Field Fisher Waterhouse

FFW/145/02

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

ENCLOSURES TO INSTRUCTIONS TO COUNSEL

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 20 January 2010

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Welcome back, everyone. Before we start, Mr Langdale, Mr Kark, I should say it has come to the Panel's attention that in our determination on facts dated 20 August 2009 we inadvertently failed to record Dr Barton's admission and our finding regarding one of the facts alleged. The head of allegation in question is 13(c) in relation to Mrs Jean Stevens, Patient L. The determination has therefore been amended to include the relevant admission and finding, and copies of the revised determination are available for all should anybody wish to have it, and the Panel assistant will have those available to distribute should anybody needs one. Mr Kark.

MR KARK: Sir, as you know you had delivered your determination on the facts on 20 August last year, and the stage which these proceedings has now reached is the stage which is governed by rules 28 to 31, which provide as follows, so far as rule 28 is concerned:

> "the Committee have recorded a finding, whether on the admission of the practitioner or because the evidence adduced has satisfied them to that effect, that the facts, or some of the facts, alleged in any charge have been proved, the Chairman shall invite the Solicitor or the complainant, as the case may be, to address the Committee as to the circumstances leading to those facts, the extent to which such facts are indicative of serious professional misconduct on the part of the practitioner, and as to the character and previous history of the practitioner."

As you know, this is now, so far as you are concerned, a single stage process, but there are two important features of it: the first is that you must decide whether Dr Barton is guilty of serious professional misconduct; the second, and that would take you through to rules 30 and 31, is if you do find that she is guilty of serious professional misconduct, you then have to decide what, if any, direction to make so far as sanction is concerned.

The issue of whether or not the doctor is guilty of serious professional misconduct is of course to be tested by reference to those charges found proved and therefore by reference to her behaviour at the time to which the charges are relevant. To that extent the test is not the same as the issue of whether a doctor's fitness to practise is impaired. You, I know, will be well aware of that, but it does bear mentioning, because of course as a modern Fitness to Practise Panel you will be well used to applying the rules so far as impairment is concerned, but it is important to underline that this is an old rules case. Whereas you would, were this an impairment case, look at the question 'What is the position now?' in respect of the doctor's fitness to practise based on the Panel's findings, serious professional misconduct is viewed historically, and you must consider and determine whether, in relation to the facts found proved, and having regard to any evidence adduced under the rules, you consider the practitioner to have been guilty of serious professional misconduct.

Now, the Legal Assessor as was, Mr Chamberlain, who has now of course been replaced by Mr Smith, gave you directions which we would respectfully encourage you to re-read. They were given on Day 39, starting at page 43. That of course is not said to undermine anything that your present Legal Assessor will say to you, but Mr Chamberlain did set out the test when he was giving you advice in relation to the issue which you then had to consider, whether the facts then found proved were incapable of amounting to serious professional misconduct. He drew your attention to the cases of *Roylance* and *McCoan* and *Doughty*, and you will recall that there is in fact no definition of serious professional misconduct, but the test that we would respectfully invite you to test yourself, and the question you may wish to ask yourself is this: looking at all of the facts which have been admitted and found proved, is

Dr Barton guilty of conduct which amounts to a serious falling below of the standard which might be expected of a doctor practising in her field in similar circumstances?

Now, whilst employed at the Gosport War Memorial Hospital as a clinical assistant between 1996 and 1999, you have found that Dr Barton offended certain basic medical principles in her treatment of the patients who were under her care at that hospital. I am going to set them out, if I may, in order of topic rather than by patient, and I am going to set out the nature of the criticisms which were in fact set out in the heads of charge. I am going to spend a little more time, not very long I promise you, but a little more time than perhaps I would have done if I were addressing you immediately after a hearing in August of last year, although we know that you have spent the last two days reviewing the material in this case and no doubt reminding yourselves of the facts.

There is, as you will appreciate, not only interest in these proceedings by some of the relatives of those patients, but there is also considerable public interest, and so it is appropriate that I should address you, albeit briefly, on the criticisms that you found of Dr Barton.

First, you expressed your concern in your determination that nurses were enabled to use their own discretion to start at a high dose of diamorphine and midazolam, and thus effectively they were enabled to start these patients on what was termed the terminal pathway. You found that Dr Barton's practice of prescribing in the way that she did was neither safe nor prudent. You noted with concern her apparent assumption, when prescribing on an anticipatory basis, that the required dose would increase, despite not knowing when that increased dose might be administered, nor by whom.

You found that although Dr Barton was well aware of the principles of applying the analgesic ladder, the BNF, and the Wessex Protocols (about which we heard much), she accepted in effect ignoring them, in the sense that she routinely prescribed outside the guidelines, even though Professor Ford and her own expert Professor Sikora both stated that the guidelines could not be ignored simply because a patient was on the terminal pathway, and that departures from the guidelines should be the exception rather than the rule. When Dr Barton did depart from the guidelines, you found that she had made no note as to why she had done so, nor provided any written justification.

In relation to each of the patients for whom Dr Barton prescribed opiates by way of anticipatory prescription on occasions, prior to the time when the patient actually needed any analgesic at all, it was in such wide variable quantities that they offended what you termed in your determination Professor Ford's one hundred per cent rule, which allowed, as you will recall, for one hundred per cent increase from lowest to highest, and so you found that Dr Barton's prescriptions were in those cases inappropriate, potentially hazardous and not in the best interests of those patients. You found that those prescriptions created the situation where drugs could be administered, and on occasion were administered, which were excessive to the patient's needs, and in some cases the drugs administered caused the patients to lose consciousness, become unrousable, and that was both unnecessary and caused considerable distress to some of those nearest and dearest to them.

You found that Dr Barton's practice of doubling up the dose greatly increased the risk of over-sedation and the adverse side effects. You found that Dr Barton evinced a marked reluctance, as I think you put it, to titrate doses before commencing patients on syringe

drivers, which marked the beginning of the terminal pathway. Titration was, Dr Barton accepted, a basic standard medical principle, but she said in evidence, "I was not taught it, I was not familiar with using it. It was not practical or feasible".

In respect of Patients A (Leslie Pittock), B (Elsie Lavender), J (Geoffrey Packman) and K (Elsie Devine), the Panel determined that even the lowest dose which Dr Barton prescribed of either diamorphine and/or midazolam were too high when looked at in conjunction with each other, and, in respect of Leslie Pittock, when Nozinan was added, and so you found that Dr Barton's prescriptions in this respect were inappropriate for those patients, potentially hazardous to them and not in the best interests of those patients.

Particularly in the case of Patient K (Elsie Devine), you specifically found that given that fentanyl was already in that patient's system, that even the lowest doses of diamorphine and midazolam as prescribed by Dr Barton would have had a profoundly sedating effect, would put the patient at severe risk of respiratory depression, coma and premature death. This lady, as you will remember, slipped into unconsciousness soon after the syringe driver was started and remained unconscious until her death two days later.

You found that syringe drivers were on occasion attached to patients unnecessarily and prior to the time when they needed it.

In respect of Mr Wilson (Patient H), Dr Barton appears to have ignored the feature which should have been of significance to her prescribing, which was his alcohol-related liver disease, and you found in that case that not only was her prescription for him potentially hazardous, but it had the potential to lead to serious and harmful consequences for him, even though you could not be sure that it was likely to do so.

In terms of preliminary assessment in the case of Patient D (Alice Wilkie), prior to the prescribing of opiates you found that Dr Barton had not performed an adequate assessment and that this failure was not in the patient's best interests.

On a similar but different topic, you found that in respect of Mr Geoffrey Packman the doctor failed to obtain further advice as his condition worsened and made no further investigations, and your view was that Dr Barton should have done both prior to starting this patient on a syringe driver.

Throughout all of this period in relation to these patients Dr Barton was failing to make relevant and necessary notes. Of course, *Good Medical Practice* does not require that everything should be written down, and we do not suggest that it would always have been practicable for her to do so, or to make a full note, but there was in evidence here, we submitted then and now, a culture of making no notes; notes which would have been highly relevant to the patient's care and management. Not only was there a failure to make notes in relation to assessment, reassessment and management, but you also found that there was a failure to make a proper note of the drug regime, which meant that nurses had no guidance as to how to apply these excessively wide and high prescriptions.

Can I take you to the relevant *Good Medical Practice* guidance, which you will find in your files at tab 2, and it should be that which was issued in 1995. If you look at page 13, you should find the date stamp of October 1995, just to make sure we are all looking at the right document. I just pause to make sure everyone has a copy. I am going to make reference to a

number of pages and a number of references. It is a matter for you, as it were, how you apply them, but I am going to draw your attention to those which may be relevant, it seems to the General Medical Council, to your decision.

We start as ever with the first paragraph, which provides that:

> "Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."

I am going to be selective, as it were, from now on.

> "Good clinical care .....
>
> This must include:
>
> - an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination;
> - providing or arranging investigations or treatment where necessary;
> - referring the patient to another practitioner, when indicated.
>
> In providing care you must:
>
> - recognise the limits of your professional competence;
> - be willing to consult colleagues;
> - be competent when making diagnoses and when giving or arranging treatment;
> - keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed;
> - keep colleagues well informed when sharing the care of patients .....
> - prescribe only the treatment, drugs, or appliances that serve patients' needs."

Under the heading "Keeping up to date", paragraph 5:

> "You must maintain the standard of your performance by keeping your knowledge and skills up to date throughout your working life."

Would you go to page 4, and the heading is "Maintaining trust: professional relationships with patients." Paragraph 11:

> "Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- Listen to patients and respect their views;
- Treat patients politely and considerately;
- ...
- Give patients the information they ask for or need about their condition, its treatment and prognosis;
- Give information to patients in a way that they can understand;
- Respect the right of patients to be fully involved in decisions about their care;
- Respect the right of patients to refuse treatment ..."

Over the page, page 5:

> "Respect the right of patients to a second opinion."

Paragraph 12:

> "You must not allow your views about a patient's lifestyle [etc] age, social status ... to prejudice the treatment you give or arrange".

Paragraph 17:

> "You must not abuse your patients' trust. You must not, for example ..."

I go to the last bullet point:

> "Deliberately withhold appropriate investigation, treatment or referral."

At page 8 it deals with working in teams and specifically delegating care to non-medical staff and students: 28:

> "You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care.
>
> You must not enable anyone who is not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor."

At 30, "Arranging cover": "You must be satisfied" – and I only mention this in the context of the evidence that was given on occasion as to why these prescriptions were written in advance:

> "30. You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors".

As I say, it is a matter for you as to how much that guidance assists you, but that is what we submit may be relevant to your considerations.

In short, none of these failings, plainly, were in the patients' best interests and many were, frankly, positively harmful to their welfare, and on behalf of the GMC we submit that there is overwhelming evidence of serious professional misconduct.

I now turn to the issue of sanction, which we deal with at the same time, as it were, although, of course, it is a quite separate decision.

The question of what sanction you apply is, of course, a matter for you as an experienced Panel applying your experience and your knowledge of this case, and what I say to you now is, of course, merely a submission by the General Medical Council as to what in this particular case the appropriate sanction should be. The sanction that the General Medical Council submits is appropriate in this case is one of erasure from the register.

A critical issue in all proceedings in regulatory tribunals, particularly, perhaps in the General Medical Council, is the issue of insight, and it is the General Medical Council's submission that Dr Barton has demonstrated, frankly, almost no insight into her failings at all. This is despite the fact that in 1991 she had the clearest warning that her practice needed to be reviewed. Even now, having heard all the evidence, and having sat and listened to the evidence of Professor Ford, and no doubt pondered upon his reports, Dr Barton told you that with the benefit of hindsight she would not have done anything differently. I am going to specifically cite her evidence.

It has been clear, and I expect there will be reference to this by the defence, that there were serious management failings and that Dr Barton could and should perhaps have received better support and guidance from those senior to her medically, and in the management of the hospital where she worked. But you may feel, having heard from Dr Barton giving evidence over many days that her character played a significant part in the fact that she was in effect left to her own devices in the management of the patients at the Gosport War Memorial Hospital. In any event, Dr Barton has personal responsibility for the prescriptions which she wrote. She allowed a system to continue where there was a lack of appropriate controls and systems to ensure that patients did not come to harm. Responsibility was on occasion devolved to nurses which was beyond their skills, their teaching or their experience.

You heard evidence about the change of patients coming into the Gosport War Memorial Hospital during the 1990s. That may also be mentioned, I do not know, but you also have to bear in mind that that was something that was apparently happening across the UK and other clinical assistants in other community hospitals do not appear to have adopted the same approach as was taken by Dr Barton.

I have mentioned the issue of insight, and I just want to remind you of a few passages of evidence which go to that issue just before I turn to the indicative sanctions guidance because, as you will see in Indicative Sanctions Guidance, the question of insight is a theme running through every sanction that you have to consider. I will give you the references so you can in due course check if you wish to that I have got the quote right.

Dealing with the 1991 issue Day 25 page 58, being examined in chief, Dr Barton said this:

> "I felt that by holding a meeting, and by reiterating to the staff that we were available and willing to answer their queries, there had hopefully been the opening of a

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> sufficient dialogue [to avoid the feeling of them being excluded] ... I felt the problems had largely been allayed."

A few days later, when asked about that specific topic by me she said, and agreed, the practice did not in fact change one jot.

On anticipatory prescribing, using syringe driver, day 25 page 63 she said:

B

> "I do not think there was a practical alternative ... So the patient could well be waiting several hours to receive adequate [pain relief] ... It was unrealistic to expect [the on call] doctors ... to prescribe appropriately and sensibly."

In relation to Patient A, Leslie Pittock (day 25/85) Dr Barton said: Having heard Professor Ford's criticism, I have not altered my view as to what I thought was appropriate at the time.

C

In relation to Patient E, Gladys Richards (day 27/14) she said: There is nothing I would change about my view and judgment as to how she was cared for by me as her doctor.

In relation to Patient F, Ruby Lake, she said (day 27/24): Does the evidence of Professor Ford cause me to review or question my actions in relation to the Patient? Not at all.

D

Patient G, Arthur Cunningham (day 28/page 13): I totally stand by what I did for Mr Cunningham that week.

Patient J, Geoffrey Packman (day 28/48): With regard to the criticisms by Professor Ford, I totally stand by my course of action during the time with this patient.

In general areas – I will have to check the reference – she was asked at the end of her cross-

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examination: If you had more time would it have affected your decisions in relation to any of these patients? Answer: No.

She was asked questions by the Panel, day 31/1 and she answered: With hindsight, having heard the evidence and the criticisms, would I have done anything differently? No. Of course, I should have formally raised the issue of workload in writing but in relation to the 12 patients, in the days and hours of their dying I would have done nothing differently. If I had

F

more medical cover and one-to-one nursing care maybe we could have organised the terminal care in a slightly different fashion, but with what we had at the time I have no regrets about the medication that any of those patients received. I would not have adjusted any prescription or referred any patient or asked for a second opinion.

She was asked by Ms Julien, who I think was asking these questions specifically: In none of those 12 cases? Answer: No.

G

She was asked this: Putting Professor Ford aside, is there anything going over these 12 cases where you think, 'oh well, maybe I should not have done it quite like that'? Her answer was: Nothing at all.

Can I take you now to *Indicative Sanctions Guidance* and for this you will need to have the latest version, which is that issued in April 2009 and then revised in August 2009.

H

THE CHAIRMAN: It is behind tab D in the blue folders.

MR KARK: The first few paragraphs of the guidance set out the aims of *Indicative Sanctions Guidance*, which is to promote consistency, etc., and I will not spend time on those. Can I take you to paragraph 18, please, on page 6:

> "The *Merrison Report* stated that the GMC should be able to take action in relation to the registration of a doctor ... in the interests of the public, and that the public interest has 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain the confidence of the public in their doctors.
>
> Since then a number of judgments have made it clear that the public interest includes, amongst other things:
>
> (a) Protection of patients.
> (b) Maintenance of public in the profession.
> (c) Declaring and upholding proper standards of conduct and behaviour."

I read on from paragraph 20:

> "The purpose of the sanctions is therefore not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect. This was confirmed in the judgment of Laws LJ in the case of *Raschid and Fatnani v The General Medical Council* [2007]1 WLR 1460, in which he said:
>
> > 'The Panel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor'."

He then cites part of *Gupta* and I was going to deal just with the last half, which actually is then in turn referring to Sir Thomas Bingham, Master of the Rolls, in *Bolton v Law Society*:

> "... where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension ... that may be an example that the practitioner may be unable to re-establish his practice when the period has passed."

There is a section headed "Proportionality" and I am just going to read paragraph 21 and the first few words of paragraph 22:

> "In deciding what sanction, if any, to impose, the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The Panel should consider the sanctions available starting with the least restrictive.
>
> Any sanction and the period for which it is imposed must be necessary to protect the public interest ..."

Going over to paragraph 23:

> "The Panel must keep the factors set out above at the forefront of their mind when considering the appropriate sanction to impose on a doctor's registration. Whilst there may be a public interest in enable a doctor's return to **safe** practice, and panellists should facilitate this where appropriate in the decisions they reach, they should bear in mind that the protection of patients and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) is their primary concern."

The mitigating and aggravating factors are deal with at paragraph 25, and it deals with how to deal with mitigation:

> "Mitigation might be considered in two categories:
>
> (a) Evidence of the doctor's understanding of the problem, and his/her attempts to address it ...

And

> (b) Evidence of the doctor's overall adherence to important principles of good practice ..."

Paragraph 26:

> "The Panel should also take into account matters of personal and professional mitigation which may be advanced, such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these should be considered and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession."

Can I straightaway say something about the lapse of time? These events we recognise were a very long time ago. You will have to consider, however, whether there is evidence of such deep-seated problems and such a lack of insight that despite the passage of time and good behaviour, no doubt, since these events, nevertheless erasure is in fact the appropriate sanction.

At paragraph 36, which follows immediately from expressions of regret and apology – and I draw your attention to the importance of evincing regret and apologising where things have gone wrong – then I read paragraph 36:

> "Awareness of and sensitivity to these issues are important in determining the following:
>
> (a) How a doctor frames his/her 'insight'.
> (b) Whether or how a doctor offers an apology.
> (c) The doctor's demeanour and attitude during the hearing.

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37. The main consideration for the Panel therefore, is to be satisfied about patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this insight may be expressed."

Can I then turn to the sanctions which you will have to consider? Of course, you start at the lowest upwards. I am not, frankly, going to bother dealing with no sanction at all, because I B do not think that is realistic in a case like this, although you will have to consider it. Can I go to page 17, which deals with conditional registration? I am really drawing your attention to it in order to indicate why on behalf of the GMC we submit that it would not be appropriate in this case. You know obviously your powers in relation to imposing conditions. Paragraph 57 says:

C "Conditions might be most appropriate in cases involving the doctor's health, performance or following a single clinical incident or where there is evidence of shortcomings in a specific area or areas of the doctor's practice. Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work."

Paragraph 61 provides:

D "The objectives of any conditions should be made clear so that the doctor knows what is expected of him or her and so that a Panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction."

Before imposing conditions, you must satisfy yourselves that:

E "The problem is amenable to improvement through conditions ...."

The objectives of the conditions are clear.

A future Panel will be readily able to determine whether the objective has been achieved and whether patients will or will not be at risk."

F We would respectfully submit that even if you were to apply conditions in a case like this, for instance, not to use opiates, there would come a time when those conditions lapsed inevitably and you have to bear in mind the doctor's responses which I have reminded you of.

Paragraph 62 we say is important when you are considering conditions:

G "When deciding whether conditions might be appropriate the Panel will need to satisfy itself that most or all of the following factors ... are apparent having regard to the type of case ... This list is not exhaustive."

Then the very first bullet point:

"No evidence of harmful deep-seated personality or attitudinal problems.

H - Identifiable areas of the doctor's practice in need of assessment or retraining.

A - Potential and willingness to respond positively to retraining ..."

Then the penultimate bullet point:

> "Patients will not be put in danger either directly or indirectly as a result of conditional registration itself."

B I turn briefly to suspension, which is dealt with at paragraph 69, which provides:

> "Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner ..."

I miss the next line; it mentions it has a punitive effect.

C

> "Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the Panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the Panel is satisfied that the behaviour or incident is unlikely to be repeated. The Panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions."

D

Paragraph 70 provides that you will want to consider:

E

> " ...where there is evidence that he/she has gained insight into the deficiencies and has the potential to be rehabilitated if prepared to undergo a rehabilitation programme."

Again there is reference in the bullet points under paragraph 75 to you wanting to see evidence that there is no evidence of harmful, deep-seated personality or attitudinal problems and that the doctor does not pose a significant risk of repeating the behaviour.

F

I turn finally to erasure, which is the sanction which the GMC submits is appropriate. Paragraph 77 provides:

> "The Panel may erase a doctor from the register in any case - except one which relates solely to the doctor's health - where this is the only means of protecting patients and the wider public interest, which includes maintaining public trust and confidence in the profession."

G

I know you will know the following words well, which are probably cited to you in almost each case that you hear, Lord Bingham's words in the case of *Bolton*, but can I just remind you of the very last words:

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> "'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'"

The *Gupta* judgment is set out briefly in paragraph 79:

> [The case] emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk: *"..the appellant's behaviour demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession".*

We do not concede, I am afraid, that in fact it can properly be said that Dr Barton does not present a risk. Paragraph 82 finally:

> "Erasure may well be appropriate when the behaviour involves **any** of the following factors (this list is not exhaustive):
>
> - Particularly serious departure from the principles set out in *Good Medical Practice* i.e. behaviour fundamentally incompatible with being a doctor.
> - A reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.
> - Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients ..."

Lastly, there is the issue of abuse of position/trust. The very last bullet point there, just above paragraph 83:

> "Persistent lack of insight into seriousness of actions or consequences."

Sir, the GMC exists to protect the public and to ensure that there is public confidence in the profession. Despite the age of these matters, these events have caused not only great anguish to many relatives of those who died at the Gosport War Memorial Hospital whilst under Dr Barton's care, but also serious public concern about the methods of an individual doctor who had considerable power at her local hospital. Each of these patients were under Dr Barton's care, as she accepted, and they and their relatives trusted her with their well-being and indeed with their lives.

The regulation of the medical profession is entrusted to the GMC and you, as a Panel, have a duty to do what you can to ensure that the right message is sent not only to other doctors about what are acceptable standards of practice and what are not, but also the message has to go to the public that they are safe when their care is entrusted to a doctor.

The GMC's submission is that the failings, acts and omissions by Dr Barton which you have found proved were entirely unacceptable and she has not demonstrated remorse or insight. The failures demonstrated in this case are so serious that, despite the passage of time, the only sanction which would ensure the protection of the public and public confidence in the profession is one of erasure.

Those are my submissions, unless I can assist you further.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Mr Kark and Mr Langdale, it occurs to me that I was perhaps remiss at an earlier stage in not noting, as Mr Kark very correctly did, that there has been a change in Legal Assessor. Noting that there are members of the public here today who have attended on previous occasions, I should say that there is nothing unusual about the change of Legal Assessor mid-case, especially in very long cases.

In this particular instance, I am happy to be able to tell you that Mr Chamberlain was given a judicial appointment at the end of our last session and so is no longer available to assist us. However, we are very fortunate that a very experienced Legal Assessor has been willing and able to join us in the form of Mr Smith. So there is nothing odd or unusual about it at all.

Mr Langdale, I know you are anxious to start, but I think what we are going to do is take a short break now to ensure that everybody is fully fresh before you do. Ladies and gentlemen, we will take a 15-minute break now.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. I should say that in the break we have had the technical services department in to attempt to increase the volume of the speakers at the back of the room and I hope that will make things easier for you. But if during the course of proceedings if at any time anybody is unable to hear, please raise a hand and try and catch my eye and I will make sure that we remedy it.

A MEMBER OF THE PUBLIC: I have come without my hearing aid, but do not worry about me, because there is someone who can relay it to me. As long as they can hear, that is fine.

THE CHAIRMAN: We do have a loop facility here. I do not know if it will work, but ---

A MEMBER OF THE PUBLIC: I can pick up bits and pieces, but someone else is writing notes.

THE CHAIRMAN: We are going to arrange for a pair of headphones to be provided to you. They may or may not assist, but we will certainly try that.

A MEMBER OF THE PUBLIC: Thank you for your consideration.

THE CHAIRMAN: Not at all. Mr Langdale?

MR LANGDALE: Sir, in addressing the Panel at this stage, I must make it clear, as you would expect, that I bear in mind the findings that the Panel has made and I bear in mind the GMC's *Indicative Sanctions Guidance*. If I fail to deal with anything in particular, it is not as a result of ignoring either of those pieces of material.

A lot of what I am going to say goes to the issue of whether there should be a finding of serious professional misconduct in the circumstances of this case. A lot of what I seek to say also goes to the question of what action or sanction the Panel thinks it appropriate to take or to impose.

