died and again right up to that including all the way up to Paragraph (43), you have failed to tell us in this prepared statement what was wrong with Mr PACKMAN.

BARTON — No comment.

DC Code A — You've been using hindsight, I think it's quite clear, throughout this prepared statement and even now you are not telling us what was clearly wrong with Mr PACKMAN.

BARTON — No comment.

DC Code A — (Pause) Okay Paragraph (44) doctor. 'Sadly Mr PACKMAN passed away on the 3rd of September 1999 (03/09/1999) at 1.50pm (1350). My belief was that death would have been consequent for myocardial infarction'. So

there you've pinned your colours to the mast and you said that it was a 'myocardial infarction'. So from the 26th of August until the 3rd of September at no stage did you say in your statement or in your notes what Mr PACKMAN was dying of, but when he's died you've said: "Yeah it was a myocardial infarction." What evidence is there that the cause of death was due to a heart condition?

BARTON — No comment.

DC Code A — Because you have repeatedly referred to symptoms that suggest a GI bleed, and even with the benefits of hindsight doctor and the review of case notes that contained details that Mr PACKMAN had a digestion like pain, he was passing fresh blood and melaena stools and the drop in his haemoglobin. Do you really think, bearing all that in mind, was your diagnosis of Mr PACKMAN correct?

BARTON — No comment.

DC Code A — I mean was it really a diagnosis other than you've given what you believe to be a cause of death?

BARTON — No comment.

DC Code A — Possibly an incorrect cause of death.

BARTON — No comment.

DC Code A	Even if PACKMAN had died of a heart attack or a myocardial infarction and you were correct in your suspicions on the 26th of August, what did you do about it?
BARTON	No comment.
DC Code A	Why didn't he have an ECG?
BARTON	No comment.
DC Code A	When was his heart listened to?
BARTON	No comment.
DC Code A	When were any tests done?
BARTON	No comment.
DC Code A	Well we actually feel that everything might point towards a GI bleed, so when were any tests done for that?
BARTON	No comment.
DC Code A	We had the blood test. When did you sign that and become aware of the drop in haemoglobin?
BARTON	No comment.
DC Code A	Something that you record in your statement 'a significant drop'.

BARTON No comment.

DC Code A Accompanying that with the black faeces and the passing of fresh blood, all this etcetera. What do you think Mr PACKMAN died of?

BARTON No comment.

DC Code A Why haven't you written any reference to the reason behind the prescription of any drug, not only in these records but also in any of the ten records that we've had?

BARTON No comment.

DC Code A I admit it I'm just, I'm going to push the drugs to one side, but before I do that do you want to say anything?

DC Code A Only when you get to Paragraph (44) doctor, when you were writing that where were you when you typed that?

BARTON No comment.

DC Code A Well I think you were up against the wall weren't you, backed into a corner with nowhere to go because you realise what you've put on that Death Certificate and yet the evidence is pointing, and it has been pointing for several paragraphs now that it has been pointing to the other diagnosis that you did consider at one stage, but

	seemingly ignored and that was that he had the GI bleed and yet you failed to investigate didn't you?
BARTON	No comment.
DC Code A	You failed to investigate the myocardial infarction possibility didn't you?
BARTON	No comment.
DC Code A	Can you tell me even now, through this prepared statement, your evidence that indicates that he had a myocardial infarction?
BARTON	(Silence).
DC Code A	Can you?
BARTON	No comment.
DC Code A	And can you, through this prepared statement, justify your entry on the Death Certificate?
BARTON	No comment.
DC Code A	(Pause) So poor old Mr PACKMAN he came into hospital and his ongoing problems were obesity, arthritis, immobility, pressure sores and constipation. So to put it bluntly he was a fat man with arthritis in his knees, his immobility was possibly due to his size, pressure sores

because he wasn't getting about and he was constipated and he's died of what you consider to be a myocardial infarction. Now forget the drugs at the moment, forget the Diamorphine and the Midazolam and all the other drugs, there was two diagnoses that you made on the 26th of August, two possible diagnoses myocardial infarction or a GI bleed, now forget which one was right, but what did you do about either?

BARTON | No comment.

DC Code A | What basic tests did you put in place?

BARTON | No comment.

DC Code A | If you were unable to treat or look after Mr PACKMAN, why didn't you move him somewhere where he could be?

BARTON | No comment.

DC Code A | We mentioned before that Mr PACKMAN seemed to be hampered by being in hospital, he was disadvantaged by being in hospital, he could have just as easily have been at home except then somebody could have called an ambulance couldn't they doctor?

BARTON | (Silent)

DC Code A | Did you consider anything, I mean of all the options that were open to you ECGs, all the different tests etcetera,

didn't you consider anything that could have been done for Mr PACKMAN?

BARTON No comment.

DC Code A Had he been suffering from a GI bleed or a heart attack on the 26th of August, was the terminal?

BARTON No comment.

DC Code A Could that have been treated?

BARTON No comment.

DC Code A And could his life have been saved?

BARTON No comment.

DC Code A Now if you bring the drugs back into it the Diamorphine and that, was the proactive prescribing done in order that you didn't have to be bothered with nighttime call out?

BARTON No comment.

DC Code A But why such a range?

BARTON No comment.

DC Code A And with what eventually becomes, it could be either I suppose, but I would say quite high doses of Diamorphine

	etcetera, was that a way of covering up the inadequate care and the treatment Mr PACKMAN received?
BARTON	No comment.
DC Code A	Just keep him quiet, out of pain and he would just eventually die of whatever was wrong with him?
BARTON	No comment.
DC Code A	Code A
DC Code A	(Pause) Doctor a GI bleed is consider, you tell me if I'm wrong, is considered as a serious and life threatening medical emergency is it not?
BARTON	No comment.
DC Code A	And as such it should require urgent and appropriate care?
BARTON	No comment.
DC Code A	On the 25th of August Doctor BEASLEY was called wasn't he?
BARTON	No comment.
DC Code A	And for out-of-hours and that was because Mr PACKMAN was passing fresh blood per rectum wasn't he?

BARTON	No comment.
DC Code A	Now (pause) Doctor BEASLEY, as a consequence what did he do? He ordered that the Clexane should be stopped didn't he?
BARTON	No comment.
DC Code A	Now was the Clexane, that was to stop DVT wasn't it, deep vein thrombosis wasn't it?
BARTON	No comment.
DC Code A	So it's an anti coagulum isn't it for blood?
BARTON	No comment.
DC Code A	It stops the blood from clotting doesn't it?
BARTON	No comment.
DC Code A	So what Doctor BEASLEY did was quit reasonable wasn't it stopping that?
BARTON	No comment.
DC Code A	Now we mentioned this GI bleeding before and if we get a lower bowel GI bleeding it comes out as red doesn't it?
BARTON	No comment.

DC Code A	Or it can do. And why is that doctor?
BARTON	No comment.
DC Code A	That's because the blood hasn't had the time, has it, to be digested from stomach to rectum (somebody coughs) and turn it into that horrible black smelly melaena. Is that right?
BARTON	No comment.
DC Code A	(Pause) So coupled with that and the fact that he had vomited, he was unwell, wasn't he at lunchtime? You were called to see him at lunchtime, then indigestion and he was becoming more unwell and that's why Mrs PACKMAN was called and we know that the HB was 7.7 from that day, but that came through later. We're pointing there, aren't we, that it was quite reasonable for you to have known that he had the GI bleed (pause) and you already knew that Doctor TANDY had asked for that haemoglobin to be chased up on the 13/08 because she suspected it. You knew that Doctor RAVINDRANE had request HB to be reviewed later on in the week when he looked at him on the 23rd (pause), so it's all pointing that was isn't it?
BARTON	No comment.
DC Code A	So why didn't you investigate that further yourself?

BARTON No comment.

DC Code A Neither of those were properly investigated were they? Neither the myocardial infarction nor the GI bleed.

BARTON No comment.

DC Code A (Pause) Was that done (inaudible)?

DC Sorry?

DC Was that done (inaudible)?

DC No you put...

DC None of that?

DC No.

DC (Inaudible). There's just a couple more things I want to ask you then, it's general things really doctor. What was your duty of care towards Mr PACKMAN?

BARTON No comment.

DC Code A Was it to treat him with his medical condition to make sure everything's done to treat his illnesses and things like that?

BARTON No comment.

DC Code A	Isn't that what the public would assume the role of a doctor to be?
BARTON	No comment.
DC Code A	To diagnose, to treat, to make better, and guidance is provided, isn't it, by things like your Job Description of what you've got to do, the extensive training you must have gone through to become a doctor in the first place, there's all sorts of other guides and policies, there's the BNF to assist you in providing that duty of care isn't there doctor?
BARTON	No comment.
DC Code A	So is it reasonable to say that a person going into hospital would think: "I'm going to hospital, a doctor will try and make me better." Is that a reasonable assumption for a member of the public?
BARTON	No comment.
DC Code A	Right well if you have a duty of care such at that, what would you consider then doctor to be a breach of that duty?
BARTON	No comment.
DC Code A	Would you consider failing to examine Mr PACKMAN a breach?
BARTON	No comment.

DC Code A	Would you consider failing to keep records a breach?
BARTON	No comment.
DC Code A	Well how about not following drug prescription guidelines?
BARTON	No comment.
DC Code A	What about the failure to follow up those blood results?
BARTON	No comment.
DC Code A	What about thinking he may have a GI bleed, but doing nothing about it?
BARTON	No comment.
DC Code A	What about thinking he may have been having a heart attack, but not doing anything about that?
BARTON	No comment.
DC Code A	What about not carrying out an ECG when the machine's available?
BARTON	No comment.
DC Code A	There's a handful of things. Would you consider any one of those to be a breach of duty of care doctor?

BARTON No comment.

DC Code A Or all of them?

BARTON No comment.

DC Code A (Pause) I mean people at times of negligent aren't they for any number of reasons. Were you negligent?

BARTON No comment.

DC Code A Well what is negligence? Is it any of those things I mentioned before failing to examine Mr PACKMAN?

BARTON No comment.

DC Code A Failing to keep the records?

BARTON No comment.

DC Code A Need I go through them all again?

BARTON No comment.

DC Code A Can you explain why you failed to conduct any of the above, any of the things I've mentioned?

BARTON No comment.

DC Code A — You see sometimes negligence can have tragic consequences can't it doctor? Is this what happened here?

BARTON — No comment.

DC Code A — You see on top of all the breaches that I've mentioned about duty care and care of Mr PACKMAN, there was no referral to another hospital was there, or a doctor, or transferring Mr PACKMAN to another hospital?

BARTON — No comment.

DC Code A — (Pause) How many single deviations doctor would you say, or devious good practice would you say was acceptable?

BARTON — No comment.

DC Code A — Do you think could the failure to treat his GI bleed have contributed to his death?

BARTON — No comment.

DC Code A — Could failure to identify whether he was suffering from myocardial infarction or a heart attack have contributed to his death?

BARTON — No comment.

DC Code A — Could the failure to seek help or assistance from more experienced doctors or a consultant have contributed to his death?

BARTON — No comment.

DC Code A — (Coughs) Could the rapid increase in Morphine based drugs have contributed to his death?

BARTON — No comment.

DC Code A — Could the combined failure of all of the ones I've just mentioned, all the things I've just mentioned, including the rapid increase in Morphine based drugs, have contributed to the death of Geoffrey PACKMAN?

BARTON — No comment.

DC Code A — So then what doctor, as a doctor with over thirty years' experience, what would you consider to be an act of medical negligence?

BARTON — No comment.

DC Code A — Let's turn that round then, how would you deal with one act of negligence that you saw in either a junior or senior doctor?

BARTON — No comment.

DC Code A	How would you deal with repeated breaches of good practice in the medical treatment of one patient?
BARTON	No comment.
DC Code A	When would you consider a doctor to be grossly negligence in carrying out their duties doctor?
BARTON	No comment.
DC Code A	Geoff?
DC Code A	(Pause) I don't have anymore.
DC Code A	No. Is there anything you wish to clarify doctor?
BARTON	No thank you.
DC Code A	Is there anything you wish to add?
BARTON	All right. We'll give you a notice explaining what will happen to the tapes and the tape recording procedure. The time is 1605 hours and I am going to turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AP

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1453 Time concluded: 1537

Duration of interview: 44 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This is a continuation of the interview with Doctor BARTON. The time is 1453 hours and a short break was taken at the end of the last tape for comfort reasons etcetera. Can you just confirm doctor that the same people are present?
BARTON	Yes.
DC Code A	And also that there has been no conversation whilst the tapes have been off about this matter?

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BARTON None at all.

DC Code A Thank you. Code A you were.

DC Code A Yes where was I? (Pause)

BARKER Well if it helps at all you had asked: "What was to stop her...

DC Code A Yes.

BARKER ...administering 200 from the start?" Doctor BARTON indicated: "No comment," and the tape ended.

DC Code A Thank you very much.

DC Code A So just to pick up on that last question then doctor, on that chart what was to stop Sister HAMBLIN or any of the other nurses from going straight to 200 milligrams of Diamorphine on setting up that syringe driver?

BARTON No comment.

DC Code A What were the guidelines in place for commencing a syringe driver at the hospital at the time?

BARTON No comment.

DC Code A If you had authorised Sister HAMBLIN, say for arguments

sake over the phone, how should she have recorded that in the notes?

BARTON No comment.

DC Code A Would she have needed another nurse with her to record what you had said?

BARTON No comment.

DC Code A Did you trust Sister HAMBLIN to carry out your instructions?

BARTON No comment.

DC Code A Would Sister HAMBLIN 'anticipate' - to use one of your words, would Sister HAMBLIN anticipate your instructions?

BARTON No comment.

DC Code A Were there ever times when Sister HAMBLIN did things thinking that you were authorising post, i.e. she would do something and then get your authorisation after it had been done?

BARTON No comment.

DC Code A — Was this something you allowed her to do? (Somebody coughs)

BARTON — No comment.

DC Code A — We know that you placed great trust in the nursing staff, or it seems that you placed great trust in the nursing staff. Was this yet another example of it?

BARTON — No comment.

DC Code A — Chris.

DC — Just to continue on the Diamorphine aspect of things. Is it correct doctor that a drug such as Diamorphine is licensed?

BARTON — No comment.

DC Code A — And within that licence there are particular ways that you can use that drug?

BARTON — No comment.

DC Code A — Can you use a drug like Diamorphine in an unlicensed way?

BARTON — No comment.

DC Code A — And if you were (clears throat), what would you be

expected to do in order to record that?

BARTON No comment.

DC Code A (Clears throat) Again on Diamorphine doctor, when you visited Mr PACKMAN on the 26th of August 1999 (26/08/1999) you were concerned that Mr PACKMAN may have suffered a myocardial infarction and accordingly you decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible myocardial infarction at a dose of 10 milligrams intramuscularly. Well first of all (inaudible) myocardial infarction is. My understanding is it is a heart attack, is that correct?

BARTON No comment.

DC Code A And my understanding is that Diamorphine can be administered for pain from a heart attack, but what would the correct dosage be?

BARTON No comment.

DC Code A You'd prescribed a dose of 10 milligrams intramuscularly. Is it right that that is double the licence dose?

BARTON No comment.

DC Code A Should that not have been a 5 milligram intramuscularly?

BARTON No comment.

DC Code A	Was that a mistake?
BARTON	No comment.
DC Code A	(Pause – clears throat) But having diagnosed a possible heart attack, how important is the previous medical history in making such a diagnosis?
BARTON	No comment.
DC Code A	What previous medical history has Mr PACKMAN got with heart problems?
BARTON	No comment.
DC Code A	(Clears throat) Well what are the symptoms for a heart attack?
BARTON	No comment.
DC Code A	Could that be chest pains?
BARTON	No comment.
DC Code A	Nausea and/or abdominal pain?
BARTON	No comment.
DC Code A	Anxiety?

BARTON	No comment.
DC Code A	Light headiness, cough?
BARTON	No comment.
DC Code A	Nausea with or without vomiting?
BARTON	No comment.
DC Code A	So if some of these symptoms were present and you made a diagnosis of a possible heart attack, what tests should you do?
BARTON	No comment.
DC Code A	An electrocardiogram or an ECG as most people know it, when should that be obtained?
BARTON	No comment.
DC Code A	You are an experienced doctor and you have to undergo an awful lot of training to get to the position you are doctor and we are just detectives with no medical training, but my understanding is is that an ECG should be obtained as soon as possible after presentation to the examining doctor. ...
BARTON	No comment.

DC Code A ...Why didn't you get an ECG?

BARTON No comment.

DC Code A Is it right that approximately one half of patients have diagnostic changes on their initial ECG?

BARTON No comment.

DC Code A Would it be right that an ECG should be preformed on any patient who is older than forty-five years and is experiencing any form of chest or stomach discomfort?

BARTON No comment.

DC Code A And would that included new epigastro or nausea?

BARTON No comment.

DC Code A (Pause) So again just carrying on from what DC Code A was asking, on what basis did you determine a dose range of Diamorphine 40 – 200 milligrams over twenty-four hours and Midazolam at 20 – 80 milligrams over twenty-four hours and it would be necessary for Mr PACKMAN?

BARTON No comment.

DC Code A Why was it necessary to adopt a more proactive prescribing policy in this case?

BARTON No comment.

DC Code A Doctor you've been called into the hospital specifically to attend to Mr PACKMAN and it was seven in the evening, so you don't have to deal with anyone else in the ward it's just Mr PACKMAN and you'd be returning to the ward twelve hours later, so why was it therefore necessary to prescribe that range of drug?

BARTON No comment.

DC Code A Code A

DC At the end of Paragraph (29) doctor the last sentence is: "I anticipate I would have indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die." Now it's a question I've asked before today that that line demands the questions again, what was he likely to die of?

BARTON No comment.

DC Code A What was causing his likely death?

BARTON No comment.

DC Code A You'd written that day: "Possibly had GI bleed or may have been myocardial infarction." You hadn't even established what was wrong with him had you?

BARTON	No comment.
DC Code A	If you felt at that stage that his life was being threatened, why didn't you cause some form of investigation into his symptoms?
BARTON	No comment.
DC Code A	But you're quite willing to tell a wife that 'her husband is dying' and at that stage you don't even know what is wrong with him.
BARTON	No comment.
DC Code A	As I understand it both conditions are serious, but are they not both reversible with correct treatment?
BARTON	No comment.
DC Code A	Would you expect somebody with a GI bleed to die?
BARTON	No comment.
DC Code A	Do you expect any patient with myocardial infarction to die?
BARTON	No comment.
DC Code A	But you did in this case didn't you?

BARTON	No comment.
DC Code A	So what was the difference between Mr PACKMAN?
BARTON	No comment.
DC Code A	How did you form the opinion that he was likely to die?
BARTON	No comment.
DC Code A DC	Code A You see again with your note on the 26th of August (pause) 'query MI – treat stat Diamorph, unless it's query a heart attack, and Oramorph overnight. Alternative possibility GI bleed but no haematemisis'. Did you do anything to find out which, if any of these symptoms, which of, if any of these diagnoses was correct?
BARTON	No comment.
DC Code A	Because I can't see it recorded anywhere else in your notes. Now Doctor REID, the consultant, reviewed this patient, I think it was on the 1st of September, we will come on to that, how was he to know what you've done and what you think?
BARTON	No comment.

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DC Code A	How about 30 then doctor?
DC	Could we just go back to 29 again Code A
DC	Yeah go on.
DC	Sorry. Paragraph (27), the blood count taken on the 26th of August subsequently shows that Mr PACKMAN's haemoglobin (HB) had dropped to 7.7 grams. You obviously feel that that is significant and it probably was significant wasn't it? But I am interested in to why you've put that at Paragraph (27) before Paragraph (29) where you're talking about his wife. Presumably you're seeing his wife the same day you wrote up the Diamorphine, which was the 26th of August and you're seeming to link 29, Paragraph (29) to Paragraph (27) aren't you?
BARTON	No comment.
DC Code A	But you can't have your cake and eat it doctor can you (somebody coughs) because we have asked you: "When did you see that Lab Report with the 7.7 grams on it?" If you recall we showed it to you, it's open for you to have a look at again, we showed it to you and it states on there that 'the lab were trying to contact the War Memorial Hospital, but couldn't get through' and the date is the 26/08, so which way round is it doctor? Did you know about the lab result on the 26/08?
BARTON	No comment.

DC Code A — If you had of known about the lab result on the 26/08 you could have linked it with his possible GI bleed obviously and you could have informed Mrs PACKMAN that her husband was badly ill, very poorly, but even so was it still, was it the case that that was a reversible condition at that time?

BARTON — No comment.

DC Code A — I say to you you wouldn't have known would you at that time?

BARTON — No comment.

DC Code A — How could you have known when you spoke to Mrs PACKMAN that her husband probably had a condition that was likely to lead to death?

BARTON — No comment.

DC Code A — I mean you certainly seem to be pretty convinced that Mr PACKMAN had suffered a heart attack or possibly a GI bleed. If we go to the Death Certificate, the Cause Of Death, in the box you actually noted that 'Mr PACKMAN had been suffering from myocardial infarction five days prior to his death', that was the 29th of August. So what made your mind up then that on the 29th of August you knew that Mr PACKMAN was having a heart attack or suffering with heart problems?

BARTON	No comment.
DC Code A	So where was this recorded in the notes?
BARTON	No comment.
DC Code A	You had already decided that that's when he, that's when it was diagnosed and that's when he was suffering from this. How were you going to treat this?
BARTON	No comment.
DC Code A	So what changed between your note on the 26th of August then and the 29th of August when according to the MCCD, when the myocardial infarction was diagnosed, and on the 26th it was 'query myocardial infarction – query GI bleed'.
BARTON	No comment.
DC Code A	How do you know he had a heart attack on the 29th of August?
BARTON	No comment.
DC Code A	Well I've been through the treatment, what I believe the treatment for a suspected heart attack is. What would you say this treatment should be?
BARTON	No comment.

DC Code A — As in this report how would Doctor REID know, the consultant, the doctor who has overall responsibility for this patient, how on earth could he be aware of your diagnosis if you haven't even written this down?

BARTON — No comment.

DC Code A — Did you discuss it verbally with Doctor REID?

BARTON — No comment.

DC Code A — Did you discuss it with anyone?

BARTON — No comment.

DC Code A — And again moving on to Paragraph (30) of your statement doctor. 'On the morning of the 27th of August 1999 (27/08/1999) Mr PACKMAN appeared to have stabilised somewhat'. Right 'I would have reviewed Mr PACKMAN again the following and indeed the Nursing Record confirms that I attended to see him then, therefore relying on the nurses' notes. Sister HAMBLIN had recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr PACKMAN apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr PACKMAN was said to remain poorly. 10 milligrams of Oramorph were

administered four hourly, together with a further 20 milligrams at night as prescribed, so that Mr PACKMAN received a total of 60 milligrams that day, though this was seemingly not enough to remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have a comfortable night'. So (pause) we are now on the 27th doctor. So by the morning of the 27th of August Mr PACKMAN appeared to have stabilized somewhat more. In addition, you would have had ample of opportunity to have obtained the result of the haemoglobin taken the day before. Why then at a time when Mr PACKMAN could have transferred more safely was this not done then?

BARTON — No comment.

DC Code A — If his condition had stabilised or he was suffering, possibly suffering from a GI bleed or a heart attack and you and the hospital are not capable of treating this, would it not have been better to have sent him to a hospital that could?

BARTON — No comment.

DC Code A — DC Code A pointed this out earlier that 'it would appear that Mr PACKMAN was actually disadvantaged by being on your ward when suffering from these illnesses that were treatable, very serious conditions but treatable. What did you do to treat them?

BARTON — No comment.

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DC Code A	What did you do in order that anyone could help Mr PACKMAN?
BARTON	No comment.
DC Code A	When did you discuss with Doctor RAVI, or Doctor REID, or the gastroenterologists, or medical team on call Mr PACKMAN's condition in particular the drop in his haemoglobin?
BARTON	No comment.
DC Code A	Why didn't you discuss him?
BARTON	No comment.
DC Code A	Paragraph (31). 'I reviewed Mr PACKMAN again the following morning and on this occasion I made a note in his records, which read reads as follows:- The 28th of August 1999 (28/08/1999) remains poorly but comfortable, please continue opiates over weekend'. Were you aware of the blood results at this time?
BARTON	No comment.
DC Code A	What action did you take?
BARTON	No comment.

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DC Code A — His blood results are here and they are saying that 'there is a significant drop' and we know you were aware of them at some time because you've signed the Lab Report. If you weren't aware and you hadn't received the Lab Report why didn't you phone the lab?

BARTON — No comment.

DC Code A — You queried a GI bleed. Wouldn't these results have been important?

BARTON — No comment.

DC Code A — The 28th, that was a Saturday, you didn't have the practice pressures on you, why didn't you write a more detailed note then?

BARTON — No comment.

DC Code A — Now this was coming up to the August bank holiday, so you were aware that the Monday was going to be a bank holiday. If this being the case, who was going to review Mr PACKMAN if his condition deteriorated?

BARTON — No comment.

DC Code A — You stated: "Please continue opiates over the weekend." How were the nurses to know how and when to increase the drugs?

BARTON — No comment.

DC Code A — What safeguards have you put in place this time?

BARTON — No comment.

DC Code A — Paragraph (34) doctor. You write 'I do not know if I would have seen Mr PACKMAN again the following morning, Monday the 30th of August, that being a bank holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr PACKMAN's condition remained poor and later that day at 2.45pm (1445) the syringe driver was set up to deliver 40 milligrams of Diamorphine and 20 milligrams of Midazolam subcutaneously. I anticipate that Mr PACKMAN would have continued to experience pain and clearly in view of the significant sacral sores, it was highly likely that he would have been experiencing further significant discomfort'. So you state that 'Monday the 30th of August was a bank holiday and you have no way of knowing whether you were on duty, but you know that at 2.45pm (1445) a syringe driver was set up containing Diamorphine 40 milligrams and Midazolam 20 milligrams subcutaneously over twenty-four hours'. Why was a syringe driver considered necessary?

BARTON — No comment.

DC Code A	Why were these drugs prescribed?
BARTON	No comment.
DC Code A	But why isn't there anything in either the doctors' or nurses' records to suggest that this decision was discussed with a doctor?
BARTON	No comment.
DC Code A	Right you stated that 'Mr PACKMAN would have been experiencing pain from his abdomen or sacral sores'. The notes do not suggest that the sores were a significant cause of pain do they doctor?
BARTON	No comment.
DC Code A	In fact the Nursing Care Plan for sleeping, entry on the 29th of August, it records that Mr PACKMAM complained of left sided abdominal pain and queried whether this was related to his bowels'. Why therefore is Mr PACKMAN commenced in these drugs?
BARTON	No comment.
DC Code A	I see you're there on a Saturday, you went on the Sunday, you possibly went on a Monday. Who authorised this?
BARTON	No comment.

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DOCUMENT RECORD PRINT

DC Code A	Code A
DC	No.
DC	(Pause) Paragraph (35) of your statement doctor. 'In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr PACKMAN had received 60 milligrams of Oramorph daily over the preceding three days and the administration of 40 milligrams of Diamorphine subcutaneously over twenty-four hours did not represent a significant increase. Mr PACKMAN would have started to have become inured to the opiate medication and an increase of this nature was, in my view, entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr PACKMAN was able to take a small amount of food'. Like you said 'Mr PACKMAN received 60 milligrams of Morphine each day over the preceding three days, and on this basis the administration of Diamorphine, which was 40 milligrams subcutaneously over twenty-four hours, did not represent a significant increase'. How do you personally calculate an appropriate dose of subcutaneous Diamorphine based on a patient's previous oral Morphine dose?
BARTON	No comment.

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DC Code A	Now DC Code A been through this with you as well. Are you aware of that chart?
BARTON	No comment.
DC Code A	(Pause) As we understand it the total twenty-four hour oral dose of Morphine is divided by three or occasionally by two, hey Code A?
DC Code A	That's right.
DC	So an appropriate dose, i.e. Diamorphine at 20 milligrams over twenty-four hours would generally be considered an appropriate conversion on this occasion. Is that correct doctor?
BARTON	No comment.
DC Code A	Why was Mr PACKMAN's doubled therefore?
BARTON	No comment.
DC Code A	The first three lines of that paragraph, 'In view of his condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying'. What was he dying of?
BARTON	No comment.

DC Code A — Was he dying of a myocardial infarction?

BARTON — No comment.

DC Code A — Did he need to die of a myocardial infarction?

BARTON — No comment.

DC Code A — Isn't myocardial infarction for a heart attack? Is it treatable?

BARTON — No comment.

DC Code A — Well what did you do to treat it?

BARTON — No comment.

DC Code A — Did you do anything?

BARTON — No comment.

DC Code A — You say 'it was your second diagnosis of a GI bleed'. Is that treatable?

