FFW/88/03

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

PAPERS FOR TRIP TO HAMPSHIRE
27-29 FEBRUARY 2008

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

PAPERS FOR TRIP TO HAMPSHIRE 27-29 FEBRUARY 2008

Black.
look at terms
'continuing care'
'rehabilitation'

27/2/08. Time.

Gill → Get GWMH
postcode

~~Also~~
+ S'ton airport?

General Medical Council	
Original was a Photocopy	
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GENERAL MEDICAL COUNCIL

DR BARTON

EXHIBITS OF RICHARD IAN REID

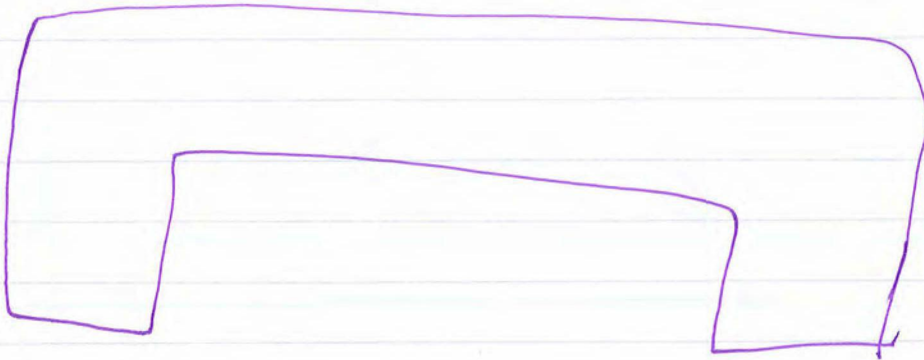
1. Statement dated 7 June 2000 regarding patient Gladys Richards
2. Statement dated 4 October 2004(1) regarding patient Elsie Devine
3. Statement dated 4 October 2004(2) regarding patient Elsie Devine
4. Statement dated 26 November 2004(1) regarding patient Elsie Devine
5. Statement dated 26 November 2004(2) regarding patient Elsie Devine
6. Statement dated 24 October 2005 regarding patient Sheila Gregory
7. Interview Record of Richard Ian Reid - 4 July 2006 (0921 – 1000 hrs)
8. Interview Record of Richard Ian Reid - 4 July 2006 (1002 – 1042 hrs)
9. Interview Record of Richard Ian Reid - 4 July 2006 (1055 – 1135 hrs)
10. Interview Record of Richard Ian Reid - 4 July 2006 (1140 – 1220 hrs)
11. Interview Record of Richard Ian Reid - 4 July 2006 (1319 – 1359 hrs)
12. Interview Record of Richard Ian Reid - 4 July 2006 (1402 – 1440 hrs)
13. Interview Record of Richard Ian Reid - 4 (June?) July 2006 (1500 – 1540 hrs)

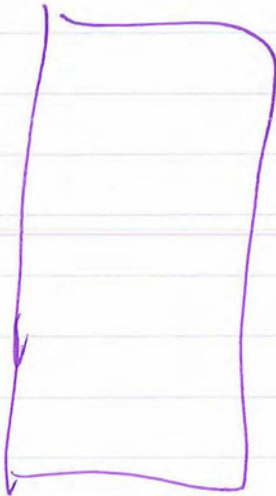
Dr Ian Reid.

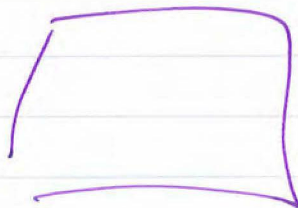
Meeting
27/02/08.

TET notes.

No avail. problems.







Background.

* started here in 1998. Consultant Geriatrician.
Part-t ~~clinical~~ medical dir P'mouth Healthcare Trust.

* med dir - Trust Board, Mgt Team

* Until 18 months ago.
Then PCT. in each of 3 diff Trusts.

clinical duties.
Based at QAH. 1 session a week in Day Hospital. Dolphin Day Hospital.

- Feb 1999 Dryad ward.
- dept change duties.
- can't remember how long that continued for.
v. rare for me to admit them.

- Dr B already in post as clinical Assistant.

- once a fortnight. 2 cons Mad p.m.
Dr B would attend alternately.
wouldn't take into a/c hols.
at most once per fortnight.

- Way it was both at same time.

- I'd conduct weekly.

- no concerns at time. I thought she was a good Dr.

'continuing care'
pt who you thought would remain in hospital for rest of their life.
not normally discharged.

- palliative care means - admin care to relieve symptoms, usually terminally ill.