May I say right away, I entirely accept, because he is obviously right, what Mr Kark has said about the judgment to be made in relation to serious professional misconduct, because this case is "under the old rules". There is no dispute between us about that. I accept also the test he has propounded for your consideration as to what amounts to or may amount to serious professional misconduct. I am not going to separate those two issues into discrete parts, because so much of the material to which I shall be referring overlaps or in fact has a bearing on both issues. It is you, the Panel, who decide whether the findings of fact that you have made and the submissions made to you on behalf of the GMC and on behalf of Dr Barton justify a finding of serious professional misconduct.

Although I am going to place before you a body – almost a lever arch file – of testimonial evidence, which will take a little time for you to digest, I should also make it clear that I do not seek to address you in this phase, as it were, at any great length. That is for two reasons. Firstly, you have heard weeks of evidence, you have heard detailed submissions made to you about the evidence, you have had the opportunity to read yourselves back into the case. The second reason is that although the hearing itself took many weeks, a great deal of time, the issues that have been canvassed before you have been very similar in terms of the patients concerned. Each patient is different, but the issues you have had to address and we have had to address you about are not widely dissimilar in any sense.

May I just say something in relation to the file of evidence that I will be asking you to receive and consider at the end of what I seek to say to you? That file has been provided to the GMC and has been available for some time. There has been a slight change to its content, because, as I will explain later on, those instructing me have made every effort to contact those who provided the testimonial material to make sure they still stood by what they were saying in the light of your findings and the nature of the case. So what you are going to be getting is in relation to people who are aware of those matters. Therefore some, because they are untraceable, have been left out from the original bundle.

May I start by saying something about the *Indicative Sanctions Guidance*? I do not need to go into it in any detail, because Mr Kark has already covered the most material items or paragraphs of the guidance. Obviously there is no dispute about the public interest – this is paragraph 19 to which he referred you – including the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour. All my remarks addressed to you, as the Panel, are fully aware of that. I do not seek to say anything to the contrary.

Paragraph 21, another one of the paragraphs which Mr Kark mentioned, is that the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. Paragraph 23 in particular states that there may be a public interest in enabling a doctor's return to safe practice. The protection of patients and the wider public interest is the primary concern, for obvious reasons. You could not have a doctor being permitted to return to safe practice unless you were satisfied that patients would be protected, but it is there in black and white.

I would just say in relation to that consideration, that guidance, you are dealing here with a doctor who, since she left the Gosport War Memorial Hospital in the year 2000, has been in safe practice for nearly ten years.

Paragraph 36 to which my learned friend referred you in relation to insight and so on and the recognition of the need for steps to be taken. I am going say a little bit more about that in a moment or two, because my submission is that it has not been – I am not going to use the word "fair", because my learned friend has been consistently fair in this case – needs further elaboration and examination before the Panel could properly accept the way he has put it.

May I also turn to the matters to which Mr Kark has referred you in relation to the issues with regard to erasure? You have these in front of you; I am not going to repeat them all. It is absolutely right that what is said in the guidance should be followed. Those are matters which are not matters of dispute between myself and Mr Kark in any way at all, but you will be paying no doubt careful attention to the wording of what is said there, I am sure. Again, I am not going to repeat to you the cases that are cited.

In relation to paragraph 82, which deals with where erasure might be appropriate, it sets out that it might be appropriate when the behaviour involves any of the following factors, the list not being exhaustive. We submit on behalf of Dr Barton that when one looks at each one of those indicators – they are not exclusive – the answer to the question: did the behaviour involve any one of these, would properly be no.

Reckless or particularly serious departure from the principles set out in Good Medical Practice, i.e. behaviour fundamentally incompatible with being a doctor. Of course there is an acceptance on behalf of Dr Barton that she did depart from a principle, by way of example, the principle about proper note keeping, but the mere fact that there was that departure does not mean that it is particularly serious. The Panel will remember the evidence about it and the evidence from more than one professionally trained and competent person, how note taking in those days was rather different and how in some cases her note taking was rather better than in the case of others. I say that by way of example and the need for the Panel, as I am sure the Panel will observe in any event, to look at the wording in relation to these examples.

"A reckless disregard for the principles": nobody has suggested ever that Dr Barton was recklessly disregarding anything, or indeed was reckless in her conduct. "Doing serious harm" and so on. As I say, we suggest that on the evidence and your findings, each one of those, if the question was asked "Did the behaviour involve any of these factors?" the answer would be "No", and I bear in mind the very last point which Mr Kark stressed to you, as it were, the last of the bullet points, "Persistent lack of insight into seriousness of actions or consequences". I will be saying something more to you, if I may, about that.

May I just lastly say something to you in terms of the guidance as to the expression that is used, and it is justifiably used, and it is absolutely critical, the question of public trust and confidence in the profession. May I just stress this: that means properly informed public trust and confidence. It does not mean the view of members of the public who have relied on uninformed, biased and/or inflammatory reports in the media. Nor does it mean the view of relatives whose understandable emotions have, again understandably, clouded their perception of the case. Those reactions or emotions are not to be dismissed, but in considering the question of public trust and confidence in the profession it means properly informed trust and confidence without bias, whatever may have brought about the bias.

Perhaps the central question to be asked is really in two parts: first of all, and this is applying obviously to this case, would the protection of patients be adversely affected if Dr Barton

remained in practice as a GP? I will come on to the question of conditions in due course. We submit that there is proof positive that, subject maybe to conditions, the protection of patients would not be adversely affected.

The second part of the question that has to be asked in relation to this issue of public trust and confidence: would public trust and confidence in the profession not be maintained if Dr Barton remained in practice? We submit that although that concept is a little bit more elusive than the concept of the protection of patients, public trust and confidence would be maintained if Dr Barton, again maybe subject to conditions, remained in practice, bearing in mind that it is not part of the Panel's function to punish the doctor for any failings on her part that the Panel may have found, and bearing in mind the factors, to which I shall turn in a moment in more detail, which could be summarised in this way: (1) the area of practice in which she was engaged at Gosport War Memorial Hospital; (2) the conditions in which she was operating; (3) the particular failings which the Panel have found to have taken place; (4) the fact that it is accepted that whatever those failings may have been, Dr Barton was at all times acting as she saw it, genuinely saw it, in the best interests of her patients; (5) the fact that she has not practised in that area of medicine for some ten years, nearly ten years now, coupled with the fact that she has shown herself to be, and is, we suggest, on the evidence as opposed to comment, a very conscientious, caring and indeed esteemed GP.

Having said that by way of general comments about the guidance with regard to possible sanctions, may I turn to first of all briefly general background mitigation material. Again, I am keeping this short because the Panel heard from Dr Barton in evidence, as well as indeed from evidence from others, about her background and so on. It is clear the Panel can be satisfied, we suggest, that she is a hard working doctor of great integrity, a doctor who was a good doctor – people have not suggested she was a bad doctor – taking into account the failings that the Panel have found, that she had an unblemished medical career over many years, qualifying in 1972, beginning as a trainee GP in 1974, and a partner in her present practice since 1980. There has been high praise of her from those who worked with her. You will be seeing, from the evidence I shall place before you in due course, she has extraordinarily high praise from her patients.

Immediately leading on from that, by way of general background, may I tackle a particular aspect of this case that counsel on behalf of the GMC has laid great stress upon: the suggestion that she is a doctor who lacks insight, and indeed my learned friend has gone far enough to say or to suggest to you that there is some evidence of a deep-seated – these are the words used – personality or attitudinal problem. We suggest on behalf of Dr Barton that that assertion cannot be justified when one looks at the matter in the whole.

My learned friend cited, by way of example of her lacking insight, that it was clear in 1991 that her practice needed review, and he suggested that the evidence showed that she has, as it were, ignored that. That, with great respect, just is not justified. The Panel will remember all the evidence that was heard about the contretemps that developed in the early 90s; the views of some nurses and so on and so forth about whether these prescriptions were justified; those who thought they were only justified in terms of patients who were suffering from cancer, and so on. The Panel will (a) remember it, I am sure, in general terms, and you can remind yourselves of it in detail if necessary, but the picture is very clear: Dr Barton did not stand alone as some figure asserting something that was contrary to the practice of others, or somebody who ignored what was being said by the nursing staff. There were meetings (in the plural), and her medical, if you like, superiors, the consultants involved, as well as senior

nursing staff, did not suggest to her that she should change her practice. Dr Logan, the consultant at the time, did not say to her, "Dr Barton, you really must review what you are doing", or suggest for a moment that what she was doing was wrong, or not in accordance with what he regarded as acceptable practice. We suggest that that sort of assertion should be looked at by the Panel extremely closely before accepting that the events of the early 1990s somehow show Dr Barton to have been somebody who possessed no insight or was ignoring red flags being waved in front of her face.

"Where does this suggestion come from?" is the question that one has to ask. It comes from Dr Barton's own evidence. If she was somebody, and again perhaps this goes to the question of her integrity apart from anything else, if she was somebody who was trying to give an easy ride for herself in some way, she could very easily have taken a certain course. For her to maintain, as she has done, and you have been reminded of particular passages, that what she did at the time she stands by, does not indicate of itself somebody who lacks insight, somebody who is not ready to change, somebody who is unduly arrogant, nor, again with respect to my friend, does it justify a suggestion that she has some deep-seated (again I quote the words) personality or attitudinal problems, which my friend then seeks to build on to suggest to you that (a) she should be erased if you find serious professional misconduct, and you should not properly consider allowing her to remain in practice subject to conditions. She said in her evidence that in her view, looking back and bearing in mind the circumstances in which she had to operate, her decisions were made correctly, and that the conditions of the patients concerned justified the treatment she gave them. She has maintained, for example, that her decision at Mr Packman's bedside, that he was not fit for transfer back to the hospital, was in her judgement correct. That, we submit, is not arrogance, nor does it justify a conclusion that Dr Barton is not ready to learn, or that she is not ready to change to meet developing medical practice. That is why I am stressing the circumstances in which she was operating at the time.

She has acknowledged – this seemed to almost pass the GMC by – failings from the start of these proceedings. Her inadequate note-taking, accepted by her from the start; particularly, the inadequacy of her note-taking with regard to the rationale for her decisions in certain cases. She acknowledged from the start the dose ranges of her anticipatory prescriptions were not appropriate, because they carried with them a risk that they might provide a basis for an improper administration of opiates.

It is not, we suggest, an appropriate process of thought to conclude that the fact that Dr Barton still considers that her judgement was right, and I underline these words, as it were, in these cases, that that means she is indifferent to changes in methods and practice, and that is the leap that is made, unjustified intellectual leap. The Panel will bear in mind, in considering Dr Barton's stance, "I was there. I made the judgement I thought was right at the time and I do not think my judgement was wrong", that stance does not mean that she is somebody who can be regarded as possessing a deep-seated personality or attitudinal problem.

It is worth bearing in mind too, in relation to this area of medicine, the difficulties that faced not only Dr Barton but any doctor in this particular field with these often difficult judgements. You have made findings that in certain cases the prescription was not in the best interests of the patient. I am summarising obviously. She is somebody who in her view at the time, looking at the patient and considering the patient, thought that it was justified in the context, because anticipatory prescriptions were accepted.

You will also bear in mind that a lot of the findings you have made against her relate to the risk rather than the fact that a patient's situation was actually harmed. May I just remind you of these matters in considering certain assertions made about the patients and the allegations against them. Leaving aside the question of risk, or inappropriate, or not in the patient's best interests because it was inappropriate or there was a risk, it was suggested on behalf of the GMC that many were, actually were, harmful. Again, I invite the Panel to remind itself – it hardly probably needs reminding as they are your findings and you have refreshed yourselves of them in any event – but may I remind the Panel and ask you to consider this, that in fact the findings of the Panel as to whether these prescriptions were harmful, not surprisingly, because of the difficulty of establishing whether in fact it was the opiate which contributed improperly to the problem or the dying process itself, you actually found, I think in relation to two patients, a specific finding that, as it were, harm had been caused. In relation to Enid Spurgin, you found that the dosage, in the particular dosage that you were concerned with, was excessive to the patient's needs. That is a finding of fact that you made. In relation to Elsie Devine, the lowest doses which she prescribed would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression, and in your finding you coupled with that the fact that she was on fentanyl – and you will remember this case no doubt – at the time that the syringe driver process was started; the fentanyl would have had, I am stressing that word, a profoundly sedating effect. You found in her case the prescription put the patient at severe risk of respiratory depression, coma and premature death.

You also noted, again Mr Kark referred to this particular case, that she had lapsed into unconsciousness shortly after the commencement of the syringe driver. May I just say this, and it does not alter the impact of the finding I do not think, it does not alter the gist of what I am seeking to say to you now, in fact in that case she did not lapse into unconsciousness until she died. You may remember that Code A I think it was Code A gave evidence that in fact although the nursing staff on duty, or one of the nurses, thought she would not get a response, the patient Code A did squeeze her hand. She was not in fact unconscious throughout. I am just saying that as a matter of fact because that point was specifically mentioned by my learned friend.

That, we suggest, needs to be looked at and considered very much in the context of the suggestions being made that Dr Barton saying, "I stand by what I did. I could see the patient. I was using my experience and my judgement to prescribe as I did in the context of anticipatory prescribing, and to make the judgements that I did, that in fact, for example, in Mr Packman's case", I am putting it bluntly, "that there was no point, it was not in his best interests to be returned to hospital". That fact does not indicate, cannot be used, and I stress this as much as I can, as a proper basis for concluding that Dr Barton lacks insight, or that she lacks an ability to change and adapt in the year 2010 to changed medical practices and views, if she was ever to go back into the field of palliative care medicine, because she has no intention or desire to go back into that field. If it was the case, the Panel can be safe in concluding obviously she would ensure that she received training with regard to the latest methods, principles and procedures, and she would ensure that she implemented those approaches and methods under suitable consultant supervision: or is this is a bizarre example of a doctor who in every other respect in terms of her training, her methods, her procedures and her actions is subject to no criticism whatsoever, nobody suggests she has an attitudinal or personality problem as a GP, quite the contrary, a bizarre example of somebody who somehow exhibited these features in connection with the particular field of medicine she was operating in over 10 years ago, it does not, we suggest, make sense.

You will be considering, I hope, amongst the material that I will be providing you with, the latest appraisal of her by a doctor – I will refer you to it later if I may – which makes it clear that in fact – and you will remember this from the evidence you have heard in the course of the hearing – the Liverpool Care Pathway material, something which she has seen and considered and taken an interest in, not exhibiting the slightest sign of somebody who is just saying, "Well I know it all; I don't need to bother to look at that".

Dr Barton has been in practice now for over 30 years, and in practice for nearly 10 years since she left the Gosport War Memorial Hospital. It has not been suggested from any quarter, but most importantly by any medical practitioner, that she is somebody who does not apply up to date procedures and learning. The Panel will also bear in mind in relation to this suggestion that is made, that we are concerned with 12 patients treated by Dr Barton out of hundreds who were treated by her at the Gosport War Memorial Hospital.

Another general heading, if I may, with regard to the approach we suggest the Panel should take in this case, and that is to consider what the context was in which she operated and in which she failed in the way the Panel have found the context. It is perhaps a vital consideration affecting the course the Panel decides to take as a consequence of its findings.

I am not going to go into this at any great length. The Panel will remember the evidence, but it can fairly be said that these 12 cases were treated in accordance with her normal prescribing practice. It is not a case, perhaps I can say in parenthesis, that she was somebody who ignored – that is the word that was used – the guidelines in that she paid no attention to them. Dr Barton was aware of the guidelines. She made her own judgment based on the condition of the patient she was dealing with. So it is not a case that she ignored them. You found there was a failure in some cases to observe the guidelines when that would have been appropriate but it is not a case of a doctor saying, "To hell with the guidelines, they make no difference to me". She was aware of them; she applied her own judgment about them.

Her practice was known to all consultants, one of whom was also the Medical Director, Dr Reid. Those consultants included Dr Logan and Dr Grunstein, and must indeed have included Dr Wilkie, whose name surfaced at certain periods earlier on. They did not question her practice and did not criticise it. Of course it is right for the Panel to say, as you did, that as a medical practitioner she retained ultimate responsibility for her own actions. That is something that Dr Barton would not resile from for a single moment, but she could properly, and we suggest did properly, feel she was acting with approval and sanction. She was not a doctor operating in a vacuum. She was entitled to expect, and did expect, that they would provide her with guidance and advice if they felt that she needed it. One can add too in terms of the context other doctors also saw her patients on occasion. Dr X, Dr Knapman, Dr Beesley and Dr Briggs: none, from what they saw – admittedly they were not carrying out day to day treatment of the patients, but from what they saw – none of them concluded that Dr Barton was doing anything that they would query.

In terms of the consultants, perhaps it is also worth bearing in mind that there was an agreed protocol in relation to the question of prescribing in the way she did, which was defence document D4. You will probably remember it was produced in the course of the evidence called by the defence.

If I can add to the doctors and the consultants the nurses: generally it was clear from the nurses that they did not criticise or query what Dr Barton was doing, but it is notable in general terms, apart from the generality, it is notable that those nurses, who were quite capable of complaining if they had concerns, you may remember Nurse Giffin, Nurse Turnbull, Nurse Tubritt, and in a rather different category Nurse Hallman, they were all people who were quite capable of complaining if they felt there was a need to complain. None of them at any time, either when any of these 12 patients were receiving treatment, or afterwards when they made statements either to the police or to the GMC, none of them voiced any concerns about what was prescribed or administered to these 12 patients. Indeed, they, the nurses I have referred to specifically by name, like all the nursing staff, found Dr Barton to be a good doctor, with the interests of her patients at heart.

Again, with regard to the nurses one has to consider the difference between a risk, a risk that should not have been run but a risk and the actuality, bearing in mind the nature of your findings in many cases – we abide by them, obviously, because they are your findings – that it was the risk, the potential for harm that meant that they were not in the best interest of the patients, and in addition to the consultants, the doctors and the nurses, may I also remind you of the evidence about the pharmacist, again somebody who was in a position to check on, criticise, discuss with Dr Barton what she was prescribing, the combinations and so on. Leave aside the question as to whether in fact, looking back at it, or a different consultant might take a different view, that was the context in which Dr Barton was operating.

Also in that context, as you know, Dr Barton placed great reliance on the nursing staff and their judgment, and, indeed, had good reason to do so. Not one non-nursing witness suggested that Dr Barton was not entitled to place great reliance on that, but it did mean that she could not herself be making her own judgments about the condition of patients 12 or 24 hours a day – you will remember the evidence about that – far from it.

A further consequence of the conditions under which she was operating was the fact that certain procedures, which might be possible or available in a fully staffed hospital or a teaching hospital, were not possible or available to her at Gosport. Titration and so on: I do not need to go over the evidence. You will remember the evidence about it.

Her note-taking, as you know, and, indeed, that of her staff, suffered. She has accepted that failing, but in mitigation of that failure, which was not brought about by laziness or sloppiness, it can fairly be said that there was no case amongst the 12 patients in this case of that failure causing any problem at all – these 12 patients – to any consultant, nor to any nursing staff. Somebody has suffered as a result of that failure, and that is Dr Barton. She has to face the consequences for her failure.

I have already mentioned, but may I remind you in this context, of the evidence about note-taking at that time and the evidence of Dr Tandy – I can give you the reference, day 18/48 about note-taking generally and her view that in some instances Dr Barton's note-taking was better than some other. Then this too in terms of the context: the lack of consultant cover. A lack of medical input. I am touching here in a way on management issues. If there had been more consultant cover and medical input then the burden on her would be less. Furthermore, the consultants did not expect her to come to any of them to seek their sanction with regard to treating a patient with palliative or end of life care. She was not expected to seek their sanction. If she made a clinical decision that a patient was not suitable for return to the hospital from which the patient had originally come and therefore not suitable for further

intervention: it may seem a bit much, quite frankly, to somehow blame Dr Barton's character. That is what was being suggested, for the failure of consultants to do more, for their failure to indicate to her, if they thought it, there was something wrong with what she was doing. How it can possibly be suggested that somehow her character is at fault in that regard is perhaps difficult to understand. No consultant has suggested how he or she was frightened of Dr Barton: "I didn't dare challenge Dr Barton. I would not possibly go against anything she said". Of course they respected her experience and her judgment, but to suggest that somehow her character is to blame, as I say, does not perhaps stand up to close examination.

Of course Dr Barton has to take responsibility for any findings the Panel have made which are adverse to her, but when assessing the impact of those findings it has, we suggest, to be borne in mind, she was not receiving adequate medical supervision, guidance and advice. This was not a situation of her making. She got on with what she had got. There was a failure of management generally. I do not think there is any dispute about this, because my learned friend Mr Kark has acknowledged that there were failures. If the management had set things up so as to provide effective clinical governance then this problem would not have occurred. Anticipatory prescribing would not have taken place in the way that it did. Titration would have been possible. There would have been audit, annual appraisals and so on. There would have been multi-disciplinary team meetings, no doubt, and sufficient time for Dr Barton to maintain proper records. There would have been challenges, as it were, within the system. It is not her fault that those features were absent. What response did she get when she spoke to consultants and management about concerns? The response was: I see your point, but there is nothing really I can do about it, and no doubt the Panel, when these criticisms are made of Dr Barton, will bear in mind what happened when she resigned, for perfectly proper and understandable reasons. Instantly matters changed and management made sure that greater resources were put in to cover the same job that Dr Barton was doing.

You will remember the fact that it was the case I think that a staff grade doctor was put in place, working full-time, with out of hours cover also being provided in relation to something like tripling of the amount of time and direction that Dr Barton had been able to give in the circumstances in which she was placed.

This as a further sub-heading which we invite the Panel to bear in mind very much when considering whether what she did amounts to serious professional misconduct and, if it does, what the consequences should be. That is the area of practice in which she was engaged. A difficult area, and one which operated rather differently to the way it does now. You have heard evidence from Professor Ford and Professor Sikora about this: now everything is much more guided and monitored. I have mentioned the Liverpool Care Pathway and so on. Methods of administering and so on are, it seems, more uniform. Greater care is taken to inform patients and their relatives about the situation than was the case 10 to 15 years ago across the country.

It has to be said too, it is still an area of discussion and debate as to what was the appropriate course, what the appropriate approach should be for patients in this difficult, painful and troublesome time of their lives. Furthermore, it was an area where there were differing views and attitudes to palliative or terminal care, and about the proper doses to employ in such care.

You will remember that the BNF and the palliative care handbook did not attempt to give guidance in relation to patients being treated in that way. You saw examples of differing attitudes. Indeed, you took account (if I may say so perfectly properly of course) about the

divergence of view in the profession (paragraph 10 of your determination). Those nurses who expressed concerns about patients being put on syringe drivers when they were not suffering from cancer; different views as to what level of pain was to be tolerated by patients; different views as to what the administration or oral or subcutaneous morphine was appropriate. Those, who like Professor Ford, saw it as only appropriate if the patient was suffering from pain as opposed to distress and so on, and those like Dr Barton and Dr Logan who saw it as appropriate to administer to relieve distress and so on.

It is worth noting and you will remember, Professor Ford did find it acceptable in the case of patients who were suffering from cancer. You will remember too the evidence of Professor Sikora who also said that you might use properly the administration of subcutaneous morphine to relieve distress, fear of dying and so on. He also did not see that there should be a difference between the relief of pain, depending on what it was the patient was suffering from, no difference therefore between the cancer patient and the patient who was dying from some other cause, and suffering pain, distress, agitation and so on.

Perhaps one can say this: it is perhaps implicit in your findings that you found that Dr Barton came down too heavily on one side of the scales, that of her overriding concern to ensure that her patients did not suffer pain, and that coming down too heavily on that side of the balance – and it is a difficult balancing exercise, the evidence shows – that of course had the effect of there being an expense on the other side of the balance, which was that of trying to keep a patient in a reasonable state of alertness. You dealt with this in your finding, and you made it clear what you saw as Dr Barton's clear position. As I say, that was a balancing exercise and if that was an error of judgment on her part, as you have found, it was an error made in a difficult area and without any ill intent: far from it.

Before turning to what submissions I make in respect of what would be the appropriate order in this case, may I just mention one other feature of the case? We suggest it is a cardinal feature of the case and I have touched upon it already.

Underlying the essential features of Dr Barton's actions was a particular attitude – now we can talk about an attitude on an evidential basis – and concern that she had, in that she was endeavouring at all times to act in the best interests of her patients. It has not been suggested that she was quite categorically seeking to hasten the end of any patient under her care. That was her case throughout and the GMC did not suggest to the contrary.

It is important, we suggest, to lay great stress on that core element, not only because it will no doubt have considerable bearing on what the Panel thinks it appropriate to order so far as Dr Barton's professional future is concerned, but also to give the lie to some of the wilder and more exaggerated statements that have been made in the media, hinting darkly at Dr Shipman or claiming that Dr Barton was practising euthanasia. One comes back to the point I was making earlier on about when one considers public confidence and trust, it has to be informed public confidence and trust.

The central concern that Dr Barton had was to ensure that her patients did not suffer any unnecessary pain, agitation or distress at the time they entered the last phase of their lives. There was no desire to harm any patient. There was only a desire to care for them as best she could, as she judged the situation to be. You have found that in some instances that judgment was wrong, but you will not forget, I am sure, her motivation.