BARTON — No comment.

DC Code A — What can you do to save a person that is suffering a GI bleed?

BARTON — No comment.

DC Code A — Is it always a terminal condition?

BARTON — No comment.

DC Code A — But you were concerned to ensure that he did not suffer pain and distress as he was dying. Would it not have been better doctor to have tried to cure the underlying cause rather than increase the dose of the Diamorphine?

BARTON — No comment.

DC Code A
DC — Code A

Well doctor you have been given a copy of those Medical Records, a full copy of the Medical Records that are available and you've had some time to read them through and then make this statement that you've presented to us and in this Paragraph (35) I'll draw your attention to five words 'poor condition, terminally ill and dying'. Not anywhere there does it say what his poor condition was, what he was terminally ill with or what he was dying from. Even now, seven years later, when you read this Hospital Record, even now you cannot state, can you, what was causing his death.

BARTON — No comment.

DC Code A — I am saying to you, I put it to you that at that stage you did not know what his condition was did you?

BARTON	No comment.
DC Code A	But you were content to assume that he was dying,...
BARTON	No comment.
DC Code A	...so content that you told his wife that he was dying according to you,...
BARTON	No comment.
DC Code A	...so content that you failed to find, or to investigate the cause of his condition,...
BARTON	No comment.
DC Code A	...so content that you merely ramped up the analgesic to keep him pain free,...
BARTON	No comment.
DC Code A	...but you had already suspected that he might have one of two reversible and treatable conditions.
BARTON	No comment.
DC Code A	Why in Paragraph (35) have you not said what he was dying from?

BARTON	No comment.
DC Code A	Right Paragraph (36) then doctor. 'I anticipate that the nursing staff', it's 'I anticipate' again isn't it? 'I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazolam and this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone'. Doctor this is a direct contrast to Paragraph (34). You state that 'nursing would have liaised with you and that the Diamorphine and Midazolam would have been commenced on your instruction'. So therefore did you authorise the commencement of that Diamorphine?
BARTON	No comment.
DC Code A	If you did, why didn't you put an entry in the notes when you next came on duty as you had previously?
BARTON	No comment.
DC Code A	Did you have an arrangement with Sister HAMBLIN that she could commence patients on syringe drivers with Diamorphine when she deemed it suitable?
BARTON	No comment.
DC Code A	Well who therefore made the decision to increase Mr PACKMAN's Diamorphine by at least double the amount?

BARTON	No comment.
DC Code A	Well that is a significant increase, it's double the amount doctor.
BARTON	No comment.
DC Code A	Well what is the purpose of medial practitioners reviewing patients and deciding on levels of prescriptions then?
BARTON	No comment.
DC Code A	(Pause) You said 'this would have been on your instruction directly if you had been at the hospital, or otherwise by phone'. What's the effect then of doubling the Diamorphine?
BARTON	No comment.
DC Code A	Code A?
DC	Yeah. 'I anticipate that the nursing staff bla, bla, bla. This would have been set up on my instruction directly, or otherwise by phone'. Well let's take 'directly' shall we. If it was directly, I'm assuming that you are there in the ward. Let's take 'directly', let's assume it was 'directly', you were there in the ward. Why didn't you make a record there and then on the notes that you had authorised the setting up of that driver?

BARTON	No comment.
DC Code A	No you didn't did you? So let's assume that it wasn't directly.
BARTON	No comment.
DC Code A	Let's go then for 'or otherwise by phone' then surely (somebody coughs) if it was by phone again there would be some record wouldn't there?
BARTON	No comment.
DC Code A	But there isn't is there?
BARTON	No comment.
DC Code A	So let's go for another possibility, which you haven't put down in Paragraph (36) and that is that Sister HAMBLIN set up the syringe driver on her own...
BARTON	No comment.
DC Code A	...without speaking to you?
BARTON	No comment.
DC Code A	Had you had an arrangement with Sister HAMBLIN that she could put up the syringe driver when she felt it was the right time to do so?

BARTON	No comment.
DC Code A	Was that an arrangement that was common practice between the two of you?
BARTON	No comment.
DC Code A	Was that an acceptable arrangement do you think?
BARTON	No comment.
DC Code A	Okay. Well let's go for another option then and let's say: "Is it possible that Sister HAMBLIN did that of her own accord without any consultation with you?"
BARTON	No comment.
DC Code A	And what was to stop her, you had prescribed the Diamorphine and the Midazolam; you'd given the broad range. Was she entitled to set up the syringe driver because you had already prescribed it?
BARTON	No comment.
DC Code A	And if that last one was the case, is that why there's no record of it?
BARTON	No comment.

DC Code A

Well is it doctor? Is it: "Let's leave well alone and let's hope it doesn't get noticed."

BARTON

No comment.

DC Code A

(Pause) Obviously if it had been done on the telephone, if authority had been given over the telephone there would be more likely I suppose to be an entry because the policy says that 'it would have to be signed by two nurses'. Is that not correct doctor?

BARTON

No comment.

DC Code A

Let's take Paragraph (37) and Paragraph (38) then doctor. 'On the morning of the 31st of August Mr PACKMAN was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning. I believe I would have seen Mr PACKMAN again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered and that he would have remained comfortable. Similarly, I would probably have seen Mr PACKMAN again on the morning of 1st of September, but would have been unable to record this. I anticipate that his condition was again unchanged. Five separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded'. So you stated that 'on the morning of the 31st of August Mr PACKMAN was recorded as passing a large amount of black faeces'. Isn't this a pure indication of one of your queried diagnosis, of

your indication of a gastro intestinal bleed?

BARTON — No comment.

DC Code A — And I will ask you again next to the dates that we have got. When did you obtain or review that full blood count that you signed?

BARTON — No comment.

DC Code A — Why didn't you refer Mr PACKMAN to a more senior colleague at this point?

BARTON — No comment.

DC YATES — So according to you doctor Mr PACKMAN was either suffering from a heart condition, or a GI bleed according you're your entry on the 26th of August. You've commenced him on varying, increasing doses of Diamorphine. You say that you, you stated somewhere, on the 26th, the 27th, the 28th, the 31st and the 1st of September you've made two entries in the notes and neither of which reasons why he has been given any medication. There was no evidence that an ECG, or any tests to address his heart condition had been thought about or carried out. And in relation to his GI bleed you wrote 'A large form of haemoglobin levels, passing of black stools' and yet again there was no record of investigations for treatment plans, or referrals to senior colleagues, why not?

BARTON	(Silent)
DC Code A	Doctor why not?
BARTON	No comment.
DC Code A	So what care were you providing for Mr PACKMAN?
BARTON	No comment.
DC Code A	(Pause) Were you just allowing him to die?
BARTON	No comment.
DC Code A	Anything Code A?
DC Code A	Yeah. And it's very similar to a set of questions I asked you a few moments ago doctor. Paragraph (37) – 'He then passed a large amount of black faeces that morning'. Paragraph (27) I think it was when 'you agree that you signed the Lab Report with a 7.7 reading on (inaudible). Previous to this you've written into this statement that 'you queried myocardial infarction plus you queried 'possible GI bleed', and now you have got the clearest indication that that is probably what he has got a GI bleed because you've put on here 'passed a large amount of black faeces'. Black faeces plus the 7.7, what is that an indication of doctor?
BARTON	No comment.

DC Code A

Well we both know don't we that that is an indication of a GI bleed, and yet even now at this stage, in this prepared statement, prepared statements you've had time to write it, we haven't asked you to do it in five minutes, even now Chapter 30, or Paragraph (37) you still haven't written down what is wrong with Mr PACKMAN and that's the clearest indication yet that we've got so far and we'll carry on with the questioning, but expect another question on that in a minute doctor.

BARTON

No comment.

DC Code A

Right doctor we'll move on to Paragraph 41. 'Sister HAMBLIN recorded later in the Nursing Records that the syringe driver was renewed at 7.15pm (1915) with 60 milligrams of Diamorphine and 60 milligrams of Midazolam subcutaneously as the previous dose was not controlling Mr PACKMAN's symptoms. It appears therefore that Mr PACKMAN was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress'. So on the evening of the 1st of September now then 'the first Diamorphine was increased to 60 milligrams and Midazolam to 60 milligrams over a twenty-four hour period', that's at quarter-past-seven (1915) in the evening because the previous dose wasn't controlling the symptoms (coughs). Sister HAMBLIN has recorded this, you haven't. Who has authorised the change in dosage?

BARTON	No comment.
DC Code A	So that's a Diamorphine increase of 50% and the Midazolam dose was trebled. Why was this?
BARTON	No comment. (TAPE BUZZES)
DC Code A	Where is it recorded in the records that Mr PACKMAN was in pain or distress?
BARTON	No comment.
DC Code A	So you're going to say that 'you anticipate that the nursing staff would have contacted you and you have authorised this moderate increase in his medication'. Well moderate is 50% of Diamorphine and trebling the Midazolam, but where have you authorised this?
BARTON	No comment.
DC Code A	Was it over the telephone?
BARTON	No comment.
DC Code A	In which case an entry would have been made by the nurses. Is that correct?
BARTON	No comment.

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DC Code A	Were you there?
BARTON	No comment.
DC Code A	In which case you have signed it yourself?
BARTON	No comment.
DC Code A	Or did Sister HAMBLIN just authorise it herself?
BARTON	No comment.
DC Code A	I'll let you think about that for a moment doctor because I'm going to take this opportunity to change the tape. The time is 1537 hours and I am going to turn the recorder off.
	INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

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RECORD OF INTERVIEW

Number: Y20AO

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1359 Time concluded: 1443

Duration of interview: 44 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / 1162 Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This is a continuation of the interview with Doctor BARTON. The time is 1359 hours. The reason we've had this second break was the fault in the tape machine, which hopefully has been rectified by changing it. Can I just ask you doctor to confirm that that is the reason why we took that break?
BARTON	It is.
DC Code A	And has there been any conversation about the matter

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whilst the tape has been off?

BARTON None at all.

DC Code A Thank you. Doctor we'll try and pick up where we left off and we were referring to Paragraph (24). This states, this is your statement, 'I do not know if I reviewed Mr PACKMAN on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister HAMBLIN has recorded that Doctor RAVI, locum consultant geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr PACKMAN was noted to be "not for resuscitation". Sister HAMBLIN may have contacted Doctor RAVI if I was unavailable that morning. The nursing record goes on to indicate that Mr PACKMAN then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as followed:- 26th of August 1999 (25/08/1999) called to see, pale, clammy, unwell. Suggest, query MI, treat stat Diamorph and Oramorph overnight. Alternative possibility GI bleed but no haematemisis. Not well enough to transfer to acute unit. Keep comfortable. I am happy for nursing staff to confirm death. As my note indicates, I was concerned that Mr PACKMAN might have suffered a myocardial infarction and accordingly I decided to administer opiates in the form of Diamorphine for pain and distress consequent on the possible mycocardial infarction, at a dose of 10 milligrams intramuscular. In addition, I

would have been conscious that he had large pressure sore areas on his sacrum and thighs, which would have been causing him significant pain and discomfort. I prescribed 10 milligrams Diamorphine intramuscularly to be given immediately, which is recorded on the Drug Chart as a verbal instruction. An alternative diagnosis, which I recorded was that Mr PACKMAN had had a gastro intestinal bleed'. Now you state that 'you were called to see Mr PACKMAN on the 26th'. This must have been after six o'clock in the evening. There's an entry on Page 168 that shows you gave a verbal order at that time to Sister HAMBLIN for Diamorphine. This is now nearly four days since Mr PACKMAN arrived. Well why is that the first time that you've seen him?

BARTON — No comment.

DC Code A — On Page 168 of the medical notes (pause), (inaudible) Page 172 (pause) there are two entries for Oramorph there. Why is that?

BARTON — No comment.

DC Code A — And also on Page 168 'once only and pre-medication drugs'. There are two prescriptions for Diamorphine on there. Why is that?

BARTON — No comment.

DC Code A — That will be the only one that was given?

BARTON	No comment.
DC Code A	Mr BARKER can I just say something here that obviously all questions are important, but we feel that the questioning around the Prescription Chart is very important to your client and can you just confirm that your client has had an opportunity to consult with those original charts?
BARKER	You've provided the original Prescription Chart to Doctor BARTON, it's available for her to consider, but I don't think it's appropriate for me to comment...
DC Code A	No thank you...
BARKER	...further.
DC Code A	...that's fine, thank you very much for that cheers.
DC	What other drugs did you prescribe on the 26th?
BARTON	No comment.
DC Code A	(Pause) Now the Drug Chart shows that he received Diamorphine, 10 milligrams at six o'clock in the evening and that was the verbal order. As I pointed out the prescription was repeated below this one, it doesn't appear to have been given. 'Or a Morphine solution, Oramorph was commenced regularly, 10 – 20 milligrams every four hours with 20 milligrams at night', which meant Mr

	PACKMAN had continued until ten o'clock on the 30th of August 1999 (30/08/1999). Regular Oramorph solution 10 milligrams every four hours was also prescribed in the Daily Review Prescription. Is that where it should be?
BARTON	No comment.
DC Code A	Because it appears as though it's duplication doctor, I just wonder if you could clarify?
BARTON	No comment.
DC Code A	(Pause) Diamorphine 40 – 200 milligrams and Midazolam 20 – 80 milligrams subcutaneously over a twenty-four period were also prescribe on the 26th of August 1999 (26/08/1999) (coughs), that's on Page 171. Why was this doctor?
BARTON	No comment.
DC Code A	Why did you prescribe these drugs?
BARTON	No comment.
DC Code A	On Page 171 doctor... Have you got it there Code A
DC Code A	(Inaudible)

DC Code A ...what explanation can you give as to why Jill HAMBLIN has completed a prescription for Oramorph on Page 171 and you have countersigned it? That signifies it is blatantly not in your handwriting although signed by you with the blue pen, that Jill HAMBLIN's used elsewhere.

BARTON No comment.

DC Code A Should she fill in that part of the prescription sheet?

BARTON No comment.

DC Code A Did Jill HAMBLIN prescribe it?

BARTON No comment.

DC Code A Was this given as a verbal order?

BARTON No comment.

DC Code A (Pause) You know that on the 26th of August 1999 (26/08/2006) doctor that the nurses contacted Doctor RAVI, who is a locum consultant geriatrician who advised that the Clexane be discontinued and that Mr PACKMAN's haemoglobin to be checked on the 26th and 27th of August 1999 (26-27/08/1999). The haemoglobin level on the 26th of August was 7.7, it's on Page 205.

For the benefit of the tape DCs Code A and Code A talk between themselves, which is inaudible.

DC Code A — If you can just bear with me doctor.

For the benefit of the tape there is a long pause whilst DCs Code A and Code A talk between themselves, which is inaudible.

DC Code A — We'll have to come back to that Code A

DC Code A — Yeah come back.

DC Code A — We'll come back to that doctor. (Pause) Right still moving on here though throughout your statement doctor you refer to Mr PACKMAN being 'not for resuscitation', several times in your statement. What explicitly is your understanding of the meaning and implications of that term?

BARTON — No comment.

DC Code A — (Inaudible) that a medical judgement has been made that in the event of a patient's heart or breathing stopping unexpectedly, cardio respiratory arrest, there is little or no chance of cardiopulmonary resuscitation being successful or medically futile and therefore it should not be attempted. Is that right doctor?

BARTON — No comment.

DC Code A — Is this usually on the background of a progressive life

threatening illness, or other significant medical problems?

BARTON — No comment.

DC Code A — Does this status mean that the patient is automatically excluded from receiving all appropriate treatment for other medical problems that may arise?

BARTON — No comment.

DC Code A — (Pause) You know that Mr PACKMAN deteriorated about lunchtime on the 26th of August 1999 (26/08/1999) as he was reported 'to have had a fairly good morning'. This would have represented an acute deterioration in his condition. Your entry note that Mr PACKMAN was 'pale, clammy and unwell'. Does this suggest he was shocked?

BARTON — No comment.

DC Code A — And I will invite you to look at these Medical Records yourself doctor if you wish, but why weren't his basic observations such as his temperature, heart rate and blood pressure recorded?

BARTON — No comment.

DC Code A — What would these observations have told you?

BARTON — No comment.

DC Code A	Why did you feel that it wasn't necessary to perform or record these findings?
BARTON	No comment.
DC Code A	The nursing notes/entries suggest that 'he was complaining of indigestion with pain in the throat, which was not radiating', again associated with vomiting. Why did you query a myocardial infarction?
BARTON	No comment.
DC Code A	What were the medical findings that led you to consider that he had a myocardial infarction?
BARTON	No comment.
DC Code A	What examination, or tests did you undertake that would lead you to consider that he had a myocardial infarction?
BARTON	No comment.
DC Code A	You also recorded that 'an alternative possibility was a gastro intestinal bleed, but note that Mr PACKMAN had not vomited blood', given Mr PACKMAN's history of possible melaena, reported at the QA Hospital, which is on Page 54, and the fresh bleeding the day before. Why didn't you make any further enquiries to determine whether Mr PACKMAN was suffering from a GI bleed?

BARTON No comment.

DC Code A What is a GI bleed?

BARTON No comment.

DC Code A (Pause) How should it be treated?

BARTON No comment.

DC Code A (Pause) How was it diagnosed?

BARTON No comment.

DC Code A So what medical findings led you to consider he may have had a gastro intestinal bleed?

BARTON No comment.

DC Code A All that together doctor, on what basis did you satisfy that a myocardial infarction was the more likely diagnosis?

BARTON No comment.

DC Code A Why was Mr PACKMAN prescribed Diamorphine for the treatment of pain due to his pressure sores?

BARTON No comment.

DC Code A (Pause) At the Queen Alexandra Hospital his only

analgesic was Paracetamol. In the medical clerking whilst transferred to Dryad Ward, which is on Page 55 I think, and in the Nursing Care Plan relating to his pressure sores he only need Paracetamol. Why then was there a need to significantly increase the opioid levels?

BARTON — No comment.

DC Code A — Why wasn't this decision making process recorded, especially as you were called in to specifically treat Mr PACKMAN?

BARTON — No comment.

DC Code A — (Pause) Code A do you want to ask anything?

DC Code A — No not at the moment Chris.

BARTON — No comment.

DC Code A — Paragraphs (25), (26) and (27) then doctor. Paragraph (25) – 'My impression when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health'. (26) – 'The nursing note for the 26th of August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr PACKMAN

complaining of indigestion and a pain in his throat, which was not radiating'. Paragraph (27) – 'The blood count taken on the 26th of August subsequently showed that Mr PACKMAN's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams, which had been recorded two days earlier'. Now the part where you state that 'Mr PACKMAN was very ill and in view of his condition and a previous decision that he was not for resuscitation, transfer to an acute unit was quite inappropriate'. Could you explain that to me doctor?

BARTON No comment.

DC Code A (Pause) Why, although ill and deemed not for resuscitation, does this exclude Mr PACKMAN from receiving appropriate medical care?

BARTON No comment.

DC Code A (Pause) Why, given your clinical description of Mr PACKMAN being shocked, did you not undertaken simple observations such as temperature, pulse and blood pressure?

BARTON No comment.

DC Code A (Pause) If you were convinced that a myocardial infarction was likely, why didn't you perform an ECG to help make the diagnosis for a myocardial infarction?

BARTON — No comment.

DC Code A — (Pause) Given that you considered the possibility of a gastro intestinal haemorrhage why not, in addition to the simple observation, get into contact with the laboratory to obtain a result of the haemoglobin taken earlier that day?

BARTON — No comment.

DC Code A — Because as we know, and you've put in your statement doctor, it turns out we've revealed the drop of haemoglobin to 7.7., a considerable drop. (Pause) During Mr PACKMAN's acute deterioration, which was considered significant, why didn't you discuss it with Doctor RAVI, or Doctor REID, or the medical team on call at the QA Hospital?

BARTON — No comment.

DC Code A — If a patient becomes unexpectedly, or acutely unwell doctor, wouldn't it generally be appropriate to identify the reason for it and to investigate appropriate medical management?

BARTON — No comment.

DC Code A — (Pause) And taken into account this patient's particular circumstances, could this include insuring they are cared for in an environment best suited to meet their medical needs?

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BARTON — No comment.

DC Code A — So what you said doctor is 'he was so ill that he couldn't be transferred'? (Pause) What would happen if Mr PACKMAN had been at home and his wife found him in this way?

BARTON — No comment.

DC Code A — Would it have been reasonable to expect that an ambulance would be called and he would be taken to a hospital where he would be cared for?

BARTON — No comment.

DC Code A — Well would a doctor make a decision that he's so ill moving him would be deleterious to his condition so we'll leave him at home?

BARTON — No comment.

DC Code A — Because surely the same would apply at the Gosport War Memorial Hospital. If the hospital is not set up to deal with the man's condition, would it not be appropriate to move him doctor?

BARTON — No comment.

DC Code A — Having made the diagnoses that he was suffering from

	myocardial infarction, or a gastro intestinal bleed, both serious but both treatable, why did you choose to leave him on Dryad Ward?
BARTON	No comment.
DC Code A	Why didn't you perform an ECG?
BARTON	No comment.
DC Code A	We know that there was an ECG available at the hospital. Where was it doctor?
BARTON	No comment.
DC Code A	(Pause) Actually doctor let me show you the Lab Report that we couldn't find just now. (Pause) His specimen was taken on the 26th of August 1999 (26/08/1999) and this shows the drop (pause) in the haemoglobin had dropped to 7.7 grams from 12 grams from two days earlier. Is that your signature on that doctor?
BARTON	No comment.
DC Code A	I know you've seen that doctor because you mentioned it in your own prepared statement, so I am showing you it again it is Page 205 of the copy file.
DC Code A	Code A could, what you've got in your hand, could you read the bit there for the doctor?

DC Code A	Yes it says Comment – Many attempts were made to phone these results, no answer from Gosport War Memorial switchboard.
DC Code A	So the lab had obviously realised that there's a drop, they want to get those results through. Why didn't you phone the lab when you suspected a GI bleed?
BARTON	No comment.
DC Code A	What attempts did you make to treat either of the illnesses that you diagnosed?
BARTON	No comment.
DC Code A	What would the treatment for myocardial infarction be?
BARTON	No comment.
DC Code A	And what is the treatment for a GI bleed?
BARTON	No comment.
DC Code A	Do you know what a GI bleed is?
BARTON	No comment.
DC Code A	Would I be correct in thinking that even a medical student would understand that a GI bleed could be a medical

emergency?

BARTON — No comment.

DC Code A — In fact it has been mentioned to me, and I did put it to test, that you can put GI Bleed into Google and find out that it's a medical emergency.

BARTON — No comment.

DC Code A — If you weren't sure, why didn't you take advice?

BARTON — No comment.

DC Code A — (Pause) What are the specific guidelines on the usual management of acutely ill patients at the Gosport War Memorial Hospital?

BARTON — No comment.

DC Code A — Were there any guidelines, or protocols, or practices in existence that would specifically prevent, or encourage the transfer of acutely ill patients to the main hospital?

BARTON — No comment.

DC Code A — (Pause) What facilities for general resuscitation were available, e.g. the ability to obtain venous access, (inaudible) venous infusion or fluid?

BARTON	No comment.
DC Code A	For blood transfusions, things like that?
BARTON	No comment.
DC Code A	When did you become aware, doctor, of the full blood count result from the 26th of August?
BARTON	No comment.
DC Code A	Because we can see you were aware of it at some time because you initialled it doctor.
BARTON	No comment.
DC Code A	(Pause) Why wasn't it documented in his medical notes?
BARTON	No comment.
DC Code A	Did you notify Doctor RAVI or Doctor REID with the result?
BARTON	No comment.
DC Code A	You signed that Lab Report doctor, which is Page 205, and given that a large drop of haemoglobin had been demonstrated, on what grounds did you continue to consider a myocardial infarction more likely?

BARTON — No comment.

DC Code A — Not only did you regard it as 'more likely', it was recorded as the cause of death.

BARTON — No comment.

DC Code A — What made that the stronger diagnosis than your alternative diagnosis of a gastro intestinal bleed?

BARTON — No comment.

DC Code A — So that was in light of the Lab Report that you received showing that significant drop in blood?

BARTON — No comment.

DC Code A — Code A

DC Code A — Doctor you've recorded 'query melaena', myocardial infarction sorry 'and possible GI bleed', and Chris has just asked you 'what steps you took to eliminate one or the other'. So in other words to find out what was wrong with Geoffrey PACKMAN. You've got an opportunity now, today, to tell us what steps you took to find out what was wrong with Geoffrey PACKMAN. What steps did you take doctor?

BARTON — No comment.

DC Code A — What steps could you have taken doctor?

BARTON — No comment.

DC Code A — For instance regarding myocardial infarction, could you have arranged for an ECG to be performed?

BARTON — No comment.

DC Code A — And would that have indicated to you that he had or didn't have myocardial infarction?

BARTON — No comment.

DC Code A — Similarly we've just discussed GI bleed and as I understand it if somebody is bleeding lower in the intestine you're stools would come out red. Is that right?

BARTON — No comment.

DC Code A — And if it's higher they come out black tarry. Is that right?

BARTON — No comment.

DC Code A — And it is one of the simpler diagnoses to make I believe isn't it...

BARTON — No comment.

DC Code A — ...for even a junior doctor?

BARTON	No comment.
DC Code A	How would you go about investigating whether a patient had a GI bleed?
BARTON	No comment.
DC Code A	Well you can ask for blood results, blood tests couldn't you?
BARTON	No comment.
DC Code A	And in fact bloods were asked for weren't they?
BARTON	No comment.
DC Code A	Doctor REID, Doctor RAVI had asked for the blood tests.
BARTON	No comment.
DC Code A	And was it not your plan to await lab results...
BARTON	No comment.
DC Code A	...for Mr PACKMAN?
BARTON	No comment.
DC Code A	Well you did wait for blood results didn't you?

BARTON No comment.

DC Code A And when I say that you just waited. Is that right?

BARTON No comment.

DC Code A What else could you have done to establish whether Mr PACKMAN had a GI bleed?

BARTON No comment.

DC Code A Did you consider and endoscopy?

BARTON No comment.

DC Code A What are the considerations for an endoscopy with a patient suffering (somebody coughs), suffering from a GI bleed?

BARTON No comment.

DC Code A You'd put it down on the paperwork that 'he might have a GI bleed' and yet it looks as if you haven't followed this up.

BARTON No comment.

DC Code A Well the lab obviously recognised that he was a medical emergency and tried to contact the hospital, but couldn't get through. We can't blame you for not answering the phone can we? No

one is seeking to, but what steps did you take to get the results of those blood tests?

BARTON No comment.

DC Code A Well when did you see those tests then?

BARTON No comment.

DC Code A You signed them didn't you?

BARTON No comment.

DC Code A We've already asked you 'why you didn't feel that he could go to the QA Hospital'. In Mr PACKMAN's case doctor. No let me start again, if you had gone out to a patient at home with the same symptoms that Mr PACKMAN had, i.e. you queried whether that patient lying in their bed at home had an myocardial infarction or possibly a GI bleed. Would you have just left them in their bed at home?

BARTON No comment.

DC Code A I take it you wouldn't, and I take it you would have caused him to treble nined (999) to the nearest hospital. Would you have done that?

BARTON No comment.

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DC Code A — Why didn't you do that with Mr PACKMAN?

BARTON — No comment.

DC Code A — Do you feel that Geoffrey PACKMAN was at a disadvantage because he was already in your hospital then?

BARTON — No comment.

DC Code A — If you weren't willing to have him transferred to an acute bed, do you feel he was at a disadvantage?

BARTON — No comment.

DC Code A — Right now we'll move on then to Paragraph 28. You state that 'you were concerned that Mr PACKMAN should receive appropriate medication to relieve his pain and distress, and therefore gave him Oramorph 10 – 20 milligrams four times a day and 20 milligrams at night'. So what dose of drug was given to Mr PACKMAN during the day?

BARTON — No comment.

DC Code A — Was it 10, or was it 20 doctor?

BARTON — No comment.

DC Code A — Page 172 of the notes show that a range was available, but the record does not show what dose was given. Why is

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this?

BARTON	No comment.
DC Code A	When this range is given, who decides on the size of the dose given?
BARTON	No comment.
DC Code A	(Pause) And what safeguards were in place preventing the inadvertent, or inattentive administration of these drugs to Mr PACKMAN?
BARTON	No comment.
DC Code A	So what doses of Morphine did Mr PACKMAN actually receive that day?
BARTON	No comment.
DC Code A	I'll change it slightly then, what explicitly was the pain and distress that Mr PACKMAN was in?
BARTON	No comment.
DC Code A	It's this range of drug again doctor isn't it? 10 – 20 milligrams four times a day, 20 milligrams at night. If I was to pick up those medical notes as a nurse, how would I know whether to give 10 or whether to give 20 milligrams?