→ not nec terminal. Could be in for years
No reason why end of life imminent.

p45 11:40.

Don't remember when I had a conv with Dr B which pt. it was with regard to.
Can't say it was re SG.
Bank Hol w/end cover hard to get
she said prescribed range so pt wouldn't have to wait/suffer.

I accepted that expln at time

---

1 partic pt sparked it.

---

wasn't aware happening frequently.

Drug chart - Range ^where^ written not normally where I would have looked

folds in 3.

at back - could write up so could vary day to day.

That was v. rarely used.

Taken out of blue folder to see it.

WR.

* would look at med records, spk to nursing staff.
  look at drug chart what they're on at that time.
  wouldn't have looked at reverse side as v. rarely used.

  No recollection of seeing charts at time.

* Go back + identify which pt records Dr R. had involvement

Back sheet.
what used for - Warfarin could be used for.
No real cause to use.

Wasn't practice to have any reviews.
Not just here, accross the board.

- contact for assistance.
  From time to time would ring + ask for advice.

- Not expect to be told if pt died / get better / position changed.

Anticipatory prescribing.

used?
  if on my own, if in pain + I had concerns
  would work through analgesic ladder
  in certain circs antic presc good practice.
  e.g. if operation + written up post-op.

- spk to nurses, look at med records, decide if treatment needed to change.

p15/34 - significant changes

- said another

notekeeping
adequate on most occasions if signif change recorded
v. conscious she was working hard
Didn't want to add to burden of responsibility.

in an ideal world would want notes like in an acute hospital where FT junior staff but Dr B working PT.

---

p22/34

Can remember early 2000.
corridor conversation, in passing informal rather than he asking to see me.

Got impression funding pressures difficult.

Can't remember exact details of conversation.

Poorer when came here.
consequence?

empty beds as could discharge to nursing homes pressure to fill beds

would be a departmental ~~xxx~~ dec'n not discussed formally I don't think
would be funded by ~~NHS~~ Trust.

colleagues + I extremely grateful for care she'd provided to pts. Came in 7.30, aft, eve. W'out her didn't see how hospital would function.
Not many other GPs would.
Trying to sow seeds - is it tenable to pressures.

All in one conversation. informally.
saying can't see that SM will
change so she'd have chance
to reflect.

- Subsequently handed in
resig. not to me.

---

influenced by complaints.
Early 2000
Gladys Richards complaint
Elsie Devine Mrs Reeves early 2000.
|
not aware of issues at time.

---

wasn't thinking
Didn't think needed to get rid of
Dr Barton.

couple of other informal complaints.
I felt that some of these generated
by inflexibility of attitude.
not concerned about practice.

---

pt in on morphine tablets, disc'td
by Dr B + put on less strong +
family complained.

---

lady developed heart failure Fri
Dr B presc. morphine. Q approp.
I saw on Monday + stopped
morphine as pt better.

They were concerned re diamorphine.

inflex of attitude.

Dr B + Hamblin worked v. closely for a long time 'their ways of doing things. If challenged they found that q. diff to be flexible.
If I said wanted something done it was.

* picked this up from speaking to pt relatives.

these 2 complaints - when I stepped in complaints disappeared.
2 in a year.
concerns not being appreciated. not a regular feature.

Main concern workload.

Dr B had acted appropr. just concerns re flexibility.

---

* now consultant in elderly medicine based primarily at GWMH
QAH - emergency take, on call etc.

---

policies / practises diff.

Police.

- Gave a witness statement
  2 patients in 2005.

  - Elsie Devine
  - Sheila Gregory.

- Interviewed under caution in police station
  2006.
  on another 3 days.

  Another 2 patients.

  ? Enid Spurgin.
  92 yr old.
  Geoffrey Packman.
  - grossly obese.

  all these 2 cases.
  interviews under caution.

- first time I've seen these.

Code A

Chris Thomas Notes
Dr Reid interview

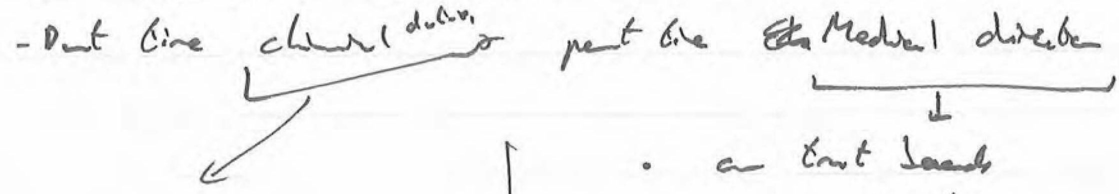
#2 Dr Richard Reid. @ 3.30pm ("RR")
27 Feb 2008 @ Gosport War Memorial Hospital