What can we say about the appropriate order in this case? I am approaching this on the basis that if you have found there was serious professional misconduct, then this is the context in which you would have to consider this approach to the order. We suggest on the evidence she is demonstrably fit to practise. It is only in this difficult area that complaint has been made about her. It can fairly be said that a clear demonstration of her commitment and dedication to her work has been given by her continuing to provide excellent care to her patients, despite having had allegations of various kinds hanging over her head as well as the strain of the proceedings before you, for some ten years. Since 2000, she has been in practice subject to a voluntary condition that she does not prescribe – and I am using the expression very generally – opiates. You heard the evidence in the course of the case.

As a result of an Interim Orders Panel in 2008 – and this is the condition she is currently operating under – missing out the concomitant conditions in relation to notifying the GMC and so on and so forth, condition 5 is that she must not prescribe diamorphine and she must restrict her prescribing of diazepam in line with BNF guidance. One has to say that was I think a justifiable concern. What is the basis for suggesting that somehow the facts of this case demonstrate that if you thought it was appropriate, a condition or conditions should not be imposed? How can it be suggested in all conscience if, first of all voluntarily and then, following an order, an identical condition laid down by the Interim Orders Panel, in observing exactly what those conditions are, she has not been demonstrating in her practice some deep-seated personality or attitudinal problem such that she disregards what she has to do, that she disregards current proper practice and so on? I invite the Panel to look at the facts when considering the suggestion made on behalf of the GMC that really, conditions are not appropriate in this case.

Furthermore, I invite the Panel to remember that when it has been suggested that there might be some sort of problem, because you can only impose conditions for three years and goodness gracious me, Dr Barton might suddenly, if that was done, in the fourth year, she would start going haywire and somehow the protection of patients would be affected and public trust and confidence and would be affected. Really.

No doubt you will have in mind that if there was the slightest risk of that and indeed in any event, if that condition or conditions of that kind were imposed, they can be reviewed at the end of the period. Again, it is not a justifiable reason for saying that conditions would not be appropriate in this case. She will never be, to pursue the point that was being made on behalf of the GMC, ever again in her life, conditions or no conditions, in the same situation as she was in the 1990s, nor would she be in that area of practice in the way that she was, save whenever aspects of her practice as a GP might involve dealing with somebody or treating somebody who was getting near to the end of their life. Nor will she ever be applying the approaches that applied in the 1990s. You can be satisfied, we suggest, absolutely that the situation would never be repeated and indeed there is no lack of insight with regard to the inadequacies of the situation that pertained in which she was operating then.

I have already made the point that you cannot properly or sensibly in the case of Dr Barton make the jump that because she stands by what she did in 1996, 1997, 1998, 1999, whatever it was, she somehow is somebody who has no insight and would not follow proper procedures.

Subject to the condition I have mentioned, first voluntarily adopted by her and then applied by the Interim Orders Panel in 2008, she has clearly been practising good medicine since she

left the Gosport War Memorial Hospital. It does not seem to be possible in all reason to suggest that she somehow poses a risk – that was the expression that was used – it was seriously suggested on behalf of the GMC that she poses a risk to patients. Is counsel on behalf of the GMC right and are those who know her and who have appraised her and made a professional judgment about her wrong? That is a matter for the Panel to consider on the evidence that first of all it has already heard and I hope on the evidence that I will be providing in a moment or two in regard to testimonials.

We suggest that – of course this is a matter for you, if you consider that a condition should be imposed – erasure is not the proper course and is not justified here, bearing in mind the standards you have to apply and that any properly informed person could have absolute confidence – and I am putting it as strongly as that – and trust in Dr Barton as a doctor and in the profession as a whole. She is a good, experienced, caring and conscientious GP who continues in practice and continues providing to the community an important and vital service.

Her fitness to practise we suggest, if necessary subject to the existing conditions, is not in doubt. In support of that contention I am going to ask that you receive a bundle of testimonials. One always feels like apologising when providing a lot of written material, but I am not going to apologise, because it is rather important so far as Dr Barton is concerned in terms of some of the suggestions that have been made, particularly today, about her.

Can I, rather than have a porter's job being carried out now, simply say something to you about its nature and then you can receive then and I by then will have stopped, because no doubt you will wish to consider the import and effect of them on some later occasion than this afternoon. Can I conclude in this way?

You will find – and I venture to suggest it is a pretty exceptional collection – that there are 184 testimonials in letter or report form from differing people: patients and so on and other professionals in the medical profession. I venture to suggest that it demonstrates overall her popularity with patients, the fact that they are ready to wait longer than normal in order to see Dr Barton at the practice, the range of illnesses and problems she has had to deal with, her sympathetic approach attested to by many and the fact that they bear out what I said earlier on by way of a contention made by counsel that she is a good, caring, conscientious doctor, indeed, an excellent family doctor, and somebody who is astute, trustworthy and ethically sound, absolutely contrary, we suggest, to the suggestion that there is some kind of deep-seated personality or attitudinal problem – this is the last time I am going to mention it – that is just not borne out. Are all these people wrong? Have they all missed something? The answer on a sensible basis, we suggest, for your consideration must be no, they have not.

In terms of the last four of these people, they are people who sent unsolicited testimonials about Dr Barton, that is, unsolicited by those instructing me. All of the people on this list have seen the heads of charge and the findings of fact and all have indicated, having been contacted by those instructing me, that they wish their letters or reports to be used. There are six who gave their authority this morning, or at least that is when it reaching those instructing me. So you have a very small bundle of six. You will find the appraisal that I referred you to, this is the latest appraisal by Dr Beale, at pages 266 and 267. Perhaps I can say this, again to avoid an unnecessary bulk of paper, we have provided you with the latest appraisal. There are earlier appraisals and there is no difficulty about providing those to you if you would find

A them to be of help. I am reminded that the last four which I mentioned earlier on, as I understand it wrote directly to the GMC. That is how they came into the picture.

Sir, that is all I seek to say to the Panel. Thank you.

THE CHAIRMAN: Thank you very much, Mr Langdale. The Panel will receive the bundle of testimonials and mark it exhibit D8. (Same distributed) Mr Kark?

B

MR KARK: I am not rising to reply, because I do not have a further right to do so, but can I just give you the right reference which I had wrong earlier, if you remember. It was in fact Day 28/64 and 65.

Can I also mention this? I suspect the Panel will obviously want to read the material before receiving your advice from the Legal Assessor and that I presume will be given tomorrow. I C myself unfortunately am engaged in another hearing, in fact in this building, and that Panel very kindly agreed not to sit so that I could attend today, but as you see, Mr Fitzgerald, who has been with me throughout the proceedings, will be here tomorrow and I gather we may have an opportunity of seeing the Legal Assessor's advice in advance in any event, so I hope you will not take it as any discourtesy if I am not here tomorrow, but I will make myself available for your final determination, providing I can square that, as it were, with my current Chairman in the other hearing.

D

THE CHAIRMAN: In the event that the Panel, having had advice and comments from parties, were to encounter the need for further advice, would we be calling upon yourself or Mr Fitzgerald?

MR KARK: As I say, the hearing is next door. If Mr Fitzgerald feels he needs me, then I will make sure that I can attend, but I am absolutely sure Mr Fitzgerald will be able to cope E with anything that may arise.

THE CHAIRMAN: Of course. Thank you. Mr Langdale?

MR LANGDALE: I appreciate what my friend has said and I am grateful to him for indicating it. May I just say this? Obviously the timing is entirely a matter for you and the Panel as a whole. Dr Barton in fact would not be able to be here tomorrow – I am just F pointing that out as a fact, so that you know.

THE CHAIRMAN: As long as Dr Barton is happy for us to continue, receive advice and so on, I anticipate that we will at some stage tomorrow be going into camera and I will leave it open-ended this time. I will not give any indication as to how long we are likely to be, other than to say that as soon as things become clear in terms of time, we will let everybody know, and that of course includes family and other visitors who may wish to be present to hear the G reading of the determination when that happens.

MR LANGDALE: May we take it then, sir, if I may inquire, whether we should, as it were, be on the end of a telephone tomorrow and maybe thereafterwards?

THE CHAIRMAN: I think we can say that after we have read through that considerable bundle, we would then be expecting to hear from our Legal Assessor and we probably can H attempt to put some sort of time on that now, if it would assist.

MR LANGDALE: It would, sir. (After a pause)

THE CHAIRMAN: I have taken the opportunity to confer with the Legal Assessor as to how long he is likely to need in any event and also for us to consider, as you have indicated, a weighty bundle that needs to be read with care. We are going to say two o'clock, if that assists.

MR LANGDALE: Thank you. It does.

THE CHAIRMAN: Very well. That is it for today. The Panel will be hear again tomorrow afternoon at two o'clock to hear the advice of the Legal Assessor. If parties are interested to attend for that, they are of course most welcome.

(The Panel adjourned until 2.00 p.m. on Thursday 21 January 2010)

General Medical Council

Regulating doctors
Ensuring good medical practice

Indicative Sanctions Guidance

for the Fitness to Practise Panel

April 2009
(with 7 August 2009 revisions)

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Council

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Contents

Introduction

Role and status of the Indicative Sanctions Guidance

1. This guidance has been developed by the General Medical Council (GMC) for use by its Fitness to Practise Panels when considering what sanction to impose following a finding that the doctor's fitness to practise is impaired. It also contains guidance on the issue of warnings where a Panel has concluded that the doctor's fitness to practise is not impaired. It outlines the decision-making process and factors to be considered. The Indicative Sanctions Guidance is an authoritative statement of the GMC's approach to sanctions issues.

2. The guidance is a 'living document', which will be updated and revised as the need arises. Please email any comments or suggestions for further revisions to pandevteam@gmc-uk.org.

The GMC's statutory purpose

3. The statutory purpose of the GMC is to protect, promote and maintain the health and safety of the public. It does this through the four main functions given to it under the Medical Act 1983 as amended (the Act):

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC's role in setting standards

4. The GMC has a statutory role in providing guidance to doctors on standards of professional conduct, performance and medical ethics. Its guidance booklet *Good Medical Practice*[1], which has been drawn up after wide consultation, sets out the principles and values on which good medical practice is founded, and the standards which society and the profession expects of all doctors (irrespective of their area of practice) throughout their careers.

5. The GMC also publishes supplementary ethical guidance[2], which expands on the principles in *Good Medical Practice*, providing more detail on how to comply with them. This supplementary guidance is published in six additional booklets (on consent, confidentiality, end-of life care, research, management and children) as well

[1] http://www.gmc-uk.org/guidance/good_medical_practice/index.asp. Previous and no longer current editions of *Good Medical Practice* are at http://www.gmc-uk.org/guidance/archive/index.asp
[2] http://www.gmc-uk.org/guidance/ethical_guidance/index.asp

as a range of shorter statements – from writing references to reporting gunshot wounds – all of which can be found on the GMC's website. When viewing *Good Medical Practice* on-line there are direct links through to the supplementary guidance and other information from the relevant paragraphs.

6. *Good Medical Practice*, together with the supplementary ethical guidance on specific issues (for example consent, prescribing, acting as an expert witness, personal beliefs etc.) has therefore become a pivotal reference point in the current structures and processes for healthcare regulation, service provision and inspection, and underpins all the GMC's functions.

7. As confirmed in the introductory statements to *Good Medical Practice* ("How Good Medical Practice Applies to you") outlining the context in which the guidance should be read, it is the responsibility of doctors to follow the guidance, exercising their judgement in any given circumstance, and being prepared to explain and justify decisions and actions. As the guidance warns doctors: "*serious or persistent failure to follow this guidance will put your registration at risk*".

8. The Indicative Sanctions Guidance provides a crucial link between two key regulatory roles of the GMC: that of setting standards for the profession and of taking action on registration when a doctor's fitness to practise is called into question because those standards have not been met. Although GMC members do not sit on Fitness to Practise Panels, the GMC is responsible – under the Medical Act 1983, as amended (the Act) – for all decisions taken by the Panels. The medical and lay panellists appointed to sit on Panels exercise their own judgements in making decisions, but must take into consideration the standards of good practice the GMC has established. Decisions taken by panellists in relation to sanction are at their discretion, however, panellists are expected to refer to this guidance and to confirm that it has been followed or, if not, to explain why not.

9. The Indicative Sanctions Guidance aims to promote consistency and transparency in decision-making. It ensures that all parties are aware from the outset of the approach to be taken by a Fitness to Practise Panel to the question of sanction. It has received strong endorsement from the judiciary, and Mr Justice Collins in the case of *CRHP -v- (1) GMC (2) Leeper [2004] EWHC 1850* recorded that:

> *"It helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The [panel] must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff".*

10. Mr Justice Newman, in *R (on the application of Abrahaem) v GMC [2004]* described the Indicative Sanctions Guidance as

> *"Those are very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues. But one has to come back to the essential exercise which the law now requires in what lies behind the purpose of sanctions, which, as I have already pointed*

out, is not to be punitive but to protect the public interest; public interest is a label which gives rise to separate areas of consideration.

Equality and Diversity Statement

The GMC's responsibilities

11. Doctors practise medicine to serve patients. It is a central function of the GMC, through the Fitness to Practise Panel, to promote the interests of patients and to protect them by ensuring a good standard in the practice of medicine by doctors who are fit to practise.

12. The GMC is committed to valuing diversity and promoting equality throughout the GMC, ensuring that our processes and procedures are fair, objective, transparent and free from unlawful discrimination. Promoting equality is also a requirement under current and emerging equality legislation. Everyone who is acting for the GMC is expected to adhere to the spirit and letter of this legislation. The GMC has published an equality scheme[3], which will help to embed further the promotion of equality and diversity into our work.

The Doctors' responsibilities

13. Doctors are required to treat both colleagues and patients fairly, to the best of their ability and without discrimination. Fuller guidance is in *Good Medical Practice* (in paragraphs 7 and 46).

Publication of Outcomes

14. All restrictions placed on a doctor's registration (with the exception of restrictions that relate to a doctor's health) are published on the GMC's website via the List of Registered Medical Practitioners[4]. Copies of the minutes of Fitness to Practise Panel hearings held in public are also available on our website (Searching Fitness to Practise and IOP Decisions)[5] for approximately twelve months after the date of the hearing.

[3] http://www.gmc-uk.org/about/equality_scheme/index.asp
[4] http://www.gmc-uk.org/register/search/index.asp#
[5] http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_decisions.asp

Some general principles regarding sanctions

Role of the Panel and the three-stage process

15. Rule 17(2) of the Fitness to Practise Rules[6] (the Rules) provides for a three-stage process before a Panel reaches a determination on sanction. The Panel has to decide in turn:

a. Whether the facts alleged have been found proved;

b. Whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired;

c. If so, whether any action should be taken against the doctor's registration; if the Panel has not found the doctor's fitness to practise impaired, whether a warning should be issued.

16. In the interests of fairness to both parties, the Panel should invite evidence and/or submissions from the GMC and the doctor at each stage of the proceedings. When considering the options available the Panel should take account of the submissions made.

17. The Court of Appeal in Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460 made it plain that the functions of a Panel are quite different from those of "a court imposing retributive punishment."[7]

The purpose of sanctions and the public interest

18. The Merrison Report[8] stated that 'the GMC should be able to take action in relation to the registration of a doctor..... in the interests of the public', and that the public interest had 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain the confidence of the public in their doctors.

19. Since then a number of judgments have made it clear that the public interest includes, amongst other things:

a. Protection of patients

b. Maintenance of public confidence in the profession

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[6] The General Medical Council (Fitness to Practise) Rules Order of Council 2004 as amended by The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008 (2008 No.1256) and The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009 (2009 No. 1913)

[7] Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460, at paragraph 16

[8] Report of the Committee of Inquiry into the Regulation of the Medical Profession (1975)

c. Declaring and upholding proper standards of conduct and behaviour.

20. The purpose of the sanctions is therefore not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect. This was confirmed in the judgment of Laws LJ in the case of Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460 in which he stated:

> *"The Panel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor."*[9]

He referred to the earlier Privy Council decision in Gupta v The General Medical Council [2002] 1 WLR 1691 which stated

> *"It has frequently been observed that, where professional discipline is at stake, the relevant committee is not concerned exclusively, or even primarily, with the punishment of the practitioner concerned. Their Lordships refer, for example, to the judgment of Sir Thomas Bingham MR in Bolton v Law Society [1994] 1 WLR 512, 517-519 where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension that the practitioner may be unable to re-establish his practice when the period has passed."*

Proportionality

21. In deciding what sanction, if any, to impose the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The Panel should consider the sanctions available starting with the least restrictive.

22. Any sanction and the period for which it is imposed must be necessary to protect the public interest (see paragraphs 18 – 20). In making their decision on the appropriate sanction, Panels need to be mindful that they do not give undue weight to whether or not a doctor has previously been subject to an interim order for conditions or suspension imposed by the Interim Orders' Panel, or the period for which that order has been effective. Panels need to bear in mind that the Interim Orders' Panel makes no findings of fact and that its test for considering whether or not to impose an interim order is entirely different from the criteria used by the Fitness to Practise Panels when considering the appropriate sanction. It is for this reason that an interim order and the length of that order are unlikely to be of much significance for Panels. Further detail

[9] Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460, at paragraph 18

about the test applied when considering the imposition of interim orders is set out in the GMC's Guidance for imposing interim orders[10].

23. The Panel must keep the factors set out above at the forefront of their mind when considering the appropriate sanction to impose on a doctor's registration. Whilst there may be a public interest in enabling a doctor's return to **safe** practice, and panellists should facilitate this where appropriate in the decisions they reach, they should bear in mind that the protection of patients and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) is their primary concern.

24. Further guidance on the factors to bear in mind when considering each of those sanctions is set out in paragraphs 45 - 113 below.

Aggravating and mitigating factors

25. In any case before them, the Panel will need to have due regard to any evidence presented by way of mitigation by the doctor. Mitigation might be considered in two categories:

a. *Evidence of the doctor's understanding of the problem, and his/her attempts to address it.* This could include admission of the facts relating to the case, any apologies by the doctor to the complainant/person in question (see also paragraphs 32 - 37 below), his/her efforts to prevent such behaviour recurring or efforts made to correct any deficiencies in performance;

and

b. *Evidence of the doctor's overall adherence to important principles of good practice* (i.e. keeping up to date, working within his/her area of competence etc. - see also paragraph 28 below). Mitigation could also relate to the circumstances leading up to the incidents as well as the character and previous history of the doctor. This could also include evidence that the doctor has not previously had a finding made against him or her by a previous Panel or by any of the Council's previous committees.

26. The Panel should also take into account matters of personal and professional mitigation which may be advanced such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these should be considered

[10] http://www.gmc-uk.org/Imposing_Interim_Orders___Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf_snapshot.pdf

and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession.

27. The GMC may wish to draw attention to aggravating factors relating to the facts found proved by the Panel, for example the circumstances surrounding the events that took place, e.g. whether the doctor has abused their position of trust by taking advantage of a vulnerable person (breaching paragraphs 32 and 33 of *Good Medical Practice*). The Panel should also take into account any previous findings and sanctions imposed on the doctor's registration either by the GMC or any other regulator.

28. The principles in *Good Medical Practice* emphasise that doctors should take a mature and responsible approach to their career; being personally accountable for problems that arise, learning from mistakes, and working as a team. Panellists may wish to see evidence to support a doctor's contention that he/she has taken steps to mitigate his/her actions or to prevent problems arising. Panellists may wish to note in this respect that *Good Medical Practice* states that doctors should:

a. raise concerns where he/she has good reason to think that patient safety may be seriously compromised by inadequate premises, equipment or other resources, and should put matters right where possible (*Good Medical Practice*, paragraph 6);

b. protect patients from risk of harm posed by another colleague's conduct, performance or health (*Good Medical Practice*, paragraph 43);

c. be open and honest with patients if things go wrong (*Good Medical Practice* paragraphs 30 and 31);

d. cooperate with any complaints procedure and/or formal inquiry into the treatment of a patient disclosing information relevant to an investigation to anyone entitled to it (*Good Medical Practice* paragraphs 68 and 69);

e. keep their knowledge and skills up to date and work with colleagues and patients to improve the quality of their work and promote patient safety (*Good Medical Practice* paragraphs 12 to 14).

29. Further guidance on considering references and testimonials and on expressions of regret and apology is set out below at paragraphs 30 - 37.

Guidance on considering references and testimonials

30. The doctor may present references and testimonials as to his/her standing in the community or profession. Panels should consider, where these have been provided in advance of the hearing, whether the authors are aware of the events leading to the hearing and what weight, if any, to give to these documents.

31. As with other mitigating or aggravating factors any references and testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend on the standing of a practitioner. There may be cultural reasons for not requesting them and the Panel should also be aware of this. In addition, acquiring references and testimonials may pose a difficulty for doctors who qualified outside the United Kingdom and who are newly arrived in the UK. The Panel will need to consider all such factors when looking at references and testimonials.

Expressions of regret and apology

32. *Good Medical Practice* provides the following guidance at paragraph 30 and 31 to doctors when things go wrong:

> 'Being open and honest with patients if things go wrong
>
> 30 If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.
>
> 31 Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.'

This reflects a number of expectations on behalf of the profession and the public, including that:

a. Patients should be protected from similar events reoccurring, and

b. Doctors should take positive steps to learn from their mistakes, or when things go wrong.

33. The duty to "offer an apology" where appropriate reflects that, in our society, it is almost always expected that a person will apologise when things go wrong. However, to some individuals (and this may or may not depend on their culture), offering an apology amounts to an acceptance of personal guilt which, depending on the facts, a doctor may regard as inappropriate or excessive. It is also possible that occasionally a doctor may be constrained by issues involving legal liability, for example a criminal investigation, and/or legal advice and therefore does not offer an apology.

34. This 'insight' - the expectation that a doctor will be able to stand back and accept that, with hindsight, they should have behaved differently, and that it is

expected that he/she will take steps to prevent a reoccurrence - is an important factor in a hearing. When assessing whether a doctor has insight the Panel will need to take into account whether he/she has demonstrated insight consistently throughout the hearing, e.g. has not given any untruthful evidence to the Panel or falsified documents. But the Panel should be aware that there may be cultural differences in the way that insight is expressed, for example, whether or how an apology or expression of regret is framed and delivered and the process of communication, and that this may be affected by the doctor's circumstances, for example, their ill health.

35. Cross-cultural communication studies show that there are great variations in the way that individuals from different cultures and language groups use language to code and de-code messages. This is particularly the case when using a second language, where speakers may use the conventions of their first language to frame and structure sentences, often translating as they speak and may also be reflected in the intonation adopted. As a result, the language convention, subtleties or nuances of the second language may not be reflected. In addition, there may be differences in the way that individuals use non-verbal cues to convey a message, including eye contact, gestures, facial expressions and touch.

36. Awareness of and sensitivity to these issues are important in determining the following:

a. How a doctor frames his/her 'insight'.

b. Whether or how a doctor offers an apology.

c. The doctor's demeanour and attitude during the hearing.

37. The main consideration for the Panel therefore, is to be satisfied about patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this insight may be expressed.

Where no impairment is found

38. Where a Panel finds a doctor's fitness to practise is **not** impaired, the following options are available:

a. No action;

b. Issue a warning.

39. In the interests of fairness to both parties, Panels should invite submissions from the GMC and the doctor on whether a warning should be issued before considering whether to conclude the case with no action or a warning.

Warnings

40. If the Panel finds that the doctor's fitness to practise is **not** impaired, it may issue the doctor with a warning as to his/her future conduct or performance, with reference to the facts found proved. A warning may be issued where there has been a significant departure from *Good Medical Practice*; or there is a significant cause for concern following an assessment of the doctor's performance. Warnings are not appropriate in cases relating solely to a doctor's health, but may be issued in multi-factorial cases in which health is raised as one of the issues.

41. Further guidance on the purpose of warnings, the factors to take into account when considering whether to impose a warning and the circumstances in which a warning might be appropriate is set out in the GMC's Guidance on Warnings[11].

42. When considering the wording of a warning, Panels should have regard to the Guidance on Warnings.

43. It is important that Panels give clear reasons for issuing, or for not issuing, a warning.

44. Warnings are disclosed to any person or body who brought the allegation to the attention of the GMC, the practitioner's employer, and any other enquirer. They are published via the GMC's website on the List of Registered Medical Practitioners for a five-year period.

[11] http://www.gmc-uk.org/Guidance_on_Warnings.pdf_snapshot.pdf

Where impairment is found

45. Where a Panel finds a doctor's fitness to practise is impaired, the following options are available:

a. No action (see paragraph 48);

b. Impose conditions on the doctor's registration for a period up to three years (see paragraphs 56 - 68);

c. Direct that the doctor's registration be suspended for up to 12 months (see paragraphs 69 - 76);

d. Direct erasure of the doctor's name from the register, except in cases that relate **solely** to a doctor's health (see paragraphs 77 - 84).

Panels may agree as an alternative to imposing any sanction any **written** undertakings (including any limitations on his/her practice) offered by the doctor (see paragraphs 49 – 55).