BARTON	No comment.
DC Code A	Or would the choice just be mine?
BARTON	No comment.
DC Code A	Code A do you want to ask anything?
DC	Yeah. Not only that doctor, we showed you earlier on this 'prescribing elderly medicine' blown up chart taken from the BNF GJQ/HF/21, and we showed you, did we not, that we had the 10 milligrams Morphine Sulphate oral solution and you'd prescribed 40 milligrams of Diamorphine, which was beyond the guidelines, above the guidelines, you should have been prescribing say 20 milligrams, and Chris has just said: "What safeguards did you put in place to make sure that Mr PACKMAN didn't receive the wrong drugs, or too much of the drugs?" because as we pointed out with the Oramorph how would a nurse know whether to give the 10 or the 20?
BARTON	No comment.
DC Code A	And similarly how would a nurse know whether to give 10 milligrams of Oramorph and on this chart it's second in the table on the weaker side, or 200 milligrams of Diamorphine which is way down here look on the right hand side.
BARTON	No comment.

DC Code A — What prevents a nurse from doing that doctor...

BARTON — No comment.

DC Code A — ...because that is the open range you've prescribed isn't it...

BARTON — No comment.

DC Code A — ...on the same day that you prescribed the Oramorph?

BARTON — No comment.

DC Code A — Do you think that is an acceptable way to write up a Prescription Chart?

BARTON — No comment.

DC Code A — In answer to what DC Code A has just been asking, Paragraph (29), you actually say 'I also wrote up prescriptions for Diamorphine 40 – 200 milligrams subcutaneously over 24 hours, together with 20 – 80 milligrams of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr PACKMAN's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr PACKMAN's wife explaining her husband's condition and the medication we were using. I anticipate I would have

indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die'. As DC Code A said 'you've written up prescriptions with Diamorphine 40 – 200 milligrams on the same day as you've written Oramorph 'on an anticipatory basis'. If that was the correct way of doing things doctor, where in the medical notes does it say that?

BARTON — No comment.

DC Code A — Well where in the medical notes does it say 'to advise the nurses that this is just on an anticipatory basis and that you would require contacting'?

BARTON — No comment.

DC Code A — I can't see any safeguard.

DC Code A — Well let's just take that on a little bit further doctor, let's expand on that because 'safeguard' is the appropriate word I think because when the Diamorphine syringe driver was started it was started, was it not, by Sister HAMBLIN?

BARTON — No comment.

DC Code A — And yet you haven't recorded your authority anywhere for her to start that?

BARTON — No comment.

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DC Code A — It's possible isn't it that she didn't have your authority to start it specifically?

BARTON — No comment.

DC Code A — 'It was not my intention that this subcutaneous medication should be administered at that time'. So at what time was it to be administered?

BARTON — No comment.

DC Code A — And how was that to be conveyed to the nurses?

BARTON — No comment.

DC Code A — Because it seems it was started with nothing down on paper from you even post a decision. Did you give verbal authority for that medication to be started at that time?

BARTON — No comment.

DC Code A — What I say it doesn't look as if (TAPE BUZZES), it doesn't look as if you have does it? And what is to stop, well I'll let you answer that question first, it doesn't look as if you have does it?

BARTON — No comment.

DC Code A — And what was to stop that nurse from prescribing anywhere between the 20 milligrams of Diamorphine up to the 200?

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BARTON	No comment.
DC Code A	She seemed to start it where she thought fit?
BARTON	No comment.
DC Code A	What was to stop her from prescribing, from administering 200 milligrams from the start?
BARTON	No comment.
DC Code A	The buzzer sound, if we change the tapes over. Is there anything you wish to clarify?
BARTON	No thank you.
DC Code A	Is there anything you wish to add?
BARTON	No thank you.
DC Code A	And are you happy to continue straight on?
BARTON	(Silent)
DC Code A	Yeah. Okay the time is 1443 hours and I am turning the recorder off.
	INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AM

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2004

Time commenced: 1311 Time concluded: 1349

Duration of interview: 38 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: Mr BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This interview is being tape recorded, I am DC Code A Code A My colleague is?
DC Code A	DC Code A
DC Code A	I am interviewing Doctor Jane BARTON. Doctor will you please give me your full name and your dated of birth?
BARTON	Jane Ann BARTON, 19/10/48.

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DC Code A	Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself and your full name?
BARKER	Certainly. It's Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.
DC Code A	Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1311 hours and the date is Thursday the 6th of April 2006 (06/04/2006). At the end of the whole procedure that's when I'll sort out the paperwork for the tapes okay. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?
BARTON	Fine thank you.
DC Code A	Okay. If at any time you wish to stop the interview and take legal advice just say and the interview will be stopped in order that you can do this. I'd also like to point out that you have attended voluntarily, you're not under arrest and you have come here of your own free will. So if at any time that you wish to leave you're free to do so okay.
BARTON	Thank you.
DC Code A	I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention, when

questioned, something which you later rely on in court and anything you do say maybe given in evidence. Do you understand that caution doctor?

BARTON — I do.

DC Code A — I broke it down earlier this morning, is there any need for me to break that caution down now?

BARTON — No thank you.

DC Code A — Likewise, the same as this morning, on this occasion the room that we're in has been equipped with a monitoring facility. Whenever that red light there is on it means that somebody is listening to the interview, this afternoon it's Detective Inspector GROCOTT who will be monitoring the interview. When the tapes aren't running and it's not in record mode, no conversation can be heard in this room by that facility okay. Right (clears throat) now we've had a break for lunch doctor, can I just ask you to confirm that there's been no conversation between us, the police, and yourself regarding this matter when the tapes haven't been running?

BARTON — None at all.

DC Code A — Thank you. What I would like to move on to now doctor is Death Certificates. The completion of a Death Certificate is a formal legal requirement that can only be undertaken by a medical practitioner. There are specific guidelines to

be followed and what I'd like to try and get is an explanation from you as to your understanding of what was required of you in the completion of this process. Now I have in front of me the Medical Certificate Of Cause Of Death for Geoffrey PACKMAN. We'll have to give that an identification reference I believe won't we?

DC Code A — Yeah. The next one will be 22.

DC — So it's CSY/HF/22. Can you see this doctor?

BARTON — (Silence)

DC Code A — Who completed this Death Certificate with regard to Geoffrey PACKMAN?

BARTON — No comment.

DC Code A — (Pause) At the bottom of this certificate doctor is a, well there is a certificate saying: "I hereby certify that I was in medical attendance during the above named deceased's last illness and that the particulars and cause of death above written are true to the best of my knowledge and belief." And it has a signature; can I ask you to confirm if that is your signature?

BARTON — (Pause) Yes.

DC Code A — And underneath is written J. A. BARTON with your address. And the cause of death, which took place on the

3rd of September 1999 (03/09/1999) has been recorded as 'myocardial infarction' and the approximate interval between the onset of this illness and death you recorded as five days. Is that correct?

BARTON No comment.

DC Code A (Coughs) What procedure did you follow when certifying or recording the death of this patient?

BARTON No comment.

DC Code A What procedure did you follow in certifying or recording the death of any patient?

BARTON No comment.

DC Code A Who informed the registrar or coroner?

BARTON No comment.

DC Code A Who decided the cause of death?

BARTON No comment.

DC Code A Why was the death recorded as myocardial infarction?

BARTON No comment.

DC Code A (Pause)

For the benefit of the tape DCs Code A and Code A talk between themselves, which is inaudible.

DC Code A — Isn't that right doctor that this process should be carried out by the consultants or senior clinician?

BARTON — No comment.

DC Code A — Why were you completing the certificates?

BARTON — No comment.

DC Code A — (Pause) Here on this certificate there doctor it states that 'a post-mortem was not being held and the patient was seen after death by you'.

For the benefit of the tape, DCs Code A and Code A talk between themselves, which is inaudible.

DC Code A — Supervision doctor, and this gives you an opportunity to explain how the line management operated at the hospital and whether the supervision that you were provided with was efficient. What supervision were you given or provided with in respect of the care of Geoffrey PACKMAN?

BARTON — No comment.

DC Code A — Were you happy with the level of supervision?

BARTON No comment.

DC Code A Were you happy with the training that you had been provided with in order to care for patients whilst a Clinical Assistant at the War Memorial Hospital?

BARTON No comment.

DC Code A If there were any deficiencies what were they?

BARTON No comment.

DC Code A If there were any deficiencies how did you try to address them?

BARTON No comment.

DC Code A At the time of Mr PACKMAN's admission to the Gosport War Memorial Hospital, did you have any concerns regarding your personal workload?

BARTON No comment.

DC Code A How would you report whether you had any concerns regarding staff or workload issues?

BARTON No comment.

DC Code A What concerns, if any, did you have about the Gosport War

	Memorial Hospital at this time?
BARTON	No comment.
DC Code A	What training, in respect of any issues whether they were medical or pharmaceutical, did you raise in (inaudible due to banging in background)?
BARTON	No comment.
DC Code A	Who was your line manager?
BARTON	No comment.
DC Code A	And who did you supervise yourself?
BARTON	No comment.
DC Code A	What would have been the correct route for you to take if you had any concerns about the level of supervision at that hospital?
BARTON	No comment.
DC Code A	Did you have an appraisal system in operation there?
BARTON	No comment.
DC Code A	How was your contract renewed at GWMH?

BARTON No comment.

DC Code A Did you have, if you had an appraisal system or something like that, did you have the opportunity to discuss with your supervisors your role, how things were going etcetera?

BARTON No comment.

DC Code A Did you, in any way; discuss your role and how it was going with any supervisors?

BARTON No comment.

DC Code A Did you have any concerns about the way your role was going?

BARTON No comment.

DC Code A You've already discussed previously, I believe, your (clears throat) role at the hospital and how things had not significantly changed from you starting there. In actual fact I think I was able to show you that the number of beds had decreased in the late '90s compared to the number that you were expected to supervise and be responsible for when you first took the role up, and yet you say in your first 'prepared statement' that 'things were getting too much'. Did you discuss that with anybody there at the hospital?

BARTON No comment.

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DC Code A	Do you think that it had an impact on your ability to do your job at the hospital...
BARTON	No comment.
DC Code A	...sufficiently?
BARTON	No comment.
DC Code A	Efficiently?
BARTON	No comment.
DC Code A	Professionally?
BARTON	No comment.
DC Code A	Competently?
BARTON	No comment.
DC Code A	Adequately?
BARTON	No comment.
DC Code A	Code A?
DC Code A	No.

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DC Code A

What I'll do now is to try and take you chronologically through the Medical Records for the period that Mr PACKMAN was on Dryad Ward. And probably the most simple place to start is with Page 54 and this is the initial assessments or clerking by Doctor RAVINDRANE. Now the clerking doctor noted that Mr PACKMAN's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. It was noted that Mr PACKMAN was 'on a high protein diet, queried melaena which was on the 13th of August 1999 (13/08/1999), his haemoglobin was stable, he was better in himself with a good mental test score and no pain. There was little to find here on this doctor, Page 54 which is in front of you if you want to examine it, that there was anything wrong with Mr PACKMAN bar obesity, the swollen legs and pressure sores. Do you agree?

BARTON

No comment.

DC Code A

We can move on possibly to the nursing notes now on Page 62. Do feel free doctor to have a look at any of these pages if you wish. Now they record that Mr PACKMAN was transferred from Ann Ward, I think it's at the Queen Alexandra Hospital following an episode of immobility and (inaudible sounds like sickle) sores, he was catherised, on a profile bed hoist only, able to feed himself and Mrs PACKMAN is waiting decision (inaudible) at the QA Hospital tomorrow'. Now several nursing plans, or Nursing Care Plans were produced, Page 78, Page 82, Page 84, Page 96 and these plans were for his immobility, in fact

he was prone to constipation. There was a care plan for the urinary catheter. Another care plan for the pressure sore areas. Who instigated these care plans?

BARTON — No comment.

DC Code A — If the nursing staff had these care plans, whose directions were they following?

BARTON — No comment.

DC Code A — (Pause) I think it's Page 170, which is a Drug Chart, that reveals he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day, (inaudible – Clexane?) 40 milligrams twice a day, Paracetamol 1 gram, or 1g four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, which is a laxative and that was subsequently taken intermittently and as required Gaviscon. So that was the drugs that he was taking on the 23rd of August. So where doctor, when you look at the Nursing Care Plans, you look at the clerking, you look at the medication, where does it say that there is anything wrong with Mr PACKMAN bar his obesity, swollen legs and pressure sores?

BARTON — No comment.

DC Code A — (Pause) On the 24th of August Mrs, this is quite interesting, on Page 90 is a handling profile (pause) and in this section for pain it is noted 'pain needs to be controlled'. Now this

is at odds with the medical notes, or the clerking, where it says that 'there was no pain'. Can you explain how this entry came to be?

BARTON — No comment.

DC Code A — Pain is not mentioned anywhere else. 'His bowels were well open, there's no melaena specified and swabs were taken from his pressure sores from Microbiology'. (Pause) Right Page 207 (pause) should be a blood test result. The blood test revealed a haemoglobin of 12 grams/DL. The white cell count was 12.2x10 (inaudible – mumbles), it's on Page 207. Have you got that?

DC Code A — Yeah.

DC — What does that mean?

BARTON — No comment.

DC Code A — I think it also states that 'there's a marginally (inaudible) of 8.9 and a reduced albumin'. Now both these forms had been signed just there doctor J.A.B. Is that your initials?

BARTON — No comment.

For the benefit of the tape DCs Code A and Code A talk between themselves, which is inaudible.

DC Code A — Page 190 of the Medical Records doctor is (pause) a

Biochemistry Report authorised on the 26th of August 1999. Again there is the initials of J.A.B. written there. Is that your initials?

BARTON — No comment.

DC Code A — I am going to hold it up in front of you doctor so that you can see it.

BARTON — No comment.

DC Code A — Doctor would a doctor initial these reports to say that he or she had seen the results?

BARTON — No comment.

DC Code A — What would those results indicate to you?

BARTON — No comment.

DC Code A — Do you want to say anything Code A?

DC Code A — Why do doctors initial those reports Doctor BARTON?

BARTON — No comment.

DC Code A — Is it not to acknowledge that they have seen the report?

BARTON — No comment.

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DC Code A

(Pause) On the 25th of August doctor Mr PACKMAN was noted to have bowels open, melaena formed, leaking some fluid and later several loose bowel actions throughout the afternoon and evening, some fresh blood present, query due to medication, (inaudible) stopped to review later'. That's Pages 82 and 83. (Pause) Now the 'nursing summary notes' record that 'Mr PACKMAN had been passing fresh blood and queried. Was it due to the (inaudible) or the Clexane? And a verbal order from Doctor BEASLEY was to withhold the six o'clock in the evening dose and review with Doctor BARTON in the morning'. Did you review this the next morning?

BARTON

No comment.

DC Code A

Page 171 says that 'Mr PACKMAN was also vomiting and Metoclopramide, 10 milligrams, was given at five-to-six (1755) in the evening. Mr PACKMAN was taking Temazepam 20 milligrams at five-past-ten (2205) that night and Loperamide 4 milligrams, which I believe is for diarrhoea as a one off dose' and it's a time that I can't quite work out I must admit, it's on Page 168. (Pause) On the 26th of August the 'nursing summary notes' record 'a fairly good morning, no further vomiting. Doctor RAVI contacted re' (inaudible) or the Clexane and advised to discontinue and will repeat haemoglobin today and tomorrow, not for resuscitation, unwell at lunchtime, colour poor, complaining of feeling unwell. (Pause sounds like door being shut) This was seen by Doctor BARTON this afternoon, await result of haemoglobin, further

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deterioration complaining, query indigestion, pain in throat, not radiating, vomited again this evening'. Now verbal order from Doctor BARTON 'Diamorphine 10 milligrams stat', which was given at six o'clock that evening. Did you see Mr PACKMAN on the 26th of August in the afternoon?

BARTON — No comment.

DC Code A — What were you expecting from the results of the haemoglobin?

BARTON — No comment.

DC Code A — Why did you give the verbal order for Diamorphine?

BARTON — No comment.

DC Code A — Again on Page 55 I think it is, these should be your notes I think.

DC — Yeah.

DC — 'Called to see pale, clammy, unwell. Suggest query myocardial infarction. Treat stat Diamorphine and Oramorph overnight. Alternative possibility gastro intestinal bleed, or GI bleed, but no haematemisis'. What made you think that it was possibly a myocardial infarction doctor?

BARTON — No comment.

DC Code A	What is a myocardial infarction?
BARTON	No comment.
DC Code A	Did Mr PACKMAN have any previous medical history of myocardial infarction?
BARTON	No comment.
DC Code A	If Mr PACKMAN had suffered a myocardial infarction, what benefits would 10 milligrams of Diamorphine be?
BARTON	No comment.
DC Code A	(Pause) You've got 'suggest query myocardial infarction'. Does that mean it was just a possibility it was a mycocardial infarction?
BARTON	No comment.
DC Code A	The same with the 'alternative a possibility of a GI bleed'. With those two possible diagnoses, what did you do to treat Mr PACKMAN?
BARTON	No comment.
DC Code A	You also state 'he was not well enough to transfer to an acute unit, keep comfortable and I am happy for nursing staff to confirm death'. (Pause) Have you got any

questions on that Geoff?

DC Code A — My understanding doctor is that when a doctor puts a question mark in front of something, that is because something has happened to the patient that leads that person to believe that whatever follows the question mark may be occurring or may have occurred. Is that right?

BARTON — No comment.

DC Code A — The fact that you put the question mark in front of myocardial infarction and then queried the gastro internal bleed in the case that you felt that that's what might be happening to Mr PACKMAN, is that right?

BARTON — No comment.

DC Code A — Now presumably a doctor wouldn't just think 'the person might be having this, the person might be having that' and then not do something to find out whether that person was having this or that. Is that right?

BARTON — No comment.

DC Code A — What investigations did you then commence to find out what that patient, Mr PACKMAN, was suffering from?

BARTON — No comment.

DC Code A — All right that takes us up to the 26th where you're queering

the myocardial infarction or a GI bleed. What I am going to do then is just take you to some of the questions around your 'prepared statement'. (Pause) Geoff have you got a calendar? (Pause) Have you got an identification reference?

DC Code A

CSY/HF/23.

DC

Thank you. Paragraph (3) of your statement doctor, I can see you have it in front of you, in that statement (clears throat) 'I indicated when I'd first taken up the post the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was, in effect, left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the GWMH in 1998. I confirm that these comments are indeed a fair and accurate summary of the position then though, if anything, it had become even more difficult by 1999 when I was involved in the care of Mr PACKMAN'. Geoff do you want to...

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DOCUMENT RECORD PRINT

BARTON — No comment.

DC Code A — Yeah, okay. Doctor so we look at this exhibit, which we're calling now CSY/HF/23, and it's a printout of the calendar months for August and September of 1999 and you can see from that that I'm showing you look that on the 23rd of August Geoffrey PACKMAN was admitted to the ward, Dryad Ward, and on the 24th you made an entry on his records, on the 26th sorry not the 24th you made an entry didn't you on his records and you made entries into, I can't remember what the 24th was Chris, do you know what it was?

BARTON — No comment.

DC Code A — Yes on the Drug Chart.

BARTON — No comment.

DC Code A — On the Drug Chart that's right. But in the main records you've only made two entries, the 26th and the 28th, the 28th being a Saturday. Now going on your previous history of what you've told us and what we've worked out of your daily routines, if we count out the number of days Mr PACKMAN was in hospital, at your hospital, he came in on the 23rd, one, two, three, four, five, six, seven, eight, nine, ten, he was in for ten days in total. Now you say that 'you visited the hospital three times a day maximum, so that makes a total of thirty possible visits doesn't it? Thirty possible times you could have seen Mr PACKMAN given

that you think on the 26th, as early as the 26th you think he's possibly had a myocardial infarction or a GI bleed. You only have one other visit to him after that recorded. Is that right?

BARTON — No comment.

DC Code A — How can you account for the fact that despite this man being go gravely ill that you have recommended the nurses to, or happy for them to confirm death. You've got no entries, very relative entries, very few entries in the notes, only two in his medical notes (somebody coughs) the 26th and the 28th. Can you explain that doctor?

BARTON — No comment.

DC Code A — Explain, can you explain to us what the Speciality History sheet is for then?

BARTON — No comment.

DC Code A — (Pause) Well can you tell us which of those days from the 23rd up to his death on the 3rd of September, can you tell us which of those days you were not available for?

BARTON — No comment.

DC Code A — You say in your statement that 'the pressure is put on you on how busy you were and had become considerable in 1999'. The Dryad Ward Admissions book, which is

BJC/89, which I will put in front of you, it shows quite clearly that between the 17th of August 1999 (17/08/1999) and the 31st of August 1999 (31/08/1999), that's fourteen days, two patients were admitted to that ward Mr PACKMAN and a Margaret MORRIS. Now I accept that the other beds may be full, but you had two new admissions. Now part of your Job Description says that 'you must see new admissions'. Is that correct?

BARTON — No comment.

DC Code A — Does that register indicate that that was a busy time?

BARTON — No comment.

DC Code A — (Pause) It doesn't seem to doctor, or you tell us otherwise?

BARTON — No comment.

DC Code A — (Pause) The last patient before Mr PACKMAN was almost a week before. Is that right?

BARTON — No comment.

DC Code A — And the next patient after Mr PACKMAN was the day after. (Pause) Is that right?

BARTON — No comment.

DC Code A — And does that represent a really busy time at the hospital

for you...

BARTON — No comment.

DC Code A — ...compared to other times?

BARTON — No comment.

DC Code A — You see Paragraph (22) in your statement says that 'you state that you anticipate that you would have reviewed Mr PACKMAN on the basis that you prescribed drugs for him on the 24th of August, that's Page 168 of your medical notes. Now you state in your generic statement on pages 3 and 4 that 'you visited patients every day and you would admit and write up charts etcetera. In addition you'd return to the hospital every evening to continue with these duties'. DC Code A is just showing you the calendar there, why then did it take you three days to make an entry in Mr PACKMAN's medical notes?

BARTON — No comment.

DC Code A — Why isn't there any reference to his general condition, or comment re.: care plans or drugs?

BARTON — No comment.

DC Code A — Let me take you back doctor to Paragraphs (12) and (13) of your statement. Paragraphs (4) to (11) are pretty much Mr PACKMAN's previous medical history, so if we go to

Paragraph (12) 'it was also noted on the 6th of August that in view of pre-morbid state/multiple medical problems, Mr PACKMAN was not for CPR in event of arrest. A Barthel score was stated to have been assessed on the 5th of August (presumably the 6th of August in error) was recorded as zero, indicating that Mr PACKMAN was completely dependent'. Paragraph (13) 'Mr PACKMAN was reviewed by the specialist registrar the following day, 7th of August, who agreed, presumably on the basis of what was felt to be Mr PACKMAN's poor condition at that stage, that he was not to be resuscitated in the event of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it caused dehydration. Mr PACKMAN was given Flucloxacillin 500 milligrams 4 times daily, supplemented by Penicillin 500 milligrams four times a day to combat the cellulites'. Now this cardiac arrest and resus policy, I think we spoke about this earlier on this morning, what is the resus policy, or not for resus policy?

BARTON — No comment.

DC Code A — Am I right in thinking that should somebody have a heart attack, or stop breathing, then for those purposes they're not for resuscitation?

BARTON — No comment.

DC Code A — What about any illnesses they may have, should you still be treating those?

BARTON — No comment.

DC Code A — I mean Paragraph (19) 'an entry in Mr PACKMAN's records for 20th of August by the specialist registrar indicates that Mr PACKMAN was due for transfer to the Gosport War Memorial Hospital on the 23rd of August. The Specialist Registrar also noted that Mr PACKMAN remained not for resuscitation. A Barthel score measured on the 21st of August again recorded a score of zero indicating his complete dependence'. Yet on his arrival at the Gosport War Memorial Hospital it was six. Was that not an improvement?

BARTON — No comment.

DC Code A — Any questions Code A

DC — No.

DC — The tape is about to come to an end so the time is 1359 hours, I am going to turn the recorder off.

INTERVIEW CONCLUDED. TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AL

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1121 Time concluded: 1155

Duration of interview: 34 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This is a continuation of the interview with Doctor BARTON. I am DC Code A the other officer present is?
DC Code A	DC Code A
DC Code A	Thank you. The time by my watch is 1121 hours. The last tape finished before we could actually give an end time and that was 1116 hours that the last tape ended. It's just really

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been a change over of tapes. Doctor can you confirm it's the same people in the room?

BARTON — I can.

DC Code A — Would you care to confirm whether there's been any conversation about this matter while the tapes have been off?

BARTON — None at all.

DC Code A — Okay doctor. I must still remind you that you are still under caution. We were talking about Midazolam weren't we?

BARTON — (Silent)

DC Code A — Right. What is the purpose doctor of prescribing a range of parameters for the administration of this drug, Midazolam, i.e. 20 – 80 milligrams?

BARTON — No comment.

DC Code A — Is this what is known as 'proactive prescribing'?

BARTON — No comment.

DC Code A — Why doctor did you prescribe a range of this drug to Mr PACKMAN?

BARTON	No comment.
DC Code A	How would the nurses know where to start within this range?
BARTON	No comment.
DC Code A	Where is it recorded within the medical notes your prescribing instructions to the nurses as to why, when and by how much the dose can be altered within this range?
BARTON	No comment.
DC Code A	And by whom?
BARTON	No comment.
DC Code A	How would a nurse know why to alter the dose?
BARTON	No comment.
DC Code A	How would a nurse know when to alter the dose?
BARTON	No comment.
DC Code A	And very importantly, how would a nurse know how much to alter the dose by?
BARTON	No comment.

DC Code A	Doctor would you expect to see an entry in the notes as to the justification for this drug being administered?
BARTON	No comment.
DC Code A	What safe guards were in place to ensure that Mr PACKMAN did not receive an excessive dose of Midazolam?
BARTON	No comment.
DC Code A	What part did the Wessex Protocols play in the prescription of Midazolam?
BARTON	No comment.
DC Code A	Did they play any part at all?
BARTON	No comment.
DC Code A	(Pause) Why didn't you follow the guidelines for the prescription of Midazolam, i.e. arrange starting at 5 milligrams a day?
BARTON	No comment.
DC Code A	Code A?
DC	No.

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DOCUMENT RECORD PRINT

DC Code A	Doctor Diamorphine. What is Diamorphine?
BARTON	No comment.
DC Code A	Why is Diamorphine used?
BARTON	No comment.
DC Code A	(Interference on tape) What kinds of analgesics are normally used (inaudible interference on tape) Diamorphine?
BARTON	No comment.
DC Code A	Where does Diamorphine fit within the Analgesic Ladder?
BARTON	No comment.
DC Code A	Why didn't you record what the purpose was for Diamorphine on the records?
BARTON	No comment.
DC Code A	Why was the Diamorphine written up to 200 milligrams?
BARTON	No comment.
DC Code A	Would you have allowed a nurse to administer this much without you reviewing the patient?

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DOCUMENT RECORD PRINT

BARTON No comment.

DC Code A How would you stop this happening?

BARTON No comment.

DC Code A Why was a Proactive Prescribing Policy needed if you were seeing the patients every day?

BARTON No comment.

DC Code A (Pause) In your Job Description, GJQ/HF/14, your very first duty is 'to visit the units on a regular basis and to be available on call as necessary'. If you complied with this duty, what was the necessity for proactive prescribing?

BARTON No comment.

DC Code A Duty (4) to be responsible for the writing up of initial case notes and to ensure that follow-up notes are kept up to date and reviewed regularly. Why haven't you performed this duty doctor?

BARTON No comment.

DC Code A Where is it recorded, bearing in mind that duty, on how much the nurses can increase the dosage of any drug when arranged as prescribed?

BARTON No comment.

RESTRICTED

DC Code A	(Coughs) (Pause) What checks and valve safes were put in place to prevent overdosing?
BARTON	No comment.
DC Code A	(Pause) Why was Diamorphine prescribed to Mr PACKMAN?
BARTON	No comment.
DC Code A	Is it normal to prescribe Diamorphine as a required drug?
BARTON	No comment.
DC Code A	Was Mr PACKMAN in his terminal phase in your view?
BARTON	No comment.
DC Code A	How was he diagnosed as being in need of Diamorphine?
BARTON	No comment.
DC Code A	How would you decide how much Diamorphine to prescribe?
BARTON	No comment.
DC Code A	What is the purpose of prescribing a range of parameters for the administration of a drug, i.e. 20 – 80 milligrams?