Pre-amble to Witness Statement
Availability : fine
in Sept '08

Career @ Gosport WMH

+ Dryad :

Working Relationship with Dr B



1998 → Consultant Geriatrician
- part time clinical (duties) → part time ~~Ed~~ Medical director

Mainly @ Queen Alexandra Hospital

(→ 1 day/per week here @ the day session (Dolphin Day Hospital))

- on trust board
- management team
- usual roles (advising)
- helping policies

- dual role until 2 years ago

- then Medical Director of PCT (i.e. one of 3 of them)

≈ Feb 1999
- we used to change duties every once → a while
- → so then I assumed resp. for Dryad Ward
- can't remember how long that went on for

- Patients @ Dryad - were consulted there
- it would be very unusual for me to have consulted them there

Dr. B was already in post when he took on this role

At the rest once/fortnight
- ~~[illegible]~~ - occasionally see her at odd occasions - but regularly once/2 weeks

Why both you & Dr Lord
do rounds @ same time?

Any concerns of Dr. B at the time?

How describe her as a doctor?

The term "continuity care"?

& "palliative care"?

Re. Sheila Gregory
- Dr. B gave 60-80mg

rather the range was 20-200mg!

as pg 45 of transcript
that started @ 11:40

Why did she stick out?

Just the way it was
I'd do ward rounds weekly
Dr. B would go to each evry other week

No.

Good doctor

probably

at that time • patients would remain in hospital for rest of their life
• not normally discharged back to nursing home

death not imminent or even foreseen

means administering to relieve symptoms
patients who are terminally ill
eg. cancer.
≈ no cure possible, so at this stage dealing with pain...

I don't remember speaking to Dr. B about any patient in particular
⟷ I did speak to Dr. B re. doses - but I couldn't remember which patient it related to.

• Dr. B said she prescribed in this way in case a doctor wasn't available (eg. weekend) so if a patient needed it ASAP there was no problem

o your view of the method
of prescribing?

Why weren't you aware of it happening
– as you were the consultant?

I accepted it.

This was one particular example of why the issues ~~[illegible]~~ arose.

I was not aware that this (i.e. such large doses) was happening so frequently.

~~Really~~ Re Drugs ~~Sheet~~ chart....

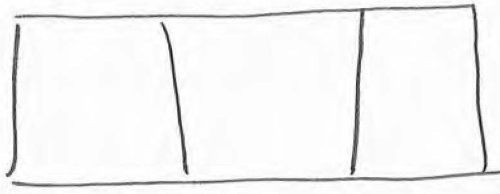
- It was on somewhere where normally it was somewhere where I wouldn't look

↳ the ~~Drugs Sheet~~ / Drug Chart

- & the place where you should write the varying day to day drugs was in wrong place

↳ to extent that I'd have had to take a sheet out of the folder to see it.

-



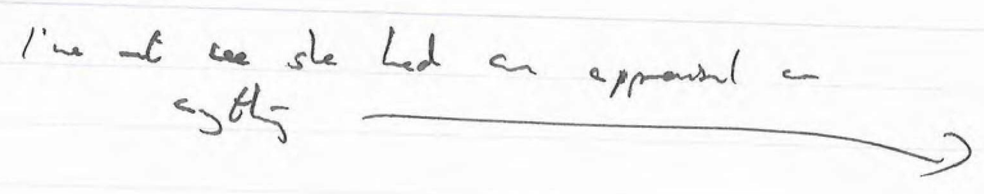
I'd look at what they were currently on - i.e. not what they could be on in the future

↳ this was very ~~rarely~~ rarely used, so no reason to look

※ We'll need to show RR the medical records to see what he'd have seen ※

when would the bed sheet be used for?

General Supervision of Dr. B
- You were Consultant involved
- & supervision back then was very different



She contact you much other times?

Clarify re. 14.02 interview p.8 of 47
@ that time you didn't know of her anticipating prescribing techniques

Hardly ever – Warfarin perhaps (blood thinner)
↓
but actually ever rarely this
as done separately
↳ so we need to use the sleet
ever really

⇒ Correct – no forms of assessment – but it was simply
not done at that time
↳ & not done anywhere (very different today
onwards)

Sometimes ~~rang~~ rings
Sometimes ~~rang~~ rings for advice – not anything like once/week tho!

I'd not expect to be informed if a patient had ~~started~~
died in between my visits
↳ not expect to be told of
deaths, deterioration, going home ...