46. Before moving to a vote the Panel should ensure that it fully discusses the case, the submissions made by both parties as to the appropriate sanction and all the options available to it. The submissions made by both parties are just that, submissions; the final decision as to the appropriate sanction is for the Panel alone to make operating within the relevant legislation[12] and the framework set out by the Indicative Sanctions Guidance.

47. It is important that the Panel's determination on sanction makes clear that it has considered all the options and provides clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction, especially where it is lower, or higher, than that suggested by this guidance and where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why a particular period of sanction was considered necessary.

[12] e.g. Medical Act 1983 as amended, General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) and various other Rules

No action

48. Where a doctor's fitness to practise is impaired the Council expects that Panels will take action against the doctor's registration in order to protect the public interest (protection of patients, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour, see paragraphs 18 - 24). There may, however, be **exceptional** circumstances in which a Panel might be justified in taking no action against a doctor's registration. Such cases are, however, likely to be very rare. No action might be appropriate in cases where the doctor has demonstrated considerable insight into his/her behaviour **and** has already embarked on, and completed, any remedial action the Panel would otherwise require him/her to undertake. The Panel may wish to see evidence to show that the doctor has taken steps to mitigate his/her actions – see paragraphs 25 - 29 above. In such cases it is particularly important that the Panel's determination sets out very clearly the reasons why it considered it appropriate to take no action notwithstanding the fact that the doctor's fitness to practise was found to be impaired.

Undertakings

49. The Rules[13] provide that a Panel may agree as an alternative to imposing any sanction **written** undertakings offered by the doctor provided that the doctor agrees that the Registrar may disclose the undertakings (except those relating exclusively to the doctor's health) to

a. His/her employer or anyone with whom he/she is contracted or has an arrangement to provide medical services,

b. Anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and

c. Any other person enquiring.

50. Undertakings relating to a doctor's practice are published on the List of Registered Medical Practitioners on the GMC's website (save those relating exclusively to the doctor's health).

51. Undertakings may include restrictions on the doctor's practice or behaviour, or the commitment to undergo medical supervision or retraining. As with conditions (see paragraphs 56 – 68), they are likely to be appropriate where the concerns about the doctor's practice are such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing them, or where the doctor has the insight to limit his/her practice.

52. Undertakings will only be appropriate where the Panel is satisfied that the doctor will comply with them, for example, because the doctor has shown genuine insight into his/her problems/deficiencies and potential for remediation. The Panel may wish to see evidence that the doctor has taken responsibility for his/her own actions and/or otherwise taken steps to mitigate his/her actions (see also paragraphs 25 - 29 above).

53. The GMC has published separate guidance, Undertakings at FTP hearings[14] which Panels should follow if considering whether to accept undertakings.

54. Panellists should ensure that any undertakings are appropriate, proportionate, are sufficient to protect patients and the public, and are an effective way of addressing the concerns about the doctor. Undertakings should normally follow the format of the standard undertakings in the bank of undertakings[15]. The bank comprises standard sets of undertakings, which allow for effective monitoring by the GMC and disclosure of information to any person requesting information about his/her registration status.

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[13] Rule 17(2)(m) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[14] http://www.gmc-uk.org/Undertakings_at_FTP_Panel_hearings_Aug_09.pdf_snapshot.pdf

[15] http://www.gmc-uk.org/Undertakings_Bank.pdf_snapshot.pdf

55. Where a Panel accepts undertakings, the Registrar will monitor the doctor's progress and consider any new information received in relation to them, including representations from the doctor or otherwise to suggest that the undertakings are no longer appropriate. The Registrar will consider any breaches of undertakings or information indicating further concerns about the doctor's fitness to practise and will refer for a review hearing if appropriate. Further detail about the post-hearing procedure is provided in the guidance on Undertakings at FTP hearings and also the separate Guidance on dealing with breaches of undertakings and criteria referral to Fitness to Practise Panels .[16]

[16] http://www.gmc-uk.org/Guidance_on_dealing_with_breaches_of_undertakings_and_criteria_referral_to_a_Fitness_to_Practise_Panel.pdf_snapshot.pdf

Conditional registration (maximum 3 years)

56. Conditions may be imposed up to a maximum of three years in the first instance, renewable in periods up to 36 months thereafter. This sanction allows a doctor to practise subject to certain restrictions (e.g. restriction to NHS posts or no longer carrying out a particular procedure). Conditions are likely to be appropriate where the concerns about the doctor's practice are such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing them.

57. Conditions might be most appropriate in cases involving the doctor's health, performance or following a single clinical incident or where there is evidence of shortcomings in a specific area or areas of the doctor's practice. Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work.

58. The purpose of conditions is to enable the doctor to deal with his/her health issues and/or remedy any deficiencies in his/her practice whilst in the meantime protecting patients from harm. In such circumstances, conditions might include requirements to work with the Postgraduate Dean or GP Director.

59. The GMC has published separate guidance about making referrals to the Postgraduate Dean or GP Director[17] along with information about the medical career structure of doctors[18]. Panels will need to take this guidance into account bearing in mind that where the issues relate to misconduct or a criminal conviction, or to untreated health problems, referral to a Postgraduate Dean is not an appropriate way forward as they are not able to provide remedial help in such circumstances.

60. When assessing whether the potential for remedial training exists, the Panel will need to consider any objective evidence submitted, for example, reports on the assessment of the doctor's performance or health, or evidence submitted on behalf of the doctor, or that is otherwise available to them, about the doctor's practice or health.

61. The objectives of any conditions should be made clear so that the doctor knows what is expected of him or her and so that a Panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction. Only with these established will it be able to evaluate whether they have been achieved. Any conditions should be appropriate, proportionate, workable and measurable, and in practical terms should be discussed fully by the Panel before voting. Before imposing conditions the Panel should satisfy itself that:

[17] http://www.gmc-uk.org/Guidance_for_making_referrals_to_the_Postgraduate_Dean.pdf_snapshot.pdf
[18] http://www.gmc-uk.org/Medical_career_structure___doctors_in_training.pdf_snapshot.pdf

a. The problem is amenable to improvement through conditions or, in cases involving the doctor's health, whether his/her medical condition can be appropriately managed.

b. The objectives of the conditions are clear.

c. A future Panel will be readily able to determine whether the objective has been achieved and whether patients will or will not be at risk.

62. When deciding whether conditions might be appropriate the Panel will need to satisfy itself that most or all of the following factors (where applicable) are apparent having regard to the type of case (health, performance, misconduct etc.) This list is not exhaustive:

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of the doctor's practice in need of assessment or retraining.
- Potential and willingness to respond positively to retraining, in particular evidence of the doctor's commitment to keeping his/her knowledge and skills up to date throughout his/her working life, improving the quality of his/her work and promoting patient safety (*Good Medical Practice*, paragraphs 12-14 regarding Maintaining good medical practice).
- Willingness to be open and honest with patients if things go wrong (*Good Medical Practice*, paragraphs 30 – 31).
- In cases involving health issues, evidence that the doctor has genuine insight into any health problems, has been compliant with the GMC's guidance on health (*Good Medical Practice*, paragraphs 77-79) and that he/she will abide by conditions relating to his/her medical condition(s), treatment and supervision.
- Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.
- It is possible to formulate appropriate and practical conditions to impose on registration.

63. Where a Panel has found a doctor's fitness to practise impaired by reason of adverse physical or mental health the conditions should include conditions relating to the medical supervision of the doctor as well as conditions relating to supervision at his/her place of employment. Generally, it is inappropriate to impose conditions regarding medical supervision if the doctor's fitness to practise has not been found impaired by reason of adverse physical or mental health. An exception would be a case where a doctor has refused to undergo a health assessment.

64. Conditions should normally follow the format of conditions as set out in the FTP Conditions Bank[19]. Panellists may also find it helpful to refer to the definitions of the roles of individuals involved in doctors' supervision as provided by the GMC in the Glossary of terms used in FTP actions[20].

65. The conditions bank has been developed to indicate appropriate wording for restrictions to a doctor's practice (which are published) and for their treatment (which are not published). It is important that Panels follow the suggested wording in the bank, where possible, and to maintain a clear distinction between practice and treatment conditions. If practice conditions are imposed that contain a reference to the treatment of a doctor's health, real practical difficulties are caused by the conflict between the GMC's duty to publish practice restrictions and the desirability of maintaining medical confidentiality for the doctor.

66. It is, of course, open to Panels to impose conditions that are not set out in the conditions bank, as appropriate, in the circumstances of the particular case whilst taking account of the general principles outlined above.

67. If imposing conditions, it is also normally appropriate for Panels to direct a review hearing. Further guidance about review hearings is set out at paragraphs 114 - 120 below.

68. Panels must also consider, as required by Rule 17(2)(o)[21], whether the conditions imposed should take effect immediately. When doing so Panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Panels should explain fully the reasons for any decision reached. Further guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

[19] http://www.gmc-uk.org/FTPP_Conditions_Bank.pdf_snapshot.pdf
[20] http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf_snapshot.pdf
[21] General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

Suspension (up to 12 months but may be indefinite in certain circumstances in health only cases)

69. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the Panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the Panel is satisfied that the behaviour or incident is unlikely to be repeated. The Panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions (see paragraphs 25 -29 above).

70. Suspension is also likely to be appropriate in a case of deficient performance in which the doctor currently poses a risk of harm to patients but where there is evidence that he/she has gained insight into the deficiencies and has the potential to be rehabilitated if prepared to undergo a rehabilitation programme. In such cases, to protect patients and the public interest, the Panel might wish to impose a period of suspension, direct a review hearing and to indicate in broad terms the type of remedial action which, if undertaken during the period of suspension, may help the Panel's evaluation at any subsequent review hearing. The Panel should, however, bear in mind that during the period of suspension the doctor will not be able to practise. He/she may, however, have contact with patients similar to that of a final year medical student, i.e. under the supervision of a fully registered medical practitioner, **and** provided that the patients have been informed of the doctor's registration status, the events which resulted in the suspension of the doctor's registration and have given their full consent.

71. The length of the suspension may be up to 12 months and is a matter for the Panel's discretion, depending on the gravity of the particular case. In health only cases, there are provisions to suspend a doctor's registration indefinitely – see paragraph 73 below.

72. As far as doctors with serious health problems are concerned, the option of erasure does not exist unless there are also other factors (such as a conviction, misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. In those cases, suspension is appropriate where the doctor's health is such that he/she cannot practise safely even under conditions. In such cases, the Panel may direct a review hearing to obtain further information as to whether the doctor is then fit to resume practice either under conditions or unrestricted.

73. In cases which relate solely to a doctor's health, it is open to the Panel, if the doctor's registration has been suspended for at least two years because of two or more successive periods of suspension, to suspend the doctor's registration indefinitely. If the Panel decides to direct indefinite suspension there is no automatic further hearing of the case, although it is open to the doctor to request a review after a period of two years has elapsed from the date when the indefinite suspension took effect.

74. Panels must provide reasons for the period of suspension chosen, including the factors that led them to conclude that the particular period of suspension, whether the maximum available or a shorter period, was appropriate.

75. This sanction may therefore be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- A serious breach of *Good Medical Practice* where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public interest.

- In cases involving deficient performance where there is a risk to patient safety if the doctor's registration were not suspended **and** where the doctor demonstrates potential for remediation or retraining.

- In cases which relate to the doctor's health, where the doctor's judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions.

- No evidence of harmful, deep-seated personality or attitudinal problems.

- No evidence of repetition of similar behaviour since incident.

- Panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.

76. Panels must also consider, as required by Rule 17(2)(o)[22], whether to direct that the doctor's registration be suspended with immediate effect. When doing so Panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

[22] General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

Erasure

77. The Panel may erase a doctor from the register in any case - except one which relates solely to the doctor's health - where this is the only means of protecting patients and the wider public interest, which includes maintaining public trust and confidence in the profession.

78. Lord Bingham, Master of the Rolls, in the case of Bolton v The Law Society[23], stated that:

> *'Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again. On applying for restoration after striking off, all these points may be made, and the former solicitor may also be able to point to real efforts made to re-establish himself and redeem his reputation.* ***All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. Thus it can never be an objection to an order of suspension in an appropriate case that the solicitor may be unable to re-establish his practice when the period of suspension is past. If that proves, or appears likely to be, so the consequence for the individual and his family may be deeply unfortunate and unintended. But it does not make suspension the wrong order if it is otherwise right. The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'*** *[our emphasis]*

79. The Gupta[24] judgment, which adopted the approach set out in Bolton v The Law Society, emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk:

> *"..the appellant's behaviour demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession".*

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[23] Bolton v The Law Society [1994] 1 WLR 512, [1993] EWCA Civ 32. The Court of Appeal's ruling in the case of The Law Society v John Brendan Salsbury [2008] EWCA Civ 1285 2008 WL4963085 endorsed this approach.
[24] Dr Prabha Gupta v GMC (Privy Council Appeal No. 44 of 2001)

80. In the case of Bijl v the GMC[25], which involved two **clinical** errors of judgement/mistakes relating to one operation performed by Dr Bijl, the Privy Council stated that [a Panel] should not feel it necessary to erase:

> *"an otherwise competent and useful doctor who presents **no danger** to the public in order to satisfy [public] demand for blame and punishment [emphasis added].*

and drew attention to the statement that:

> *"**honest failure** should not be responded to primarily by blame and retribution but by learning and by a drive to reduce risks for future patients"* [emphasis added].

81. There are some examples of misconduct where the Privy Council has upheld decisions to erase a doctor despite strong mitigation. This has been because it would not have been in the public interest to do otherwise given the circumstances concerned.

82. Erasure may well be appropriate when the behaviour involves **any** of the following factors (this list is not exhaustive):

- Particularly serious departure from the principles set out in *Good Medical Practice* i.e. behaviour fundamentally incompatible with being a doctor.
- A reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.
- Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 112 - 113 regarding failure to provide an acceptable level of treatment/care).
- Abuse of position/trust (see *Good Medical Practice* paragraph 57 "you must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession").
- Violation of a patient's rights/exploiting vulnerable persons (see for example *Good Medical Practice* paragraphs 24 to 28 regarding children and young people, paragraph 33 regarding expressing personal beliefs, and paragraphs 61 to 62 regarding information about services).
- Offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 92 - 104).
- Offences involving violence.

[25] Dr Willem Bijl v GMC (Privy Council appeal No. 78 of 2000)

- Dishonesty, especially where persistent and/or covered up (see further guidance at paragraphs 105 - 111 below)[26].

- Putting own interests before those of patients (see *Good Medical Practice* – "Make the care of your patient your first concern", and paragraphs 75 to 77 regarding conflicts of interest).

- Persistent lack of insight into seriousness of actions or consequences.

Erasure is **not** available in cases where the **only** issue relates to the doctor's health.

83. When directing erasure, Panels must also consider, as required by Rule 17(2)(o)[27], whether to make an order suspending the doctor's registration with immediate effect. When doing so Panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

84. A doctor who has been erased cannot apply to be restored to the register until five years have elapsed[28]. At that stage the Panel will have to decide whether the doctor is fit to resume unrestricted practice. Further guidance on doctors' restoration to the register is provided in the Guidance for doctors on registration following erasure by a Fitness to Practise Panel [29].

[26] The Law Society v John Brendan Salsbury [2008] EWCA Civ 1285 2008 WL4963085.
[27] General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
[28] Section 41(2)(a) Medical Act 1983 as amended
[29] http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_snapshot.pdf

Other issues relevant to sanction

Considering conviction, caution or determination allegations

85. Convictions refer to a decision by a criminal court in the British Isles, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.

86. Cautions refer to offences committed in the British Isles or elsewhere but where no court proceedings took place because the doctor has admitted the offence and criminal proceedings were considered unnecessary.

87. Determinations refer to decisions by another health or social care regulatory body, in the United Kingdom or elsewhere, which has made a determination that the fitness to practise of the doctor as a member of that profession is impaired or an equivalent finding.

88. Where the Panel receives in evidence a signed certificate of the conviction or determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction or determination, then the Panel is bound to accept the certificate as conclusive evidence of the offence having been committed or the facts found by the determination.[30] In accepting a caution, the doctor will have admitted committing the offence.

89. The purpose of the hearing is not to punish the doctor a second time for the offences for which he/she was found guilty. The purpose is to consider whether the doctor's fitness to practise is impaired as a result and, if so, whether there is a need to restrict his/her registration in order to protect the public who might come to the doctor as patients and to maintain the high standards and good reputation of the profession.[31] Panellists will be aware of the paragraphs in *Good Medical Practice* regarding the need to be honest and trustworthy, and to act with integrity (paragraphs 56 to 57).

90. The Panel should, however, bear in mind that the sentence or sanction previously imposed is not necessarily a definitive guide to the seriousness of the offence. There may have been personal circumstances[32] that led the court or regulatory body to be lenient. For example, the court may have expressed an expectation that the regulatory body would erase the doctor. Similarly, the range of sanctions and how they are applied may vary significantly amongst other regulatory bodies.

91. Panels may wish to note that *Good Medical Practice* imposes a duty on doctors to "inform the GMC without delay if, anywhere in the world, [they] have accepted a caution, been charged with or found guilty of a criminal offence, or if another

[30] Rule 34(3) and (4) General Medical Council (Fitness to Practise) Rules Order of Council 2004
[31] Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).
[32] CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 (Admin)

professional body has made a finding against [their] registration as a result of fitness to practise procedures." (*Good Medical Practice* paragraph 58).

Sexual misconduct

92. This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues or patients' relatives. See further guidance on sex offenders and child pornography at paragraphs 95 - 104 below.

93. Panels should note the principle set out in paragraph 32 of *Good Medical Practice* "You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them." and the separate guidance issued on Maintaining Boundaries[33].

94. Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust which a doctor occupies, or where a doctor has been required to register as a sex offender. The risk to patients is important. In such cases erasure has therefore been judged the appropriate sanction:

> *'The public, and in particular female patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved against Dr Haikel undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the public interest.*[34]

Sex offenders and child pornography

95. Any doctor who has been convicted of, or has received a caution for a sexual offence listed in Schedule 3 of the Sexual Offences Act 2003 is required to notify the police ("register") under S80 of the Sexual Offences Act 2003 and may be required to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing or other involvement in child pornography, which involves the exploitation or abuse of a child. Such offences seriously undermine patients' and the public's trust and confidence in the medical profession and breach a number of principles set out in *Good Medical Practice* (paragraphs 56-57 regarding "Being honest and trustworthy", paragraph 21 regarding fulfilling "your role in the doctor-patient partnership", particularly 21b about the need to "treat patients with dignity" and paragraphs 24 to 28 regarding "Children and young people", in particular paragraph 25 "You must safeguard and protect the health and well-being of children and young people...").

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[33] http://www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp

[34] Dr Mohamed Shaker Haikel v General Medical Council (Privy Council Appeal No. 69 of 2001). See also Dr Ali Abdul Razak v General Medical Council [2004] EWHC205 (Admin).

96. In the case of CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 (Admin) the Court gave some guidance on the handling of cases involving Internet child pornography.

97. Taking, making, distributing or showing with a view to being distributed, to publish, or possession of an indecent photograph or pseudo-photograph of a child is illegal and regarded in UK society as morally unacceptable. For these reasons any involvement in child pornography by a registered medical practitioner raises the question whether the public interest demands that his/her registration be affected.

98. Whilst the courts properly distinguish between degrees of seriousness, the Council considers any conviction for child pornography against a registered medical practitioner to be a matter of grave concern because it involves such a fundamental breach of patients' trust in doctors and inevitably brings the profession into disrepute. It is therefore highly likely that in such a case, the only proportionate sanction will be erasure but the Panel should bear in mind paragraphs 15 - 24 and 45 - 113 of this guidance, which deal with the options available to the Panel, and the issue of proportionality. If the Panel decides to impose a sanction other than erasure, it is important that particular care is taken to explain fully the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.

99. The Panel should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possibly to court ordered disqualification from working with children. **The Council has made it clear that no doctor registered as a sex offender should have unrestricted registration**. The Panel will therefore need to ensure that, in cases where it imposes a period of suspension, the case should be reviewed before the end of the period of suspension to consider whether a further period of suspension is appropriate or whether the doctor should be permitted to resume practice subject to conditions.

100. The Council has also expressed the view that, in order to protect the public interest, the Panel should consider whether any such conditions ought to include no direct contact with **any** patients during the period the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography.)

101. The Panel should also consider whether doctors registered as sex offenders should be required to undergo assessment, for example by a clinical psychologist, to assess the potential risk to patients before they may be permitted to resume any form of practice.

102. When Panels are reviewing cases where the doctor has completed the prescribed period of registration as a sex offender (which is dependent on the nature and gravity of the offence) and is no longer required to register as a sex offender Panels should take into account the following factors:

a. The seriousness of the original offence.

b. Evidence about the doctor's response to any treatment programme he/she has undertaken.

c. Any insight shown by the doctor.

d. The likelihood of the doctor re-offending.

e. The possible risk to patients and the wider public if the doctor was allowed to resume unrestricted practice.

f. The possible damage to the public's trust in the profession if the doctor was allowed to resume unrestricted practice.

103. Each case should be considered on its merits and decisions taken in the light of the particular circumstances relating to the case.

104. Where Panels have **doubt** about whether a doctor no longer required to register as a sex offender should resume unrestricted practice, the doctor should **not** be granted unrestricted registration.

Dishonesty

105. The GMC's guidance, *Good Medical Practice,* states that registered doctors must be honest and trustworthy, and must never abuse their patients' trust in them or the public's trust in the profession.

> "Probity means being honest and trustworthy, and acting with integrity: **this is at the heart of medical professionalism**." [emphasis added] (*Good Medical Practice* paragraph 56)
>
> "You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession." (*Good Medical Practice* paragraph 57)

106. In relation to financial and commercial dealings *Good Medical Practice* also sets out that:

> "-You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. ...
>
> -...If you manage finances, you must make sure that the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances." (*Good Medical Practice* paragraph 73).
>
> The GMC's guidance further emphasises the duty to avoid conflicts of interest (see *Good Medical Practice* paragraphs 74 to 76 and our separate guidance on

Conflicts of Interest[35]) and not to "make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients." (*Good Medical Practice* paragraph 61).

107. In relation to providing and publishing information about their services *Good Medical Practice* advises doctors that:

> "- If you publish information about your medical services, you must make sure the information is factual and verifiable." (paragraph 60)
>
> "- You must not make unjustifiable claims about the quality of outcomes of your services in any information you provide to patients...." (paragraph 61)
>
> "You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health." (paragraph 62)

108. Dishonesty, even where it does not result in direct harm to patients but is for example related to matters outside the doctor's clinical responsibility, e.g. providing false statements or fraudulent claims for monies, is particularly serious because it can undermine the trust the public place in the profession. The Privy Council has emphasised that:

> *'...Health Authorities must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole.'*[36]

109. Examples of dishonesty in professional practice could include defrauding an employer, falsifying or improperly amending patient records or submitting or providing false references, inaccurate or misleading information on a CV and failing to take reasonable steps to ensure that statements made in formal documents are accurate. (see *Good Medical Practice* paragraph 3(f) regarding the duty to keep clear, accurate and legible records, and paragraphs 63 to 67 regarding writing reports and CVs, giving evidence and signing documents; see also our separate guidance on writing references[37]).

110. Research misconduct is a further example. The term is used to describe a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious. Paragraph 71 of *Good Medical Practice* states that:

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[35] http://www.gmc-uk.org/guidance/current/library/conflicts_of_interest.asp
[36] Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).
[37] http://www.gmc-uk.org/guidance/current/library/writing_references.asp

"If you are involved in designing, organising or carrying out research, you must:

(a) put the protection of the participants' interests first
(b) act with honesty and integrity
(c) follow the appropriate ....guidelines...."

(see also our separate guidance on Research: The Role and Responsibilities of Doctors[38]

111. Dishonesty, especially where persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 82 above).[39]

Failing to provide an acceptable level of treatment/care

112. Cases in this category are ones where a practitioner has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards (please refer to the guidance set out at paragraphs 2 – 11 of *Good Medical Practice*, under the heading 'Good Clinical Care'), particularly where a reckless disregard for patient safety or a breach of the fundamental duty of doctors to "Make the care of your patient your first concern" have been demonstrated.

113. A particularly important consideration in such cases is whether or not a doctor has, or has the potential to develop, insight into these failures. Where this is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.[40]

[38] http://www.gmc-uk.org/guidance/current/library/research.asp
[39] Dr Jamal Abdi Farah v General Medical Council [2008] EWHC 731 Admin and Dr Sushant Varma v General Medical Council [2008] EWHC 753 Admin and The Law Society v John Brendan Salsbury [2008] EWCA Civ 1285 2008 WL4963085
[40] See judgment in the case of Dr Purabi Ghosh v General Medical Council (Privy Council Appeal No. 69 of 2000). Also Dr John Adrian Garfoot v General Medical Council (Privy Council Appeal No. 81 of 2001).

Review hearings

114. Rule 22 sets out the procedure a Panel must follow at a review hearing. The Panel will need to consider and make a finding as to whether the doctor's fitness to practise is impaired or he/she has failed to comply with any conditions imposed at the previous hearing (giving reasons for its decision)[41] before determining whether to impose a further order. The Panel's powers to impose orders at a review hearing are set out in section 35D of the Act. The guidance provided in this section applies in relation to orders at review hearings as well as regarding a Panel's initial decision as to sanction.

