Field Fisher Waterhouse

FFW/150/05.

GENERAL MEDICA

-and-

DR BARTON

'D' DOCUMENTS

Field Fisher Waterhouse

FFW

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

'D' DOCUMENTS

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1 OF 1

11914 v1

"D" Docs.

D1 – letter from S Hallman to Code A dated 24/3/00.

D2 - Notes of meeting - SM, BW + RS 30/3/00.

D3 - Notes of meeting Dr B, RS on 7/4/00.

- D4 - Memo - learning Pt from Wilson Comp (dated 27/10/99

D5 - Protocol for Px + admin of diamorph by subcut infusion. (3/12/99 bottom pg).

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PORTSMOUTH
HealthCare
NHS
TRUST

D1

Code A

Our ref

Your ref

Date 24.3.00

Ext

Dear Code A

I write to complain about the way I am being harassed at work almost to the point of leaving my job and the trust.
I wish to evoke the Trusts harassment policy and I know that things have gone so far that the informal stage would be of no use, so I wish to go to formal stage immediately.
I work on Dryad ward at GWHH as the F grade and I've been in post for two years.
I am constantly being harrassed by my line manager Jill Hamblin to consider moving to QAH as an E grade.
Recently I have received similar overtures from Dr I Barton. It is obvious to anyone listening that I am not wanted on Dryad Ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the Status Quo to apply.
I realize that things are going to be uncomfotable but I have reached the end of my tether and know that what is happening is not right.

yours sincerely

Code A

COMMUNITY HEALTH SERVICES
Gosport War Memorial Hospital
Bury Road, Gosport, Hampshire PO12 3PW
Tel: 023 92524611 Fax: 023 92580360

D2

Notes of the Meeting held between Shirley Hallman, Code A and Code A on Thursday 30 March 2000 at 9.00am. in the Potteries.

This meeting was arranged as part of the formal investigation into a harassment claim brought by Shirley Hallmanounder the umbrella of the Trust Policy 'Harassment - policy for the prevention of'.

The meeting began with Shirley recounting the reasons why she had needed to have an extended period of sick leave between the beginning of November 1999 and the January 2000. This had included gynaecological surgery and a tooth extraction, following several weeks of pain. Shirley had found this time very traumatic, particularly as she has 'difficult memories' to manage during the Christmas period.

Shirley returned to work on January 24 2000.

Shirley had an IPR review with Gill Hamblin in February. Shirley has not yet received a report from this review. At the time of the original IPR, Shirley was in an acting-up capacity as Gill Hamblin was on long term sick. A copy of the original IPR carried out by Barbara Robinson on 1st April 1999 and a memo written by Barbara Robinson on April 9th 1999 are attached to these notes.

Shirley described how during the IPR review she had discussed with Gill Hamblin, her frustrations of her current role in the team. She felt her role as deputy was ill-defined, with little responsibility and opportunity to use her initiative. She felt bored and asked for opportunities to develop her management/leadership skills. She recognised that their working relationship was strained and sought ways to improve this. She would like to be able to support Gill more, " to be leaned on".

Shirley emphasised that she had been feeling like this about her job prior to her sick leave and had resolved on returning to work that she would try to sort it out. She was feeling so much better and she did not wish work stresses to cause further illness.

As part of this resolve she had applied for an G-grade post at Queen Alexander's Hospital.(QAH)

Shirley described how an opportunity had arisen for some of the Gosport Team to go and work at QAH for one month to assist with a vacancy problem. Gill Hamblin encouraged her to consider this and so she went to work on Edith Keen Ward which coincidentally was the ward where the post she had applied for was. A member of the Edith Keen staff had also applied for it and Shirley was conscious of the tensions associated with this. She described how she had sought support for this from Gill Hamblin and had frequently phoned her.

Shirley was interviewed for the G-grade post but was not successful. She received interview feed back from Barbara Robinson, who previously had always been very supportive, but was surprised at some of the content. She was told that she had a reputation of having an 'attitude problem'and that Dr Barton found her challenging to work with. She was told that there were no F-grade vacancies at QAH but there were E-grade posts which she might wish to apply for. Shirley stated that she did not like the fast track nature of the acute service work and decided to return, with some apprehension, to her post on Dryad Ward at Gosport.

On March 10th Shirley received a phone call from Gill informing her that she was to work a "straight shift" on the Sunday and that she wished to meet with her on the following Tuesday, March 14th.

Shirley described this meeting on March 14th in great detail and frequently referred to notes she had made straight afterwards. She described how she began the meeting with apologies for not supporting Gill in the way she could expect from her deputy. She was then told by Gill that following consultation with Maureen Mills, Senior Personnel Manager, a performance plan had been drawn up.

Shirley said that she was told that this plan had been produced because she had a poor "communication manner, when under stress" and that "all grades of staff including Porters and Caterers" had complained about this. Shirley was shocked as she was not aware of this and it had never been discussed with her before. In fact during her period of acting-up, she had received very good feedback from the staff and had been complimented on the good atmosphere of the ward.