Correct

↓

Q would you do "anticipating prescribing" ~~technique~~ techniques

When you did ward rounds – you looked at patients at that point
↳ not their condition / treatment overall?

Q re the drug range
you said ~~a~~ dose of 20-40 of diamorphine is acceptable

on pg 13

but 20-200 is unacceptable

Re Dr. Barton's record keeping Interview @ 15.00
p15 of 34

~~Interview 15.42 – hasn't got~~
→ 15.42 interview p. 2
re: record keeping
– you said hers wasn't "to the letter" of requirement

Your remaining concerns of her note keeping?

Yes I would if someone was in pain
& in case current pain killers not enough
↓
in some circumstances (not here!) I'd say
it was good practice

I'd do both – I'd speak to nursing staff
first as to history, & then I'd see
the patient

Yes

[add "change" post "significant"]

I felt it was adequate
was in most cases, if there was a significant
change in condition, then was noted
(& she was under a lot of pressure
– I was very conscious that she
was working very hard →

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Interview pg 22/23/24 & 34

Nature of ward & hospital
changed significantly

& she say?

I & didn't want to burden her seeing
as she had so much on her already

↳ so Yes I accept she didn't have perfect
notes. but they were adequate
- & as she ~~was~~ had so much on
I didn't want to burden her.

I do remember having at least one conversation
with her, in say early 2000
↳ but more of an informal
in passing conversation (i.e. corridor chat)

I got impression she found the pressures difficult
- but I can't remember more than that

? patients were more poorly here ????
[notes confused]

There was pressure to transfer patients int empty
beds,
↳ so Drayad took on patients who weren't
continuing care patients per se

↳ so nature of the patients change
&
∴ no. of patients increased
& sickness of patients got worse too

& staff more pressured.

You decided you needed a staff graded doctor.

Were your views on needing a full time Dr. influenced by the complaints arising at the same time.

↓
∴ whole system got under more pressure.

~~[illegible] anxiety with politics~~

In my time here there were big changes

- we had pressure to fill the empty beds

→ Yes - but this was a departmental decision & could be funded by the Trust

↳ I did not discuss it with the other consultants formally.

My colleagues & I were very ~~[illegible]~~ grateful for D. B.
- she came in early & so other afternoons & other times,

↓
without her hard to see how the hospital could operate

↓
~~[illegible]~~ Thus & in informal way I told her that the pressures on her were likely to continue & pressures would only increase if anything.

↓ & shortly afterwards she resigned (not directly to me)

No. - only 1 ~~[illegible]~~ complaint had arisen at the time

My thinking for needing a full time post was
not based on fear of a problem
with Dr. Barton.

what were the informal complaints?

& Inflexibility

Comment.

There had been a couple of ethical approval complaints

↳ + I thought they were from an inflexibility of attitude

↳ but they weren't from performance/competence

① a patient had been on morphine tablets, + Dr B took her off them for something less strong

↳ + family complained

② a patient ~~[illegible]~~ had heart failure

- + Dr. B gave diamorphine (+ properly so)

- + RR took her off it - + family raised concerns

Dr B + Sister Hamblin worked very close together for a ~~[illegible]~~ very long time + had their ways of doing things

↳ + when challenged found it difficult to ~~[illegible]~~ flexible

If I had said I wanted it done in a certain way it would be fine + Dr. B would agree

↳ it was more the patients' families thought she was inflexible

Once I stepped in the problem went away

↳ but it wasn't common ~~[illegible]~~

Current Role

> how epidurals/syringe drivers done very differently?

> your view on our results [?] compared to benchmark [?]?

∴ my main concern (& ∴ why wanted full time role) was for her workload.

∴ Dr. B did act appropriately
↳ but there might have been some inflexibility.

●

Now : Consultant in Elderly Medicine
- primarily @ GWMH.
& Queen Alexandra
↳ cover Emergency @ weekends & on call as others are

●

Yes - have they are

Today wouldn't be, eg. 20-200

The whole episode is unfortunate

No thought of any mal-intent
↳ Dr B cared treat my mother !

What other incident with Police?

↓

it was as the whole system was under pressure.

1) Gave a Witness Statement re. x2 patients in 2005

- Elsie Devine
- Sheila Gregory

2) + the 2006 statement under Caution (Fareham Police Station)
(one we have ↗)

↳ interviewed in a cell for 4 days!

+ this was
- maybe Shirin Purnell?
- was Mr. Packman

* I never got the witness statements on these from the police

(the FFW docs. were the first time I'd seen these)

ian.reid@porthosp.nhs.uk

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RICHARD
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AGENDA

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