115. Where the Panel decides that a period of conditional registration or suspension would be appropriate, it must decide whether or not to direct a review hearing, to be held shortly before the expiry of the period. The Panel should give reasons for its decision whether to direct a review hearing or not so that it is clear that the matter has been considered and the basis on which the decision has been reached. Where the Panel does not direct a review hearing, the reasons should include an explanation of the factors that led it to decide that the doctor would be fit to resume unrestricted practice following expiry of the period of conditions or suspension. Where the Panel directs a review hearing, it may wish to make clear what it expects the doctor to do during the period of conditions/suspension and the information he/she should submit in advance of the review hearing. This information will be helpful both to the doctor and to the Panel considering the matter at the review hearing.

116. It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the Panel considers that he/she is safe to do so. In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. In most cases, however, where a period of suspension is imposed and in all cases where conditions have been imposed the Panel will need to be reassured that the doctor is fit to resume practice either unrestricted or with conditions or further conditions. The Panel will also need to satisfy itself that the doctor has fully appreciated the gravity of the offence, has not re-offended, and has maintained his/her skills and knowledge and that patients will not be placed at risk by resumption of practice or by the imposition of conditional registration. The Panel should consider whether the doctor has produced any information/objective evidence regarding these matters.

117. Where a Panel has found that the doctor has not complied with the conditions on his/her registration it may direct erasure (except in a health only case) or suspension (up to 12 months)[42]. The Panel will need to consider carefully whether the breach was wilful, i.e. the doctor is culpable. If it finds that the breach was **not** wilful and therefore does not constitute a failure to comply within the meaning of the Act and the Rules, but considers that the doctor's fitness to practise is impaired, it may direct

[41] Rule 22(f) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
[42] Section 35D (9) and (10) Medical Act 1983 as amended

erasure, suspension, extend the conditions for a period up to three years, revoke or vary any of the previous conditions.[43]

118. Where a doctor's registration is suspended, the Panel may direct that the current period of suspension be extended (up to 12 months), that the doctor's name be erased from the register (except in a health only case) or impose a period of conditions (up to three years)[44]. In cases involving solely the doctor's health, it is also open to the Panel to suspend the doctor's registration indefinitely[45] (see also paragraph 73 of this guidance).

119. Where a review hearing cannot be concluded before the expiry of the period of conditional registration or suspension, the Panel may extend that period for a further short period[46] to allow for re-listing of the review hearing as soon as practicable, with the objective of preserving the status quo pending the outcome of the review hearing. It is advisable for Panels to invite submissions from both parties as to the length of time they might require and determine the period of extension accordingly.

120. The Panel may as an alternative to imposing any sanction take into account any written undertakings offered by the doctor, which it considers sufficient to protect patients and the public interest and provided that the doctor agrees that the Registrar may disclose the undertakings (except those relating exclusively to the doctor's health) to:

a. His/her employer or anyone with whom he/she is contracted or has an arrangement to provide medical services.

b. Anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and

c. Any other person enquiring.

[43] Section 35D (11) and (12) Medical Act 1983 as amended
[44] Section 35D (5) Medical Act 1983 as amended
[45] Section 35D (6) Medical Act 1983 as amended
[46] Under the provisions of Section 35D Medical Act 1983 as amended

Immediate orders (suspension or conditions)

121. The doctor is entitled to appeal against any substantive direction affecting his/her registration. The direction does not take effect during the appeal period (28 days) or, if an appeal is lodged, until that appeal has been disposed of. During this time, the doctor's registration remains fully effective unless the Panel also imposes an immediate order.

122. The Panel may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest, or is in the best interests of the practitioner[47]. The interests of the practitioner include avoiding putting him or her in a position where he/she may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put him/her at risk of committing a criminal offence (e.g. irresponsible prescribing when the doctor is in prison, particularly of drugs of addiction; *Good Medical Practice*, paragraphs 3b, 3f, 14h and 'Good practice in prescribing medicines)[48]. These factors should be balanced against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require the imposition of an immediate order.

123. An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, for example where he/she has provided poor clinical care (i.e. breached paragraphs 2 – 11, *Good Medical Practice*) or abused a doctor's special position of trust (*Good Medical Practice* paragraph 32, 56-57), or where immediate action is required to protect public confidence in the medical profession.

124. It is sometimes argued by doctors, or their representatives, that no immediate order should be made as the doctor needs time to make arrangements for the care of his/her patients before the substantive order for suspension or erasure takes effect. In considering such arguments, Panels will need to bear in mind that any doctor whose case is considered by a Fitness to Practise Panel will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients prior to the hearing should the need arise. In any event, the GMC also notifies the doctor's employers, or in the case of general practitioners, the Primary Care Trust, of the date of the hearing and they have a duty to ensure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.

125. Where the Panel has directed a period of conditional registration as the substantive outcome of the case, it may impose an immediate order of conditional registration. Where the Panel has directed erasure or suspension as the substantive outcome of the case, it may impose an immediate order to suspend registration. Before making a decision the Panel must consider any submission or evidence and will need to invite these from both parties in advance of making a decision.

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[47] Section 38 of the Medical Act 1983 as amended

[48] http://www.gmc-uk.org/guidance/current/library/prescriptions_faqs.asp

126. Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the Panel based on the facts of each case. The Panel should, however, have regard to the seriousness of the matter which led to the substantive direction and consider carefully whether it is appropriate for the doctor to continue in unrestricted practice pending the substantive order taking effect. The Panel should consider the matter in camera and when announcing its decision whether or not to impose an immediate order, give reasons for the decision taken.

Annex A

List of other documents and guidance available to Panels

Medical Act 1983 (as amended):
http://www.gmc-uk.org/about/legislation/medical_act.asp

General Medical Council (Constitution of Panels and Investigation Committee) Rules 2004: http://www.opsi.gov.uk/si/si2004/20042611.htm

General Medical Council (Legal Assessors) Rules 2004:
http://www.opsi.gov.uk/si/si2004/20042625.htm

General Medical Council (Fitness to Practise) Rules 2004 (as amended):
http://www.gmc-uk.org/consolidated_version_of_FTP_Rules.pdf_snapshot.pdf

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Good Medical Practice – Current edition
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Previous and no longer current versions of Good Medical Practice, published in 2001, 1998 and 1995 respectively, can be downloaded from our archive section at http://www.gmc-uk.org/guidance/archive/index.asp

Supplementary ethical guidance
http://www.gmc-uk.org/guidance/ethical_guidance/index.asp

Guidance to the Fitness to Practise Rules:
http://www.gmc-uk.org/Guidance_to_the_FTP_Rules.pdf_snapshot.pdf

Meaning of Fitness to Practise
http://www.gmc-uk.org/the_meaning_of_fitness_to_practise.pdf_snapshot.pdf

Guidance on agreeing undertakings at the investigation stage
(Consensual Disposal)
http://www.gmc-uk.org/guidance_on_undertakings.pdf_snapshot.pdf

Pre-Adjudication Case Management Procedure Guidance Manual
http://www.gmc-uk.org/Case_Management.pdf_snapshot.pdf

Guidance for Specialist Advisers
http://www.gmc-uk.org/Guidance_for_specialist_advisers.pdf_snapshot.pdf

Guidance on warnings
http://www.gmc-uk.org/Guidance_on_Warnings.pdf_snapshot.pdf

Undertakings at FTP Panel hearings – Procedure and guidance
http://www.gmc-uk.org/Undertakings_at_FTP_Panel_hearings_Aug_09.pdf_snapshot.pdf

Undertakings bank
http://www.gmc-uk.org/Undertakings_Bank.pdf_snapshot.pdf

FTP Conditions Bank
http://www.gmc-uk.org/FTPP_Conditions_Bank.pdf_snapshot.pdf

Guidance for making referrals to the Postgraduate Dean or GP Director
http://www.gmc-uk.org/Guidance_for_making_referrals_to_the_Postgraduate_Dean.pdf_snapshot.pdf

Medical career structure – Doctors in training
http://www.gmc-uk.org/Medical_career_structure___doctors_in_training.pdf_snapshot.pdf

Glossary of terms used in FTP actions
http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf_snapshot.pdf

Guidance on the use of clinical attachments
http://www.gmc-uk.org/Clinical_attachments_guidance.pdf_snapshot.pdf

International Classification of Diseases (ICD10):
http://www.who.int/classifications/apps/icd/icd10online/

Imposing Interim Orders – Guidance for IOP and FTP Panels
http://www.gmc-uk.org/Imposing_Interim_Orders___Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf_snapshot.pdf

IOP Conditions Bank
http://www.gmc-uk.org/IOP_Conditions_Bank.pdf_snapshot.pdf

Voluntary Erasure – Guidance for decision-makers:
http://www.gmc-uk.org/voluntary_erasure_guidance.pdf_snapshot.pdf

Guidance for doctors on restoration following erasure by a Fitness to Practise Panel:
http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_snapshot.pdf

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Managing Fitness to Practise Panel hearings – guidance for panel chairmen: http://www.gmc-uk.org/Managing_FtP_Panel_Hearings__Guidance_for_Panel_Chairman.pdf_snapshot.pdf

Redacted

General Medical Council

Dr Jane Barton

Instructions to Leading Counsel to advise the General Medical Council in relation to a determination announced on 29 January 2010

Documents

Counsel will find enclosed the following documents:

1. Copy of the determinations in the above matter, both findings of fact and Serious Professional Misconduct/sanction

2. Skeleton chronology prepared by Instructing Solicitors, together with patient key

3. GMC master document used to support closing speech *(to follow)*

4. Expert reports prepared by Professor Gary Ford (on behalf of the GMC)

5. Expert reports prepared on behalf of Dr Barton

6. Bundle of testimonial evidence submitted on behalf of Dr Barton *(to follow)*

7. Press release from GMC dated 29 January 2010

In addition Instructing Solicitors have provided Counsel with an electronic copy of the transcript of the entire Fitness to Practise Panel proceedings referred to above.

Introduction

1. Instructing Solicitors act for the General Medical Council ("GMC") with whose Act and Rules Leading Counsel is familiar.

General Medical Council

Dr Jane Barton

Instructions to Leading Counsel to advise the General Medical Council in relation to a determination announced on 29 January 2010

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In addition Instructing Solicitors have provided Counsel with an electronic copy of the transcript of the entire Fitness to Practise Panel proceedings referred to above.

Introduction

1. Instructing Solicitors act for the General Medical Council ("GMC") with whose Act and Rules Leading Counsel is familiar.

2. The GMC's Fitness to Practise Panel has recently concluded its deliberations in the above matter. Counsel is referred to enclosure 1 at which she will find the detailed findings of fact and the decision as to Serious Professional Misconduct ("SPM"). The determination as to sanction is also included and Counsel will see set out a series of conditions imposed upon the registration of Dr Jane Barton.

3. Leading Counsel is asked to advise the GMC at this stage in anticipation that the Council for Healthcare Regulatory Excellence ("CHRE") may seek to commence High Court proceedings on the basis that this sanction decision was "unduly lenient".

Background

4. Counsel is referred to the chronology at enclosure, which sets out in brief detail the background to this matter and the circumstances in which the Fitness to Practise Panel only reached a final conclusion in this matter in January 2010, the conduct having occurred approximately 10 years previously.

5. In summary, a number of police investigations followed very belatedly by a Coroner's inquest led to delays in the case being listed before the GMC. The hearing commenced in the summer of 2009 but went part heard concluding in January 2010.

6. As a result of the first referral being prior to 1 November 2004 the case was brought under the GMC's "old" rules. Under the transitional provisions this case was heard by a Fitness to Practise Panel applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (as amended).

7. The matter was brought to the attention of the GMC by Hampshire Police and the charge of SPM was brought by the GMC. The families were not parties ("complainants") to the Fitness to Practise Panel proceedings.

8. The case involved the treatment of 12 patients at Gosport War Memorial Hospital in the late 1990's. The key concern being the inappropriate prescribing of drugs, including opiates and levels which were excessive, potentially hazardous and not in the patient's best interests. Multiple breaches of Good Medical Practice were established.

9. Counsel is referred to the closing speeches of both Counsel on days 37-39 of the hearing where she will find a detailed summary of the evidence in this case. She will be further assisted by the document at enclosure 3.

10. Instructing solicitors have provided only the expert reports and the testimonial evidence from the Panel bundle (enclosures 4-6). In particular those instructing do not

consider it necessary to provide medical records at this stage given the detail contained in the transcript. Further documents can be immediately provided at Counsel's request.

Potential review of determination

11. Counsel will be familiar with the powers of CHRE, which under Section 29 of the National Health Service Reform and Health Professions Act 2002, has the power to refer decisions of the Fitness to Practise Panel to the High Court where it considers that the relevant decision has been "unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed" and "that it would be desirable for the protection of members of the public for the Council to take action under this section."

12. At the conclusion of the proceedings on Friday 29 January 2010 the families of the patients concerned expressed disquiet as to the outcome and there has been subsequent media coverage and a degree of expectation that CHRE will become involved.

13. The GMC's Chief Executive issued a press statement shortly after the Panel delivered its determination, a copy of which can be found at enclosure 7.

Instructions

14. Leading Counsel is asked to advise the GMC as to the merits of the various alternative positions it might take should CHRE proceed to refer the matter to the High Court.

15. Counsel is specifically referred to the submissions on sanction made by Tom Kark (Counsel for the GMC) on 20 January 2010. For the reasons set out the GMC were seeking erasure of Dr Barton's name from the medical register.

16. Counsel will also see in the final section of the transcript that the parties were invited to address the Panel further on the effect of the passage of time.

17. Counsel will note that the GMC's position immediately after the announcement was that the decision was *"We are surprised by the decision to apply conditions in this case. Our view is that the doctor's name should have been erased from the medical register following the Panel's finding of SPM"* (Naill Dickson, Chief Executive of the GMC)

18. Conversely Counsel will note the submissions made on behalf of Dr Barton in relation to sanction and will see from the chronology that for an extensive period of time Dr

Barton was not subject to any interim order and has subsequently been subject to interim conditions in a format similar to those imposed by way of the final sanction.

19. Dr Barton provided extensive testimonial evidence to which reference is made in the Panel's determination.

20. Instructing Solicitors anticipate that the GMC will be called upon to make a rapid response to any referral made by CHRE. The GMC will need to indicate whether it supports the referral or would intend to contest it.

21. Counsel will be exceedingly familiar with the extensive authorities that have been produced as a result of CHRE's referrals under Section 29 and will be familiar with the interpretation previously applied by the Courts in relation to the assessment of "undue lenience". She will also be familiar with the GMC's indicative sanctions guidance which has been commended by the Courts and which is appropriately referred to both in submissions and in the determination.

22. Should Counsel require any additional information she should not hesitate to contact her Instructing Solicitors. The Solicitor with day to day conduct of the matter is Rachel Cooper (0161 200 1783 rachel.cooper@ffw.com) and the Partner with conduct is Sarah Ellson (0161 200 1773 sarah.ellson@ffw.com)

Field Fisher Waterhouse – 3 February 2010

General Medical Council

Dr Jane Barton

Instructions to Leading Counsel to advise the General Medical Council in relation to a determination announced on 29 January 2010

Monica Carss-Frisk QC
Blackstone's Chambers
Temple

Field Fisher Waterhouse
35 Vine Street London EC3N 2AA
Tel: 020 7861 4000
Fax: 020 7488 0084

Ref: SLE/12217152

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Revised version showing agreed amendments as at 12 June 2009

General Medical Council

Regulating doctors
Ensuring good medical practice

Fitness to Practise Panel Hearing

On 8 June – 21 August 2009 a Fitness to Practise Panel will consider the case of:

Dr Jane Ann BARTON
GMC Reference Number: 1587920

This case is being considered by a Fitness to Practise Panel applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988

The hearing will commence at 09:30 at:

General Medical Council
Third Floor
350 Euston Road
London
NW1 3JN

Type of case: New case of serious professional misconduct.

The case is expected to last 55 days.
The Panel will not be sitting on 18 June and 23 July 2009.

Panel Members:	Mr A Reid, Chairman (Lay) Ms J Julien (Lay) Mrs P Mansell (Lay) Mr W Payne (Lay) Dr R Smith (Medical)
Legal Assessor:	Mr Francis Chamberlain

The Panel will inquire into the following allegation against Jane Ann Barton, BM BCh 1972 Oxford University:

"That being registered under the Medical Act 1983, as amended,

'1. At all material times you were a medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire; **Admitted and found proved**

'2. a. i. Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care, **Admitted and found proved**

ii. between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as Diamorphine with a dose range of 40 - 80 mg over a twentyfour hour period to be administered subcutaneously ("SC") on a continuing daily basis, **Admitted and found proved**

iii. on 11 January 1996 you prescribed Diamorphine with a dose range of 80 - 120 mg and Midazolam with a range of 40 - 80 mg to be administered SC over a twentyfour hour period, **Admitted and found proved**

iv. on 15 January 1996 a syringe driver was commenced at your direction containing 80 mg Diamorphine and 60 mg Midazolam as well as Hyoscine Hydrobromide, **Admitted and found proved**

v. on 17 January 1996 the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg, **Admitted and found proved**

vi. on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed, **Admitted and found proved**

b. In relation to your prescriptions described in paragraphs 2.a.ii and 2.a.iii.,

i. the lowest doses prescribed of Diamorphine and Midazolam were too high,

ii. the dose range was too wide,

iii. the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs, **Admitted and found proved**

c. The doses of Diamorphine administered to the patient on 15 and 17 January 1996 were excessive to the patient's needs,

d. Your prescription described at paragraphs 2.a.vi.in combination with the other drugs already prescribed were excessive to the patient's needs,

e. Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and vi. were, **Amended to read:** Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and/**or** vi. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to head 2a iii and found proved**

iii. not in the best interests of Patient A;

'3. a. i. Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996, **Admitted and found proved**

ii. on 24 February 1996 you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day, **Admitted and found proved**

iii. on 26 February 1996 you increased the prescription for MST and prescribed Diamorphine with a dose range of 80 mg - 160 mgs and Midazolam with a dose range of 40 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iv. on 5 March 1996 you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg - 80 mg over a twentyfour hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg, **Admitted and found proved**

b. In relation to your prescriptions for drugs described in paragraphs 3.a.iii. and iv.,

i. the lowest commencing doses prescribed on 26 February and 5 March 1996 of Diamorphine and Midazolam were too high,

ii. the dose range for Diamorphine and Midazolam on 26 February and on 5 March 1996 was too wide, **Admitted and found proved**

iii. the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 3.a. ii., iii. and/or iv. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to heads 3a iii and iv and found proved**

iii. not in the best interests of Patient B,

d. In relation to your management of Patient B you,

i. did not perform an appropriate examination and assessment of Patient B on admission,

ii. did not conduct an adequate assessment as Patient B's condition deteriorated,

iii. did not provide a plan of treatment,

iv. did not obtain the advice of a colleague when Patient B's condition deteriorated, **Admitted and found proved**

e. Your actions and omissions in relation to your management of patient B were,

i. inadequate,

ii. not in the best interests of Patient B;

'4. a. i. on 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care, **Admitted and found proved**

ii. on 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 4.a.ii.,

i. the dose range of Diamorphine and Midazolam was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraph 4.a. ii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of your patient;

'5. a. i. on 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation, **Admitted and found proved**

ii. on or before 20 August 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20mg - 80mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs as described in paragraph 5.a. ii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs as described in paragraph 5.a.ii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient D;

'6. a. i. Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital, **Admitted and found proved**

ii. on 11 August 1998 you prescribed 10 mg Oramorphine

'prn' (as required), **Admitted and found proved.**

iii. on 11 August 1998 you also prescribed Diamorphine with a dose range of 20 mg - 200 mg and Midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 6.a.iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraph 6.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to head 6a iii and found proved**

iii. not in the best interests of Patient E;

'7. a. i. Patient F was admitted to Dryad Ward at GWMH on 18 August 1998 for the purposes of rehabilitation following an operation to repair a fractured neck of femur at the Royal Haslar Hospital, **Admitted and found proved**

ii. on 18 August 1998 you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required), **Admitted and found proved.**

iii. between 18 and 19 August 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 7.a.iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could

be administered to Patient F which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 7.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to head 7a iii and found proved**

iii. not in the best interests of Patient F;

'8. a. i. Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions, **Admitted and found proved**

ii. on 21 September 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iii. on 25 September 1998 you wrote a further prescription for Diamorphine with a dose range of 40 - 200mg and Midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescriptions for drugs described in paragraphs 8.a.ii. and/or iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 8.a.ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient G,

d. You did not obtain the advice of a colleague when Patient G's condition deteriorated; **Admitted and found proved**

'9. a. i. Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease Code A and other medical conditions, **Admitted and found proved**

ii. on 14 October 1998 you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient, **Admitted and found proved**

iii. on or before 16 October 1998 you prescribed Diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iv. on or before 17 October 1998 you prescribed Midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In light of the Patient H's history of Code A liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was, **Amended to read:** In light of Patient H's history of Code A liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was,

i inappropriate,

ii. potentially hazardous,

iii. likely to lead to serious and harmful consequences for Patient H,

iv. not in the best interests of Patient H,

c. In relation to your prescription described in paragraph 9.a. iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs, **Admitted and found proved**

d. Your actions in prescribing the drugs described in paragraphs 9.a. ii., iii. and/or iv. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to heads 9a iii and iv and found proved**

iii. not in the best interests of Patient H.,

e. You did not obtain the advice of a colleague when Patient H's condition deteriorated; **Admitted and found proved**

'10. a. i. Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital, **Admitted and found proved**

ii. on 12 April 1999 you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iii. on 12 April 1999 a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Reid, **Admitted and found proved**

b. You did not properly assess Patient I upon admission. This was,

i. inadequate,

ii. not in the best interests of Patient I,

c. In relation to your prescription for drugs described in paragraph 10.a.ii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs, **Admitted and found proved**

d. Your actions in prescribing the drugs described in paragraph 10.a. ii. were,

i. inappropriate,

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient I,

e. The dosage you authorised/directed described in paragraph 10.a. iii. was excessive to Patient I's needs. This was,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I;

'11. a. i. Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home, **Admitted and found proved**

ii. on 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J, **Admitted and found proved**

iii. you saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death', **Admitted and found proved**

iv. you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition, **Admitted and found proved**

v. on 26 August 1999 you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

vi. on 26 August 1999 you also prescribed Oramorphine 20 mg at night' **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 11.a.v.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high,

ii. the dose range was too wide, **Admitted and found proved**

iii. the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs

11.a. ii. and/or v. were,

i. inappropriate,

ii. potentially hazardous, **Admitted only in relation to head 11a v and found proved**

iii. not in the best interests of Patient J,

d. Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11.a. iv. was,

i. inappropriate,

ii. not in the best interests of Patient J;

'12. a. i. Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital. She was reported to be suffering from chronic renal failure and multi infarct dementia, **Admitted and found proved**

ii. on admission you prescribed Morphine solution 10mg in 5 ml as required, **Admitted and found proved**

iii. on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch, **Amended to read:** on 18 and 19 November 1999 there was a deterioration in Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch, **Admitted as amended and found proved**

iv. on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Amended to read:** on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg **and** Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted as amended and found proved**

b. The prescription on admission described in paragraph 12.a.ii. was not justified by the patient's presenting symptoms,

c. In relation to your prescription for drugs described in paragraph 12.a.iv.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high,

ii. the dose range was too wide,

iii. the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

d. Your actions in prescribing the drugs described in paragraphs 12.a. ii., iii. and/or iv. were,

i inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient K,

e. You did not obtain the advice of a colleague when Patient K's condition deteriorated; **Admitted and found proved**

'13. a. i. Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke, **Admitted and found proved**

ii. on 20 May 1999 you prescribed,

a. Oramorphine 10 mgs in 5 mls 2.5-5mls, **Admitted and found proved**

b. Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

c. Midazolam with a dose range of 20 to 80 mgs to be administered SC, **Admitted and found proved**

iii. you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999, **Admitted and found proved**

iv. doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999, **Amended to read:** doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient **on** 21 and 22 May 1999, **Admitted as amended and found proved**

b. In relation to your prescription for drugs described in paragraph 13.a.ii. and/or iii.,

i. there was insufficient clinical justification for such prescriptions,

ii. the dose range of Diamorphine and Midazolam was too wide, **Admitted and found proved**

iii. the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs, **Admitted and found proved**

iv. your actions in prescribing the drugs described in paragraph 13.a. ii. and or iii. were,

a. Inappropriate,

b. Potentially hazardous, **Admitted only in relation to head 13a ii b and found proved**

c. Not in the best interests of patient L,

c. You did not obtain the advice of a colleague when Patient L's condition deteriorated; **Admitted and found proved**

'14. a. You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

i. the findings upon each examination, **Admitted and found proved**

ii. an assessment of the patient's condition, **Admitted and found proved**

iii. the decisions made as a result of examination, **Admitted and found proved**

iv. the drug regime,

v. the reason for the drug regime prescribed by you, **Admitted and found proved**

vi. the reason for the changes in the drug regime prescribed and/or directed by you, **Admitted and found proved**

b. Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

i. inappropriate, **Admitted and found proved**

ii. not in the best interests of your patients; **Admitted and found proved**

'15. a. In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L, **Amended to read:** In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K **and/or** L,

b. Your failure to assess the patients in paragraph a. appropriately before prescribing opiates was not in their best interests."