In describing the performance plan, Shirley felt that little account had been taken of her IPR objectives, that she was a challenge to Gill's leadership and as a consequence responsibility and initiative were being further removed from her role. She did not feel that she her role as deputy clinical manager was being acknowledged. She felt "she was just another pair of hands"

The meeting on the 14th.March continued with more encouragement from Gill Hamblin for Shirley to consider the E-grade post at QAH. Shirley felt pressurised by this, in the light of the content of the rest of the meeting.

In discussing the provocation for the letter Shirley had written on 24th March formally requesting this investigation, Shirley described Gill Hamlin's leadership style as one of mixed messages, innuendo, no action, directionless, nothing was ever recorded and that there was a lot of exaggeration. She felt Gill was challenged by anybody with knowledge or new ideas and controlled her team by encouraging passivity. She emphasised that these feelings were based on her experiences over the 24 months she had been in post on the ward.

When asked what resolution she sought to this investigation, Shirley replied that she would like to be helped to develop a better working relationship with Gill Hamlin, based on openness, clear strategy, innovation and mutual respect.

Signed: Shirley Hallman Code A

Code A

D3

Notes of the meeting between Dr Jane Barton and Code A **Investigating Officer, on Friday 7th April.**

This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin.

Dr Barton stated that she had worked on Dryad Ward for 12 years, giving 5 sessions a week, and that she felt she knew Gill Hamblin and the team well. As a visitor to the ward she stated that she did not feel it was appropriate for her to be involved with management issues.

In describing Shirley ~~Hall~~ Hallmann's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player.'

When asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been busy as at that time the Consultant had not been admitting. Dr Barton observed that she felt Shirley appeared to enjoy 'paper work' in preference to a more clinical role.

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH and how she had photo-copied some articles for her.

Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no'. Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to do acute work. 'If I had known she did not want to work there I never would have inquired .... I bitterly regret offering support'.

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding, with unrealistic expectations and one or two had been particularly difficult.

When asked how she viewed Gill Hamblin's professional role, Dr Barton described her as the 'Clinical Boss' and with a competent control of the ward. She was consistent in her approach to all staff.

Code A

pp. Code A

Dr Jane Barton Code A

NEW EXHIBIT "D4"

illett

D4

ber 1999

Thank you for your memo and the copy of Code A letter.

1a) Microfilming/Fluid Chart

It was an unfortunate error that these particular notes were microfilmed so quickly. Notes are not usually filmed until at least one year after the patient has died or 3 years after discharge.

The company have assured us that everything is filmed except blank sheets and address labels.

2b) Nursing Care Plans

This has been picked up as part of the Clinical Governance Action Plan for Community Hospitals. It was also part of an action plan from a workshop on May 20 '99 for Clinical Managers and Clinical Practice Development facilitators. This action plan was evaluated on 20 October '99 and showed that work with Nursing Care Plans has taken place across all areas in the community Hospitals.

I will raise it at NAC to ensure it is being picked up Trust wide.

3d) Good Practice in writing up medication.

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

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

I hope this covers all the points

Code A

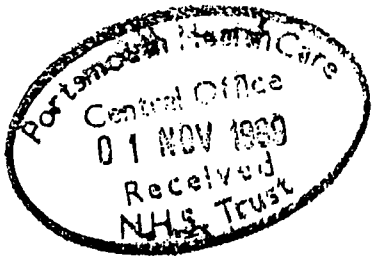
Portsmouth HealthCare NHS Trust
MEMORANDUM

New evidence?

27

From
Barbara Robinson

Ref
BFR/svn



To
Max Millett

cc

D4

27 October 1999

Mos

Learning Points from the Wilson Complaint

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Code A

D5

NEW EXHIBIT "D5"

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INTRODUCT

In community h
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This can lead tc be
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within a variable dose prescription.

DOSAGE

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given.

PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

If the previous 24 hour dose has made the patient unduly drowsy etc., the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

D5

PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION

INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription.

DOSAGE

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If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered, should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes.

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE		29/9	30/9	1/10	2/10	3/10
DOSE		10 mg	20 mg	40 mg	80 mg	80 mg
TIME INFUSION STARTED	0 hours	1400	1400	1400	1400	1400
PAIN CONTROLLED YES/NO	+4 hours (1800)	Y	Y	N	Y	
	+8 hours (2200)	Y	Y	N	Y	
	+12 hours (0200)	N	Y	Y	Y	
	+16 hours (0600)	N	N	Y	Y	
	+20 hours (1000)	N	Y	N	Y	
	+24 hours (1400)	N	Y	Y	Y	
NO. OF TOP UP DOSES OF DIAMORPHINE		3	1	3	0	
TOTAL DOSE 'TOP UPS' IN 24 HOURS		10 mg	5 mg	20 mg	0 mg	
COMMENTS						

DIAMORPHINE INFUSION AND PAIN CONTROL CHART

DATE						
DOSE						
TIME INFUSION STARTED	0 hours					
PAIN CONTROLLED YES/NO	+4 hours					
	+8 hours					
	+12 hours					
	+16 hours					
	+20 hours					
	+24 hours					
NO. OF TOP UP DOSES OF DIAMORPHINE						
TOTAL DOSE 'TOP UPS' IN 24 HOURS						
COMMENTS						