RESTRICTED

BARTON	No comment.
DC Code A	And why did you prescribe a range of this drug to Mr PACKMAN?
BARTON	No comment.
DC Code A	And very importantly, how would the nurses know where to start within this range?
BARTON	No comment.
DC Code A	(Pause) Where is it recorded then within the medical notes the prescribing instructions to the nurses as to why, when and by how much that those can be altered within this range and by whom?
BARTON	No comment.
DC Code A	Would you expect to see an entry in the notes as to the justification for this drug being administered?
BARTON	No comment.
DC Code A	What would you consider to be an excessive dose of Diamorphine for Mr PACKMAN?
BARTON	No comment.

RESTRICTED

DC Code A	What safeguards were in place to ensure that Mr PACKMAN did not receive an excessive dose of Diamorphine?
BARTON	No comment.
DC Code A	What part did the Wessex Protocols play in the prescription of Diamorphine?
BARTON	No comment.
DC Code A	That's that little book that's already been produced on the table doctor. Did it play any role at all?
BARTON	No comment.
DC Code A	Why didn't you follow the guidelines for the prescription of Diamorphine, i.e. arrange starting it at 10 milligrams a day?
BARTON	No comment.
DC Code A	(Pause) Did you ever seek advice from anyone regarding your prescribing regime in respect of Mr PACKMAN?
BARTON	No comment.
DC Code A	Why didn't you?
BARTON	No comment.

RESTRICTED

DC Code A	(Coughs) How do you know that you're prescribing regime did not lead to a worsening of Mr PACKMAN'S condition?
BARTON	No comment.
DC Code A	Where is the reasoning behind this recorded?
BARTON	No comment.
DC Code A	Why wasn't this recorded?
BARTON	No comment.
DC Code A	Doctor there's no justification documented in the medical notes for the use of Diamorphine or Midazolam and the syringe driver, why is that?
BARTON	No comment.
DC Code A	Why isn't there any record of an ongoing assessment?
BARTON	No comment.
DC Code A	There weren't any documentation notes to explain why Mr PACKMAN required increases in the doses of Diamorphine from 40 up to eventually 90 milligrams over a three-day period.

BARTON No comment.

DC Code A When did you consider that Mr PACKMAN had entered the terminal phase of his life?

BARTON No comment.

DC Code A Why did you consider Mr PACKMAN had entered the terminal phase of his life?

BARTON No comment.

DC Code A What change had taken place of Mr PACKMAN for you to reach this conclusion?

BARTON No comment.

DC Code A Where did you record this (coughs)?

BARTON No comment.

DC Code A Were you qualified to make this diagnoses doctor?

BARTON No comment.

DC Code A Were you qualified to diagnose and provide palliative care to Mr PACKMAN?

BARTON No comment.

DC Code A — Was that your responsibility?

BARTON — No comment.

DC Code A — Did you refer these decisions to a consultant?

BARTON — No comment.

DC Code A — Did you ever refer to a consultant?

BARTON — No comment.

DC Code A — Code A

DC — Yeah. Regarding the lack of notes on on-going assessment, I think it's quite appropriate with analgesics, but particularly with Diamorphine, which is, is that the strongest one you can prescribe doctor?

BARTON — No comment.

DC Code A — Don't you have a duty to regularly review that (somebody coughs) dosage on the patients?

BARTON — No comment.

DC Code A — Because otherwise how do you know what effect it's having on them?

BARTON — No comment.

DC Code A	Did you ever go back to him to find out whether the Diamorphine was having a good effect,...
BARTON	No comment.
DC Code A	...or bad effect?
BARTON	No comment.
DC Code A	Did you ever check him for his, do that simple pupil check that I understand some doctors do...
BARTON	No comment.
DC Code A	...whereby you can state, you can see from the state of the pupils whether the Diamorphine is having the right effect, or too much effect, i.e. if it makes them drowsy?
BARTON	No comment.
DC Code A	Well let's go back then to (pause) when you originally prescribed to him... Can I just take the BNF?
DC Code A	Yeah it's here.
DC Code A	Does, in the BNF, tell me if I'm reading it right, I would like you to have a look at it, does it not indicate that 'you should start at 5 milligrams of Diamorphine subcutaneously'?

BARTON	No comment.
DC Code A	Because he was on 10 milligrams of Oramorph wasn't he?
BARTON	No comment.
DC Code A	But the starting dose in the syringe driver was 40 wasn't it?
BARTON	No comment.
DC Code A	Well you prescribed it...
BARTON	No comment.
DC Code A	...and you apparently authorised it.
BARTON	No comment.
DC Code A	Well I'll tell you then it started at 40 on your prescription and apparently on your authorisation. Is that right?
BARTON	No comment.
DC Code A	Or are you saying that a nurse has now administered that without authority?
BARTON	No comment.

DC Code A — Well let me show you, this is a blow up from the Prescribing For The Elderly, which is in the BNF, and you will see on there that for the Morphine Sulphate 10 milligrams every four hours. If you go across it goes to 20 milligrams of Diamorphine. Well you didn't even start there did you, I asked you just now 'why didn't you start at 5 milligrams?', or suggested you could have done, but you don't start there you go right to 40. So if I show you that and I'll introduce that as GJQ/HF/21, if I show you that you can see that that's quite a dramatic jump isn't it?

BARTON — No comment.

DC Code A — Not only is it a dramatic jump to 40, so it looks as if it is completely out of the guidelines, is that right?

BARTON — No comment.

DC Code A — I'm just wondering why Morphine Sulphate wasn't used because you've missed that.

BARTON — No comment.

DC Code A — Now let's just go back to the 10 milligrams of Morphine - yes? And let's just think about the date when you prescribed the Diamorphine (somebody coughs), because if you look at the prescription charts on Page 171 you'll see that you prescribed the Diamorphine 40 – 200, again in a huge range on the 26th and at that stage you had also prescribed the Oramorph 10 – 20 so you didn't, presumably

that was arranged where you're authorising the nurses to administer up to 20 milligrams of Oramorph. Is that right or wrong?

BARTON — No comment.

DC Code A — Going on your prescription, would the nurse have been wrong to give Geoffrey PACKMAN 20 milligrams of Oramorph?

BARTON — No comment.

DC Code A — That was on the 26th and that was the same day that you authorised the Diamorphine.

BARTON — No comment.

DC Code A — So how did you know what the correct dose of Diamorphine would be before he had even started on that Oramorph prescription...

BARTON — No comment.

DC Code A — ...because that was a variable range wasn't it according your prescription?

BARTON — No comment.

DC Code A — Well we've told you doctor this is your opportunity to tell us things if we've got the wrong end of the stick and so we

repeat: "This is your opportunity to tell us." What was the thinking behind that?

BARTON — No comment.

DC Code A — Because how do you know what his requirement would be in terms of Diamorphine before you had given the Oramorph its chance?

BARTON — No comment.

DC Code A — Well I'll take you back to when the Diamorphine was started on the subcutaneous dosage. Did you authorise the commencement of the syringe driver?

BARTON — No comment.

DC Code A — Did you need to authorise the commencement of a syringe driver?

BARTON — No comment.

DC Code A — (Pause) If a nurse lets, for arguments sake you are in the hospital at the time, could a nurse start that syringe driver of her own accord?

BARTON — No comment.

DC Code A — A significant factor in the treatment of Geoffrey PACKMAN is just about to start. Should that nurse have contacted you?

BARTON — No comment.

DC Code A — Did that nurse contact you?

BARTON — No comment.

DC Code A — If the nurse had contacted you, should that be recorded?

BARTON — No comment.

DC Code A — Well I suggest it should have done, it should have been recorded by the nurse shouldn't it?

BARTON — No comment.

DC Code A — And then it should have been recorded by you.

BARTON — No comment.

DC Code A — Well why wasn't it recorded by you?

BARTON — No comment.

DC Code A — It wasn't recorded by the nurse either was it?

BARTON — No comment.

DC Code A — She said that 'she started the syringe driver', but she doesn't say in her note that she's had a conversation with yourself, or any other doctor come to that.

BARTON — No comment.

DC Code A — In fact it's for that doctor, in your own prepared statement you wrote: "I anticipate that the nursing staff would have liaised with me prior to commencing with the Diamorphine and Midazolam and that this would have been set up on my instruction directly if I had been at the hospital, or otherwise by phone," but you don't know do you?

BARTON — No comment.

DC Code A — Well given there's 'no comment' from you again doctor, I am now thinking along the lines that what about this for something that may have happened? The nurse has started that syringe driver without your authority and a dose far exceeding the guidelines and using the table in the BNF. Is that what happened?

BARTON — No comment.

DC Code A — Would that explain why you did not make a record afterwards?

BARTON — No comment.

DC Code A	If that was the scenario and you came into the hospital and saw that Geoffrey PACKMAN had been started on a syringe driver without your authority and on too high a dose range, what could you have done? What were your options?
BARTON	No comment.
DC Code A	Could you have made an entry in the nursing notes, in the medical notes saying 'a mistake had been made'?
BARTON	No comment.
DC Code A	Could you have stopped the syringe driver?
BARTON	No comment.
DC Code A	We've already seen that he was able to eat and drink and take oral medicine, so could you have gone a different route and changed his medication?
BARTON	No comment.
DC Code A	Were you covering up for Sister HAMBLIN Doctor REID, Doctor BARTON?
BARTON	No comment.

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DC Code A — Do you think that you and Sister HAMBLIN, at this time, followed the guidelines and the procedures correctly?

BARTON — No comment.

DC Code A — (Pause) Doctor if I can take you back to Page 54, Page 55 of these notes (pause), it will be Page 55, the Medical Records, PJC/34, your very first entry on the 26th of August 1999 (26/08/1999), the very last line of that entry which was signed by you doctor. Can you confirm that?

BARTON — Confirmed.

DC Code A — "I am happy for nursing staff to confirm death." What does that mean doctor?

BARTON — No comment.

DC Code A — And why is it recorded there?

BARTON — No comment.

DC Code A — Is there a difference between confirming and verifying and certifying death?

BARTON — No comment.

DC Code A — If there are, what are the differences?

BARTON — No comment.

RESTRICTED

DC Code A — And what was the normal practice to be followed by nurses upon the death of a patient?

BARTON — No comment.

DC Code A — And why is this statement written a number of days prior to Mr PACKMAN's death?

BARTON — No comment.

DC Code A — In fact this statement was written on the 26th of August doctor, Mr PACKMAN didn't die until the 3rd of September, it's a week. More is the point that this will appear, as far as the notes are concerned, the clinical notes, in your first interaction with Mr PACKMAN, the previous note on the 23rd of August said: "No pain," and then yours he is almost written off: "I am happy for nursing staff to confirm death." Why would that be written that early on?

BARTON — No comment.

DC Code A — Code A

BARTON — No comment.

DC Code A — (Pause) Doctor when you wrote: "Happy for staff to confirm death," what brought you to the conclusion, what were the inferences on you that led you to that conclusion to write that?

BARTON	No comment.
DC Code A	You clearly felt that he was dying, or could die. Is that correct?
BARTON	No comment.
DC Code A	And possibly when you're not in the hospital. Is that correct?
BARTON	No comment.
DC Code A	What were you aware of when he had his treatment at the QA Hospital?
BARTON	No comment.
DC Code A	Well we know that Doctor RAVINDRANE had obviously read the notes because of his clerking-in of Mr PACKMAN on the day he came in on the 23rd, and in those notes at the QA he had been written up, at least once, 'not for resus'. Were you aware of that?
BARTON	No comment.
DC Code A	Did that influence you in writing: "Happy for staff to confirm death."?
BARTON	No comment.

DC Code A	What is your understanding of that term 'not for resus'?
BARTON	No comment.
DC Code A	Well to put it crudely it doesn't mean 'to let the patient die' does it?
BARTON	No comment.
DC Code A	My understanding is that if the patient would say fall into cardiac arrest, something along those lines, he would not be considered for resuscitation in that circumstance, is that right?
BARTON	No comment.
DC Code A	(Somebody coughs) So did that term influence you when you wrote that?
BARTON	No comment.
DC Code A	Well what made you write it then?
BARTON	No comment.
DC Code A	What did you feel he was dying from?
BARTON	No comment.

DC Code A — What were the signs of him dying?

BARTON — No comment.

DC Code A — Okay Code A

DC Code A — (Pause) I'm going to do a bit more on that. (Pause) 'Not for resuscitation', paragraph 25 of your statement. 'It was my impression that when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to the (inaudible) was quite inappropriate. Any such transfer was very likely to have had a further serious effect on his health'. So you're saying in your statement that you were influenced by previous decisions that he was not for resuscitation. Is that correct doctor?

BARTON — No comment.

DC Code A — The meaning of 'not for resuscitation' is quite specific isn't it? I believe a medical judgement has been made that 'in the event of the patient's heart or breathing stopping unexpectedly, cardio respiratory arrest, there is little or not chance of cardiopulmonary resuscitation being successful, that is it being medically futile and should not be attempted. This is usually on a background of a progressive life threatening illness or other significant medical problems'. What was Mr PACKMAN's progressive life threatening illness?

BARTON | No comment.

DC Code A | And the status of 'not for resuscitation', that does not mean that the patient is automatically excluded from receiving appropriate treatment for other medical problems that may arise. I mean even patients that are suffering from really advanced cancer who may be admitted seriously unwell with an infection, they would be treated for the infection wouldn't they doctor?

BARTON | No comment.

DC Code A | (Pause) I find it (clears throat) hard with the medical notes as they are that on Page 54 Doctor RAVINDRANE is saying 'his mental score is very good, he's better in himself, there's no pain' and that's on the 23rd of August, and on the 26th of August you're writing him off doctor aren't you?

BARTON | No comment.

DC Code A | Code A?

DC Code A | That's quite a line there doctor. Had you given up hope of saving Mr PACKMAN's life...

BARTON | No comment.

DC Code A | ...at that stage?

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DOCUMENT RECORD PRINT

BARTON	(Silent)
DC Code A	At that stage doctor?
BARTON	No comment.
DC Code A	(Pause) But what was his progressive life threatening illness?
BARTON	No comment.
DC Code A	Obesity, arthritis in both knees, immobility, pressure sores? I just don't see the life threatening illness so far? Cellulitis. (Pause) (Clears throat) (Inaudible – mumbles).
DC Code A	Yeah.
DC	I don't want to move on to, if we start something else we'll probably get into too big a subject,...
DC	Yeah sure.
DC	...so I think now would be a good time to actually end this interview and take a lunchtime break shall we say, okay. Is there anything you wish to clarify doctor?
BARTON	No thank you.
DC Code A	Is there anything you wish to add?

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BARTON No thank you.

DC Code A Okay. As I said before I'll give you the notice explaining what will happen to the tapes at the end of the whole process. The time is now 1155 hours and we will turn the recorder off.

INTERVIEW CONCLUDED - TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AK

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1034 Time concluded: 1116

Duration of interview: 42 MINUTES Tape reference nos.

(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This interview is being tape recorded I am DC Code A Code A and my colleague is?
DC Code A	DC Code A
DC Code A	I am interviewing Doctor Jane BARTON. Doctor will you please give your full name and your dated of birth?
BARTON	Jane Ann BARTON 19/10/48.
DC Code A	Thank you.

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BARTON	Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself and your full name?
BARKER	Yes certainly. I am Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.
DC Code A	Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1034 hours and the date is the 6th of April 2006 (06/04/2006). At the conclusion of the whole process I will give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?
BARTON	Fine thank you.
DC Code A	If at any time you do wish to stop the interview doctor to take legal advice just say and the interview will be stopped in order that you can do this.
BARTON	Thank you.
DC Code A	I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're free to do so okay.

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BARTON — Thank you.

DC Code A — I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention, when questioned, something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

BARTON — Thank you.

DC Code A — Is there any need for it to be broken down again this time?

BARTON — No thank you.

DC Code A — Okay. As I've said before on this occasion the room that we're in has been equipped with a monitoring facility. Whenever the red light is on that means that somebody is listening to the interview. Today Detective Inspector GROCOTT is monitoring the interview with the lights on. (Somebody clearing throat) Nobody can listen to any conversation in this room when those tapes aren't playing doctor okay. Right if I can just confirm doctor that we've had a quick comfort break, but there's been no conversation about this matter whilst the tape's been off.

BARTON — None at all.

DC Code A — Thank you. If I can doctor I'd like to move on to issues surrounding the pharmacy and that's the 'prescription and administration of controlled drugs', it's a specialist subject in it's own right and I seek an explanation now as to how

	you were involved in pharmaceutical prescriptions. I would also like to know your level of training and understanding of the drugs that you prescribed and their uses. How did you ensure doctor that you were up-to-date in the knowledge that you had in respect of pharmaceutical issues?
BARTON	No comment.
DC Code A	What pharmaceutical training had you received at the time of Mr PACKMAN's admission to hospital?
BARTON	No comment.
DC Code A	What further pharmaceutical training had you received since your initial qualifications?
BARTON	No comment.
DC Code A	How would you know what drugs to prescribe to a patient?
BARTON	No comment.
DC Code A	How would you learn about new drugs that are available for administration?
BARTON	No comment.
DC Code A	How would the pharmacy at the Gosport War Memorial Hospital work in relation to the availability or the suitability of medicines and drugs?

BARTON	No comment.
DC Code A	How many pharmacists worked at the Gosport War Memorial Hospital in 1999?
BARTON	No comment.
DC Code A	Doctor what is the BNF?
BARTON	No comment. (Somebody clears throat)
DC Code A	Have you got a reference number for this?
DC	CSY/HF/12.
DC Code A	Doctor I'll show you the BNF number 42, September 2001. Is this a book that you're familiar with?
BARTON	No comment.
DC Code A	I think I'll leave that on the desk should you wish to refer to it. A similar book, that's the other one, is the NPF, Nurse Prescribers Formulary, and that's got a reference of GJQ/HF/17, this one is dated 2002/2003 (inaudible). Is that a book that you're familiar with?
BARTON	No comment.
DC Code A	What is its purpose?

BARTON	No comment.
DC Code A	What is the purpose of the BNF?
BARTON	No comment.
DC Code A	How often would you refer to it?
BARTON	No comment.
DC Code A	And finally book wise GJQ/HF/18, which is the PCF, which is the Palliative Care Formulary. Is this a book that you are familiar with doctor?
BARTON	No comment.
DC Code A	What is the purpose of that book?
BARTON	No comment.
DC Code A	And how often would you refer to it?
BARTON	No comment.
DC Code A	(Coughs) Were any of the drugs used in the treatment of Mr PACKMAN new or seldom used?
BARTON	No comment.
DC Code A	What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients?

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DOCUMENT RECORD PRINT

BARTON — No comment.

DC — Have you got a copy of that one?

DC — Sorry which one?

DC — Wessex Protocols.

DC — (Pause) No I haven't got a copy or it would be here.

DC — No?

DC — No sorry.

Code A

DC — (Inaudible)

DC — (Pause)

DC — That's it. (Pause) Have you got a reference number? We're using that as a copy aren't we?

DC — Yeah, which is (pause) CSY/HF/3.

DC — Okay CSY/HF/3 is a copy of the Palliative Care handbook and I have one here, a photocopy, and it's actually a photocopy of this small book Advice On Clinical Management. Is this a book that you're familiar with doctor?

BARTON — No comment.

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DC Code A	It's referred to often as the Wessex Protocols, it's a book, it's the 5th addition, Advice On Clinical Management, but this one is Countess Mountbatten House, Southampton University Hospital NHS Trust. That is in association with all the Wessex Specialist Palliative Care Units. How often did you refer to this book?
BARTON	No comment.
DC Code A	(Pause) What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients doctor?
BARTON	No comment.
DC Code A	What pharmacy guidelines were available for prescribing the medicines within the Gosport War Memorial Hospital?
BARTON	No comment.
DC Code A	Where was the pharmacy at the Gosport War Memorial Hospital?
BARTON	No comment.
DC Code A	How accessible was the pharmacy?
BARTON	No comment.
DC Code A	What were the opening times of the pharmacy if any?

BARTON	No comment.
DC Code A	Code A?
DC Code A	Regarding the pharmaceutical side of things, did you not have a responsibility as a general practitioner to keep up-to-date with drugs administration and prescribing?
BARTON	No comment.
DC Code A	Do you get provided with training up dates regarding these matters?
BARTON	No comment.
DC Code A	Did you, at any stage, feel that you needed that sort of training?
BARTON	No comment.
DC Code A	Did you fully understand (pause) each drug that you were prescribing?
BARTON	No comment.
DC Code A	In other words did you feel confident that you understood what that drug would do and why you should prescribe it?
BARTON	No comment.
DC Code A	If you didn't, did you ever take steps to rectify that?

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BARTON	No comment.
DC Code A	Were steps available to you at the time?
BARTON	No comment.
DC Code A	Did you ever seek advice from anybody in relation to the prescribing of controlled drugs?
BARTON	No comment.
DC Code A	Were you confident in your ability to ensure that each patient had the correct drug for their needs?
BARTON	No comment.
DC Code A	Okay.
DC Code A	Going back to your Job Description, GJQ/HF/14. Duty number (8) was to prescribe, as required, drugs for the patients under the care of the consultant physicians in geriatric medicine. (Clears throat) So that was one of your duties. Would you not be duty bound to keep up-to-date?
BARTON	No comment.
DC Code A	Right. Prescriptions. Now prescribing medicines doctor there's a requirement to complete different parts of a Prescription Chart. Now what I want to do now is try and get an explanation as to how the 'clinical assistance' was

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DOCUMENT RECORD PRINT

involved in the prescription of medicines and what protocols you followed. Now could you please describe the process undertaken in the prescribing and administering of controlled drugs?

BARTON No comment.

DC Code A Have you got a reference for this?

DC Code A CSY/HF/10.

DC Code A And that identification refers to a (inaudible) in Gosport, an NHS Primary Care Trust Prescription sheet, which I am opening out for the doctor. Could I just take you through this chart and perhaps you can identify certainly if we have anything wrong. Once you open the document out there's three pages, there's an area on the top half of the first place, which is 'for once one and pre-medication drugs'. Who is responsible for completing that part of the form?

BARTON No comment.

DC Code A Under that is 'as required prescriptions', which there's a box for the approved name of the drug, the route that is to be taken, the dose, the date and the pharmacy and the signature of the doctor and the special directions, and next to that is the administration record, which I believe the nurses complete is that correct?

BARTON No comment.

DC Code A — Who is responsible for completing the left hand box on the 'as required prescription'?

BARTON — No comment.

DC Code A — Would that be a doctor?

BARTON — No comment.

DC Code A — Again on your actual Job Description, GJQ/HF/14, one of your duties is to prescribe 'as required drugs' for the patients under the care of the consultant physicians in geriatric medicine. So would it be fair for me to think, as you accepted the job as 'clinical assistant', that that was one of your responsibilities to complete these?

BARTON — No comment.

DC Code A — On the middle page, again the left hand side of it, it would appear for the doctors, that's for 'regular prescriptions'. Were you responsible for completing any of this?

BARTON — No comment.

DC Code A — And that goes on to the next page, and finally the 'daily review prescriptions', what are they?

BARTON — No comment.

DC Code A — Right on the back there's an area 'for nursing use only, exceptions to prescribed orders'. What is this used for?

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DOCUMENT RECORD PRINT

BARTON — No comment.

DC Code A — Is this completed by a nurse when, for some reason, a prescribed order hasn't been taken...

BARTON — No comment.

DC Code A — ...or has been refused by the patient?

BARTON — No comment.

DC Code A — Or even on occasions vomited?

BARTON — No comment.

DC Code A — (Pause) What was your prescribing policy doctor?

BARTON — No comment.

DC Code A — What medicines and drugs did you prescribe to Mr PACKMAN?

BARTON — No comment.

DC Code A — What is the difference between 'once only drugs', 'as required drugs' and 'regular drugs'?

BARTON — No comment.

DC Code A — (Pause) Why are ranges of drugs prescribed for patients?

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DOCUMENT RECORD PRINT

BARTON	No comment.
DC Code A	I'm just showing you a Prescription Chart, how do you think that Prescription Chart should be completed?
BARTON	No comment.
DC Code A	So what is a 'Proactive Prescribing Policy'?
BARTON	No comment.
DC Code A	Is this a policy where a range, quite often a large range of drugs is prescribed?
BARTON	No comment.
DC Code A	How did this policy come about?
BARTON	No comment.
DC Code A	What was its purpose?
BARTON	No comment.
DC Code A	Who authorised this policy?
BARTON	No comment.
DC Code A	Was this your policy we're describing?

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DOCUMENT RECORD PRINT

BARTON — No comment.

DC Code A — Where could I find this policy?

BARTON — No comment.

DC Code A — What is meant by 'telephone prescribing' doctor?

BARTON — No comment.

DC Code A — Am I right in thinking that 'telephone prescribing' would be a nurse phoning the doctor, the doctor making a prescription over the phone, the phone had been passed to a second nurse and the prescription repeated and then both nurses, or one of the nurses would make an entry on the record, countersigned by the second nurse and later signed by the doctor when the doctor comes in. Is that correct?

BARTON — No comment.

DC Code A — So what is the purpose of a doctor on call?

BARTON — No comment.

DC Code A — Is part of the purpose of a doctor on call to conduct telephone prescribing?

BARTON — No comment.

DC Code A — Is it also expected of a doctor on call to, if required, attend the hospital?

BARTON No comment.

DC Code A If there is a doctor on call, and if there is the availability of 'telephone prescribing', why was there 'proactive prescribing'?

BARTON No comment.

DC Code A What was the necessity of prescribing for such wide ranges of drugs?

BARTON No comment.

DC Code A Was 'telephone prescribing' a recommended form of prescribing drugs?

BARTON No comment.

DC Code A Was it something that you were encouraged to do?

BARTON No comment.

DC Code A Were you ever discouraged from doing it?

BARTON No comment.

DC Code A Did you do it frequently?

BARTON No comment.

DC Code A	(Pause) Did you try to avoid 'telephone prescribing'?
BARTON	No comment.
DC Code A	If you had a Proactive Policy, would that negate the need for anybody to phone you up?
BARTON	No comment.
DC Code A	(Pause) What's the purpose of the 'proactive prescribing'?
BARTON	No comment.
DC Code A	(Pause) Was it something that you used frequently?
BARTON	No comment.
DC Code A	Did you, on a personal level, prefer 'proactive prescribing' to 'telephone prescribing'?
BARTON	No comment.
DC Code A	Okay.
DC Code A	(Pause) With 'proactive prescribing' and the ability to write up prescriptions possibly before they were needed, would that make your busy life easier?
BARTON	No comment.
DC Code A	Will I be correct in thinking with 'proactive prescribing'

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DOCUMENT RECORD PRINT

that that would negate the need to attend the hospital, and it would negate the need to be telephoned...

BARTON No comment.

DC Code A ...or certainly minimise those opportunities?

BARTON No comment.

DC Code A Because again as part of your Job Description is you're expected to be on call is that correct?

BARTON No comment.

DC Code A Code A?

DC Code A Was that a lifestyle issue doctor?

BARTON No comment.

DC Code A Did you proactively prescribe purely on medical terms on what was best for the patients...

BARTON No comment.

DC Code A ...or was it a lifestyle issue?

BARTON No comment.

DC Code A (Pause) Do you think it would have been preferable, particularly with the use of Diamorphine, to have

	prescribed in a way that would allow nurses to contact you should the patient need to have his dose varied...
BARTON	No comment.
DC Code A	...as opposed to the Proactive Prescribing Policy that you adopted?
BARTON	No comment.
DC Code A	Okay.
DC Code A	Who administers the prescribed drugs?
BARTON	No comment.
DC Code A	What training do the nurses have for the administration of the drugs?
BARTON	No comment.
DC Code A	Can any level of nurse administer drugs?
BARTON	No comment.
DC Code A	What is the purpose of the drug registers?
BARTON	No comment.
DC Code A	What has to be recorded in them?

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DOCUMENT RECORD PRINT

BARTON — No comment.

DC Code A — Why have there been drugs prescribed but no administered?

BARTON — No comment.

DC Code A — Code A?

DC Code A — No.

DC Code A — Let me move on if I can then doctor to 'syringe drivers'. Now the use of a syringe driver, what we've found so far, is normally dictated by a doctor and that there are different reasons for employing a syringe driver, one of which is once a patient can no longer take oral medicine. I want to seek an explanation now as to why a syringe driver was utilised in this case, in particular in the way in which you would envisage the driver to be used. So we'll start off doctor with what training had you had for the use and deployment of syringe drivers?

BARTON — No comment.

DC Code A — And what is a syringe driver?

BARTON — No comment.

DC Code A — How long had syringe drivers been in use in 1999?

BARTON — No comment.

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DC Code A — But why is a syringe driver used?

BARTON — No comment.

DC Code A — And what kinds of patients are most suitable for syringe drivers?

BARTON — No comment.

DC Code A — Who talks to the patient, or the family regarding the use of syringe drivers?

BARTON — No comment.

DC Code A — Well how does a syringe driver work?

BARTON — No comment.

DC Code A — Who prepares the drugs for administration via a syringe driver?

BARTON — No comment.