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

Checked: 20 August 2009 (CMC)

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

PART THREE

The Panel has made multiple findings that your conduct has been inappropriate, potentially hazardous and/or not in the best interests of your patients. It has concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

The Panel will invite Mr Kark to adduce evidence, if he wishes to do so, as to the circumstances leading up to the facts which have been found proved, the extent to which those facts indicate serious professional misconduct on your part and as to your character and previous history. The Panel will then invite Mr Langdale to address it on your behalf in relation to those matters and also to adduce evidence in mitigation, if he wishes to do so. Counsel should refer to the GMC's Indicative Sanctions Guidance (April 2009 edition, with 7 August 2009 revisions) when making submissions in relation to sanction.

Thereafter, the Panel will proceed to consider whether you have been guilty of serious professional misconduct in respect of the facts that have been found proved and, if so, they will go on to consider whether or not they should make any direction regarding your registration.

General Medical Council

Regulating doctors
Ensuring good medical practice

Fitness to Practise Panel
Session beginning 8 June 2009
Euston Road, London
Dr Jane Ann BARTON

Determination on findings of fact and as to insuffiency supporting a finding of serious professional misconduct.

20 August 2009

Dr Barton

This case centres on 12 patients, all of whom died between 1996 and 1999 on wards where you were employed as a Clinical Assistant. In order to reach conclusions on the facts alleged it has been necessary for the Panel to build up a clear picture of the practices, procedures, pressures and personalities that characterised the situation on those wards at the time. It has done this through the reception of a great deal of evidence adduced by both parties, and through its own searching, and sometimes challenging questions.

The process has been hampered by the very considerable passage of time since the events in question, the inevitable dimming of memories over that period, the equally inevitable unavailability of some witnesses, and the admitted deficiencies in your own notes, and to some extent those of the nursing staff.

Counsel have reflected on a number of general points which, though they might not form a part of specific allegations, nonetheless require the Panel to have evaluated them before they rule on the facts.

This determination falls into three parts and one annexe. The Panel will deal, firstly, with those general issues which have required consideration during the course of the case. The Panel will, secondly, set out its formal findings as to fact. Thirdly, the Panel will set out its determination as to whether the proved or admitted facts would be insufficient to support a finding of serious professional misconduct. Attached to this determination will be an annexe detailing the final and definitive heads of charge which take account of each and every amendment made since this session commenced on 8 June of this year.

PART ONE

1. Inappropriate transfers onto Dryad and Daedalus wards

i. The Panel heard and accepted evidence from many witnesses that at the time in question there was a sense among the nursing and medical staff at Gosport War Memorial Hospital (GWMH) that, due to pressure on bed space in the acute wards of Queen Alexandra and Royal Haslar Hospitals, some patients were being transferred to Dryad and Daedalus wards when their medical condition was insufficiently stable to warrant such a move. Further, that such patients were often transferred in circumstances where their medical and nursing needs were beyond the staffing and equipment capabilities of the receiving wards.

ii. The Panel received and accepted evidence that in a number of the cases before it there was an apparent incongruity between patients' discharge notes and the assessments of nursing and medical staff when the patients arrived at Dryad or Daedalus wards.

iii. The Panel also heard and accepted evidence that some patients and their families were given the impression by some staff at the transferring hospitals that the purpose of the transfer and the role of the receiving wards were more optimistic than patients' true prognoses allowed.

2. Propensity to sudden deterioration, the effects of transfer and the appropriateness of investigation

i. The Panel heard and accepted evidence from many sources, including the General Medical Council's (GMC) medical expert, Professor Gary Ford, that elderly patients with a range of co-morbidities, such as those routinely found in Dryad and Daedalus wards at the time in question, had a natural propensity toward sudden deterioration and even death, no matter how well cared for.

ii. Further, the Panel heard and accepted evidence from those sources that the physical and mental stress to such patients when subjected to inter-hospital or even inter-ward transfer, was frequently followed by deterioration in the patient. The Panel heard and accepted evidence that such deterioration occurred no matter how short and comfortable the transfer, and that the deterioration might turn out to be temporary or permanent.

iii. Whilst the Panel is of the view that early assessment of a patient is always necessary, the above made it clear that there may well be need for further re-assessments and/or investigations after an initial period of observation.

iv. The Panel noted that there appeared to be agreement among the experts that when a patient was on the terminal pathway, it would be inappropriate to subject the patient to unnecessary investigation.

3. Your dealings with patients' relatives

i. The Panel heard a large amount of evidence from health professionals who witnessed your interactions with patients' relatives, and also from patients' relatives and even patients themselves. Most characterised your approach to relatives as caring and compassionate, and the Panel heard that you would frequently come into the hospital in your own time to meet with relatives.

ii. Some relatives did not have such a positive recollection of their meetings with you, describing you as 'brusque', unfriendly and indifferent. The Panel heard evidence from some nurses who, while generally supportive of you, indicated that you had a tendency toward plain speaking. One said that you 'did not suffer fools gladly', and another that you 'called a spade a spade'.

iii. The Panel also heard evidence from you and other health professionals that your meetings with relatives were sometimes made more difficult by the fact that the relatives had been given unrealistic expectations of the progress that the patient might be expected to make at GWMH, and were often shocked by sudden deterioration in the patient, particularly when this was manifested on or shortly after transfer.

iv. The Panel concluded that your straightforward approach was not appreciated by all relatives, and that to some you might at times appear distant or even unfeeling, albeit that this was far from your intention. The Panel further concluded that the stress experienced by relatives meeting with the doctors of a loved one who was fast approaching death frequently prevented them from taking in all that they were told. It was inevitable in such circumstances that some relatives would leave a meeting with an incomplete or inaccurate view of what had taken place.

4. 'Happy for nurses to confirm death.'

i. The Panel heard considerable discussion about the significance to be attached to the use of this phrase in your notes on individual patient records. It has accepted the view of Professor Ford and numerous other witnesses that the vast majority of patients being admitted onto Dryad and Daedalus wards at the time in question would have had a natural potential to deteriorate rapidly and without warning.

ii. The Panel further accepted Professor Ford's view that it was appropriate for medical staff in these circumstances to delegate the task of confirmation of death to nurses, and that this delegation might usefully have been noted at the time of a patient's admission onto the ward. The Panel also noted his observation that "one would prefer to have a policy for a unit rather than it being done on individual patients."

5. The role of note-taking in clinical care

i. You made a number of admissions in respect to the inadequacy of your note-taking. However, Mr Kark observed "it has been suggested on numerous occasions to witnesses that Dr Barton simply did not have the time. It was a case of either looking after the patient and not making a note about it, or making copious notes but not actually looking after the patient."

ii. Professor Ford told the Panel: "with any important clinical contact where there is a major change of patient status or a major change in treatment I think it is difficult to say one is too busy to write a three, four, five line summary of what has happened. It only takes a short time to write a brief summary."

iii. The Panel notes paragraph 3 of 'Good Medical Practice' 1995 edition which states under the heading *Good Clinical Care*: "In providing care you must....keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed..."

iv. The Panel further notes the acceptance by Professor Karol Sikora, your own medical expert, that note-taking is an integral part of clinical care, and that "any suggestion that on the one hand you will take care of the patient, and then you will do the notes, is by definition inappropriate."

6. The absence of notes of specific events

i. The Panel has heard that medical students are frequently taught that 'if it isn't recorded it didn't happen.' However, as Mr Langdale pointed out in his closing remarks, you are of undisputed good character, and that adage cannot be applied to the Panel's consideration of the facts.

ii. The Panel recognises that the admitted inadequacies in your note-taking mean that while you may on certain occasions lack the corroboration that an appropriate note might have afforded you, the lack of such a note gives the Panel no assistance one way or another in deciding whether or not a claimed event took place. Accordingly, where you have said that you failed to record it but it did happen, the Panel has afforded your evidence the same weight as any other statement as to fact by a person of good character.

7. Allegations that you did not sufficiently record the drug regime in respect of specific patients

i. Mr Kark advanced the view that any failure to reduce into writing instructions governing the circumstances and required procedures in relation to the administration of anticipatory prescriptions was serious. He argued that such failure in respect of a prescription which gave nurses the authority to initiate syringe drivers at an unspecified date, and loaded with a variable dose of Diamorphine / Midazolam mix was especially serious as it reduced the ability of the prescriber to safeguard patients' interests against inappropriate action by nursing staff.

ii. The Panel observed that in managing risk it is necessary to consider not only what might happen when the best, most highly trained and experienced nurses were on duty, but also to consider what might happen when the least trained and experienced nurses were on duty. In the absence of a clear written protocol governing the administration of anticipatory prescriptions – especially those for opiates delivered by syringe driver – patients were entitled to expect that clear written instructions would be available to all those who might be expected to administer the prescription. The Panel noted with concern that nurses had used their own discretion to start a higher dose than the

minimum prescribed dose, and that a nurse had doubled the existing dose of Midazolam at a time when the corresponding dose of Diamorphine had been halved on the instruction of a consultant because of over-sedation.

iii. The Panel noted the evidence that nurses would have been aware of your wishes in this respect because they would have attended verbal handover sessions on each occasion before they started on the ward. While recognising the value and importance of handover sessions, the Panel did not accept that this was a safe or prudent way of ensuring that prescriptions were administered appropriately.

8. Euphemisms relating to end of life status

i. The Panel has heard that throughout the health service at the time in question, health professionals routinely shied away from the use of direct and plain language when recording judgments relating to the palliative care of patients close to death. The Panel noted that even today phrases such as 'on the terminal pathway' are used to indicate that a patient is expected to die within a matter of days. At the time in question:

a. 'For TLC', an acronym for 'tender loving care' was widely used as a euphemism to note that the patient was now to be treated palliatively, and frequently carried the additional connotation that the patient was close to death.

b. 'Make comfortable' meant the same as TLC.

c. The Panel also heard from numerous sources that an entry on the notes indicating that a patient had been started on a syringe driver with a combination of at least Diamorphine and Midazolam was a clear indication that the patient had entered the terminal pathway and was expected to die within a matter of days.

9. Guidelines and the Analgesic Ladder

The Panel heard that the British National Formulary (BNF) is the definitive evidence-based guide for doctors on the prescribing of drugs. It gives clear advice on prescribing in specific situations such as *Prescribing in Palliative Care* and in *Prescribing for the Elderly* where extra care needs to be exercised.

The Panel also heard evidence about the Palliative Care Handbook (The Wessex Protocol) which was in local use at the time of the allegations, and which you told the Panel you kept in your pocket when you were on the wards.

These documents contain Conversion Charts which show, for example, the equivalency of dose between oral morphine and subcutaneous Diamorphine.

Both expert witnesses gave evidence about the World Health Organisation's *Analgesic Ladder* which emphasises the importance of using analgesics appropriate to the severity of pain, and of moving from weaker to stronger analgesics in a step-wise fashion. Professor Ford encapsulated this principle as "start low, go slow".

10. Opiates in the treatment of distress, restlessness, agitation and pain

i. The Panel heard a range of opinion as to the appropriate use of opiates in patients of advanced age with a range of co-morbidities. While there was no dispute that opiates provided effective analgesia for high levels of pain, there was a divergence of view as to the appropriateness of its use in the control of distress, restlessness, and/or agitation in the presence or absence of pain.

ii. Your experience, supported by Dr Logan, other consultants with whom you worked and Professor Sikora was that the euphoric and other properties of opiates rendered them helpful in dealing with terminal distress, restlessness and agitation, whether or not pain was also present.

iii. Professor Ford did not share this view. He conceded that there might be geriatricians who would give Diamorphine to patients who were not in pain, but he noted that such a course is neither promoted nor recommended in the palliative care literature and guidelines.

11. Side effects / adverse consequences of opiates

i. The Panel heard considerable evidence on this subject. In particular, it heard that opiates are extremely powerful drugs, especially in the treatment of the elderly who tend to be particularly sensitive to their effects.

ii. The Panel heard that common side-effects or adverse consequences of opiate use include, but are not limited to:

- Drowsiness, potentially leading to unconsciousness
- Respiratory depression, potentially leading to unconsciousness and ultimately death
- Confusion
- Agitation
- Restlessness
- Hallucination
- Nausea

iii. Professor Ford told the Panel that, when dealing with elderly patients, it was incumbent on prescribers to exercise extreme caution in determining dosage to protect the patient from over-sedation. He cited the Analgesic Ladder, the BNF and the Wessex Protocol as sources of guidance on appropriate usage and dosage of opiates.

iv. You told the Panel that you were well aware of each of these sources and of the side effects and potential adverse consequences of opiate use.

v. The Panel heard a range of evidence on the difficulty of distinguishing agitation and restlessness from pain, especially in cases of dementia and unrousable or unconscious patients. The Panel concluded that in such cases the distinction was a difficult one, and that even medical and nursing staff with considerable experience of opiates in palliative care would not always be able to make that distinction.

vi. The Panel heard that it would be extremely hard to tell whether such symptoms were

occurring as a natural part of the dying process or whether they were occurring as a side effect of the opiates themselves. The Panel noted your view that when a patient was on a syringe driver drug their unconsciousness would be constant if it was induced by the medication, whereas it would fluctuate if it was natural.

12. The Diamorphine / Midazolam mix

i. You told the Panel that in your experience a combination of Diamorphine and Midazolam was an effective means of controlling pain, agitation and restlessness in patients who were on a terminal pathway. You and Professor Sikora both accepted that Midazolam has a powerful sedating effect, and that one has to be doubly cautious using Midazolam in combination with Diamorphine.

ii. Professor Sikora accepted that if a patient is on a terminal pathway that does not avoid the necessity of using the Analgesic Ladder or guidelines so as to ensure that one is not over-sedating, because the danger otherwise is that one can end up with a patient who is unnecessarily unconscious or dead.

13. Prescribing opiates outside the guidelines

i. The Panel heard evidence from both medical experts and from a number of consultants and other medical staff that in order to relieve pain they had had occasion to prescribe opiates at levels which exceeded the guidelines contained in publications such as the BNF and the Wessex Protocol, sometimes at very high doses.

ii. It was generally accepted that such a course may be justified, and that, within reasonable limits and in the absence of other evidence, it is a matter for the judgment of the clinician on the ground who is frequently best able to assess whether the analgesic needs of the patient in question require it.

iii. The general view appeared to be that departures from the guidelines were exceptional rather than routine. However it appeared to the Panel that when placing patients on syringe driver you routinely prescribed outside those guidelines in order to ensure that the patient would not experience pain.

iv. You told the Panel that you were familiar with the guidelines in both the BNF and the Wessex Protocol. However, when asked about judging accurately a patient's needs for analgesics Professor Sikora told the Panel that "the only way is to be with the patient and see what happens after a given dose of an analgesic ... is given." In your experience, you told the Panel, the doses you prescribed were necessary if the anticipated analgesic needs of the patient were to be met.

v. The Panel also heard and accepted evidence from Professor Sikora that the response to opiates varied widely from patient to patient and that "that is why the teaching is '*Look at the patient and see what happens*', rather than use any pre-conceived dosage or formula."

vi. The Panel noted that the evidence indicated that it was also accepted that when clinicians deliberately depart from the guidelines it is important that they record in the medical notes precisely what they have done and their reasons for doing so.

vii. Mr Langdale advanced the view that in the absence of such a note, no Panel could properly form the view that you had acted inappropriately. The Panel concluded that in deciding specific allegations that you had prescribed inappropriately they were required to review all the evidence and then ask themselves whether they could be sure on the basis of that evidence that you had prescribed inappropriately.

14. Anticipatory prescribing and the delegation of powers

i. The Panel heard a great deal of evidence about anticipatory prescribing and the delegation of powers. It heard that the practice of prescribing a drug in anticipation that it might be required, but before it is actually required is not uncommon, especially in the management of pain. The justification for such a practice is said to be that, if and when the immediate administration of the prescription becomes necessary, nursing staff have the discretion to administer it without having to wait for a doctor to respond to a call to come to prescribe it. If it is never required it is never administered.

ii. The value of such a practice in the swift treatment of pain is obvious. The Panel heard evidence from both Professors Ford and Sikora, as well as from the consultants who gave evidence, that they had all engaged in anticipatory prescribing.

iii. It was acknowledged that one risk attendant on anticipatory prescribing is that nursing staff might decide to administer the prescription at a time when it was not clinically justified.

iv. It was further acknowledged that this risk became of particular significance on Dryad and Daedalus wards when the prescription included variable doses of a mix of Diamorphine and Midazolam to be delivered by syringe driver. As previously noted, it was generally accepted that the starting of a syringe driver loaded with such a mix was a clear indication that the patient was now on the terminal pathway and expected to die in a matter of days. Further, and also as previously noted, Mr Kark advanced the view that one means of providing patients with some safeguard against the inappropriate administration of such a prescription would have been the provision of clear written instructions.

v. There was some inconsistency in the evidence as to the extent to which nursing staff on Dryad and Daedalus would seek approval from medical staff before starting a patient on syringe driver, and the Panel received evidence of occasions when syringe drivers had been started at the sole discretion of nursing staff. In any event, you gave clear evidence that you trusted your nursing staff to exercise their discretion appropriately, and that while you would expect them to seek approval, in the event that they were unable to reach a doctor to obtain that approval it was "their prerogative" to proceed without it.

vi. The Panel heard that the risk of inappropriate exercise of discretion to administer a prescription generally was adequately safeguarded by the fact that drugs could only be administered by two fully qualified nurses working together; and that the nurses on Dryad and Daedalus were of a calibre that rendered the risk acceptable.

vii. The Panel also heard that it was not unusual for anticipatory prescribing to allow for a range of doses. The reason for this was to enable the trained nurses administering the drug(s) to exercise their discretion as to the dose currently required by the patient

before them. The Panel heard that it was usual for nurses to begin administration of a prescription by starting at the lowest dose prescribed, though it was accepted that they were able to administer at a higher rate if they determined that it was appropriate to do so; and the Panel received evidence of occasions when they did so.

viii. The Panel noted with concern your apparent assumption when prescribing on an anticipatory basis that the required dose would increase. As a consequence the lowest dose prescribed by you in an anticipatory range would be set at a higher level than whatever was the current dose at the time of prescription, despite the fact that when you wrote the prescription you had no way of knowing when it would be administered. The Panel has seen from the specific cases with which it is concerned that the delay between prescription and administration could be anything from a matter of hours to a matter of days.

ix. It follows that the danger was if at the time of administration the prescribed minimum dose was too high that excessive dose was likely to be administered anyway. Indeed, if the nurses were to form the view that the lowest dose in the variable range was too high, in the anticipated event that they were unable to obtain assistance from a doctor, their choice of action was limited to not administering the medication at all or administering it at what they judged to be too high a dose. In the Panel's view, the appropriate safeguard would have been for you, whenever you were anticipatorily prescribing a variable range of diamorphine, to match the lowest dose in the range to the equivalent of the dose the patient was on at the time of prescription. In the case of an opiate naïve patient, the Panel accepted Professor Ford's view that a prescription in line with the Analgesic Ladder referred to at paragraph 9 above would be appropriate.

x. So far as the prescription of Midazolam in combination with Diamorphine is concerned, the Panel noted that both drugs have a sedative effect and that particular care should be exercised to take account of this when prescribing them in combination.

xi. The Panel accepted Professor Ford's view that in anticipatory prescribing a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide.

xii. You told the Panel that, where a dose of subcutaneous analgesia was not controlling the pain or other symptoms, you would in general terms follow the practice of "doubling up". The Panel noted that this would be almost certain to prevent the manifestation of breakthrough pain. However, it also greatly increased the risk of over-sedation and adverse side-effects.

xiii. In the Panel's view, this practice demonstrated your approach to protecting patients from pain even at the cost of protecting them from over-sedation and adverse side-effects.

xiv. Mr Langdale advanced the argument that although you admitted that there were occasions when the range of doses you had prescribed was too wide, the doses actually administered never reached the highest dose that the prescriptions allowed for, and were frequently a good deal lower. The Panel takes the view that while this was fortunate, the fact remains that this method of prescribing gave rise to the risk that the highest doses could be administered. This is a matter which the Panel is obliged to take into account when considering the appropriateness of the prescribing and whether or not it was in the best interests of the patient.

15. Syringe Drivers

i. The Panel received a great deal of evidence on this subject. The Panel heard that syringe drivers are used to deliver a wide variety of medications, both in the community and in hospitals. It concluded that their principal value lies in the fact that they are capable of delivering medication at a continuous and even rate over periods of up to 24 hours per load. This is particularly important in cases where, for whatever reason, oral medication is not appropriate. This is because the use of a syringe driver:

a) spares patients the discomfort and inconvenience of four hourly injections and
b) in the relief of pain, avoids the 'peaks and troughs' associated with a regular but discontinuous course of injections.

ii. The Panel found that the use of syringe drivers on Dryad and Daedalus wards at the time in question had particular significance because of two factors:

a) They tended to be loaded with combinations of drugs which included Diamorphine and Midazolam, frequently at starting doses of 20 mg of each, (with doses routinely doubling every 24 hours.)
b) There were no facilities on either ward for intra-venous hydration, and the reality was that patients who were unable to swallow, whether because they were unconscious or otherwise, did not receive hydration. Continued lack of hydration would ultimately lead to death.

iii. It was in this context that medical and nursing staff on these wards recognised that starting a patient on a syringe driver was an acknowledgment of the fact that the patient was now on a terminal pathway and not expected to live beyond a matter of days.

16. Syringe drivers and the immediate relief of pain

i. The Panel heard that such use of syringe drivers was not an effective means of providing immediate analgesia because the continuous rate of infusion meant that it would take some hours before the amount of analgesia in the patient's blood stream would reach the optimum level at which it would then be maintained. Professor Ford told the Panel *'if a patient is not already stable on a previous dose of oral morphine or injected subcutaneous morphine or diamorphine you will not see the full effect of that infusion until quite some time later, twenty hours or more.'*

ii. You expressed surprise that there should be such a delay. You told the Panel that your experience was that on your usual dosing Diamorphine / Midazolam mixes took effect a lot quicker than that.

iii. When asked about the potential for dealing with immediate pain by single injection rather than by placing the patient directly onto a syringe driver you told Mr Kark: "I was not in the habit of using intramuscular or subcutaneous Diamorphine in that way."

Mr Kark replied: "Instead of which what you effectively did was you handed the nurses the power to start the path for this lady's death."

Your response: 'I did.'

17. Titration and the use of syringe drivers

i. Professor Ford told the Panel that to ensure a patient did not suffer during the syringe driver's build-up period it was necessary to provide additional alternative analgesia first.

ii. The Panel heard that, depending on the circumstances, opiates could be delivered by a variety of routes:

- Orally (eg liquid Oramorph which will reach peak effect between 30 to 60 minutes, or sustained release tablets which will reach peak effect in a matter of hours)
- Trans-dermally (eg Fentanyl patch which will reach peak effect after about 24 hours)
- Intra-venously (eg morphine injection which will reach peak instantly)
- Intra muscularly or subcutaneously (eg Diamorphine injections which will reach peak between about 15 and 30 minutes, or syringe driver which will peak after 20 hours or more)

iii. In Professor Ford's view:

- When treating an opiate naïve patient, the first issue would be establishing the level of analgesia required to render the patient pain free whilst remaining alert and free of adverse side effects. This could most effectively be achieved by means of titration i.e. treating the patient with a series of escalating doses and observing the effect until a daily dose which completely controlled the pain was found. Ideally this might be through the use of Oramorph, but where oral opiates were not an option individual injections could be used. Once the correct level of analgesia is established a starting dose or bolus could then be administered to cover the delay in the syringe driver taking full effect.

- When treating a patient already receiving opiates, the first issue would be to determine the equivalent dose for delivery by syringe driver. This would be done by reference to the conversion charts in the BNF or Wessex Protocol. The second issue would be how to achieve the transition from the existing delivery method to the syringe driver without either increasing or decreasing the level of analgesic cover during the period of transition. This would require calculations to be made based on a comparison between the start up times of the driver and the end of efficacy times of the previous analgesia. The Panel heard evidence that nursing staff were equipped with the appropriate conversion charts and so would have been capable of calculating and delivering the appropriate dose.

iv. When asked by Mr Kark about the need for titration prior to commencing a syringe driver, Professor Sikora said "That would be the ideal situation to go for; to have either oral morphine or long-acting morphine, or in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine." He stated that, unless you did that, there was a serious danger that you are either going to start too low or too high.

v. By contrast, you evinced a marked reluctance to titrate doses before commencing patients on syringe drivers. You told the Panel, "we simply did not have the level of staffing to do that on a ward of 24 people."

When pressed by Mr Kark you said that your patients did not suffer from a lack of

nurses but that "they would have if two trained staff had been tied up titrating and drawing up and giving injections of Diamorphine, even every four hours, let alone every hour."

You also accepted that titrating doses is a basic standard medical principle.

Mr Kark asked you: "And you are saying that under your watch that simply was not being done throughout these three years?"

You replied: "I am saying that. I was not taught it. I was not familiar with using it....it was not practical....it just was not feasible."

18. The effect of staffing pressures on your prescribing practice.

i. The Panel received evidence from a wide range of witnesses that the impression given to the visitor to Dryad and Daedalus wards was that the wards were well run and that patients were taken good care of. You were full of praise for your nursing staff and the job they did. You were clear that the quality of nursing care that your patients received was not compromised by staffing pressures: you stated that opiates were never started earlier, or at a higher rate, because of inadequate staffing; you told the Panel that that would have been quite inappropriate. Your view on the effect of staffing pressures was borne out by Sister Joines and a large number of other witnesses.

ii. In terms of your own prescribing practices however, you told the Panel that staffing pressures did have some effect. You told the Panel that, in addition to reducing the time you had available to make notes in patient records, your system of anticipatorily prescribing wide ranges of opiates for delivery by syringe driver with what some might view as a high starting dose, and in the absence of titration, was a direct and necessary result of staffing pressures.

iii. Mr Langdale asked Professor Sikora: "What effect does ... reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?"

He replied: "It means there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances." The Panel noted that such a strategy might conversely create the need for a higher level of observation if patients are to be adequately protected in the event that adverse consequences manifest themselves.

19. The role of consultants

The Panel heard that, at the time in question, the presence of consultants on Dryad and Daedalus wards was extremely limited. Although the consultants who gave evidence before the Panel were supportive of you, their evidence tended to suggest that they had not critically examined your prescribing practice, and in many instances had not appreciated your admitted prescribing failures. Had they done so, this should have resulted in appropriate changes being made to your prescribing practice.

20. Mr Langdale's argument that the very fact that senior medical staff and the visiting pharmacist did not object indicated that you were doing nothing wrong

i. As stated above, the Panel took the view that the consultants on the ward systematically failed to critically examine your prescribing practice. While the effect of this failure might have been to reinforce your view that you were not acting inappropriately, it in no way rendered your inappropriate conduct appropriate. The Panel noted that as a medical practitioner you retained ultimate responsibility for your own actions.

ii. In respect of the pharmacist, the Panel has not had the advantage of receiving any evidence from her. In the circumstances the Panel is unable to draw any conclusions with respect to your actions or inactions as a consequence of her actions or inactions. However, the Panel noted your admissions with regard to your own prescribing deficiencies, and that it has heard no evidence that these were detected and acted upon by the pharmacist.

21. The principle of double effect

i. The Panel heard from Professor Ford that: "The principle of double effect is that one may need to palliate symptoms, and that the treatment one needs to give to palliate symptoms may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms."

ii. Professor Ford told the Panel: "One has to give drugs and doses that are reasonable and appropriate to palliate symptoms. Then, with certain groups of drugs like sedatives, the issue is giving excessively high doses which have an effect which go beyond what the patient needed to palliate their symptoms."

iii. The Panel has examined, in respect of each patient, the issue of the prescribing of drugs which have or might have an effect which goes beyond what the patient needed to palliate their symptoms. The Panel noted that the importance of this issue is partly explained by Professor Ford's evidence on sedation therapy.

iv. Professor Ford told the Panel that: "Sedation therapy, it has been commented, is open to misuse – I am not saying it was misused, but the problem is, because they are so powerful at producing respiratory depression, one systematic review of sedation in end of life care comments that it can ostensibly be used to relieve distress but with the manifest intent of hastening death. I am not saying that was the intent here, I am saying that is the concern about why one needs to document very carefully the use of sedation in an end of life setting, that it is used appropriately to control patients' symptoms."

v. The Panel considered that the importance of this issue is further explained by the view that in addition to the right to be provided with appropriate analgesia, the patient has a balancing right to be kept as alert and conscious as proper management of their pain allows. On the issue of balancing the need to be pain-free with the ideal of being free from side-effects, Professor Sikora told the Panel: "...usually it is achievable, to get pain-free without troubles from the side effects of the medication - including over-sedation side effects – by judicious use of the drugs..."

vi. You were clearly aware of the principle of double effect. For example:

a. Mr Langdale asked you in relation to your treatment of Patient A: "What about the concern that this (high dose) was going to cause respiratory depression or lowering his conscious level?"

You replied: "I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief."

Mr Langdale asked "Why not leave it because of the risk of it having an adverse effect?"

You replied: "At that point I was not concerned about any potential adverse effect. I wanted Mr Pittock comfortable and free of all these wretched symptoms."

b. With regard to Patient B you told the Panel: "The judgment is that I wanted to give her adequate pain relief and relief of her symptoms, of what were now becoming terminal restlessness, so I was minded to give her adequate analgesia and sedation to control those, and I was accepting that she might well be over-sedated."

c. With regard to Patient C you were asked whether there was any risk of over-sedation or respiratory depression because of the declining effects of Fentanyl.

You replied: "There would always [be] a risk. I was prepared to accept that risk in order to give her adequate analgesia and to add in the Midazolam. I thought that the risk was acceptable in this particular patient."

With respect to Patient B Mr Langdale asked you why you did not reduce the level of medication so that while managing your patient's pain you also kept her alert.

Your response was: "More alert to feel more pain."

vii. The Panel took the view that this final response gave a clear insight into how you viewed the desirability of balancing pain relief with the desirability of keeping the patient as free as practicable from the side effects of opiates.

PART TWO

At the outset of the hearing, Mr Langdale admitted a number of parts of the allegation on your behalf and the Panel found them proved.

In respect of the unadmitted parts of the allegation, the Panel has considered all of the evidence and has taken account of Mr Kark's submissions on behalf of the GMC and those made by Mr Langdale on your behalf.

The Panel has borne in mind that the burden of proof rests on the GMC and that the standard of proof applicable in these proceedings is the criminal standard, namely that the Panel must be sure beyond reasonable doubt.

Having considered each of the remaining allegations separately, the Panel has made

the following findings:

Head 1 has been admitted and found proved.

Mr Leslie Pittock (Patient A)

Head 2a in its entirety has been admitted and found proved.

Head 2b i in relation to head 2a ii (in relation to Diamorphine only, as Midazolam was not prescribed) has been found proved.

The Panel has accepted the evidence of Professor Ford that the appropriate lowest dose in the range for this opiate naïve patient would at this stage have been 15 mg of Diamorphine. The lowest dose of Diamorphine that you prescribed was 40 mg.

Head 2b i in relation to head 2a iii in relation to the Diamorphine has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of analgesia provided for in the existing prescription and was therefore too high.

Head 2b i in relation to head 2a iii in relation to the Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Head 2b ii in relation to head 2a ii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b ii in relation to head 2a iii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the

highest parameter was too wide. This dose range did not offend against that principle.

Head 2b iii has been admitted and found proved.

Head 2c has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person on both occasions and exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the doses administered were excessive to the patient's needs.

Head 2d has been found proved.

The Panel noted paragraphs 12 i and 14 x above which indicate that great care should be exercised in prescribing Diamorphine and Midazolam in combination, as both have sedative effects. The Panel also notes that this prescription contained a combination of Diamorphine, Midazolam, Haloperidol and Nozinan. The Panel notes your admission that, as Haloperidol and Nozinan both have sedative effects, you should have discontinued the Haloperidol when you introduced the Nozinan.

Heads 2e i – iii in relation to head 2a ii have been found proved.

In the light of the Panel's findings that the lowest prescribed dose of Diamorphine was too high and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that this prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iii have been found proved.
Head 2e ii in relation to head 2a iii has been admitted and found proved.

Having found that the lowest doses prescribed were too high, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and your having admitted and the Panel having found that the prescription was potentially hazardous, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iv have been found not proved.
Head 2e ii in relation to head 2a iv has been found proved.

Heads 2e i and iii in relation to head 2a v have been found not proved.
Head 2e ii in relation to head 2a v has been found proved.

Given that the charge relating to the doses of Diamorphine administered on both 15 and 17 January 1996 was not found proved the Panel could not be sure that the

prescription was either inappropriate or not in the best interests of Patient A although, by the nature of the prescription, the Panel did conclude that it was potentially hazardous.

Heads 2e i – iii in relation to head 2a vi have been found proved.

Having found that the prescription of 18 January 1996, in combination with other drugs already prescribed, was excessive to the patient's needs and, given the sedative effect of the prescribed drugs in combination, the Panel was satisfied that the prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Lavender (Patient B)

Heads 3a i – iv in their entirety have been admitted and found proved.

Head 3b i in relation to head 3a iii in relation to the Diamorphine has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the level of analgesia the patient was on at the time of prescription, and was therefore too high.

Head 3b i in relation to head 3a iii in relation to the Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Diamorphine has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person prior to issuing this prescription, and that you exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the lowest dose prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Midazolam has been found proved.

In reaching this finding, the Panel has accepted Professor Ford's evidence that Midazolam is not indicated for pain. Further, the Panel reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 x above in relation to the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 3b ii and iii have been admitted and found proved.

Heads 3c i - iii in relation to head 3a ii have been found not proved.

The Panel noted Professor Ford's opinion that the prescription of Morphine Slow Release Tablets (MST) 10 mg twice a day might be acceptable. Accordingly, the Panel could not be sure that this prescription was inappropriate, potentially hazardous and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iii have been found proved.
Head 3c ii in relation to head 3a iii has been admitted and found proved.

On 26 February 1996 you increased the prescription for MST from 10 mg to 20 mg twice a day and prescribed a variable dose combination of Diamorphine and Midazolam on syringe driver. The Panel considers that the increased dose of MST was in itself high. The Panel has noted that at the outset of the hearing you admitted that this

prescription was too wide, potentially hazardous and created a situation whereby drugs could be administered which were excessive to the patient's needs. Further, and having regard to paragraphs 11 – 14 above, in relation to the prescription of opiates, their side-effects and effect in combination with Midazolam, the Panel is satisfied that your actions in issuing this prescription were inappropriate and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iv have been found proved.
Head 3c ii in relation to head 3a iv has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above in relation to prescribing opiates outside the guidelines and the effects of opiates in combination with Midazolam. In addition, you admitted that your prescription for Diamorphine and Midazolam in combination was too wide, was potentially hazardous, and created a situation whereby drugs could be administered which were excessive to the patient's needs. Accordingly the Panel has found that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Head 3d i has been found not proved.

In reaching this finding, the Panel noted Mr Kark's concession in his closing submissions that Professor Ford found no fault with your management of the patient at the time of her admission and that your examination of her was appropriate.

Head 3d ii has been found proved.

The Panel accepted Professor Ford's view that you should have addressed the question of the cause of pain complained of by the patient. Your continuing failure to address the reason why she was experiencing pain rendered your assessment of her, as her condition deteriorated, inadequate.

Head 3d iii has been found not proved.

The Panel has noted that you saw the patient's family on 26 February 1996 and that they were aware of your assessment that she was now on the terminal pathway. Other than this, your clinical notes did not include a treatment plan beyond the need for a Pegasus mattress and analgesia if necessary. Nonetheless, whether adequate or not, there was a treatment plan.

Head 3d iv has been admitted and found proved.

Heads 3e i and ii have been found proved.

In the light of the Panel's multiple findings against you in relation to your management of the patient, the Panel concluded that your actions and omissions were inadequate and not in the patient's best interests.

Heads 14a i - iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Eva Page (Patient C)

Heads 4a and b in their entirety have been admitted and found proved.

Heads 4c i and iii have been found proved.
Head 4c ii has been admitted and found proved.

The Panel has had regard to paragraphs 12, 14 x, 16 and 17 above in relation to the combination of Diamorphine and Midazolam and the use of syringe drivers. In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient. The Panel further noted that at the time you made this prescription you had also prescribed a Fentanyl patch.

Heads 14a i –iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Head 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Alice Wilkie (Patient D)

Heads 5a and b in their entirety have been admitted and found proved.

Heads 5c i and iii have been found proved.
Head 5c ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

Further, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads14b i and ii have been admitted and found proved.

Heads 15a and b have been found proved.

The Panel has received no documentary evidence to indicate that you assessed this opiate naïve patient prior to prescribing opiates. You told the Panel that you could not be sure that you had formally assessed the patient as you might have been away

around that time. You told the Panel that on your return to the ward on about 17 August 1998 that "we had mayhem occurring", and that though you might have seen the patient, you would have relied on the verbal reporting of assessments made by nursing staff. It follows that this prescription to an opiate naïve patient was not based on an appropriate assessment by you, and that your failure was not in the patient's best interests.

Mrs Gladys Richards (Patient E)

Heads 6a and b in their entirety have been admitted and found proved.

Heads 6c i – iii in relation to head 6a ii have been found proved.

You conceded that although this patient had experienced an earlier adverse reaction to Morphine, she was effectively opiate naïve on admission to Daedalus ward on 11 August 1998. At this time her pain was being managed by Co-codamol. Accordingly the Panel had regard to paragraphs 9 and 14 ix above as to guidelines and the Analgesic Ladder and the equivalence of doses, and accepted the view of Professor Ford that you should have followed the Analgesic Ladder in prescribing for this patient.

Heads 6c i and iii in relation to head 6a iii have been found proved.
Head 6c ii in relation to head 6a iii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel accepted Professor Ford's view that you should have followed the Analgesic Ladder in prescribing for this patient.

In addition, the Panel noted that you admitted that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Ruby Lake (Patient F)

Heads 7a and b in their entirety have been admitted and found proved.

Head 7c i in relation to head 7a ii has been found not proved.

The Panel noted that you prescribed Oramorphine in response to complaints of pain by an opiate naïve patient. The Panel further noted that it is your view that this was justified as you considered her to be exhibiting symptoms of congestive cardiac failure. In the circumstances, the Panel could not be satisfied that this prescription was inappropriate.

Head 7c ii in relation to head 7a ii has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel noted that by its very nature, any prescription of opiates is potentially hazardous.

Head 7c iii in relation to head 7a ii has been found not proved.

The Panel concluded that the prescription may by its nature be potentially hazardous, but nonetheless in the best interests of the patient, and not inappropriate. That was the case here.

Heads 7c i and iii in relation to head 7a iii have been found proved.
Head 7c ii in relation to head 7a iii has been admitted and found proved.

You admitted that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In the circumstances, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Arthur Cunningham (Patient G)

Heads 8a and b have been admitted and found proved.

Heads 8c i and iii in relation to head 8a ii have been found proved.
Head 8c ii in relation to head 8a ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

In addition, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 8c i and iii in relation to head 8a iii have been found proved.
Head 8c ii in relation to head 8a iii has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above as to combining Diamorphine and Midazolam, prescribing opiates outside the guidelines, and anticipatory prescribing, and noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that your actions in prescribing the drugs were potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing these drugs were inappropriate and not in the best interests of the patient.

Head 8d has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Robert Wilson (Patient H)

Head 9a in its entirety has been admitted and found proved.

Heads 9b i, ii and iv in relation to head 9a ii have been found proved.
Head 9b iii in relation to head 9a ii has been found not proved.

The Panel noted that this was a prescription for immediate administration, and the Panel had regard to paragraph 13 above with reference to prescribing opiates outside the guidelines. The Panel noted however that the patient's alcohol related liver disease fundamentally altered the prescribing situation. The Panel accepted Professor Ford's view that "best practice would have been to go through the Analgesic Ladder through a moderate opioid to begin with, with paracetamol ..."

The Panel further accepted Professor Ford's view that, if Oramorphine became appropriate, it would have been important to have started with a low dose, bearing in mind the increased risks the prescription of opiates posed to a patient with alcohol related liver disease.

In all the circumstances the Panel concluded that the prescription at this time was:

- inappropriate;
- potentially hazardous in that it had the potential to lead to serious and harmful consequences for the patient. The Panel was unable to be sure however that the prescription was likely to lead to serious and harmful consequences for the patient;
- not in the best interests of the patient.

Head 9c in its entirety has been admitted and found proved.

Heads 9d i – iii in relation to head 9a ii have been found proved.

The Panel relies on its findings above in relation to heads 9b i – iii.

Heads 9d i and iii in relation to head 9a iii have been found proved.
Head 9d ii in relation to head 9 a iii has been admitted and found proved.

At the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above concerning equivalence of doses, and applying the appropriate conversion rate, noted that the anticipatory prescription did provide for an increase in the lowest level of analgesia, and was therefore too high. The Panel further noted your admissions in relation to your prescription that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drug was potentially hazardous.

Heads 9d i and iii in relation to head 9a iv have been found proved.
Head 9d ii in relation to head 9 a iv has been admitted and found proved.

The Panel concluded that in the light of the patient's alcohol related liver disease the prescription of even a small amount of Midazolam was inappropriate and not in the best interests of the patient, especially given that the patient had already been prescribed a significant dose of Diamorphine. The Panel further noted your admission that your actions in prescribing Midazolam were potentially hazardous.

Head 9e has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Enid Spurgin (Patient I)

Head 10a in its entirety has been admitted and found proved.

Head 10b in its entirety has been found not proved.

The Panel noted that Dr Reid had assessed the patient shortly before her transfer to the ward. The Panel also noted Professor Ford's view that it would not have been necessary for you to investigate the cause of the patient's pain at the time of admission; albeit that he felt such an investigation would have been necessary at a later stage. In the circumstances, the Panel could not be satisfied that your assessment of the patient on admission was either inadequate or not in her best interests.

Head 10c in its entirety has been admitted and found proved.

Heads 10d i and iii in relation to head 10a ii have been found proved.
Head 10d ii in relation to head 10a ii has been admitted and found proved.

In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient.

Heads 10e i – iii in relation to head 10a iii have been found proved.

The Panel had regard to paragraph 13 above relating to prescribing opiates outside the guidelines. However, it noted that when Dr Reid saw this patient on his ward round, he observed that she was over-sedated and that the width of dosage range was too wide. He ordered the dosage of Diamorphine to be reduced by 50%. In the circumstances the Panel was sure that the dosage authorised/directed by you was excessive to the patient's needs and was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Geoffrey Packman (Patient J)

Head 11a in its entirety has been admitted and found proved.

Head 11b i in relation to head 11a v in relation to the Diamorphine has been found not proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. Having regard to paragraph 14 above concerning equivalence of doses, and applying the appropriate conversion rate, the Panel calculated that the anticipatory prescription did not provide for an increase in the equivalent level of analgesia provided for in the existing prescription, and was not therefore too high.

Head 11b i in relation to head 11a v in relation to Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 11b ii and iii have been admitted and found proved.

Heads 11c i – iii in relation to head 11a ii have been found not proved.

Professor Ford was not critical of you for giving verbal permission for 10 mg of Diamorphine to be administered to the patient on 26 August 1999. In his closing submissions, Mr Kark conceded that in the light of Professor Ford's concession in respect of this head, the Panel might think it appropriate that it should fall. The Panel accepted that view.

Heads 11c i and iii in relation to head 11a v have been found proved.
Head 11c ii in relation to head 11a v has been admitted and found proved.

The Panel has found that the lowest dose of Midazolam prescribed was too high, and you have admitted that the dose range of Diamorphine and Midazolam was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drugs was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 11d i and ii in relation to head 11a iv have been found proved.

The Panel had regard to paragraph 2 iv above in relation to investigating the patient's condition. It noted Professor Ford's view that "...there would have to be a clear senior decision in a man like this ... to make a decision not to undertake active intervention for his problem...".

The Panel noted with concern your assertion that it would have made no difference to this patient's care/condition if you had obtained further medical advice and/or undertaken further investigations. In the Panel's view you should have done both before making the decision to put the patient onto the syringe driver. Accordingly, the Panel has concluded that your failure was inappropriate and not in the patient's best interests.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Devine (Patient K)

Head 12a in its entirety has been admitted and found proved.

Head 12b has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

The Panel noted Professor Ford's view that your prescription was not justified in the light of the patient's presenting symptoms, i.e. confused and agitated but no complaint of pain. The Panel accepted his view that if there were to be an anticipatory prescription for this opiate naïve patient, 2.5 mg would be the appropriate starting dose and 10 mg would be high. In all the circumstances, the Panel concluded that this prescription was not justified.

Head 12c i in relation to head 12a iv has been found proved.

The Panel noted that there had been no attempt at titration, and that even the lowest doses of Diamorphine and Midazolam would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression.

The Panel had regard to paragraphs 11, 13 ii, 16 and 17 above in relation to the side-effects / adverse consequences of opiates, prescribing opiates outside the guidelines, and the use of syringe drivers. The Panel accepted Professor Ford's view that the lowest doses of Diamorphine and Midazolam would have had a profoundly sedating effect, especially in combination with the Fentanyl which was already prescribed. Professor Ford told the Panel that when the syringe driver started the level of Fentanyl already in the patient's blood stream would have been at its peak. The Panel took the view that, as a consequence, this prescription put the patient at severe risk of respiratory depression, coma and premature death. The Panel noted that the patient lapsed into unconsciousness shortly after the syringe driver commenced at 09:25 on 19 November and that she remained unconscious until her death at 20:30 on 21 November.

Head 12c ii in relation to head 12a iv in relation to Diamorphine has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 12c ii in relation to head 12a iv in relation to Midazolam has been found proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range offended against that principle.

Head 12c iii in relation to head 12a iv has been found proved.

It follows from the Panel's finding that the lowest doses of Diamorphine and Midazolam prescribed were too high that your prescribing created a situation whereby drugs could be administered which were excessive to the patient's needs.

Heads 12d i – iii in relation to head 12a ii have been found proved.

In the light of the Panel's finding that your prescription of Morphine solution was not justified, the Panel concluded that your actions in prescribing it were inappropriate, potentially hazardous (by the very nature of the drug prescribed) and not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iii have been found proved.

The Panel accepted Professor Ford's view that, given the patient's condition, especially her dementia, and the potential side-effects of Fentanyl on such a patient, made it an inappropriate and potentially hazardous prescription which was not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iv have been found proved.

The Panel having found that the lowest doses of Diamorphine and Midazolam prescribed were too high, that the dose range in respect of the Midazolam was too wide, and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that your actions in prescribing these drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 12e has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Jean Stevens (Patient L)

Head 13a has been admitted in its entirety and found proved.

Head 13b i in relation to head 13a ii has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient had already been receiving low levels of opiates. The Panel had regard to paragraph 14 ix above in relation to equivalence of doses, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of opiates which the patient had already been receiving. Consequently, there was insufficient clinical justification for this prescription of the opiates.

With regard to the anticipatory prescription for Midazolam, the Panel noted Professor Ford's view that there was no clear evidence that the patient was suffering terminal restlessness. Further, the Panel had regard to paragraphs 12 and 14 x above concerning the caution required before prescribing Midazolam for a patient who was already receiving opiates. The Panel concluded that in light of the inherent dangers in prescribing Midazolam in conjunction with opiates, and its acceptance of the view that there was no clear evidence that the patient was suffering from terminal restlessness, there was insufficient clinical justification for the prescription of Midazolam.

Heads 13b ii and iii in relation to head 13a ii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a ii have all been found proved, save for

head 13b iv b which in relation to Diamorphine has been admitted and found proved.

You admitted and the Panel found proved that the dose range of Diamorphine and Midazolam was too wide, that the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription of the Diamorphine was potentially hazardous. The Panel further found that there was insufficient clinical justification for the prescriptions. In all the circumstances, the Panel concluded that your actions in prescribing the drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 13b i in relation to head 13a iii has been found proved

The Panel having found that there was no clinical justification for the 20 May prescription of Oramorphine, and there being no evidence of relevant change in the patient's condition at the time of this regular prescription for Oramorphine, it follows that there was insufficient clinical justification for this prescription also.

Heads 13b ii and iii in relation to head 13a iii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a iii have been found proved.

You admitted and the Panel found proved that this prescription created a situation whereby drugs could be administered which were excessive to the patient's needs. The Panel further found that there was insufficient clinical justification for this prescription. In all the circumstances, the Panel concluded that your action in prescribing the Oramorphine was inappropriate, by its nature potentially hazardous, and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

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Fitness to Practise Panel

Dr Jane Ann BARTON

Determination on Serious Professional Misconduct and Sanction

29 January 2010

Mr Jenkins

The Panel has considered Dr Barton's case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 (Old Rules). As a consequence, when determining whether the facts alleged had been proved, the Panel applied the criminal standard of proof. This means that it had to be satisfied beyond reasonable doubt of the facts alleged before it could find them proved.

The Panel wishes to make clear at this stage that it is not a criminal court and that it is no part of its role to punish anyone in respect of any facts it may find proved.

At the outset of the hearing, Mr Langdale QC admitted a number of parts of the allegation on Dr Barton's behalf and the Panel found those facts proved. The Panel made further findings in relation to the unadmitted parts of the allegation and gave detailed reasons for those findings in its earlier determination on the facts.

Serious Professional Misconduct

The task for the Panel at this stage of the hearing is first to determine whether, on the basis of the facts found proved, Dr Barton has been guilty of Serious Professional Misconduct. If the Panel finds that she has been guilty of Serious Professional Misconduct, it is then required to consider what action, if any, to take in respect of that misconduct.