DC Code A — Right. We've got a photocopy now of the instructions for the use of the Ambulatory syringe drivers. This is a notice that was found on the ward in Dryad Ward, it's got a reference number of CSY/HF/8. First of all doctor have you seen this before?

BARTON — No comment.

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DOCUMENT RECORD PRINT

DC Code A	It's titled Graseby Medical Instructions For The Use Of (inaudible) Syringe Drivers, and it depicts that there are three types of syringe drivers, the Variable Syringe Driver MS16, a Fixed Syringe Driver MS18 and the Variable Speed Driver MS26. What are the differences between these syringe drivers?
BARTON	No comment.
DC Code A	What is the difference between the MS16A and the MS26?
BARTON	No comment.
DC Code A	Has one got a boost facility?
BARTON	No comment.
DC Code A	What is a boost facility?
BARTON	No comment.
DC Code A	I believe they are actually both different colours. What colour was the syringe driver used in the case of Mr PACKMAN?
BARTON	No comment.
DC Code A	So why was Mr PACKMAN given drugs by way of a syringe driver?

BARTON	No comment.
DC Code A	And correct me if I'm wrong doctor, but Mr PACKMAN was still able to take oral medicine. Why wasn't he given pills, or Oramorph instead of a sub cut syringe driver?
BARTON	No comment.
DC Code A	(Pause) Why was it necessary to put Mr PACKMAN on a syringe driver?
BARTON	No comment.
DC Code A	(Pause) Why isn't there an entry on the Medical Records that the use of a syringe driver was now deemed necessary?
BARTON	No comment.
DC Code A	Page 55 are the only notes made by you and there's no mention of a need for a syringe driver.
BARTON	No comment.
DC Code A	So who deemed it necessary then?
BARTON	No comment.
DC Code A	Was it you?
BARTON	No comment.

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DOCUMENT RECORD PRINT

DC Code A	Was it Sister HAMBLIN?
BARTON	No comment.
DC Code A	Did Sister HAMBLIN prescribe drugs?
BARTON	No comment.
DC Code A	Why is there an entry in the nursing notes that a syringe driver is being used?
BARTON	No comment.
DC Code A	(Pause) Is the use of a syringe driver a significant factor in the care of a patient?
BARTON	No comment.
DC Code A	Code A?
DC	Yes. Doctor we've just gone through the suitability and usage of syringe drivers for particular types of patients, and we see that this syringe driver was started on the 30th of August. DC Code A has already asked you one question saying: "Why was a syringe authorised and started on the 30th when Mr PACKMAN was still able to take oral medicine?" Can you remind me why that was?
BARTON	No comment.
DC Code A	Because not only was he able to take oral medicine, but a

	nursing note on the same date, on Page 63 of those notes, (someone coughs) a nursing note states that 'a very small amount of diet taken, mainly puddings'. So that implicates, doesn't it, that Mr PACKMAN was still eating, grant you in smaller doses, but he was still eating. If he was able to eat puddings, was he able to take Oramorph?
BARTON	No comment.
DC Code A	The nursing note goes on to say, amongst other things, 'encourage fluids', which again indicates, does it not, that he was drinking still. Is that right doctor?
BARTON	No comment.
DC Code A	And yet the syringe driver was authorised. Did Mr PACKMAN fit the criteria for the commencement of a syringe driver?
BARTON	No comment.
DC Code A	And the interesting point about that entry on Page 63 is that the nurse who wrote it and says that 'he was taking mainly puddings and he was to be encouraged to have fluids', was the same nurse who started off the syringe driver having apparently discussed it with you and that nurse was Sister HAMBLIN. Have you got any comment to make about that doctor?
BARTON	No comment.

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DOCUMENT RECORD PRINT

DC Code A Why would Sister HAMBLIN start a syringe driver on a patient who was still able to drink, who was still able to take oral medicine, who was still able to eat?

BARTON No comment.

DC Code A Was she acting on your instructions?

BARTON No comment.

DC Code A Did you authorise the use of that syringe driver at that time?

BARTON No comment.

DC Code A Was she acting on your authority Doctor BARTON?

BARTON No comment.

DC Code A Should you have allowed the use of that syringe driver at that time?

BARTON No comment.

DC Code A Have you got any further questions Code A?

DC Code A Along the same lines, on the 29th of August 1999 (29/08/1999) nocte, which is night, a nurse has written 'slept for long periods, Oramorph given as prescribed', and then 'complaining of left abdominal pain'. And then on the 30th of August, the next day, was Sister HAMBLIN's entry,

which reads exactly 'condition remains poor, syringe driver commenced at 1445, Diamorphine 40 milligrams, Midazolam 20 milligrams, no further complaints of abdominal pain, very small amount of diet taken mainly puddings, re-catherised this afternoon, dressing, draining of the fluids and the dressings also reviewed'. So the whole entry for the 30th of August says, first of all it says 'syringe started' and later still 'still able to eat'. I just find it puzzling doctor; can you shed any light on it?

BARTON — No comment.

DC Code A — Having started off the syringe driver doctor and you apparently having authorised it why then, it being surely a significant factor in the care of Mr PACKMAN, why then did you not make a record in the notes explaining why the syringe driver was started?

BARTON — No comment.

DC Code A — I say it's probably because you felt unable to do so given the note in the Nursing Record,...

BARTON — No comment.

DC Code A — ...because surely your justification for using the syringe driver would have been 'unable to take oral medicine, unable to eat, unable to drink, commence syringe driver', that would go directly against what the sister had written wouldn't it?

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BARTON No comment.

DC Code A (Pause) Were you at the hospital when Sister HAMBLIN spoke to you about the syringe driver?

BARTON No comment.

DC Code A (Pause) If Mr PACKMAN was in enough pain to require Diamorphine through a subcutaneous syringe driver, what was causing that pain?

BARTON No comment.

DC Code A I'll come back to that one. Now I'd like to talk to you doctor about some drugs now and there are three drugs in particular that were prescribed and administered to Mr PACKMAN. I just want to see if we can clarify and get a further explanation as to the specific reasons behind the prescribing of these drugs and their uses and effects. Now firstly I would like to talk about Oramorph. Why was this drug, Oramorph, prescribed?

BARTON No comment.

DC Code A Why and when was this drug administered?

BARTON No comment.

DC Code A The drug was administered at 1445 hours, who authorised the drug?

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DOCUMENT RECORD PRINT

BARTON	No comment.
DC Code A	(Pause) What time did you see Mr PACKMAN?
BARTON	No comment.
DC Code A	(Pause) So what was the purpose of this drug?
BARTON	No comment.
DC Code A	(Pause) Why was no other form of painkiller prescribed as an alternative to a strong opioid?
BARTON	No comment.
DC Code A	(Pause) A little more interesting, on Page 172 of the Medical Records, which are BJC/34, if I pull the original out for you the very first entry at the doctor it says Oramorph 10 – 20. Because you've prescribed 10 – 20, how does anyone know what to administer?
BARTON	No comment.
DC Code A	(Inaudible – mumbles) then how much has been administered?
BARTON	No comment.
DC Code A	Code A?
DC	Yeah. If I was a doctor on call and I'd come out to see Mr

PACKMAN after one of those doses was administered, how would I know what amount of Oramorph he'd received?

BARTON	No comment.
DC Code A	Because it doesn't tell me there does it? It could be 10, it could be 20, and presumably it could be 15. Would you expect a doctor to have to go back to the drug book to check it out?
BARTON	No comment.
DC Code A	Why have you prescribed that in such a way then?
BARTON	No comment.
DC Code A	(Pause) (Coughs) Actually what is Oramorph doctor?
BARTON	No comment.
DC Code A	And what is its purpose?
BARTON	No comment.
DC Code A	And where does Oramorph sit on the Analgesic Ladder?
BARTON	No comment.
DC Code A	Again doctor Midazolam, what is Midazolam?

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DOCUMENT RECORD PRINT

BARTON	No comment.
DC Code A	Well why is Midazolam used?
BARTON	No comment.
DC Code A	And more specifically why was it used in relation to Mr PACKMAN?
BARTON	No comment.
DC Code A	Is it a sedative doctor?
BARTON	No comment.
DC Code A	Are there any other kinds of sedatives that can be used?
BARTON	No comment.
DC Code A	This drug appears to be commonly used in patients at the terminal end of an illness, is this why this drug was prescribed to Mr PACKMAN on this occasion?
BARTON	No comment.
DC Code A	Did you consider Mr PACKMAN was at the terminal phase of his life?
BARTON	No comment.
DC Code A	How would you know how much Midazolam to prescribe?

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DOCUMENT RECORD PRINT

BARTON	No comment.
DC Code A	Whom was he diagnosed by as being in need of Midazolam?
BARTON	No comment.
DC Code A	What is the purpose of prescribing a range of parameters for the administration of the drug (TAPE BUZZES).... Hang on. Right we'll have to turn the tapes off.
	INTERVIEW CONCLUDED - TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AJ

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0942 Time concluded: 1017

Duration of interview: 35 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This is a continuation of the interview with Doctor BARTON. The time is 0942 hours. Doctor can I just ask you to confirm that while the tapes were off there has been no conversation about this matter?
BARTON	None.
DC Code A	Thank you. Right the same people are present. I must remind you doctor that you are still under caution as well. I would like to move, if I may, on to 'existing treatment and

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conditions', and in this case it is the case of Mr PACKMAN. What specific ailments was he suffering from? I will ask questions to get an understanding of why you've prescribed various medicines, also to seek an explanation as to what Medical Records would have been available to you and what you would have reviewed, and in order to offer the correct and appropriate care medical practitioners should be aware of pre-existing medical history, prescriptions and care plans. So what notes would have been available to you when a patient arrived at the ward?

BARTON No comment.

DC Code A What process would you normally follow upon a patient's arrival at the Gosport War Memorial Hospital?

BARTON No comment.

DC Code A What was Mr PACKMAN suffering from that necessitated him being admitted to the hospital in the first place?

BARTON No comment.

DC Code A Would it be right in saying obesity, swollen legs and pressure sores?

BARTON No comment.

DC Code A (Pause) What medication was Mr PACKMAN taking at the

time of the transfer?

BARTON No comment.

DC Code A (Pause) On the Drug Chart, which is on Page 170 and 168 actually, that reveals that he was on, he was continued on regular Doxazosin 4 milligrams once a day, Frusemide 80 milligrams once a day and (Inaudible) 40 milligrams twice a day, Paracetamol 1 gram four times a day. He was commenced on Magnesium Hydroxide 10 millilitres twice a day, I believe that's a laxative and that was subsequently taken intermittently, which was two doses on the 24th and one dose on the 25th, two doses on the 28th, 29th and one dose on the 30th, and as required Gaviscon. Is that correct doctor?

BARTON No comment.

DC Code A What was the purpose of these drugs?

BARTON No comment.

DC Code A Now later Oramorph was prescribed, why was this?

BARTON No comment.

DC Code A (Pause) On Page 172 of Mr PACKMAN's medical notes (pause), Oramorph was prescribed on the 26th of August. Why was this doctor?

BARTON	No comment.
DC Code A	(Pause) Where is it recorded what the Oramorph was prescribed for?
BARTON	No comment.
DC Code A	It's not is it doctor?
BARTON	No comment.
DC Code A	Why isn't it recorded anywhere?
BARTON	No comment.
DC Code A	Doctor I think we've established that it wasn't recorded. This patient came into hospital in 1999 and we are now in the year 2006. If we can't glean from the records why he was on Oramorph then, how could anybody looking at the records in 1999, how can anybody tell what it was for then as well. So if we don't know how did anybody know then?
BARTON	No comment.
DC Code A	How did the nursing staff know what he was on the Oramorph for?
BARTON	No comment.
DC Code A	How would any other medical personnel know what he was

on the Oramorph for?

BARTON No comment.

DC Code A If somebody was called out during the night or over a weekend when you weren't available, how would they know what the Oramorph was for?

BARTON No comment.

DC Code A Similarly when you wrote in your note: 'Happy for staff to confirm death," on the 26th of August. If another doctor had been called out, how would they have known what he was dying from?

BARTON No comment.

DC Code A I think that's a fairly reasonable question to ask doctor don't you?

BARTON No comment.

DC Code A I think a doctor being called out to examine Geoffrey PACKMAN, after you wrote that note, would be entitled to know why you wrote it.

BARTON No comment.

DC Code A Similarly he'd be entitled to know why you prescribed Oramorph.

BARTON No comment.

DC Code A Code A

DC He wouldn't have been just entitled, he would need to know wouldn't he doctor?

BARTON No comment.

DC Code A Right. But on the same point wouldn't Geoffrey PACKMAN be entitled for any doctor treating him to understand what his current condition was?

BARTON No comment.

DC Code A And how could a doctor being called out understand what the current condition was properly assessing if you hadn't written down what you had done?

BARTON No comment.

DC Code A (Pause) Doctor I'd like to move on and talk about the purpose of Mr PACKMAN's stay and of your aims, your plans. Now care plans are put in place to allow a nurse and medical practitioner to follow a particular course of action. The progress of the patient is going to be monitored and the results reviewed and then the care can be altered accordingly. What I want now is to try and get an explanation as to how you were directly involved in the

process of establishing care plans. What is the purpose of a 'care plan' doctor?

BARTON No comment.

DC Code A What input do you have in that 'care plan'?

BARTON No comment.

DC Code A What was the 'care plan' that was put into place in respect of Mr PACKMAN?

BARTON No comment.

DC Code A Did that 'care plan' ever change?

BARTON No comment.

DC Code A If it did why did it change?

BARTON No comment.

DC Code A Who was the main nurse for Mr PACKMAN?

BARTON No comment.

DC Code A From the notes I believe that to be Nurse Freda SHAW. What was her role?

BARTON No comment.

DC Code A	Now I think Nurse Freda SHAW will be, as the main nurse have more contact than any other nurse with Mr PACKMAN and she certainly would have some sort of direct responsibility. So what did you discuss with her?
BARTON	No comment.
DC Code A	What have you recorded as the 'care plan'?
BARTON	No comment.
DC Code A	So was Freda SHAW left to her own devices?
BARTON	No comment.
DC Code A	Who decided on what the 'care and treatment plan' would be for Mr PACKMAN then?
BARTON	No comment.
DC Code A	How would the 'care plans' be drawn up?
BARTON	No comment.
DC Code A	Well doctor who was responsible for the treatment of Mr PACKMAN on a day-to-day basis?
BARTON	No comment.

DC Code A	Who was in overall charge of the care of Mr PACKMAN?
BARTON	No comment.
DC Code A	(Sneezes) Excuse me. What planned investigations were you going to carry out?
BARTON	No comment.
DC Code A	Code A do you want to ask anything?
DC Code A	No.
DC	(Sneezing) I'm having a sneezing fit I'm sorry.
BARTON	No comment.
DC Code A	Only this then, (DC Code A sneezes) did you just leave the 'care plans' to the nurses?
BARTON	No comment.
DC Code A	Did you have no input into the 'care plans' at all?
BARTON	No comment.
DC Code A	Well surely the nurses would need some guidance from the doctors, otherwise why have doctors?
BARTON	No comment.

DC Code A
DC

Okay.

Right. Medical Records then doctor. The recordings of interactions with patients, as we've said before, is a fundamental requirement of the Health Care Professional. In the Good Medical Practice, it's set out by the GMC that states that 'a doctor must keep clear, accurate, legible and contemporaneous records which report the relevant clinical findings and decisions made, the information given to patients and any drugs or other treatment described. That's on Page 3 of the Good Medical Practice, which is left on the desk, CSY/HF/2. So feel free to browse through that doctor. In addition that booklet states, well there's a booklet called Withholding and Withdrawing Life Prolonging Treatments...

DC Code A
DC

GJQ/HF/15.

...and on Page 30 of this document, or this book, it specifically states that 'the decision making process should be recorded'. Now with these documents in mind, I want to seek an explanation as to how you completed Medical Records, and in particular those records of Mr PACKMAN's? And I'll leave this book here for you as well doctor?

BARTON

No comment.

DC Code A

Doctor what would you record in the Medical Records of a

	patient, and what importance did you place on the completion of the records?
BARTON	No comment.
DC Code A	What would you expect to see recorded in the patient notes on a day-to-day basis?
BARTON	No comment.
DC Code A	And in that question I include the nursing and medical notes doctor?
BARTON	No comment.
DC Code A	Did you normally complete records to the standards set out by the GMC?
BARTON	No comment.
DC Code A	In fact in relation to the Good Medical Practice, the GMC booklet CSY/HF/2, doctor can you confirm if you got a copy of this booklet each year when you renewed your subscription?
BARTON	No comment.
DC Code A	Right the records of Mr PACKMAN. Other than on the Prescription Charts, there are only two pages of clinical notes for the War Memorial Hospital, which you have made

	entries on the 26th and the 28th of August. Where in those entries doctor have you recorded that Mr PACKMAN was in pain?
BARTON	No comment.
DC Code A	Would you like to see these?
BARTON	No comment.
DC Code A	Where on Page 54, which is the initial assessment by Doctor RAVINDRANE, is it recorded that Mr PACKMAN was in pain?
BARTON	No comment.
DC Code A	In fact would be right to say it was recorded that 'he was not in pain'?
BARTON	No comment.
DC Code A	Doctor what is the Analgesic Ladder?
BARTON	No comment.
DC Code A	Show me your description bit.
DC Code A	Sure.
DC Code A	That yellow piece.

DC Code A	(Pause) Just before we leave that last section doctor...
	For the benefit of the tape DC Code A and DC Code A talk amongst each other regarding the Analgesic Ladder.
DC Code A	Before we leave that last section about Mr PACKMAN being in pain and you haven't recorded anywhere in those notes what the pain was or where it was, I'm sure like DC Code A I've seen lots of Medical Records over the years in various cases I've worked on and is it not a common practice for doctors to draw diagrams of parts of the body indicating where a pain is emanated from, am I right?
BARTON	No comment.
DC Code A	And isn't that, the reason for that is so that it makes it clear to anybody else who picks up on that patient to see where pain is coming from?
BARTON	No comment.
DC Code A	So it indicates, it clears up any ambiguity as to where the pain is coming from, not necessarily what's causing it but where it's coming from?
BARTON	No comment.
DC Code A	For instance where the patient is complaining of the pain?

BARTON No comment.

DC Code A I don't think I've seen any diagrams from you regarding patients' pain. I

BARTON No comment.

DC Code A Do you not feel that that is a good idea to draw diagrams of patients then?

BARTON No comment.

DC Code A Is that a practice that you don't adhere to? I

BARTON No comment.

DC Code A Is it a practice you disagree with or some reason?

BARTON No comment.

DC Code A In fact Page 45 of these medical notes, QA notes there's some diagrams here doctor, these are the sort of things that DC Code A was talking about. Do you make any such diagrams?

BARTON No comment.

DC Code A Doctor we've just asked you about the Analgesic Ladder haven't we, and I am confident that you must be aware of the Analgesic Ladder. Am I right?

BARTON — No comment. (Somebody coughs).

DC Code A — From exhibit CSY/HF/6, these are blank Gosport medical documents from the War Memorial Hospital this is, I'm showing you a yellow copy, it's a newish document I believe. Can you see that?

BARTON — No comment.

DC Code A — Would you like to have a look at it?

BARTON — No thank you.

DC Code A — It sets out the Analgesic Ladder and it says that 'this is adopted from the WHO Analgesic Ladder and it's very very similar to the one available to you in the Wessex Protocol and it starts off (somebody coughs), it's in several steps isn't it? The first step being Step (1) Mild Pain and this is drugs, which are non-opioid such as Paracetamol, Diclofenac, Co-prox (pause), yes sorry Diclofenac etcetera, etcetera, yes, yeah? And then as the pain increases to a moderate pain you move up the ladder to weak opioids such as Codeine with Paracetamol, Co-codamol, Dihydrocodeine, Tramadol, etcetera, and then eventually we end up, if pain increases to severe pain, to Step (3) which are your strong opioids and these are basically your Morphine based drugs aren't they doctor?

BARTON — No comment.

DC Code A — So these would be your Oramorphs, MSTs, Diamorphine, Morphine. Is that right?

BARTON — No comment.

DC Code A — Is the Analgesic Ladder something that you follow when prescribing medicines for analgesics and painkillers?

BARTON — No comment.

DC Code A — Were you aware of the Analgesic Ladder in 1999?

BARTON — No comment.

DC Code A — So what previous painkillers had Mr PACKMAN been prescribed?

BARTON — No comment.

DC Code A — Is that right Paracetamol four times a day doctor?

BARTON — No comment.

DC Code A — Why isn't there any documentation, and I know we keep coming back for this, but why isn't there any documentation relating to why Morphine or other strong analgesics were prescribed?

BARTON — No comment.

DC Code A — Why was Oramorph prescribed without an alternative?

BARTON — No comment.

DC Code A — And why isn't there an entry in the Medical Records explaining why Mr PACKMAN was prescribed Diamorphine?

BARTON — No comment.

DC Code A — Geoff?

DC Code A — No.

DC Code A — (Inaudible) about the topic about Ward Rounds and these are an opportunity for doctors and nurses to review a patient aren't they to discuss and decide upon further or change treatment? So as such they too are an integral part of a doctor's duties, and what I'd like to do is get an explanation from you as to how you conducted your rounds, and the role that you saw ward rounds played in the care and treatment of a patient and in particular Mr PACKMAN. So how often did you conduct your rounds doctor?

BARTON — No comment.

DC Code A — Will I be right in saying that in the document that we've given an identification reference of GJQ/HF/14, which is the Job Description for the Clinical Assistant at Gosport

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War Memorial Hospital, Duty (1) was to visit the units on a regular basis and to be available on call as necessary. Did you do a round every time you visited the wards?

BARTON No comment.

DC Code A Who would you conduct your rounds with?

BARTON No comment.

DC Code A What time of day would you conduct your rounds doctor?

BARTON No comment.

DC Code A Now you've previously stated that you visited the ward every morning between half-past-seven (0730) and nine (0900), most afternoons and some evenings. We know that you had certainly three afternoon commitments with the surgery, but you certainly state that 'you visited the hospital every morning'. Would you conduct a round every morning?

BARTON No comment.

DC Code A What was the purpose of the ward rounds?

BARTON No comment.

DC Code A How long did they take?

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BARTON No comment.

DC Code A If you conducted ward rounds, would the nurses accompany you?

BARTON No comment.

DC Code A Would the nurses have any input into the rounds?

BARTON No comment.

DC Code A (Coughs) In what form did the ward rounds take place?

BARTON No comment.

DC Code A Would the ward rounds consist of visiting each patient at their bed, or you conducted in an office with the nursing staff?

BARTON No comment.

DC Code A How often did the consultants conduct, well the consultants conduct their rounds?

BARTON No comment.

DC Code A Again Duty (7) from your Job Description, which is GJQ/HF/14, states that you should take part in the weekly consultant rounds. I would assume from your Job Description that the consultant rounds were weekly. Did

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	you take part?
BARTON	No comment.
DC Code A	What time of the day did the consultant rounds take place?
BARTON	No comment.
DC Code A	Was it after nine o'clock?
BARTON	No comment.
DC Code A	Did you attend a consultant round with regards to Mr PACKMAN?
BARTON	No comment.
DC Code A	Did you ever attend any consultant rounds?
BARTON	No comment.
DC Code A	Because I'm having a problem working out your actual daily schedule again doctor. It was a busy day that you had, half-past-seven (0730) until nine o'clock at the hospital, nine (0900) until half-eleven (1130) at the surgery, afternoon clinics. When did you ever have time to do a consultant's round?
BARTON	No comment.

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DC Code A	Was that just a blatant disregard for one of your duties?
BARTON	No comment.
DC Code A	And if you did attend them, how did their rounds differ from yours?
BARTON	No comment.
DC Code A	Well did they differ?
BARTON	No comment.
DC Code A	If you saw Mr PACKMAN every day, why didn't you make an entry in the medical notes each time?
BARTON	No comment.
DC Code A	Code A
DC Code A	What was the nurses' responsibility when it came down to ward rounds?
BARTON	No comment.
DC Code A	The nursing staff?
BARTON	No comment.
DC Code A	We touched on it there whether the ward rounds were an act

	of you physically walking from bed to bed and physically seeing each patient. Did you actually do that doctor?
BARTON	No comment.
DC Code A	Or did you conduct them more as an office conference perhaps?
BARTON	No comment.
DC Code A	Was it the case that you sat in an office with the nursing staff and discussed the patient?
BARTON	No comment.
DC Code A	The notes already indicate that you placed quite some responsibility on to the nursing staff. Was this another example of how you conducted your rounds or not?
BARTON	No comment.
DC Code A	Did you encourage or allow the nursing staff to conduct ward rounds on their own?
BARTON	No comment.
DC Code A	Did Sister HAMBLIN in particular conduct ward rounds on her own?
BARTON	No comment.

DC Code A — If you weren't in hospital for some reason and legitimately that would probably happen wouldn't it on some days? Would Sister HAMBLIN conduct (somebody coughs) a ward round on her own?

BARTON — No comment.

DC Code A — If she did, was that the practice that crept in gradually until she was doing more ward rounds than perhaps she should have been doing?

BARTON — No comment.

DC Code A — Okay.

DC Code A — Doctor what I want to talk about is 'consultants' assessments and their responsibilities'. As we know consultants certainly play and integral part in the care and treatment of patients. I think it's essential that we give you the opportunity to offer an explanation as to how the role and the function of consultants is performed in the respect of Mr PACKMAN, and also I would like to know if you've had any concerns that you may have raised and raised them to whom. But did you have any concerns and how many consultants supported you at the Gosport War Memorial Hospital?

BARTON — No comment.

DC Code A	If you did, when did you raise these concerns?
BARTON	No comment.
DC Code A	Again if you did, how did you raise these concerns?
BARTON	No comment.
DC Code A	Where would a written record of these concerns be found?
BARTON	No comment.
DC Code A	Why would you have concerns?
BARTON	No comment.
DC Code A	Who was the consultant that was responsible for the care of Mr PACKMAN whilst he was a patient on that ward?
BARTON	No comment.
DC Code A	What did you understand the consultant's responsibilities to be?
BARTON	No comment.
DC Code A	Well what involvement did the consultant have with Mr PACKMAN to your knowledge?
BARTON	No comment.

DC Code A	Did you have any concerns as to how the consultants performed their role in respect of this patient?
BARTON	No comment.
DC Code A	Were you given sufficient support by the consultants in order to carry out your own work?
BARTON	No comment.
DC Code A	How was this support offered?
BARTON	No comment.
DC Code A	Did you ever raise concerns with anyone?
BARTON	No comment.
DC Code A	If you did, whom did you raise these concerns to?
BARTON	No comment.
DC Code A	(Coughs) And if you did, when did you raise these concerns?
BARTON	No comment.
DC Code A	And probably more importantly, why did you raise concerns of anyone?

BARTON	No comment.
DC Code A	Code A?
DC	I think Doctor REID was the consultant...
DC	He was.
DC	...in this case wasn't he doctor? Yeah and DC Code A has confirmed it by reading from your notes. Did you have any problems with Doctor REID?
BARTON	No comment.
DC Code A	I understand that Doctor RAVINDRANE was involved, and Doctor RAVINDRANE was a registrar above yourself and below Doctor REID. Did you raise any concerns regarding either of those two doctors?
BARTON	No comment.
DC Code A	Did you have any concerns with those two doctors?
BARTON	No comment.
DC Code A	If you had had concerns, how would you have raised them? Would you have known how to raise them?
BARTON	No comment.

DC Code A	You had, part of GJQ/HF/14 your Job Description, a letter accompanying it from Pauline DANCE, and it states in there that 'should you have any grievance relating to your employment, you are entitled to discuss the matter in the first instance with the consultants to whom you are responsible'. Did you ever do that?
BARTON	No comment.
DC Code A	'And where appropriate, you can consult either in person or in writing with the personnel officer'. That's the nearest hospital. And it goes on to say that 'there is a Section 32 of the General (Inaudible) Council Conditions Of Service that you can also refer to affecting your conditions of service. Did you ever do that?
BARTON	No comment.
DC Code A	And there is an agreed disciplinary procedure available to you in the Personnel Department at St. Mary's. Did you ever have a look at that?
BARTON	No comment.
DC Code A	Did anything happen at Gosport War Memorial that led you to go down that path?
BARTON	No comment.

DC Code A	Did you have any personal issues with Doctor RAVINDRANE?
BARTON	No comment.
DC Code A	Did you have any personal issues with Doctor REID…
BARTON	No comment.
DC Code A	…that would prevent you from making a complaint that it was justified?
BARTON	No comment.
DC Code A	Okay.
DC	Again the tapes have about three or four minutes to go, I think we'll change the tapes. In fact we might take a ten minute break now actually.
DC Code A	Yeah.
DC	All right. Is there anything you wish to clarify at the moment doctor?
BARTON	No thank you.
DC Code A	Is there anything you wish to add?
BARTON	No thank you.

DC Code A — The time by my watch is 1017 hours and I am going to turn the recorder off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AK

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 1034 Time concluded: 1116

Duration of interview: 42 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This interview is being tape recorded I am DC Code A Code A and my colleague is?
DC Code A	DC Code A
DC	I am interviewing Doctor Jane BARTON. Doctor will you please give your full name and your dated of birth?
BARTON	Jane Ann BARTON 19/10/48.

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DC Code A	Thank you.
BARTON	Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself and your full name?
BARKER	Yes certainly. I am Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.
DC Code A	Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 1034 hours and the date is the 6th of April 2006 (06/04/2006). At the conclusion of the whole process I will give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?
BARTON	Fine thank you.
DC Code A	If at any time you do wish to stop the interview doctor to take legal advice just say and the interview will be stopped in order that you can do this.
BARTON	Thank you.
DC Code A	I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're

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free to do so okay.

BARTON Thank you.

DC Code A I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention, when questioned, something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?

BARTON Thank you.

DC Code A Is there any need for it to be broken down again this time?

BARTON No thank you.

DC Code A Okay. As I've said before on this occasion the room that we're in has been equipped with a monitoring facility. Whenever the red light is on that means that somebody is listening to the interview. Today Detective Inspector GROCOTT is monitoring the interview with the lights on. (Somebody clearing throat) Nobody can listen to any conversation in this room when those tapes aren't playing doctor okay. Right if I can just confirm doctor that we've had a quick comfort break, but there's been no conversation about this matter whilst the tape's been off.

BARTON None at all.

DC Code A Thank you. If I can doctor I'd like to move on to issues

surrounding the pharmacy and that's the 'prescription and administration of controlled drugs', it's a specialist subject in it's own right and I seek an explanation now as to how you were involved in pharmaceutical prescriptions. I would also like to know your level of training and understanding of the drugs that you prescribed and their uses. How did you ensure doctor that you were up-to-date in the knowledge that you had in respect of pharmaceutical issues?

BARTON No comment.

DC Code A What pharmaceutical training had you received at the time of Mr PACKMAN's admission to hospital?

BARTON No comment.

DC Code A What further pharmaceutical training had you received since your initial qualifications?

BARTON No comment.

DC Code A How would you know what drugs to prescribe to a patient?

BARTON No comment.

DC Code A How would you learn about new drugs that are available for administration?

BARTON No comment.

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DOCUMENT RECORD PRINT

DC Code A — How would the pharmacy at the Gosport War Memorial Hospital work in relation to the availability or the suitability of medicines and drugs?

BARTON — No comment.

DC Code A — How many pharmacists worked at the Gosport War Memorial Hospital in 1999?

BARTON — No comment.

DC Code A — Doctor what is the BNF?

BARTON — No comment. (Somebody clears throat)

DC Code A — Have you got a reference number for this?

DC Code A — CSY/HF/12.

DC Code A — Doctor I'll show you the BNF number 42, September 2001. Is this a book that you're familiar with?

BARTON — No comment.

DC Code A — I think I'll leave that on the desk should you wish to refer to it. A similar book, that's the other one, is the NPF, Nurse Prescribers Formulary, and that's got a reference of GJQ/HF/17, this one is dated 2002/2003 (inaudible). Is that a book that you're familiar with?

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BARTON	No comment.
DC Code A	What is its purpose?
BARTON	No comment.
DC Code A	What is the purpose of the BNF?
BARTON	No comment.
DC Code A	How often would you refer to it?
BARTON	No comment.
DC Code A	And finally book wise GJQ/HF/18, which is the PCF, which is the Palliative Care Formulary. Is this a book that you are familiar with doctor?
BARTON	No comment.
DC Code A	What is the purpose of that book?
BARTON	No comment.
DC Code A	And how often would you refer to it?
BARTON	No comment.
DC Code A	(Coughs) Were any of the drugs used in the treatment of

	Mr PACKMAN new or seldom used?
BARTON	No comment.
DC Code A	What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients?
BARTON	No comment.
DC Code A	Have you got a copy of that one?
DC Code A	Sorry which one?
DC	Wessex Protocols.
DC	(Pause) No I haven't got a copy or it would be here.
DC	No?
DC	No sorry.
DC	(Inaudible)
DC	(Pause)
DC	That's it. (Pause) Have you got a reference number? We're using that as a copy aren't we?
DC Code A	Yeah, which is (pause) CSY/HF/3.

DC Code A — Okay CSY/HF/3 is a copy of the Palliative Care handbook and I have one here, a photocopy, and it's actually a photocopy of this small book Advice On Clinical Management. Is this a book that you're familiar with doctor?

BARTON — No comment.

DC Code A — It's referred to often as the Wessex Protocols, it's a book, it's the 5th addition, Advice On Clinical Management, but this one is Countess Mountbatten House, Southampton University Hospital NHS Trust. That is in association with all the Wessex Specialist Palliative Care Units. How often did you refer to this book?

BARTON — No comment.

DC Code A — (Pause) What was the purpose of the Wessex Protocols in relation to prescribing medicines to patients doctor?

BARTON — No comment.

DC Code A — What pharmacy guidelines were available for prescribing the medicines within the Gosport War Memorial Hospital?

BARTON — No comment.

DC Code A — Where was the pharmacy at the Gosport War Memorial Hospital?

BARTON No comment.

DC Code A How accessible was the pharmacy?

BARTON No comment.

DC Code A What were the opening times of the pharmacy if any?

BARTON No comment.

DC Code A Code A?

DC Code A Regarding the pharmaceutical side of things, did you not have a responsibility as a general practitioner to keep up-to-date with drugs administration and prescribing?

BARTON No comment.

DC Code A Do you get provided with training up dates regarding these matters?

BARTON No comment.

DC Code A Did you, at any stage, feel that you needed that sort of training?

BARTON No comment.

DC Code A Did you fully understand (pause) each drug that you were prescribing?

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BARTON	No comment.
DC Code A	In other words did you feel confident that you understood what that drug would do and why you should prescribe it?
BARTON	No comment.
DC Code A	If you didn't, did you ever take steps to rectify that?
BARTON	No comment.
DC Code A	Were steps available to you at the time?
BARTON	No comment.
DC Code A	Did you ever seek advice from anybody in relation to the prescribing of controlled drugs?
BARTON	No comment.
DC Code A	Were you confident in your ability to ensure that each patient had the correct drug for their needs?
BARTON	No comment.
DC Code A	Okay.
DC	Going back to your Job Description, GJQ/HF/14. Duty number (8) was to prescribe, as required, drugs for the

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patients under the care of the consultant physicians in geriatric medicine. (Clears throat) So that was one of your duties. Would you not be duty bound to keep up-to-date?

BARTON No comment.

DC Code A Right. Prescriptions. Now prescribing medicines doctor there's a requirement to complete different parts of a Prescription Chart. Now what I want to do now is try and get an explanation as to how the 'clinical assistance' was involved in the prescription of medicines and what protocols you followed. Now could you please describe the process undertaken in the prescribing and administering of controlled drugs?

BARTON No comment.

DC Code A Have you got a reference for this?

DC Code A CSY/HF/10.

DC Code A And that identification refers to a (inaudible) in Gosport, an NHS Primary Care Trust Prescription sheet, which I am opening out for the doctor. Could I just take you through this chart and perhaps you can identify certainly if we have anything wrong. Once you open the document out there's three pages, there's an area on the top half of the first place, which is 'for once one and pre-medication drugs'. Who is responsible for completing that part of the form?

BARTON No comment.

DC Code A Under that is 'as required prescriptions', which there's a box for the approved name of the drug, the route that is to be taken, the dose, the date and the pharmacy and the signature of the doctor and the special directions, and next to that is the administration record, which I believe the nurses complete is that correct?

BARTON No comment.

DC Code A Who is responsible for completing the left hand box on the 'as required prescription'?

BARTON No comment.

DC Code A Would that be a doctor?

BARTON No comment.

DC Code A Again on your actual Job Description, GJQ/HF/14, one of your duties is to prescribe 'as required drugs' for the patients under the care of the consultant physicians in geriatric medicine. So would it be fair for me to think, as you accepted the job as 'clinical assistant', that that was one of your responsibilities to complete these?

BARTON No comment.

DC Code A On the middle page, again the left hand side of it, it would

appear for the doctors, that's for 'regular prescriptions'. Were you responsible for completing any of this?

BARTON — No comment.

DC Code A — And that goes on to the next page, and finally the 'daily review prescriptions', what are they?

BARTON — No comment.

DC Code A — Right on the back there's an area 'for nursing use only, exceptions to prescribed orders'. What is this used for?

BARTON — No comment.

DC Code A — Is this completed by a nurse when, for some reason, a prescribed order hasn't been taken...

BARTON — No comment.

DC Code A — ...or has been refused by the patient?

BARTON — No comment.

DC Code A — Or even on occasions vomited?

BARTON — No comment.

DC Code A — (Pause) What was your prescribing policy doctor?

BARTON	No comment.
DC Code A	What medicines and drugs did you prescribe to Mr PACKMAN?
BARTON	No comment.
DC Code A	What is the difference between 'once only drugs', 'as required drugs' and 'regular drugs'?
BARTON	No comment.
DC Code A	(Pause) Why are ranges of drugs prescribed for patients?
BARTON	No comment.
DC Code A	I'm just showing you a Prescription Chart, how do you think that Prescription Chart should be completed?
BARTON	No comment.
DC Code A	So what is a 'Proactive Prescribing Policy'?
BARTON	No comment.
DC Code A	Is this a policy where a range, quite often a large range of drugs is prescribed?
BARTON	No comment.

DC Code A	How did this policy come about?
BARTON	No comment.
DC Code A	What was its purpose?
BARTON	No comment.
DC Code A	Who authorised this policy?
BARTON	No comment.
DC Code A	Was this your policy we're describing?
BARTON	No comment.
DC Code A	Where could I find this policy?
BARTON	No comment.
DC Code A	What is meant by 'telephone prescribing' doctor?
BARTON	No comment.
DC Code A	Am I right in thinking that 'telephone prescribing' would be a nurse phoning the doctor, the doctor making a prescription over the phone, the phone had been passed to a second nurse and the prescription repeated and then both nurses, or one of the nurses would make an entry on the record, countersigned by the second nurse and later signed

by the doctor when the doctor comes in. Is that correct?

BARTON No comment.

DC Code A So what is the purpose of a doctor on call?

BARTON No comment.

DC Code A Is part of the purpose of a doctor on call to conduct telephone prescribing?

BARTON No comment.

DC Code A Is it also expected of a doctor on call to, if required, attend the hospital?

BARTON No comment.

DC Code A If there is a doctor on call, and if there is the availability of 'telephone prescribing', why was there 'proactive prescribing'?

BARTON No comment.

DC Code A What was the necessity of prescribing for such wide ranges of drugs?

BARTON No comment.

DC Code A Was 'telephone prescribing' a recommended form of

prescribing drugs?

BARTON No comment.

DC Code A Was it something that you were encouraged to do?

BARTON No comment.

DC Code A Were you ever discouraged from doing it?

BARTON No comment.

DC Code A Did you do it frequently?

BARTON No comment.

DC Code A (Pause) Did you try to avoid 'telephone prescribing'?

BARTON No comment.

DC Code A If you had a Proactive Policy, would that negate the need for anybody to phone you up?

BARTON No comment.

DC Code A (Pause) What's the purpose of the 'proactive prescribing'?

BARTON No comment.

DC Code A (Pause) Was it something that you used frequently?

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DOCUMENT RECORD PRINT

BARTON	No comment.
DC Code A	Did you, on a personal level, prefer 'proactive prescribing' to 'telephone prescribing'?
BARTON	No comment.
DC Code A	Okay.
DC	(Pause) With 'proactive prescribing' and the ability to write up prescriptions possibly before they were needed, would that make your busy life easier?
BARTON	No comment.
DC Code A	Will I be correct in thinking with 'proactive prescribing' that that would negate the need to attend the hospital, and it would negate the need to be telephoned...
BARTON	No comment.
DC Code A	...or certainly minimise those opportunities?
BARTON	No comment.
DC Code A	Because again as part of your Job Description is you're expected to be on call is that correct?
BARTON	No comment.

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DC Code A	Code A?
DC Code A	Was that a lifestyle issue doctor?
BARTON	No comment.
DC Code A	Did you proactively prescribe purely on medical terms on what was best for the patients…
BARTON	No comment.
DC Code A	…or was it a lifestyle issue?
BARTON	No comment.
DC Code A	(Pause) Do you think it would have been preferable, particularly with the use of Diamorphine, to have prescribed in a way that would allow nurses to contact you should the patient need to have his dose varied…
BARTON	No comment.
DC Code A	…as opposed to the Proactive Prescribing Policy that you adopted?
BARTON	No comment.
DC Code A	Okay.

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DOCUMENT RECORD PRINT

DC Code A	Who administers the prescribed drugs?
BARTON	No comment.
DC Code A	What training do the nurses have for the administration of the drugs?
BARTON	No comment.
DC Code A	Can any level of nurse administer drugs?
BARTON	No comment.
DC Code A	What is the purpose of the drug registers?
BARTON	No comment.
DC Code A	What has to be recorded in them?
BARTON	No comment.
DC Code A	Why have there been drugs prescribed but no administered?
BARTON	No comment.
DC Code A	Code A?
DC	No.

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DC Code A	Let me move on if I can then doctor to 'syringe drivers'. Now the use of a syringe driver, what we've found so far, is normally dictated by a doctor and that there are different reasons for employing a syringe driver, one of which is once a patient can no longer take oral medicine. I want to seek an explanation now as to why a syringe driver was utilised in this case, in particular in the way in which you would envisage the driver to be used. So we'll start off doctor with what training had you had for the use and deployment of syringe drivers?
BARTON	No comment.
DC Code A	And what is a syringe driver?
BARTON	No comment.
DC Code A	How long had syringe drivers been in use in 1999?
BARTON	No comment.
DC Code A	But why is a syringe driver used?
BARTON	No comment.
DC Code A	And what kinds of patients are most suitable for syringe drivers?
BARTON	No comment.

DC Code A — Who talks to the patient, or the family regarding the use of syringe drivers?

BARTON — No comment.

DC Code A — Well how does a syringe driver work?

BARTON — No comment.

DC Code A — Who prepares the drugs for administration via a syringe driver?

BARTON — No comment.

DC Code A — Right. We've got a photocopy now of the instructions for the use of the Ambulatory syringe drivers. This is a notice that was found on the ward in Dryad Ward, it's got a reference number of CSY/HF/8. First of all doctor have you seen this before?

BARTON — No comment.

DC Code A — It's titled Graseby Medical Instructions For The Use Of (inaudible) Syringe Drivers, and it depicts that there are three types of syringe drivers, the Variable Syringe Driver MS16, a Fixed Syringe Driver MS18 and the Variable Speed Driver MS26. What are the differences between these syringe drivers?

BARTON — No comment.

DC Code A — What is the difference between the MS16A and the MS26?

BARTON — No comment.

DC Code A — Has one got a boost facility?

BARTON — No comment.

DC Code A — What is a boost facility?

BARTON — No comment.

DC Code A — I believe they are actually both different colours. What colour was the syringe driver used in the case of Mr PACKMAN?

BARTON — No comment.

DC Code A — So why was Mr PACKMAN given drugs by way of a syringe driver?

BARTON — No comment.

DC Code A — And correct me if I'm wrong doctor, but Mr PACKMAN was still able to take oral medicine. Why wasn't he given pills, or Oramorph instead of a sub cut syringe driver?

BARTON — No comment.

DC Code A — (Pause) Why was it necessary to put Mr PACKMAN on a syringe driver?

BARTON — No comment.

DC Code A — (Pause) Why isn't there an entry on the Medical Records that the use of a syringe driver was now deemed necessary?

BARTON — No comment.

DC Code A — Page 55 are the only notes made by you and there's no mention of a need for a syringe driver.

BARTON — No comment.

DC Code A — So who deemed it necessary then?

BARTON — No comment.

DC Code A — Was it you?

BARTON — No comment.

DC Code A — Was it Sister HAMBLIN?

BARTON — No comment.

DC Code A — Did Sister HAMBLIN prescribe drugs?

BARTON — No comment.

DC Code A — Why is there an entry in the nursing notes that a syringe driver is being used?

BARTON — No comment.

DC Code A — (Pause) Is the use of a syringe driver a significant factor in the care of a patient?

BARTON — No comment.

DC Code A — Code A?

DC Code A — Yes. Doctor we've just gone through the suitability and usage of syringe drivers for particular types of patients, and we see that this syringe driver was started on the 30th of August. DC Code A has already asked you one question saying: "Why was a syringe authorised and started on the 30th when Mr PACKMAN was still able to take oral medicine?" Can you remind me why that was?

BARTON — No comment.

DC Code A — Because not only was he able to take oral medicine, but a nursing note on the same date, on Page 63 of those notes, (someone coughs) a nursing note states that 'a very small amount of diet taken, mainly puddings'. So that implicates, doesn't it, that Mr PACKMAN was still eating, grant you in smaller doses, but he was still eating. If he was able to eat puddings, was he able to take Oramorph?

BARTON No comment.

DC Code A The nursing note goes on to say, amongst other things, 'encourage fluids', which again indicates, does it not, that he was drinking still. Is that right doctor?

BARTON No comment.

DC Code A And yet the syringe driver was authorised. Did Mr PACKMAN fit the criteria for the commencement of a syringe driver?

BARTON No comment.

DC Code A And the interesting point about that entry on Page 63 is that the nurse who wrote it and says that 'he was taking mainly puddings and he was to be encouraged to have fluids', was the same nurse who started off the syringe driver having apparently discussed it with you and that nurse was Sister HAMBLIN. Have you got any comment to make about that doctor?

BARTON No comment.

DC Code A Why would Sister HAMBLIN start a syringe driver on a patient who was still able to drink, who was still able to take oral medicine, who was still able to eat?

BARTON No comment.

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DC Code A — Was she acting on your instructions?

BARTON — No comment.

DC Code A — Did you authorise the use of that syringe driver at that time?

BARTON — No comment.

DC Code A — Was she acting on your authority Doctor BARTON?

BARTON — No comment.

DC Code A — Should you have allowed the use of that syringe driver at that time?

BARTON — No comment.

DC Code A — Have you got any further questions Code A?

DC Code A — Along the same lines, on the 29th of August 1999 (29/08/1999) nocte, which is night, a nurse has written 'slept for long periods, Oramorph given as prescribed', and then 'complaining of left abdominal pain'. And then on the 30th of August, the next day, was Sister HAMBLIN's entry, which reads exactly 'condition remains poor, syringe driver commenced at 1445, Diamorphine 40 milligrams, Midazolam 20 milligrams, no further complaints of abdominal pain, very small amount of diet taken mainly

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puddings, re-catherised this afternoon, dressing, draining of the fluids and the dressings also reviewed'. So the whole entry for the 30th of August says, first of all it says 'syringe started' and later still 'still able to eat'. I just find it puzzling doctor; can you shed any light on it?

BARTON — No comment.

DC Code A — Having started off the syringe driver doctor and you apparently having authorised it why then, it being surely a significant factor in the care of Mr PACKMAN, why then did you not make a record in the notes explaining why the syringe driver was started?

BARTON — No comment.

DC Code A — I say it's probably because you felt unable to do so given the note in the Nursing Record,...

BARTON — No comment.

DC Code A — ...because surely your justification for using the syringe driver would have been 'unable to take oral medicine, unable to eat, unable to drink, commence syringe driver', that would go directly against what the sister had written wouldn't it?

BARTON — No comment.

DC Code A — (Pause) Were you at the hospital when Sister HAMBLIN

spoke to you about the syringe driver?

BARTON No comment.

DC Code A (Pause) If Mr PACKMAN was in enough pain to require Diamorphine through a subcutaneous syringe driver, what was causing that pain?

BARTON No comment.

DC Code A I'll come back to that one. Now I'd like to talk to you doctor about some drugs now and there are three drugs in particular that were prescribed and administered to Mr PACKMAN. I just want to see if we can clarify and get a further explanation as to the specific reasons behind the prescribing of these drugs and their uses and effects. Now firstly I would like to talk about Oramorph. Why was this drug, Oramorph, prescribed?

BARTON No comment.

DC Code A Why and when was this drug administered?

BARTON No comment.

DC Code A The drug was administered at 1445 hours, who authorised the drug?

BARTON No comment.

DC Code A (Pause) What time did you see Mr PACKMAN?

BARTON No comment.

DC Code A (Pause) So what was the purpose of this drug?

BARTON No comment.

DC Code A (Pause) Why was no other form of painkiller prescribed as an alternative to a strong opioid?

BARTON No comment.

DC Code A (Pause) A little more interesting, on Page 172 of the Medical Records, which are BJC/34, if I pull the original out for you the very first entry at the doctor it says Oramorph 10 – 20. Because you've prescribed 10 – 20, how does anyone know what to administer?

BARTON No comment.

DC Code A (Inaudible – mumbles) then how much has been administered?

BARTON No comment.

DC Code A Code A?

DC Code A Yeah. If I was a doctor on call and I'd come out to see Mr PACKMAN after one of those doses was administered,

	how would I know what amount of Oramorph he'd received?
BARTON	No comment.
DC Code A	Because it doesn't tell me there does it? It could be 10, it could be 20, and presumably it could be 15. Would you expect a doctor to have to go back to the drug book to check it out?
BARTON	No comment.
DC Code A	Why have you prescribed that in such a way then?
BARTON	No comment.
DC Code A	(Pause) (Coughs) Actually what is Oramorph doctor?
BARTON	No comment.
DC Code A	And what is its purpose?
BARTON	No comment.
DC Code A	And where does Oramorph sit on the Analgesic Ladder?
BARTON	No comment.
DC Code A	Again doctor Midazolam, what is Midazolam?

BARTON No comment.

DC Code A Well why is Midazolam used?

BARTON No comment.

DC Code A And more specifically why was it used in relation to Mr PACKMAN?

BARTON No comment.

DC Code A Is it a sedative doctor?

BARTON No comment.

DC Code A Are there any other kinds of sedatives that can be used?

BARTON No comment.

DC Code A This drug appears to be commonly used in patients at the terminal end of an illness, is this why this drug was prescribed to Mr PACKMAN on this occasion?

BARTON No comment.

DC Code A Did you consider Mr PACKMAN was at the terminal phase of his life?

BARTON No comment.

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DC Code A — How would you know how much Midazolam to prescribe?

BARTON — No comment.

DC Code A — Whom was he diagnosed by as being in need of Midazolam?

BARTON — No comment.

DC Code A — What is the purpose of prescribing a range of parameters for the administration of the drug (TAPE BUZZES).... Hang on. Right we'll have to turn the tapes off.

INTERVIEW CONCLUDED – TAPE MACHINE SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20AI

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FAREHAM POLICE STATION

Date of interview: 06/04/2006

Time commenced: 0901 Time concluded: 0940

Duration of interview: 39 MINUTES Tape reference nos.
(→)

Interviewer(s):

Other persons present: MR BARKER - SOLICITOR

Police Exhibit No: Number of Pages:

Signature of interviewer producing exhibit

Person speaking	Text
DC Code A	This interview is being tape recorded. I am DC Code A Code A My colleague is?
DC Code A	DC Code A
DC Code A	I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
BARTON	Jane Ann BARTON, 19/10/48.

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DC Code A — Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself here for me?

BARKER — Certainly it's Ian Steven Petrie BARKER and I am Doctor BARTON's solicitor.

DC Code A — Thank you. This interview is being conducted in an Interview Room at Fareham Police Station in Hampshire. The time is 0901 hours and the date is the Thursday the 6th of April 2006 (06/04/2006). At the conclusion of the whole interview process doctor, I will give you a notice explaining what will happen to the tapes okay. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?

BARTON — Fine thank you.

DC Code A — If at any time you wish to stop the interview and take legal advice, then if you just say doctor and we will stop the interview and you can do that. I'd also like to point out that you have attended voluntarily and so you're not under arrest, you've come here of your own free will and so if at any time you wish to leave you know you're free to do so okay.

BARTON — Thank you.

DC Code A

I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court and anything you do say may be given in evidence. Do you understand that caution doctor?

BARTON

I do.

DC Code A

(Inaudible) I'll break it up again anyway. The caution can be broken into three sections. The first, which is the very simple bit, is that it is your right not to say anything when asked questions by us okay. The second part is the slightly more confusing part and that is if this matter should go to court, and as I say 'even if this matter should go to court' it may harm your defence if you wish to rely on something as part of your defence, if you've had the opportunity to mention it now. In other words a court might think, or draw an inference and say: "Why didn't you say that earlier?" The third and last part again is quite simple, the interview is being recorded and so should the matter go before a court a transcript of the interview can be read out, or the tapes can be played. Are you quite happy with the sound of that?

BARTON

Thank you.

DC Code A

On this occasion the room is equipped with a remote monitoring facility, it's that red light on top of the tapes there doctor. When that red light is on it means it's being monitored, and it is being monitored at the moment by

Detective Inspector GROCOTT. It's being monitored purely just to facilitate any enquiries we might want to do as a result of this interview quickly. When those tapes are turned off though nothing can be heard in this room throughout the remote facility, so if you want to take legal advice or anything like that you can do in this room, it can't be heard. So that will be me speaking to you the majority of the time, DC Code A will be taking some notes and he will also be asking some questions. Now Operation Rochester, this is an investigation that's being conducted by the Hampshire Constabulary and it started in September 2002, so this particular investigation has been running for over three years now. It is an investigation into allegations of the unlawful killing of a number of patients at the Gosport Ware Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence, or any offence has been committed but it's important for you to be aware that the offence range being investigated runs from potential murder right the way down to assault. Now part of the ongoing enquiries is to interview witnesses who were involved in the care and treatment of the patients at the hospital during that period. You were a clinical assistant at the Gosport War Memorial Hospital at the times of these deaths, so your knowledge of the working of the hospital and the care and the treatment of the patients is very central to our enquiry. Today doctor in this interview we will be concentrating on the patient Geoffrey PACKMAN. He was a 68 year-old-man admitted to Dryad Ward on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital. He died on the 3rd of

September 1999 (03/09/1999). Now I'm going to ask you quite a few questions today and all these groups of questions will come under particular topics and headings, and what I'll try to do is I'll endeavour to explain each topic at the start.

BARKER — Can I just indicate the,...

DC Code A — Uh-huh.

BARKER — ...just confirm again the nature of the advise that I've given Doctor BARTON that she should make 'no comment' to the questions that you put her and invite her to indicate if she accepts that advise and for the reasons that she's previously stated to.

BARTON — (Silent.)

DC Code A — Yeah that's okay. Now that's the advice given to you by your solicitor, it's entirely up to you whether you take that advice, but I still have a duty to ask you a number of questions, which I propose to do okay. Right the following questionnaire is designed so that we can try and get an explanation from you as to the role you performed in the care and treatment of Geoffrey PACKMAN. The questions follow on from the initial 'prepared statement' that you tendered during a voluntary interview in 2005. The explanations or lack of that you give will be considered by the senior investigating officer as to whether they will ultimately be sufficient evidence to formulate criminal

charges. The asking of each of these questions seems fundamental to the overall investigation of this case and will therefore take some time. Now it is important that you are given sufficient time to understand and reflect on the question and any answer before we ask you further questions, so there will be gaps after the questions, this is purely so that you can consider your reply. Now you were given copies of Geoffrey PACKMAN's Medical Records back in 2005. Is that correct?

BARTON — Correct.

BARKER — And I am confirming that as well.

DC Code A — Yeah. And you've also got a copy of your own 'prepared statement', is that right?

BARTON — (Silent)

DC Code A — Right the first topic area I would like to cover today is 'clerking'. Now clerking the patient is essential to ensuring that the patient's needs and treatments are identified and that suitable care plans are put in place. And what I want to establish is what you believe is the purpose of 'clerking' and what your own procedures were? I also want to try and identify what you see as the role of either the nurse or the doctor in clerking? (Pause) The GMC, General Medical Council booklet for Good Medical Practice, which we have a copy of here, a photocopy of, and it's got an identification reference of CSY/HF/2. In here, I'll leave this if you want

to consult it doctor, it states that 'Good clinical care must include adequate assessment of the patient's condition based on the history and symptoms and, if necessary, an appropriate examination'. And it goes on after that to say - 'In providing care you must keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings with decisions made, the information given to patients and any drugs or other treatments prescribed'. And it also goes on to say – 'Good clinical care must include taking suitable, prompt action where necessary', and that's going to form quite an important part of today's questions. Also it says – 'Prescribe drugs, including repeat prescriptions only when you have adequate knowledge of the patient's health and medical needs'. Doctor did you provide a suitable and adequate assessment of Mr PACKMAN's care?

BARTON — No comment.

DC Code A — What is the purpose of the clinical assistant in the context of looking after patients?

BARTON — No comment.

DC Code A — We have here a copy of the Job Description for the Clinical Assistant at the hospital and it's got an identification reference of GJQ/HF/14, and it lists thirteen duties. Have you read this document?

BARTON — No comment.

DC Code A — (Pause) The duties, the thirteen duties are to visit the units on a regular basis and to be available on call as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day-to-day medical management of patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up-to-date and reviewed regularly. To complete upon discharge the Discharge Summary, an HRM60. To ensure the prompt preparation of Death Certificates and Cremation Certificates where appropriate. To take part in the weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant physicians in geriatric medicine. To participate, wherever possible, in the multi disciplinary case conferences and discussions related to the patients on the unit. To provide clinical advice and professional support to other members of the caring team. To identify opportunities to improve services so that a high level of care can be provided within the resources available. To be available, when required, to advise and counsel relatives and to be responsible for liaison with the general practitioners with whom the patient is registered with other clinicians and agencies as necessary. Did you carry out these duties in your role?

BARTON — No comment.

DC Code A — How often doctor would you visit the patients?

BARTON No comment.

DC Code A I believe you have said in previous statements that 'you would visit the patients Monday to Friday between half-seven and nine o'clock (that's in the morning), virtually every lunchtime and quite often about 1900, seven o'clock in the evening especially if you were the duty doctor'. Is that correct?

BARTON No comment.

DC Code A Doctor could you take me through what your daily routine was?

BARTON No comment.

DC Code A As I mentioned before you've implied that 'you visit the hospital between half-past-seven (0930) and nine o'clock every morning'. Is it correct that you then have your GP Practice to attend between nine (0900) and eleven (1100) every morning?

BARTON No comment.

DC Code A And quite often don't leave until half-eleven (1130)?

BARTON No comment.

DC Code A (Inaudible – mumbles).

DC Code A	Now that was every morning Monday to Friday. Is it correct that you also had other duties at your practice?
BARTON	No comment.
DC Code A	Did you have other clinics to attend?
BARTON	No comment.
DC Code A	Did also, on a Tuesday evening, have an evening surgery between half-past-four (1430) and quarter-past-five (1715)?
BARTON	No comment.
DC Code A	Is that in rotation with your partners?
BARTON	No comment.
DC Code A	Did you used to conduct post-natal, the post-natal clinic on a Monday afternoon...
BARTON	No comment.
DC Code A	...between half-past-one (1330) and half-past-three (1530)?
BARTON	No comment.
DC Code A	On a Thursday, again in the afternoon, did you attend an anti-natal clinic between half-past-one (1330) and four o'clock?

BARTON	No comment.
DC Code A	And on a Friday afternoon between half-past-one (1330) and three o'clock and immunisation clinic?
BARTON	No comment.
DC Code A	Is your name included on the Obstetric list?
BARTON	No comment.
DC Code A	Doctor (pause) this is information that was requested back in January 1990, it's a questionnaire, a medical list and local directory of family doctors and it actually has an identification reference of...
DC Code A	GJQ/HF/1.
DC	Oh lovely thank you. Which has been filled in by hand. On Page 13, is that your signature doctor?
BARTON	No comment.
DC Code A	In relation to Mr PACKMAN, why was he admitted to the Gosport War Memorial Hospital?
BARTON	No comment.
DC Code A	And what was the purpose of his stay?

BARTON	No comment.
DC Code A	And why was he admitted to Dryad Ward?
BARTON	No comment.
DC Code A	Well where did Mr PACKMAN come from before he went to Dryad Ward?
BARTON	No comment.
DC Code A	Doctor is it correct that Mr PACKMAN came on the 23rd of August 1999 (23/08/1999) from the Queen Alexandra Hospital?
BARTON	No comment.
DC Code A	Doctor what is 'continuing care'?
BARTON	No comment.
DC Code A	(Inaudible – speaks to DC Code A).
	Doctor can I draw your attention to a document…
DC Code A	CSY/HF/4.
DC Code A	HF/4, Portsmouth Health Care NHS Trust. It's the Department Of Medicine For Elderly People Essential

Information for Medical Staff. There is an entry here about 'continuing care and long stay', and on the fifth (5th) paragraph it says: "It is often difficult to know on first encounter if the patient on the ward whether they are appropriate for continuing care or not. Patients who are severely physically disabled and require a medical input can go to continuing care for a period of assessment over a few weeks to one month. If at the end of that time they have complex medical problems that need continuing input from nursing, medical and other professionals, and their Barthel score is lower than four our to twenty (4/20) then they should be appropriately cared for on continuing care. Some of these patients will improve with time, in which case the situation would have to be reviewed. Those patients who do not need regular input from a specialist team would be most appropriate for nursing home care. This assessment should be explained to patients and their families'. Now would you say that that is a fair definition of continuing care?

BARTON — No comment.

DC Code A — Is that a definition you are familiar with Doctor BARTON?

BARTON — No comment.

DC Code A — So what is the difference between 'continuing care' and 'rehabilitation'?

BARTON — No comment.

DC Code A	And 'palliative care'?
BARTON	No comment.
DC Code A	(Pause) Doctor if I may draw your attention to Page 54 of the medical notes for Geoffrey PACKMAN, which are BJC/34 and they're the clinical notes. On the 23rd of August 1999 (23/08/1999), which is when Mr PACKMAN came into the hospital, he was seen by a doctor. Are they your notes doctor?
BARTON	No comment.
DC Code A	Now there's a page of notes here where the patient has been initially seen by a doctor and it was Doctor RAVI...
DC	RAVINDRANE.
DC	RAVINDRANE. There's on full page of notes there. Is that what you would expect to see when the patient was clerked?
BARTON	No comment.
DC Code A	On either admission or transference of a patient to the ward, what process should then take place?
BARTON	No comment.

DC Code A	Is that what clerking is?
BARTON	No comment.
DC Code A	Who should carry out this function?
BARTON	No comment.
DC Code A	Should it be a doctor?
BARTON	No comment.
DC Code A	Should it be a nurse?
BARTON	No comment.
DC Code A	Were you present at the time of Mr PACKMAN's admission?
BARTON	No comment.
DC Code A	What notes would be available at the time of Mr PACKMAN's admission?
BARTON	No comment.
DC Code A	Would the notes from the Queen Alexandra Hospital accompany Mr PACKMAN to the War Memorial Hospital?
BARTON	No comment.

DC Code A	So what is then the purpose of the initial clerking?
BARTON	No comment.
DC Code A	What is an adequate assessment for the patient's condition?
BARTON	No comment.
DC Code A	Again if I show you again Page 54, I've shown you that before, it's a page of notes made by a doctor, that's on Mr PACKMAN's initial attendance at the hospital on the 23rd of August 1999 (23/08/1999). For the rest of his stay there's less than a page. Now in fact I believe you've just made two more entries on there. (Pause) Is that what you would say was that 'an adequate assessment for the patient when they arrived at the hospital'?
BARTON	No comment.
DC Code A	(Pause) Shall we take the doctor through that entry Code A?
DC	Yeah.
DC	That entry doctor, you have a copy available I believe in front of you, if you just have a look at it. It reads (1) Obesity, (2) Arthritis bilateral knees, (3) Immobility, (4) Pressure sores. On a high protein diet. Query Myeloma 13/08/1999, HP stable, Q15 29, constipated on Doxazosin, MST = very good better in himself, 0JVP, CVS. Now do

you think that that was a reasonable example of how to clerk-in a patient?

BARTON No comment.

DC Code A Now Mr PACKMAN actually suffered a fall and that's why he was initially admitted to the Queen Alexandra Hospital. Again I'll draw your attentions to Pages 44 and 45 of the medical notes. There's two pages here as an initial assessment for the clerking. Is this what you would expect to see?

BARTON No comment.

DC Code A So why is this initial assessment important?

BARTON No comment.

DC Code A What examination did you carry out on Mr PACKMAN?

BARTON No comment.

DC Code A So what baseline were you and your colleagues going to have if Mr PACKMAN's condition changed?

BARTON No comment.

DC Code A Would this one page assessment and clerking on Page 54 of medical notes, is what the baseline is?

BARTON	No comment.
DC Code A	Is it your normal practice just to write on notes at the time of admission that you're happy for staff to confirm death?
BARTON	No comment.
DC Code A	Had you formed the opinion that Mr PACKMAN was at the terminal phase of his life?
BARTON	No comment.
DC Code A	If you had, why?
BARTON	No comment.
DC Code A	Because after the initial assessment the next entry of his clinical notes is the 26th of August, and your last sentence on that eight line entry was: "I am happy for the nursing staff to confirm death." What was wrong with Mr PACKMAN?
BARTON	No comment.
DC Code A	(Pause) Again DC Code A read out the initial assessment, or clerking and it appears as obesity, arthritis, immobility and pressure sores and Myeloma. Was there anything else wrong with Mr PACKMAN?
BARTON	No comment.

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DC Code A	At that stage doctor, although it was (inaudible) Myeloma, at that stage his HP was stable. Was that significant to you?
BARTON	No comment.
DC Code A	And his mental test score has been recorded as 'very good'. He's not suffering from any pain he's better in himself. It would appear that he is obese, the immobility is probably because of the obesity and he has pressure sores. What else was wrong with the man?
BARTON	No comment.
DC Code A	It directly links to clerkings initial assessments, and I would like to see if I can identify what you consider to be the fundamental purpose of initial assessments of a patient?
BARTON	No comment.
DC Code A	Can I just ask her one more question please?
DC Code A	Yeah sure.
DC Code A	Doctor just going back to that you wrote: "I am happy for nursing staff to confirm death," on the 26/08 after Doctor RAVINDRANE had seen him on the 23rd. What was he dying of?
BARTON	No comment.

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DC Code A — You must have thought he was dying for you to have written that surely?

BARTON — No comment. (Somebody coughs)

DC Code A — Okay.

DC Code A — Right so we'll move on to 'initial assessment' then doctor and I'd like to identify what you consider to be the fundamental purpose of the initial assessment with a patient, specifically this will include what routine you follow and the reasons behind the assessment and what the benefit is to both the patient and the medical practitioners. Okay I'm going to quote from the Good Medical Practice from the General Medical Council, which is CSY/HF/2, the copy it's still on my desk there, and that states that 'good clinical care must include adequate assessment for the patient's condition based on the history and symptoms and, if necessary, an appropriate examination'. Now I believe that the purpose of the initial assessment should be to provide a contemporaneous record of a doctor's interaction with their patient for analysis by all medical staff. What was your standard practice when it came to initial assessments?

BARTON — No comment.

DC Code A — What is the purpose of an initial medical assessment with a patient when they arrive on the ward?

BARTON No comment.

DC Code A Who would you expect to make an entry on the medical notes?

BARTON No comment.

DC Code A Who would you be expecting to read the entry?

BARTON No comment.

DC Code A So as the clinical assistant doctor when would you see a patient for the first time?

BARTON No comment.

DC Code A Now the initial assessment in the case of Mr PACKMAN was conducted by another doctor, Doctor RAVINDRANE. When did you first see the doctor, uh first see the patient?

BARTON No comment.

DC Code A Your first notes were recorded on the 26th of August, which is three days later. Why would that be?

BARTON No comment.

DC Code A So what physical examination of Mr PACKMAN did you carry out?

BARTON	No comment.
DC Code A	What assessment, or examination did you carry out on Mr PACKMAN?
BARTON	No comment.
DC Code A	Just the basic things then doctor, who took his temperature.
BARTON	No comment.
DC Code A	Who took his pulse?
BARTON	No comment.
DC Code A	Who took his blood pressure?
BARTON	No comment.
DC Code A	Who listened to his heart and lungs etcetera?
BARTON	No comment.
DC Code A	And where was this recorded?
BARTON	No comment.
DC Code A	Now just taking Mr PACKMAN, what were you treating him for?

BARTON No comment.

DC Code A You've had access to the medical notes now, do you know what you were treating him for?

BARTON No comment.

DC Code A What medical management did you put in place for Mr PACKMAN?

BARTON No comment.

DC Code A What was your Medical Care Plan for Mr PACKMAN?

BARTON No comment.

DC Code A If I refer to Pages 82 and 83 of Mr PACKMAN's medical notes, BJC/34, it's the Nurses' Care Plan and it's to deal with Mr PACKMAN obviously and his bowels. On the 23rd of August the problem identified is that due to immobility Mr PACKMAN was prone to constipation, there was then a desired outcome, which is to try to achieve a regular bowel movement pattern. The evaluation date (inaudible) was daily. Well the nursing action was for, to try and encourage adequate fibre in Mr PACKMAN's diet, to encourage adequate fluid intake, to ensure privacy at all times and to administer...

DC Code A (Inaudible)

DC Code A	...(inaudible) as prescribed, and then after that there's all the notes made by the nurses PWO – bowels open. Is that what you would say was a well laid out Nursing Care Plan?
BARTON	No comment.
DC Code A	And there are Nursing Care Plans then for all sorts of aspects for Mr PACKMAN's care, there's urinary catheter, his personal hygiene and it goes on. Who instructs the nurses and what care plans should be put in place?
BARTON	No comment.
DC Code A	Well where do the nurses get their directions from?
BARTON	No comment.
DC Code A	Who sets the care plans?
BARTON	No comment.
DC Code A	So how do nurses know what care plans to put into place?
BARTON	No comment.
DC Code A	Is it something that's left to chance and the nurses just put in whatever care plans that they see fit?
BARTON	No comment.

DC YATES	So what directions are given to them by doctors?
BARTON	No comment.
DC Code A	Have you got anything?
DC Code A	Yeah. (Pause) When Geoffrey PACKMAN came in on the 23rd Doctor RAVINDRANE wrote down a full page from his initial assessment and it looks like the nurses have taken up on that, so they've got a reasonably clear lead as to what they should be doing with Mr PACKMAN and DC Code A has just read out one page of the Nursing Care Plan and it looks as if the Nursing Care Plan is fairly reasonable and there are a few pages of it. You have been told, you have been cautioned at the start of this interview doctor and I think it's important for us to remind you that your solicitor has advised you to go 'no comment', but we will remind you that this is an opportunity for you to tell us what you know about Geoffrey PACKMAN in particular. Now if you look at this, in the absence of a 'no comment' interview, in the absence of anything from you it looks to me, looking at it, as if you just let the nurses get on with caring for Mr PACKMAN with minimal input from you.
BARTON	No comment.
DC Code A	We again you say 'no comment', but that is an interpretation that I can put on that at the moment, there's very very little written by you in these medical notes,...

BARTON No comment.

DC Code A ...so do you just rely on the experience of the nurses to just get on and look after Mr PACKMAN as best they can?

BARTON No comment.

DC Code A Thank you.

DC With the clerking and the initial examination, Doctor RAVINDRANE he noted that Mr PACKMAN's ongoing problems were obesity, arthritis in his knees, immobility, pressure sores and constipation. He noted that Mr PACKMAN was on a high protein diet, he queried Myeloma on the 13th of August 1999 (13/08/1999), his haemoglobin was stable, he was better in himself with a good mental test score and no pain. So there was little to find on examination of him, but his obesity, swollen legs and pressure sores, is that correct doctor?

BARTON No comment.

DC Code A I can refer you back to Page 54 of the medical notes if you wish.

BARTON No comment.

DC Code A But it does look like yet another example of you relying on nurses to inform you of any changes in the patients'

	conditions. Is that what was happening at the War Memorial doctor?
BARTON	No comment.
DC Code A	If I refer you again doctor back to the document GJQ/HF/14, it's a Job Description and other duties. Duties (3) to be responsible for the day-to-day medical management of the patients, and (4) to be responsible for the writing up of the initial case notes and to ensure that follow-up notes are kept up-to-date and reviewed regularly. That's your job description doctor, did you do that?
BARTON	No comment.
DC Code A	If you didn't, who did?
BARTON	No comment.
DC Code A	Anything on that?
DC Code A	No.
DC Code A	Right that tape is on about forty (40) minutes so it will buzz in a minute. What I'll do then is I'll, we'll stop the interview here and put another tape in, so the time by my watch is 0940 hours and we'll turn the recorder off.

THE INTERVIEW CONCLUDED – THE TAPE MACHINE WAS SWITCHED OFF.

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DOCUMENT RECORD PRINT

RECORD OF INTERVIEW

Number: Y20M

Enter type: FULL TRANSCRIPT
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: BARTON, JANE ANN

Place of interview: FRAUD SQUAD, NETLEY SUPPORT HQ

Date of interview: 17/11/2005

Time commenced: 0914 Time concluded: 0941

Duration of interview: 27 MINUTES (→) Tape reference nos. CSY/JAB/12

Interviewer(s): DC Code A / DC Code A

Other persons present: MR BARKER , SOLICITOR

Police Exhibit No: CSY/JAB/12A Number of Pages: 21

Signature of interviewer producing exhibit

Tape counter times(↲)	Person speaking	Text
	DC Code A	This interview is being tape recorded. I am DC Code A Code A. My colleague is ...
	DC Code A	DC Code A.
	DC	... I'm interviewing Doctor Jane BARTON. Doctor will you please give your full name and your date of birth?
	BARTON	Jane Ann BARTON, 19/10/48.

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DC Code A	Thank you. Also present is Mr BARKER, who is Doctor BARTON's solicitor. Can you please introduce yourself?
BARKER	Certainly confirm that my name's Ian BARKER and I am Doctor BARTON's solicitor.
DC Code A	Thank you. The time is 09 (coughs) excuse me, 0914 hours and the date is the 17th of November 2005. At the conclusion of the interview I will give you a notice explaining what will happen to the tapes. I must remind you doctor that you're still entitled to free legal advice. Mr BARKER is here as your legal advisor. Have you had enough time to consult with Mr BARKER in private or would you like further time?
BARTON	I've had time thank you.
DC Code A	Thank you. If at any time you do wish to stop the interview and take legal advice just say and the interview will be stopped in order that you can do this. I'd also like to point out that you have attended voluntarily, you're not under arrest and you've come here of your own free will. So if at any time that you wish to leave you're free to do so okay. I'll also caution you, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say maybe given in evidence. Do you understand that caution?
BARTON	I do.

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DC Code A	I'll break it up again anyway. It can be broken into three sections. The first is that it is your right not to say anything when asked questions by us. The second part is the slightly more confusing part, if this matter should go to court it may harm your defence if you wish to rely on something as part of your defence, if you've had the opportunity to mention it now. In other words a court may draw, and it is a may draw, well it's called an adverse inference and they'll wonder why you did not mention it earlier when interviewed if it was known to you then. The third and last part is again that's quite simple, the interview is being tape recorded, if it should go to court and it was felt necessary the tapes can be played or a transcript can be read. Is that a fair description? Yeah. On this occasion again this room isn't equipped for remote monitoring so DS GROCOTT who we know is outside so he can't hear anything that's going on in here at all and as before it will be me speaking to you the majority of the time. DC Code A will almost certainly be taking some notes. Mr BARKER I think the last time we met was Thursday the 27th of October?
BARKER	That's right.
DC Code A	And I handed you by way of advance disclosure for this interview, copies of the medical notes of Geoffrey PACKMAN and a brief synopsis of his care.
BARKER	You did indeed.

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DC Code A — I believe those notes weren't particularly good and you had to be given a further copy is that right?

BARKER — That's correct yes one of your colleagues very kindly produced a ...

DC Code A — But they were satisfactory?

BARKER — ... they were yes.

DC Code A — Okay. This investigation is being conducted by Hampshire Constabulary and started in September 2002 it's already been running over three years. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. Now no decision has been made as to whether an offence or any offence has been committed but it's important to be aware that the offence range being investigated runs from potential murder right the way down to assault. Part of the ongoing enquiry is to interview witnesses who were involved in the care and treatment of the patients during that period. You were a clinical assistant at the Gosport War Memorial Hospital at the time of these deaths so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview today will concentrate on the care and treatment of Geoffrey PACKMAN. Mr PACKMAN was admitted to Gosport War Memorial Hospital and subsequently died on the 3rd of September 1999. The cause of death was given as Myocardial Infarction. Perhaps Doctor in your own words

you can tell me what you recollect of Mr PACKMAN and the care and treatment that he received whilst at the Gosport War Memorial Hospital. Now you've already passed them out now, I believe you're going to read from a prepared statement.

BARTON — That's correct.

DC Code A — Is that correct, yeah. Is that statement yours doctor?

BARTON — It is.

DC Code A — And you've made it?

BARTON — I did.

DC Code A — Okay if you'd care to read that, thank you.

BARTON — I am Dr Jane BARTON of the Forton Medical Centre, White's Place, Gosport, Hampshire . As you are aware, I am a General Practitioner, and from 1988 until 2000, I was in addition the sole Clinical Assistant at the Gosport War Memorial Hospital.

I understand you are concerned to interview me in relation to a patient at the Gosport War Memorial Hospital, Mr Geoffrey PACKMAN. Unfortunately, at this remove of time I have no recollection at all of Mr PACKMAN. As you are aware, I provided you with a statement on the 4th November 2004, which gave information about my practice generally, both in relation to my role as a General

Practitioner and as the clinical assistant at the Gosport War Memorial Hospital. I adopt that statement now in relation to general issues insofar as they relate to Mr PACKMAN.

In that statement I indicated when I had first taken up the post, the level of dependency of patients was relatively low and that in general the patients did not have major medical needs. I said that over time that position changed very considerably and that patients who were increasingly dependent would be admitted to the wards. I indicated that certainly by 1998 many of the patients were profoundly dependent with minimal Barthel scores and there was significant bed occupancy. The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients. The statement largely represented the position at the Gosport War Memorial Hospital in 1998.

I confirm that these comments are indeed a fair and accurate summary of the position then, though if anything, it had become even more difficult by 1999 when I was involved in the care of Mr PACKMAN.

Mr Geoffrey PACKMAN was a 67 year old man who lived at home with his wife and daughter in Emsworth. It appears that he was visited regularly at home by the District Nurse who in February of 1999 noted that he had a large red weeping area on the shin of his right leg. A Doppler's test was performed, being an ultrasound

measurement of the pressure in the veins of the legs. Mr PACKMAN's GP appears to have referred him to Consultant Urologist Mr CHIVERTON at some point after April 1999. The GP referred in his letter to symptoms of prostatism and a raised PSA. He said that Mr PACKMAN had had a negative mid-stream urine test, but rectal examination, presumably to assess the size of the prostrate, had been virtually impossible because of Mr PACKMAN's huge size and inability to lie properly on his side. The GP noted that Mr PACKMAN was grossly obese, and indeed a subsequent measurement of his weight was recorded at 146kg - in excess of 23 stone.

Mr PACKMAN was noted to have a raised random blood sugar and was also due to have a glucose tolerance test to exclude diabetes mellitus.

At the end of June his GP then made a further referral, this time to Consultant Dermatologist Dr KEOHANE in relation to Mr PACKMAN's leg ulceration. Mr PACKMAN had apparently been attending the District Nurse's leg ulcer clinic for many months and had hugely oedematous legs. The District Nurse had drawn the GP's attention to a large granulomatous raised area on the back of his right calf, and Dr Code A's advice was requested. At this stage it seems that Mr PACKMAN was being visited by the District Nurse 3 times a week in order to dress the leg ulceration, that he had recently become immobile and his condition had worsened. Mr PACKMAN was seen in the dermatology clinic on 30th June 1999, the Senior House Officer reporting back that Mr PACKMAN

had bi-lateral severe oedema with some leg ulceration secondary to venous hypertension. Mr PACKMAN was to be brought in for further Doppler's testing.

On 6th August 1999 Mr PACKMAN was then admitted to the Queen Alexandra Hospita l having suffered a fall. He was unable to mobilise and 2 Ambulance crews were called to assist. It was noted on admission that the GP and the District Nurse were unable to cope with Mr PACKMAN at home. The diagnoses at that stage were bi-lateral leg oedema, with ulcers on the left leg, obesity and it was noted that he was simply not coping.

In the course of clerking-in on 6th August, it appears that Mr PACKMAN was suspected to be in atrial fibrillation. An ECG was arranged which showed atrial fibrillation at the rate of 85. Blood tests revealed that he has a white cell count of 25,000, an ESR of 31 and a CRP of 194. He was felt to have cellulitis in the groin and left lower leg, he was commenced on antibiotics and his diuretic medication was changed to Frusemide. His past medical history was noted to consist of the bi-lateral leg oedema, which he had apparently had for 5 years, hypertension which had been treated since 1985 and arthritis.

It appears that about the time of admission Mr PACKMAN was recorded as having a large black blistered area on his left heel in addition to the leg ulceration.

Following assessment his problems were recorded as cellulitis of the left leg, chronic leg oedema, poor mobility,

morbid obesity, raised blood pressure and possible atrial fibrillation. In relation to the latter and prior to the performance of the ECG, anticoagulants were suggested if atrial fibrillation was confirmed, and the possibility of left ventricular dysfunction was also raised. Shortly thereafter Mr PACKMAN was commenced on Clexane 40mgs twice daily.

At this stage Mr PACKMAN's creatinine level was noted at 173, with urea at 14.9, suggesting that the insult due to the infection in his legs was resulting in compromise of his renal function.

It was also noticed on 6th August that "in view of pre-morbid state + multiple medical problems [Mr PACKMAN was] not for CPR in event of arrest". A Barthel score stated to have been assessed on 5th August (presumably 6th August in error) was recorded as zero, indicating that Mr PACKMAN was completely dependant.

Mr PACKMAN was reviewed by the Specialist Registrar the following day, 7th August, who agreed, presumably on the basis of what was felt to be Mr PACKMAN's poor condition at that stage, that he was not to be resuscitated in the vent of arrest. It was suggested that his anti-hypertensive medication should be changed to an ACE inhibitor in view of the oedema and he was considered for a beta-blocker in view of his atrial fibrillation. His diuretic was changed lest it cause dehydration. Mr PACKMAN was given Flucloxacillin 500 mgs 4 times daily,

supplemented by Penicillin V 500 mgs 4 times a day to combat the cellulitis.

Although steps were apparently taken to prevent the development of pressure sores, on 8th August Mr PACKMAN was noted to have sores to the sacrum, being described as "Grade 3". I believe this would have been a reference to a wound classification system, Grade 3 suggesting that there was full thickness skin loss involving damage of subcutaneous tissue.

Over the next few days it appears that Mr PACKMAN's cellulitis improved but the overall assessment of his suitability of resuscitation did not change - on 11th and again on 13th August it was again specifically noted that he was not for resuscitation - recorded as "Not for 555".

On 13th August Mr PACKMAN was reviewed by a Consultant Geriatrician Dr Jane TANDY . She noted that he had had black stools overnight. The following day a nursing note records that when the dressings on the pressure sores were renewed, the wounds to the left buttock and right lower buttock and thigh were very sloughy and necrotic in places, and very offensive smelling. Clearly by that time, Mr PACKMAN had developed significant pressure sores.

A Barthel score measured on 14th August again recorded a score of zero indicating his complete dependence.

It appears that by 15th August a decision had been made that Mr PACKMAN should be transferred to the Dryad Ward at the Gosport War Memorial Hospital. A note in the nursing records indicates that Staff Nurse HALLMAN at Gosport War Memorial Hospital had indicated that we were not in a position to take Mr PACKMAN at that time. This is likely to have been an indication that there were no beds available and that we would have been under considerable pressure in consequence of the high bed occupancy.

An entry in Mr PACKMAN's records for 20th August by the Specialist Registrar indicates that Mr PACKMAN was due to transfer to Gosport War Memorial Hospital on 23rd August. The Specialist Registrar also noted that Mr PACKMAN remained not for resuscitation. A Barthel score measured on 21st August again recorded a score of zero indicating his complete dependence.

Mr PACKMAN was then admitted to the Gosport War Memorial Hospital on 23rd August 1999. There is a clerking-in note contained within his records, but I do not recognise the handwriting or signature of the doctor who assessed him on this occasion. His problems were noted to be obesity, arthritis, immobility and pressure sores. The episode of melaena on 13th August was noted, with his haemoglobin being stable. At that stage he was said to be in no pain. Cardiovascular and respiratory systems were thought to be normal. The clinician admitting Mr PACKMAN also prescribed medication in the form of Doxazosin 4 mgs daily for hypertension, Frusemide 80 mgs

once a day as a diuretic for Mr PACKMAN's oedema, Clexane 40mgs twice a day for DVT prophylaxis and atrial fibrillation. Paracetamol 1gm 4 times daily for pain relief, Magnesium Hydroxide 10 mls twice daily for constipation, together with Gaviscon for indigestion and cream for his pressure sores.

On this occasion, a Barthel score of 6 was recorded for 23rd August, suggesting that, although Mr PACKMAN might have improved to a degree, he was still significantly dependent.

I anticipate that I would have reviewed Mr PACKMAN the following day as part of my assessment of all the patients on the ward, though it appears that I did not have an opportunity to make any entry in his medical records on this occasion. The prescription chart shows that I prescribed Temazepam for Mr PACKMAN on a PRN basis - as required - at a dose range of 10-20 mgs. 10 mgs of Temazepam was then given on the night of 24th August, with a night nursing record indicating that he slept for long periods.

I anticipate that I would have reviewed Mr PACKMAN the following day, 25th August, although again I did not have an opportunity to make an entry in his records. It appears that Mr PACKMAN then was noted to have passed blood per rectum, and Dr BEASLEY was contacted, Dr BEASLEY presumably being on duty out-of-hours. He advised that the Clexane should be discontinued. Dr BEASLEY also appears to have prescribed

Metoclopromide by way of verbal order, which I later endorsed, together with Loperamide. The Metoclopromide was apparently given at 5.55pm (1755) with good effect. The dressings on the pressure sores were removed on 25th August and were noted to be contaminated with faeces.

I do not know if I reviewed Mr PACKMAN on the morning of 26th August. He was noted by the nurses to have had a fairly good morning. Sister HAMBLIN has recorded that Dr RAVI , locum Consultant Geriatrician, was contacted and he confirmed that the Clexane should be discontinued and the haemoglobin repeated. Again, Mr PACKMAN was noted to be "not for resuscitation". Sister HAMBLIN may have contacted Dr RAVI if I was unavailable that morning. The nursing record goes on to indicate that Mr PACKMAN then deteriorated at about lunchtime, that his colour was poor and that he complained of feeling unwell. I was called to see him, my entry in his records on this occasion reading as followed.

'Called to see, pale, clammy, unwell
Suggest ? MI. treat stat diamorph
And oramorph overnight
Alternative possibility GI bleed but no haematemisis
Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death'.

As my note indicates, I was concerned that Mr PACKMAN might have suffered a myocardial infarction and accordingly I decided to administer opiates in the form of

Diamorphine for pain and distress consequent on the possible myocardial infarction, at a dose of 10 mgs intramuscularly. In addition, I would have been conscious that he had large pressure sore areas on his sacrum and thighs which would have been causing him significant pain and discomfort. I prescribed 10 mgs Diamorphine intramuscularly to be given immediately, which is recorded on the drug chart as a verbal instruction. An alternative diagnosis which I recorded was that Mr PACKMAN had had a gastro intestinal bleed.

My impression when I assessed Mr PACKMAN on this occasion was that he was very ill. I felt that in view of his condition and the previous decisions that he was not for resuscitation, transfer to an acute unit was quite inappropriate. Any such transfer was very likely to have had a further deleterious affect on his health.

The nursing note for 26th August indicates that we were to await blood test results. There was then a further deterioration later in the day, with Mr PACKMAN complaining of indigestion and a pain in his throat, which was not radiating.

The blood count taken on 26th August subsequently showed that Mr PACKMAN's haemoglobin had dropped to 7.7 grams, a substantial drop from the 12 grams which had been recorded 2 days earlier.

It appears that I re-attended to see Mr PACKMAN at 7.00pm (1900) on 26th August. Concerned that he should

have further appropriate medication to relieve his pain and distress, I prescribed Oramorph 10-20 mgs 4 times a day together with 20 mgs at night. 20 mgs of Oramorph was later given at 10.00pm (2200).

I also wrote up prescriptions for Diamorphine 40-200 mgs subcutaneously over 24 hours, together with 20-80 mgs of Midazalam via the same route on an anticipatory basis, concerned that further medication might be required in due course to relieve Mr PACKMAN's pain and distress. It was not my intention that this subcutaneous medication should be administered at that time. The nursing record also indicates that I saw Mr PACKMAN's wife , explaining her husband's condition and the medication we were using. I anticipate I would have indicated to Mrs PACKMAN that her husband was very ill indeed and in all probability that he was likely to die.

I would have reviewed Mr PACKMAN again the following morning and indeed the nursing record confirms that I attended to see him then. Sister HAMBLIN has recorded that there had been some marked improvement since the previous day and that the Oramorph was tolerated well and should continue to be given, though Mr PACKMAN apparently still had some discomfort later that afternoon especially when the dressings were being changed. In spite of the earlier improvement, Mr PACKMAN was said to remain poorly. 10 mgs of Oramorph were administered 4 hourly, together with a further 20 mgs at night as prescribed, so that Mr PACKMAN received a total of 60 mgs that day, though this was seemingly not enough to

remove his pain and discomfort when his dressings were being changed. The nursing records indicate that he appeared to have had a comfortable night.

I reviewed Mr PACKMAN again the following morning and on this occasion I made a note in his records which reads as follows:

'28-8-99 Remains poorly but comfortable
please continue opiates over weekend'.

The nursing record indicates that Mr PACKMAN remained very poorly with no appetite. However, the Oramorph again seems to have been successful in keeping Mr PACKMAN comfortable at night.

I do not believe I would have seen Mr PACKMAN on Sunday 29th August. The nursing record indicates that he slept for long periods but that he also complained of pain in his abdomen. The sacral wounds were said to be leaking a lot of offensive exudate.

I do not know if I would have seen Mr PACKMAN again the following morning, Monday 30th August, that being a Bank Holiday. I have no way of knowing now if I was on duty then. If I did see him as part of my review of all the patients on the two wards, I did not have an opportunity to make a specific entry in his records on this occasion. A Barthel score was recorded as 4. The nursing record indicates that Mr PACKMAN's condition remains poor and later that day - at 2.45pm (1445) the syringe driver was set

up to deliver 40 mgs of Diamorphine and 20 mgs Midazalam subcutaneously. I anticipate that Mr PACKMAN would have continued to experience pain and clearly in view of the significant sacral sores, it's highly likely that he would have been experiencing further significant discomfort.

In view of his poor condition I anticipate that I considered him to be terminally ill and I would have been concerned to ensure that he did not suffer pain and distress as he was dying. Mr PACKMAN had received 60 mgs of Oramorph daily over the preceding 3 days and the administration of 40 mgs of Diamorphine subcutaneously over 24 hours did not represent a significant increase. Mr PACKMAN would have started to have become inured to the opiate medication and an increase of this nature was in my view entirely appropriate to ensure that his pain was well controlled. Indeed, the nursing record goes on to state that there were no further complaints of abdominal pain and Mr PACKMAN was able to take a small amount of food.

I anticipate that the nursing staff would have liaised with me prior to the commencement of the Diamorphine and Midazalam and that this would have been set up on my instruction, directly if I had been at the hospital, or otherwise by phone.

On the morning of 31st August Mr PACKMAN was recorded as having had a peaceful and comfortable night, though he then passed a large amount of black faeces that morning.

I believe I would have seen Mr PACKMAN again that morning, though again I did not have an opportunity to make an entry in his records. I anticipate his condition would have been essentially unaltered and that he would have remained comfortable. Similarly, I would probably have seen Mr PACKMAN again on the morning of 1st September but would have been unable to record this. I anticipate that his condition was again unchanged. 5 separate pressure sore areas were noted by the nurses. A Barthel score of only 1 was recorded.

Mr PACKMAN was reviewed the same day by Consultant Geriatrician Dr REID . Dr REID noted that Mr PACKMAN was rather drowsy but comfortable. He had been passing melaena stools. His abdomen was noted to be huge but quite soft and Dr REID also recorded the presence of the pressure sores over the buttocks and across the posterior aspects of both thighs. He noted that Mr PACKMAN remained confused and was for "TLC". The Frusemide and Doxazosin were to be discontinued and Mr PACKMAN's wife was said to be aware of his poor prognosis.

The entry by Dr REID that Mr PACKMAN was to have "TLC" - tender loving care - was clearly an indication that Dr REID also considered Mr PACKMAN to be terminally ill. Dr REID had the opportunity to review the medication which Mr PACKMAN was receiving at that time and clearly felt it appropriate.

Sister HAMBLIN recorded later in the nursing records that the syringe driver was renewed at 7.15pm (1915) with 60 mgs of Diamorphine and 60 mgs of Midazalam subcutaneously as the previous dose was not controlling Mr PACKMAN's symptoms. It appears therefore that Mr PACKMAN was experiencing yet further pain and discomfort. I anticipate that the nursing staff would have contacted me and that I authorised this moderate increase in his medication in order to alleviate the pain and distress.

That night, Mr PACKMAN was noted to be incontinent of black tarry faeces but otherwise he had a peaceful night and the syringe driver was said to be satisfactory.

I believe I would have reviewed Mr PACKMAN again the following day, 2nd September. The nursing notes show that his medication was again increased, the Diamorphine to 90 mgs and the Midazalam to 80 mgs subcutaneously. I anticipate again that Mr PACKMAN would have been experiencing pain and distress and that I and the nursing staff were concerned that the medication should be increased accordingly to ensure that he did not suffer pain and distress as he died. That night, Mr PACKMAN was said to remain ill, but was comfortable and the syringe driver was satisfactory.

Sadly, Mr PACKMAN passed away on 3rd September 1999 at 1.50pm (1350). My belief was death would have been consequent on the myocardial infarction.

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The Oramorph, Diamorphine and Midazalam were prescribed and in my view administered solely with the aim of relieving Mr PACKMAN's pain and distress, ensuring that he was free from such pain and distress as he died. At no time was any medication provided with the intention of hastening Mr PACKMAN's demise.

DC Code A — Thank you. I must, I don't think there's anything that needs altering on that unless you've made any, again doctor thank you it's a very full prepared statement. Can I ask you if you would to sign it and date it and time it as being handed to me DC Code A? Mr BARKER would you care to countersign it, thanks? Thank you. For the purpose of the tape I'll give this prepared statement an identification reference of JB/PS/11. Doctor we'll call a stop to the interview now so that we can go away and consider the statement that you've just read out. I may well wish to put a number of questions to you about this statement if I do would you be prepared to answer those questions?

BARTON — No.

DC Code A — No okay.

BARKER — Can I just say?

DC Code A — Yeah.

BARKER — That's on the basis of the advice previously tended and for the reasons previously given which I know is ...

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DC Code A	Okay. Is there anything that you wish to clarify Doctor?
BARTON	No thank you.
DC Code A	Is there anything you wish to add? Right we'll give you a notice explaining what will happen to the tapes and the tape recording procedure. The time is 9.41 (0941) hours and we'll turn the recorder off.

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Statement number: S329S

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STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

Age: 49 Date of Birth: Code A

Address: Code A Postcode: Code A

Occupation: CONSULTANT PHYSICIAN GERIATRIC MEDICINE

Telephone No.: Code A

Statement Date: 17/01/2006

Appearance Code: Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane BARTON re Geoffrey PACKMAN . In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Job Description for Clinical Assistant Post to the Geriatric Division in Gosport as provided to me by the Hampshire Constabulary (February 2005).

2.2 Statement of Dr Jane BARTON re Geoffrey PACKMAN as provided to me by Hampshire Constabulary (January 2006). Appendix 1

2.3 Statement of Dr Jane BARTON as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Geoffrey PACKMAN (BJC/ 34) Professor D BLACK 2005.

3. COMMENTS

3.1 Comments on Job Description (2.1)

3.1.1 This confirms the Clinical Assistant is responsible for a maximum of 46 patients and confirms that all patients are under the care of a named Consultant Physician who would take overall responsibility for their medical management. A Clinical Assistant should take part in the weekly consultant ward rounds.

3.1.2 A specific responsibility is the writing up of the original case notes and ensuring the follow up notes are kept up to date and reviewed regularly.

3.1.3 The post is for five sessions a week i.e. is half what a full time doctor would commit to the post. However, the time to be spent in the unit is not specified as the time is allowed to be "worked flexibly".

3.1.4 There appears to be some confusion between the statements in the job summary, that "patients are slow stream or slow stream for rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients.

3.1.5 There is no comment on the medical cover to be provided when the post holder is unavailable for out of hours or longer period of leave such as holidays. Lack of explicit cover might explain some gaps in the notes.

3.2 Report on the statement of Dr Jane BARTON re Geoffrey PACKMAN (2.2).

3.2.1. Paragraphs 28 and 29 of Dr BARTON's statement clarify some of the drug prescribing difficulties set out in my report. I now agree that Oramorphine 10-20mg 4 hourly is prescribed on the 26 to the 29th of August not Diamorphine . Also it does not appear that s/c Diamorphine was given at the same time as I postulated was possible in paragraph 5.15. However it is still not possible for me to tell from the notes if the nursing staff gave 10mg or 20mg of the Oramorphine thus a total daily dose of 60mg up to 100mg is possible. Thus the statements of 60 mg in paragraphs 30 and 35 of Dr BARTON's report are unproven. I agree that Diamorpnine s/c 40 mg was given from the 30th of August and this was an appropriate dose.

3.2.2 In view of the above paragraph 6.9 should say Oramorphine on a regular basis, not Diamorphine.

3.3.3 Paragraph 6.10 should say "... after single dose of Diamorphine on the 26th he receives regular Oramorphine, then Diamorphine and Midazolam until his death."
The same paragraph should also say : "He appears to have been started on between 60 and (possibly)100mg of Oramorphine in 24 hours, subsequently (on the 30th) converted to 40mg of Diamorphine together with 20 mg of Midazolam. In my view this is a higher dose than most clinicians would start with, which would be 20-40mg of Oramorphine in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes."

3.3.4 Paragraph 7.2 should say Oramorphine not Diamorphine.

3.2.5 These alterations do not effect the overall conclusions in my report.

3.3 Report on the Statement of Dr Jane BARTON as provided to me by the Hampshire Constabulary (2.3):

3.3.1Page 1 paragraph 3: States that she works eight general practice surgery sessions. It is my understanding that most full time General Practitioners work eight or nine sessions. This suggests to me that she is undertaking a full time General Practitioner job and a half time community hospital job. Despite the fact the job description says that the job can be worked flexibly, an opinion should be obtained from an experienced General Practitioner as to whether this workload is actually deliverable within a reasonable working week.

3.3.2 Page 1 paragraph 4: The job description states 46 beds, Dr
BARTON states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) Dr BARTON uses the phrase "continuing care for long stay elderly patients". The job description also referred to slow stream or slow stream rehabilitation as well as holiday relief and shared care patients. There may have been confusion between staff in terms of the objectives of individual patient management.

3.3.3 Page 1 paragraph 5: This statement is incorrect as the post of Clinical Assistant is not a training post but a service post in the NHS. The only medical training grade posts are pre-registration house officers, senior house officers, specialist registrars and GP registrars.

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Dr BARTON to deliver the aspects of care provided.

3.3.5 Page 2 paragraph 3: This does confirm that there were consultants responsible for all the patients under the care of Dr. BARTON. Thus a consultant should always have been available for discussing complex or difficult management decisions. However,(page 3 paragraph 1) , in my view it would be completely unacceptable of the Trust to have left Dr BARTON with continuing medical responsibilities for the inpatients of Gosport Hospital without consultant supervision and regular

ward rounds. This would be a serious failure of responsibility by the Trust in its governance of patients and in particular failings and in my view the Trust would need to take part of the responsibility for any clinical failings.

3.3.6 Page 3 paragraph 3: This again suggests that Dr BARTON was trying to provide her half time responsibilities by fitting the work around her full time responsibilities as a General Practitioner. She suggests 5 patients were admitted each week, implying approximately 250 admissions and discharges a year. With a bed occupancy around 80%ealth Authority, this would suggest an average length of stay of 5 - 6 weeks. However, CHI state the actual figures were somewhat less, 1997/98 were 169 FCE's for Dryad and Daedalus and 197 FCE's in 1998/99. A new patient assessment including history and examination, writing up the notes, drug charts, talking to the nurses, talking to any relatives present and undertaking blood tests if these had to be taken by a doctor rather than any other staff, would take a maximum of 60 minutes.

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients' physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

It is my view that with less than 200 FCE's and a total of 44 inpatients, then this should be satisfactorily managed by somebody working half time as a Clinical Assistant with regular consultant supervision.

3.3.7 Page 4 paragraph 2: This suggests that Dr BARTON is stating that she takes personal responsibility for most changes in medication, rather than it being a nursing decision.

3.3.8 Page 9 paragraph 2: An individual doctor must take responsibility for their prescribing however I would agree that consultants should also take responsibility for ensuring patients under their care were having appropriate medical management. It does appear that there was a consultant

responsible for all patients in both Dryad and Daedalus Ward.

4. Conclusions

4.1 Having read all the documents provided by Hampshire Constabulary, I would wish to make a few change to my expert report.

4.2 Paragraph 6.9 should say Oramorphine on a regular basis, not Diamorphine

4.3 Paragraph 6.10 should say "... after single dose of Diamorphine on the 26th he receives regular Oramorphine, then Diamorphine and Midazolam until his death." The same paragraph should also say : "He appears to have been started on between 60 and (possibly)100mg of Oramorphine in 24 hours, subsequently (on the 30th) converted to 40mg of Diamorphine together with 20 mg of Midazolam. In my view this is a higher dose than most clinicians would start with, which would be 20-40mg of Oramorphine in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes."

4.4 Paragraph 7.2 should say Oramorphine not Diamorphine

4.5 These alterations do not effect the conclusions in my report

APPENDIX 1

APPENDIX 2

RESTRICTED

DOCUMENT RECORD PRINT

Statement number: S329S

Signed: D BLACK

Signature witnessed by:

RESTRICTED

Statement number: S329J

DOCUMENT RECORD PRINT

STATEMENT PRINT

Surname: BLACK

Forenames: DAVID ANDREW

Age: Date of Birth: Code A

Address: Code A Postcode: Code A

Occupation: CONSULTANT PHYSICIAN GERIATRIC MEDICINE

Telephone No.: Code A

Statement Date: 30/10/2005

Appearance Code: Height: Build:

Hair Details: Position Style Colour

Eyes: / Complexion: /

Glasses: Use:

Accent Details: General Specific Qualifier

Number of Pages:

SUMMARY OF CONCLUSIONS

Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

- gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

2.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions

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5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

5.1 Geoffrey PACKMAN a sixty eight year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

5.2 Mr PACKMAN had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

5.3 Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management(255). He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for Sensitive. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

5.4 He appeared to make some progress and on 9th August his cellulitis was settling (48) . A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

5.5 On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

5.6 Later on the 13th black bowel motion is noted but the doctor who examines him records a

brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no comment is made on the possible gastrointestinal (G.I) bleed , but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

5.7 On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

5.8 He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

5.9 On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62,82).

5.10 On 26th August a doctor (Dr BARTON) is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

5.11 On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

5.12 On 31st he is recorded as passing a large amount of blood rectally (83) and on the 9th September (55 and 64) he is reviewed by a consultant Dr REID who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr REID records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

5.13 Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August - 23rd August.

5.14 The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then there is two days later on 28th August, Diamorphine IM 10 mgs signed Dr BARTON. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

5.15 On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine though written up regularly is never given. Diamorphine 40 - 200 mgs subcut in 24

hours is prescribed and appears to have been given 40mgs on 28th, 29th and 30th 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 - 80 mgs subcut in 24 hours is written up and Midazolam is given 20 mgs on the 28th and 29th August, 40mgs on 30th August, 60mgs on 1st September and 80mgs on 2nd September.

5.16 However, on the next regular page of the drug chart (172) Diamorphine 10-20mgs 4 hourly is written up and is signed up to Have been given for 4 doses on 27th, 28th and 29th August. I cannot tell from the drug chart whether 10mgs or 20mgs is given. It is also totally unclear whether this was given at the same time as the syringe driver, at least on the 28th and 29th August, or whether the drug chart was completely misunderstood as to how it should be used. This will need to be clarified with Dr BARTON and the nursing staff. My assumption is that Mr PACKMAN only actually received 40 mgs of Diamorphine on the 28th and 29th August and not 80mgs as might be implied. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey PACKMAN. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey PACKMAN, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2 Mr PACKMAN had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

6.3 He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate

admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed.

6.4 He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

6.5 In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

6.6 He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital. He is appropriately clerked on admission and indeed appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

6.7 On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr BARTON suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr

PACKMAN has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

6.8 Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr BARTON identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital. Dr BARTON makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

6.9 Mr PACKMAN deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 - 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. There may or may not be confusion over the prescribing of Diamorphine on a regular basis particularly on the 28th and 29th August and the drug chart is used in a most irregular fashion over that period of time. I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

6.10 From the 26th August Mr PACKMAN is dying and after a single dose of Diamorphine on the 26th August, receives regular Diamorphine and Midazolam until his death. Diamorphine while specifically prescribed for pain is commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the starting dose of Diamorphine. This would be complicated in this case by the massive obesity

which might well effect the absorption of the Diamorphine from subcutaneous injection, together with his serious pressure sores which would be extremely painful on being dressed. He appears to have been started on 40mgs of Diamorphine in 24 hours with 20mgs of Oramorphine (equivalent to another 10mgs of Diamorphine) at night together with 20mgs of Midazolam. In my view this is a higher dose than most clinicians would start with which would be more likely to be 10-20 mgs in the first 24 hours. However I can find no evidence that there was any significant side effects from the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

6.11 He is reviewed by a consultant (Dr REID) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr REID is happy with the management and later in the day the Diamorphine is increased because the previous dose is no longer controlling his symptoms. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

6.12 In my view, based on the evidence in the notes the doses of Diamorphine used although higher than might have been conventional at the start, were required to control Mr PACKMAN's symptoms and did not contribute in any significant fashion to his death.

6.13 In my view a death certificate should read:
1a Gastro-intestinal haemorrhage
2 Pressure sores and morbid obesity

7. OPINION

7.1 Mr Geoffrey PACKMAN was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

7.2 There are a number of weaknesses in the clinical care provided to Mr PACKMAN:

- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to further medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

a difficult clinical decision is made without appropriate involvement, of senior medical opinion.
- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.
- a higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is my opinion that Mr PACKMAN died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

RESTRICTED

Statement number: S329J

DOCUMENT RECORD PRINT

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise..
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and

complete professional opinion.

Signed: D A BLACK

Signature witnessed by:

Geoffrey Packman statements 20th June 2006

CONTENTS

1. **INSTRUCTIONS**

To examine and comment upon the witness statements in the case of Geoffrey Packman. In particular, if they raise issues that would impact upon any expert witness report prepared.

2. **DOCUMENTATION**

This report is based on the following document:

2.1 Witness statements to the hospital care and death of Geoffrey Packman provided to me by the Hampshire Constabulary (June 2006). In total 27 statements.

2.2 Report regarding Geoffrey Packman (BJC/34) Dr D Black 30th October 2005.

3. **COMMENTS**

3.1 Comments on Witness Statement (2.1)

3.1.1 I have read all the statements in particular the statements of Nurse Hamblin and Hallman . Based on these and the previous statement of Dr Barton I feel that I need to produce a new version of my expert statement, taking into account some clarification over the drug chart.

4. **CONCLUSION**

4.1 Having read all the documents above provided by Hampshire Constabulary, I would wish to make changes to my expert report, and enclose a new version (20th June 2006).

Version 3 of complete report 20th June 2006 – Geoffrey Packman

SUMMARY OF CONCLUSIONS

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman:
- gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.
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- prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

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To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.
2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

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Secondary care as part of the whole system. Laing & Buisson conference on intermediate care. April 2001
The impact of the NSF on everyday Clinical Care. Conference on Clinical governance in elderly care . RCP May 2001
The Geriatricians view of the NSF. BGS Autumn Meeting 2001
The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001
The future of Geriatric Medicine in the UK. Workshop: American Geriatrics Society May 2002
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Revalidation - the State of Play. A Survival Guide for Physicians. Mainz July 2002
Medical Aspects of Intermediate Care. London Conference on building intermediate care services for the future. Sept 2002
Developing Consultant Careers. Workshop: BAMM Medical Directors Meeting. Nov 2002
Lang and Buisson. Update on Intermediate Care Dec 2002
Intermediate Care Update: London National Elderly Care Conference. June 2003.
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Professional Performance & New Consultants. London Deanery Conference April 2004
Mentoring as part of induction for new consultants. Mentoring in Medicine Conference. Nottingham. April 2004
The Future of Chronic Care- Where, How and Who? CEO & MD conference. RCP London. June 2004
Mentoring as part of consultant induction. Surviving to Thriving. New Consultant Conference, London June 2004
360 Degree Appraisal. Chairman National Conference. Nottingham June 2004
Maintaining Professional Performance. BAMM Annual Summer School. June 2004

Chronic Disease management. BGS Council Study Day. Basingstoke. July 2004
MMC post FP2. BGS Study Day. Basingstoke. July 2004
Designing care for older peoples. Emergency services conference. London July 2004.
The Modern Geriatric Day Hospital. Multidisciplinary Day. South East Kent hospitals. Sept 2004
Geriatricians and Acute General Medicine. BGS Autumn Meeting . Harrogate Oct 2004

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Geoffrey Packman (BJC/34)

[2] Operation Rochester Briefing Document Criminal Investigation Summary.

[3] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[4] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[5] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5. **CHRONOLOGY/CASE ABSTRACT.** (The numbers in brackets refer to the page of evidence).

5.1. Geoffrey Packman a sixty eight year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

5.2. Mr Packman had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

5.3. Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management(255). He had become increasingly immobile complicated by the fact that his wife who lived with him and provided care was being investigated for Sensitive The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

5.4. He appeared to make some progress and on 9th August his cellulitis was settling (48) . A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

5.5. On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

5.6. Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no

comment is made on the possible gastrointestinal (G.I) bleed , but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

5.7. On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

5.8. He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A reasonable history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

5.9. On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62,82).

5.10. On 26th August a doctor (Dr Barton) is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

5.11. On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with

dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

5.12. On 31st he is recorded as passing a large amount of blood rectally (83) and on the 9th September (55 and 64) he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

5.13. Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August – 23rd August.

5.14. The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then there is two days later on 28th August, Diamorphine IM 10 mgs signed Dr Barton. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

5.15. On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine (171) though written up regularly is never given. Diamorphine 40 – 200 mgs subcut in 24 hours is prescribed on the 26th (171) and appears to have been given as 40mgs on 30th, 31st, 1st changed to 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been

properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 – 80 mgs subcut in 24 hours is written up and Midazolam is probably given 20 mgs on the 30th and 31th August, 40mgs on 1st September, changed to 60mgs on 1st September and given 80mgs on 2nd September.

5.16. On the next regular page of the drug chart (172) Oramorphine 10-20mgs 4 hourly is written up and is signed up to have been given for 4 doses daily on 27th, 28th and 29th August, with two further doses in the morning of the 30th August. I cannot tell from the drug chart whether 10mgs or 20mgs is given. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey Packman. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey Packman, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. Mr Packman had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

6.3. He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed.

6.4. He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

6.5. In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the

gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

6.6. He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital. He is appropriately clerked on admission and indeed appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

6.7. On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr Barton suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr Packman has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

6.8. Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital. Dr Barton makes the decision that the

patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

6.9. Mr Packman deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 – 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. The drug chart is used in a most irregular fashion and I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

6.10. From the 26th August Mr Packman is dying and after a single dose of Diamorphine on the 26th August, receives regular Oramorphine, then Diamorphine, and Midazolam until his death. Both Oramorphine and Diamorphine while specifically prescribed for pain are commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the starting dose of Oramorphine and he appears to receive 60mg in total on the 26th. Calculating the dose would be complicated in this case due to his the massive obesity which might well effect the oral dose required , together with his serious pressure sores which would be extremely painful on being dressed. He appears subsequently to have been started on 40mgs of Diamorphine in 24 hours with 20mgs of Oramorphine (equivalent to another 10mgs of Diamorphine) at night, together with 20mgs of Midazolam. The dose of s/c Diamorphine is usually given in a ratio of 1:2, so 20mg might have been the equivalent of the day time dose of 40mg of Oramorphine. However I can find no evidence in the notes that there were any significant side effects from the Oramorphine or the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

6.11. He is reviewed by a consultant (Dr Reid) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr Reid is happy with the management and later in the day the Diamorphine is increased because the previous dose is no longer controlling his symptoms. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

6.12. In my view, based on the evidence in the notes, the doses of Oramorphine and Diamorphine used although higher than might have been conventional at the start, were required to control Mr Packman's symptoms and did not contribute in any significant fashion to his death.

6.13. In my view a death certificate should read:
1a Gastro-intestinal haemorrhage
2 Pressure sores and morbid obesity

7. OPINION

7.1. Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

7.2. There are a number of weaknesses in the clinical care provided to Mr Packman:
- gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven, he is continued on his anticoagulant.
- despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.
- on assessment on 25th August a further bleed does not lead to further medical attention.
- on 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.
- a difficult clinical decision is made without appropriate involvement, of senior medical opinion.
- prescribing management and use of drug charts by both the nursing

and clinical staff, in particular for controlled drugs, is unacceptably poor.

Despite all of the above it is my opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:________________________________ Date: ______________