In making this first decision, the Panel has considered whether the actions and omissions found proved in relation to Dr Barton's care of the 12 patients who have featured in this case amounted to misconduct which offends against the professional standards of doctors. If it did, the Panel has then determined whether that misconduct was serious.

The Panel has taken into account all the evidence it has heard and read throughout this hearing. It has referred to its determination on the facts found proved and the reasons for its findings, as well as the GMC's publication 'Good Medical Practice' (1995 edition)

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which was applicable at the time. Further, the Panel has had regard to the context and circumstances in which Dr Barton was then working.

The Panel considered the submissions made by Mr Kark on behalf the General Medical Council (GMC) and by Mr Langdale and yourself on Dr Barton's behalf, and accepted the advice of the Legal Assessor.

Mr Kark submitted that Serious Professional Misconduct should be viewed historically. He reminded the Panel that while there is no definition of serious professional misconduct the test to apply is whether, when looking at all the facts that have been admitted and found proved, Dr Barton's conduct amounts to a serious falling below the standard which might be expected of a doctor practising in the same field of medicine in similar circumstances.

Mr Langdale concurred.

The Panel took account of the above and exercised its own judgment, having regard to the principle of proportionality and the need to balance the protection of patients, the public interest and Dr Barton's own interests.

The Panel made multiple findings of fact which were critical of Dr Barton's acts and omissions. These included but were not limited to:

- The issuing of prescriptions for drugs at levels which were excessive to patients' needs and which were inappropriate, potentially hazardous and not in the patients' best interests,
- the issuing of prescriptions for drugs with dose ranges that were too wide and created a situation whereby drugs could be administered which were excessive to the patient's needs,
- the issuing of prescriptions for opiates when there was insufficient clinical justification,
- acts and omissions in relation to the management of patients which were inadequate and not in their best interests. These included failure to conduct adequate assessments, examinations and/or investigations and failure to assess appropriately patients' conditions before prescribing opiates,
- failure to consult colleagues when appropriate,
- acts and omissions in relation to keeping notes which were not in the best interests of patients, including failure to keep clear, accurate and contemporaneous notes in relation to patients, and in particular, in relation to examinations, assessments, decisions, and drug regimes.

The Panel has concluded that Dr Barton failed to follow the relevant edition of 'Good Medical Practice' in relation to the following aspects of her practice:

- Undertaking an adequate assessment of the patient's condition based on the history and clinical signs, including where necessary, an appropriate examination,
- providing or arranging investigations or treatment where necessary,
- referring the patient to another practitioner where indicated,
- enabling persons not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor,
- keeping clear accurate and contemporaneous patient records,
- keeping colleagues well informed when sharing the care of patients,
- ensure suitable arrangements are made for her patients' medical care when she is off duty,
- prescribing only the treatment, drugs or appliances that serve patients' needs,
- being competent when making diagnoses and when giving or arranging treatment,
- keeping up to date,
- maintaining trust by
    - listening to patients and respecting their views,
    - treating patients politely and considerately,
    - giving patients the information they ask for or need about their condition, treatment and prognosis,
    - giving information to patients in a way they can understand,
    - respecting the right of patients to be fully informed in decisions about their care,
    - respecting the right of patients to refuse treatment,
    - respecting the right of patients to a second opinion,
- abusing her professional position by deliberately withholding appropriate investigation, treatment or referral.

Further, Dr Barton failed to recognise the limits of her professional competence.

The Panel has already commented at length on Dr Barton's defective prescribing practices, her inadequate note taking and her failures with regard to consultation, assessment, examination and investigation. It does not refrain from emphasising and holding her to account for creating the risks and dangers attendant upon such conduct and omissions.

As a consequence of the Panel's findings of fact as outlined above, Dr Barton's departures from Good Medical Practice as outlined above, and the attendant risks and dangers previously commented on, the Panel has concluded that she has been guilty of multiple instances of Serious Professional Misconduct.

The Panel then went on to consider, in the light of those findings, what if any action, it should take. The Panel considered:

- the submissions made by both counsel,
- the advice of the Legal Assessor,
- the facts found proved,
- the aggravating and mitigating features of those facts,
- the passage of time between the events giving rise to the complaint and the determination of the issues,

- Dr Barton's good character and other matters of personal mitigation including the bundle of testimonials submitted on her behalf.

Punishment

The Panel accepted the advice of the Legal Assessor that it is neither the role of this Panel nor the purpose of sanctions to punish, though sanctions may have that effect.

Proportionality

The Panel accepted the advice of the Legal Assessor that "This is a balancing exercise", where Dr Barton's interests must be weighed against the public interest in order to produce a fair and proportionate response.

The public interest

Both the Legal Assessor and Mr Kark addressed the Panel on the meaning to be ascribed to the phrase, "the public interest". The Panel accepted that the public interest includes:

- the protection of patients,
- the maintenance of public confidence in the profession,
- the declaring and upholding of proper standards of conduct and behaviour,
- on occasions, the doctor's safe return to work, but bearing in mind that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors.

The ambit of enquiry

The Panel accepted the Legal Assessor's advice that its task is to make judgments in the case against Dr Barton alone. It is no part of this Panel's role to make findings in respect of other persons who might have been the subject of criticism during the course of the evidence.

The Panel further accepted the Legal Assessor's advice that Dr Barton's actions should not be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systemic failings beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence in that regard, and is well placed to define that context. This in no way detracts from Dr Barton's own personal responsibilities as a medical practitioner however.

Looking to the future

The Panel accepted the advice of the Legal Assessor that where the Panel has found Serious Professional Misconduct, it must look forward when considering the appropriate response to those findings, and is open to the criticism that it is exercising retributive justice if it fails to do so.

Matters found proved

As indicated above, the Panel made multiple adverse findings of fact in respect of Dr Barton's prescribing practices, note keeping, consulting colleagues, assessments, examinations and investigations. Further, the Panel concluded that she had been guilty of multiple instances of Serious Professional Misconduct.

Aggravating and mitigating features

In accordance with the Legal Assessor's advice the Panel went on to consider both the aggravating and the mitigating features of the facts found proved. It took into account also the evidence contained in the testimonials and character evidence called.

i. Aggravating (offence)

- Although Dr Barton conceded that, with hindsight, she should have refused to continue to work in a situation that was becoming increasingly dangerous for patients, she insisted that, in the circumstances of the time, her actions had been correct.

- She told the Panel that were the situation and circumstances of the time to repeat themselves today, she would do nothing different.

- The Panel concluded that this response indicated a worrying lack of insight. It was particularly concerned by Dr Barton's intransigence over matters such as the issue of balancing the joint objectives of keeping a patient both pain-free and alert.

- This, combined with her denigration of senior colleagues and guidelines, produced an image of a doctor convinced that her way had been the right way and that there had been no need to entertain seriously the views of others.

ii Mitigating (offence)

- The Panel noted that the nature and volume of Dr Barton's work and responsibilities increased greatly between the date of her appointment and the time with which this Panel is concerned.

- In particular, the Panel notes that increased and often inappropriate referrals from acute wards to her own put Dr Barton, her staff and resources under unreasonable pressure.

- The Panel noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits. Even when there was Consultant cover it was often of a calibre which gave rise to criticism during the course of evidence.

- The Panel accepted Mr Langdale's submission that the response of hospital management and senior colleagues to complaints against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors.

- Dr Barton's practice of anticipatory prescribing of variable doses of diamorphine for delivery by syringe driver was validated by a protocol evidenced in a letter from Barbara Robinson, Senior Manager at Gosport War Memorial Hospital dated 27 October 1999.

iii Personal mitigation

- Over a period of ten years since the events in question Dr Barton has continued in safe practice as an NHS GP;

- She has already been under what has been described by GMC counsel as her "own voluntary sanction" for eight years, and for the last two years under formal conditions imposed by the Interim Orders Panel of the GMC;

- The bundle of testimonials from colleagues and patients as to her current working practices and her positive good character.

The passing of time

In considering the appropriate response to its findings of Serious Professional Misconduct the Panel recognised that it was faced with a most unusual set of circumstances:

- There had been a gap of ten years between the events in question and the date of this hearing,
- during that period Dr Barton had continued in safe practice as a GP in the community,
- for the first eight of the ten years she practised under self-imposed conditions of her own devising; for the latter two years, under conditions directed by the GMC's Interim Orders Panel,
- the Panel had received a large bundle of testimonials on Dr Barton's behalf which attested to details of her safe working practice in that period.

In the circumstances the Panel considered it to be important that it receive advice on the appropriate weight that should be attached to the issue of elapsed time, the principles to be applied to its consideration in these circumstances and whether any binding authority could be found. None was.

Mr Kark submitted that the Panel should follow the Indicative Sanctions Guidance and that no party should be disadvantaged by reason of the delay.

You submitted that:

- The Panel should consider the misconduct in the context of the guidance and standards applicable at the time.

- Dr Barton's working conditions at the relevant time differed from any that a hospital doctor would be expected to accept today. You suggested that clinical governance has moved on dramatically since then and that the Panel could conclude that in that respect Dr Barton could no longer pose any risk to patients.

The Legal Assessor advised that the passing of time served the Panel well in that it provides a context in which Dr Barton's attitudes and practices could be viewed and judged. It allowed the Panel to judge the efficacy of conditions as a workable sanction by opening a ten year window through which to view it.

Response

The Legal Assessor advised that in determining the appropriate response to Dr Barton's Serious Professional Misconduct the Panel should consider:

- the aggravating and mitigating features of the facts found proved
- the passing of time between the events which gave rise to the findings against her and the date of this hearing
- her performance during that time
- the Indicative Sanctions Guidance
- the protection of patients and the public interest.

i. No action or Reprimand

- Having found that Dr Barton has been guilty of multiple instances of Serious Professional Misconduct, the Panel considered whether in all the circumstances it would be sufficient, appropriate and proportionate either to take no action or to issue her with a reprimand.
- The Panel had no hesitation in concluding that given the seriousness and multiple instances of her professional misconduct it would be insufficient, inappropriate and not proportionate either to take no action or to issue her with a reprimand.

ii. Conditions

The protection of patients

Mr Kark submitted that Dr Barton has demonstrated neither remorse nor insight in respect of the matters found proved and that her departures from the principles set out in *Good Medical Practice* were particularly serious. He submitted that, in those circumstances she presented a continuing risk to patients, and urged the Panel to conclude that, despite the long delay, her case should be dealt with by way of erasure.

Mr Langdale submitted that:

- Dr Barton presents no continuing risk to patients. He said this was proved by her safe practice as a GP throughout the ten years since her departure from the Gosport War Memorial Hospital.

- This view was further supported by the many testimonials of both patients and professional colleagues who commented on her current working practices as well as her qualities as a GP.

- The authors of the nearly two hundred written testimonials were informed in that they were aware of the allegations against Dr Barton, the findings of the Panel, and indeed the adverse publicity this case has attracted.

The Panel accepted that it was unrealistic to consider that Dr Barton could ever again find herself in the situation she faced at the Gosport War Memorial Hospital.

Given the seriousness of the Panel's multiple findings against Dr Barton, and the aggravating features of those findings noted above, in particular her intransigence and lack of insight, the Panel was unable to accept that she no longer posed any risk to patients.

However, the Panel did accept that in the light of the mitigating features listed above, and the fact that she has been in safe practice for ten years – with eight of them operating under conditions of her own devising and two under conditions imposed by the GMC's Interim Orders Panel – it might be possible to formulate conditions which would be sufficient for the protection of patients.

The maintenance of public confidence in the profession.

Mr Langdale submitted that public trust and confidence in the profession meant the trust and confidence of the informed public. He said that while the authors of the testimonials received by the Panel were informed members of the public, this case has attracted much media attention and that there have been ill-informed and unjustified media comparisons with an unrelated but infamous case involving a doctor accused of deliberately causing multiple patient deaths.

The Panel wishes to make it clear that this is not such a case. However, the GMC have alleged and the Panel has found proved that there have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death.

The Panel takes an extremely serious view of any acts or omissions which put patients at risk. It had no hesitation in concluding that Dr Barton's Serious Professional Misconduct was such that it is necessary, even after ten years of safe and exemplary post-event practice, to take action against her registration in order to maintain public confidence in the profession.

The Panel considered that taking action against Dr Barton's registration would send a message to the public that the profession will not tolerate Serious Professional Misconduct.

The declaring and upholding of proper standards of conduct and behaviour.

For the same reasons and having carefully considered all the circumstances, the Panel is satisfied that it might be possible to formulate a series of conditions which would be sufficient both to maintain public confidence in the profession and uphold proper standards of conduct and behaviour.

The public interest in preserving the services of a capable and popular GP.

The Panel was greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the last ten years and the high regard in which she is held by numerous colleagues and patients.

The Panel noted Mr Langdale's assurance that the authors of the testimonials were either colleagues and/or patients who were aware of the allegations against Dr Barton, this Panel's findings on facts, and the media coverage of the case.

The Panel was mindful of the fact that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors. However, the Panel was satisfied that there is an informed body of public opinion which supports the contention that preserving Dr Barton's services as a GP is in the public interest.

Order

The Panel has formulated a series of conditions. In all the circumstances, the Panel is satisfied that it is sufficient for the protection of patients and is appropriate and proportionate to direct that Dr Barton's registration be subject to conditions for a period of three years.

The following conditions relate to Dr Barton's practice and will be published:

1 She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the GMC with the contact details of her employer and the PCT on whose Medical Performers List she is included.

2 At any time that she is providing medical services, which require her to be registered with the GMC, she must agree to the appointment of a workplace reporter nominated by her employer, or contracting body, and approved by the GMC.

3 She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

4 She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination.

5 She must inform the GMC if she applies for medical employment outside the UK.

6. a. She must not prescribe or administer opiates by injection. If she prescribes opiates for administration by any other route she must maintain a log of all her

prescriptions for opiates including clear written justification for her drug treatment. Her prescriptions must comply with the BNF guidelines for such drugs.

b. She must provide a copy of this log to the GMC on a six monthly basis or, alternatively, confirm that there have been no such cases.

7. She must confine her medical practice to general practice posts in a group practice of at least four members (including herself).

8. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.

9. She must attend at least one CPD validated course on the use of prescribing guidelines within three months of the date from which these conditions become effective and forward evidence of her attendance to the GMC within one week of completion.

10. She must not undertake Palliative Care.

11. She must inform the following parties that her registration is subject to the conditions, listed at (1) to (10), above:

a. Any organisation or person employing or contracting with her to undertake medical work
b. Any locum agency or out-of-hours service she is registered with or apply to be registered with (at the time of application)
c. Any prospective employer or contracting body (at the time of application).
d. The PCT in whose Medical Performers List she is included, or seeking inclusion (at the time of application).
e. Her Regional Director of Public Health.

In deciding on the length of conditional registration, the Panel took into account the fact that Dr Barton has been practising safely in general practice for the past ten years. During that time she has complied with the prescribing restrictions which she initiated and which were subsequently formalised by the GMC's Interim Orders Panel. This Panel is satisfied, looking forward, that the conditions it has directed provide further safeguards for the protection of patients, and therefore concluded that it was appropriate and proportionate to impose the conditions for the maximum period.

Shortly before the end of the period of conditional registration, Dr Barton's case will be reviewed by a Fitness to Practise Panel. A letter will be sent to her about the arrangements for that review hearing. Prior to the review hearing Dr Barton should provide the GMC with copies of her annual appraisals from the date of this hearing.

The effect of the foregoing direction is that, unless Dr Barton exercises her right of appeal, her registration will be made subject to conditions 28 days from the date on which written notice of this decision is deemed to have been served upon her.

Dr Barton is the subject of an interim order of conditions. The Panel proposes, subject to any submissions to the contrary, in accordance with Rule 33A of the 1988 rules, to vary the existing order by substituting its conditions with the conditions contained in this determination.

2

Chronology

General Medical Council

In the matter of Dr Barton

Chronology

Date	Event
1996-1999	Patient deaths occurred at Gosport War Memorial Hospital ("GWMH").
September 1998	The Hampshire Police (the "Police") receive a complaint against Dr Barton, following the death of Gladys Richards (Patient E).
1998-2006	The Police conducted a series of investigations into patient deaths at GWMH.
21 June 2001	Interim Orders Committee hearing - no order made.
21 March 2002	Interim Orders Committee hearing - no order made.
July 2002	Patients C, D, E, G and H referred to the PPC.
29 August 2002	Patients C, D, E, G and H referred by the PPC to the PCC.

General Medical Council

In the matter of Dr Barton

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21 March 2002	Interim Orders Committee hearing - no order made.
July 2002	Patients C, D, E, G and H referred to the PPC.
29 August 2002	Patients C, D, E, G and H referred by the PPC to the PCC.

19 September 2002	Interim Orders Committee hearing - no order made.
October 2002 – July 2008	Dr Barton entered into a voluntary agreement not to prescribe diamorphine and would restrict her prescribing of diazepam in line with BNF guidance.
2006	CPS decided that no case would proceed with a criminal investigation or charge. The police passed the papers to the GMC.
2006-2008	GMC/FFW investigation takes place during which an additional 7 patients (Patients A, B, F, I, J, K and L) are added to those cases to go before the FtP hearing.
11 July 2008	Interim Orders Panel imposed conditions on Dr Barton Registration.
September 2008	FtP hearing scheduled to commence (postponed pending Coroner's Inquest).
18 March – 20 April 2009	Coroner's Inquest held in respect of 10 patients.
8 July to 20 August 2009	FtP Hearing held (determination of facts given on 20 August 2010).
8-28 January 2010	FtP Hearing resumed.

29 January 2010	Panel's determination on SPM and sanction.

Patient Key

A	Lesley Pittock
B	Elsie Lavender
C	Eva Page
D	Alice Wilkie
E	Gladys Richards
F	Ruby Lake
G	Arthur Cunningham
H	Robert Wilson
I	Enid Spurgin
J	Geoffrey Packman
K	Elsie Devine
L	Jean Stevens

3

4

MEDICO-LEGAL REPORT

Re: Gladys Mabel RICHARDS
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:
Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of
Newcastle upon Tyne

For: Hampshire Constabulary

Date: 12th December 2001

Contents

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, LM Baldacchino, M Berry, JM Brewer, J Cook, E Dalton, W Edgar, A Fletcher, J Florio and A Funnell.

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments *"quality of life has ↓↓ markedly last 6/12"*. She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states *'After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.'* Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on.3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented *'I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was *'noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'*. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes *'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *in the medical notes "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death"*. The summary admitting nursing notes record *"now fully weight bearing and walking with the aid of two nurses and a Zimmer frame"*. On 12th August the nursing notes record *"Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

*minutes at a time. Did not seem to be in pain".*On 13th August nursing notes record *"found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote *'sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?"* A further entry the same day states *"Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks".*

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv.sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Code A (House Officer) states *"fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night."* A transfer letter to the nurse in charge at Daedalus ward states *"Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing".*

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h *"in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml".* A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August *"still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable".* Nursing notes record *"reviewed by Dr Barton for pain control via syringe driver".* At 2000h *"patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs".* On 19th August the nursing notes record *"Mrs Richards comfortable"* and in a separate entry *"apparently pain free".* There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton *"much more peaceful. Needs hyoscine for rattly chest".* The nursing notes record *"patient's overall condition deteriorating. Medication keeping her comfortable".* A staff

nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
17 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Code A provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement '*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Sackman and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Code A that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "... *it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to

frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death.'* On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr
midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following".* On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record *"agitated at 2300h, syringe driver boosted with effect"*

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states *"This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry".* The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states *"Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI".* Dr Lord writes on 10th August 1998 *'Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–If no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine'.* The next entry is by Dr Barton on 21st August *"Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy".* The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration"* and that she was seen by Dr Peters. The nursing assessment sheet notes *"does have pain at times unable to ascertain where".* The nutrition care plan states on 6th August 1998 *"Due to dementia patient has a poor dietary intake".* And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 *"Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain".* There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states *"ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".*

5.2 On 7th October the notes record he was *"not keen on residential home and wished to return to his own home".* Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October , notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Code A Code A Code A At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, Code A Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter "*On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged*". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads *"Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL* (activities of Daily Living)*, hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation".* On 16th November the notes record; *'Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ In arms and legs. Diagnosis ?silent MI, ? decreased __ function. ↑frusemide to 2 x 40mg om '.* On 17th October the notes record *'comfortable but rapid deterioration'.* On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October *"History of left humerus fracture, arm in collar and cuff.* Code A *LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles".* On 15th October *"Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor".* An earlier note states *"settled and slept well".* On 16th October *"seen by Dr Knapman an as deteriorated over night. Increase*

frusemide to 80mgdaily. For A.N.C (active nursing care)". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:

14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr
midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr
midazolam 40mg/24hr

Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time. on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Code A on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate *"mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Code A) *'In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'*. On 13th February the notes record *'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'*. The notes record *'son agrees not suitable for invasive Tx* (treatment). *Matron from RH visiting today will check on ability to cope'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February *'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'*. On 19th February the notes summarise her problems *'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'*. On 18th February the medical notes state *"No change. Awaiting Charles Ward bed"*.

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes *"confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes *"Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting, Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing.staff to confirm death".* The nursing notes state she was admitted for *'palliative care'*, that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states *'encourage adequate fluid intake'.* On 28th February an entry in the medical notes by **Code A** (duty GP) record *'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records *'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states *' spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.'* A further entry by Dr Lord that day records *'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record *"commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states *"S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded".* On 3rd March a rapid deterioration in Mrs Page's condition is recorded *'Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease; lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.

7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments *'it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 **Diamorphine**

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, *"sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. *"midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0:6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine.*'

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

APPENDIX 2

BNF Prescribing in palliative care

GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

This report is provided for the General Medical Council at the request of Field Fisher Waterhouse solicitors. It covers principles of medical care and matters specific to Gosport Memorial Hospital and relates to separate individual reports provided on eleven patients.

Declaration of interest in matters relating to Gosport War Memorial Hospital

1. I previously provided a report dated 12 December 2001, at the request of Hampshire Constabulary to examine the clinical notes of five patients treated at Gosport War Memorial Hospital and comment on a number of issues relating to patient management and clinical practices at the hospital. I have reviewed and refer to this report in reference to five patients I have been asked to provide reports on to the General Medical Council. I have not changed the views or opinions I expressed in that report. There are some typographical errors in that report that I have corrected in the relevant supplementary patient reports. I have also referred to additional information in some of the relevant supplementary patient reports.

2. I was a member of the Medical Case Note Review Team that supported the Commission for Health Improvement investigation of Gosport War Memorial Hospital (http://www.cqc.org.uk/_db/_documents/04005353.pdf).

Principles of Medical Care

3. **Pain Relief**

Pain is a common health problem faced by older people and relief of pain is one of the most important duties of a doctor. Pain may be defined as *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"*. [1] Pain is usually grouped into 4 main classes: nocioceptive, neuropathic, undetermined and psychological. These are usually managed in different ways. Nocioceptive pain such as due to arthritis is generally treated with analgesics. Neuropathic pain due to the nervous system is treated with anti-depressants and/or anticonvulsants. Pain of unclear or undetermined origin is treated with these and other approaches and psychological pain due to sanitization of conversion disorders with psychological approaches.

4. The principles of treatment of acute pain are to determine the underlying cause from history examination and appropriate investigation and to then treat the underlying cause and give adequate pain relief. The nature of the underlying cause and the severity of pain reported by the patient would influence the decision whether to start with a mild analgesic or proceed to use a more potent drug. Because the response to analgesia is

unpredictable and there is a risk, particularly in older people, of drug toxicity the general approach of starting low and progressively increasing the dose and potency of drugs used is followed in older people. However to avoid patients remaining in pain with inadequate analgesia good management of severe pain requires the use of as required (prn) drugs in addition to regular drug doses and the re-evaluation of patients. Increases in drug dose or substitution of a more powerful analgesic is required if analgesia is not achieved. If patients experience adverse effects a reduction in dose or change in drug is required.

5. The management of chronic pain is more complex and requires a consideration of potential long-term adverse effects of drugs and consideration of risks of addiction and the use of other psychological interventional approaches. [1]

6. Good basic principles to follow are to keep drug regimens simple, to reassess patients frequently and recognise that drug doses need to be individualised and that in some patients large doses may be required. There have been concerns that older people may be denied adequate analgesia because of undue concerns about adverse effects from moderate and potent analgesics.

7. The analgesic ladder is a commonly used framework for using analgesic drugs. Drugs are grouped into 3 main classes related to the severity of pain for which they are suitable to be prescribed. For mild pain non-opioid analgesics such as aspirin, paracetamol and ibuprofen are recommended. If these are ineffective or if the patient has more severe pain more potent anti-inflammatory drugs, such as diclofenac or naproxen, or mild opioids (codeine or dihydrocodeine) should be given in combination with paracetamol. For patients who are in severe pain or fail to achieve pain control on drugs for moderate pain more potent opioids (morphine, diamorphine) are recommended.

8. In the majority of patients with acute pain initial treatment would therefore be with drugs from the first two steps of the analgesic ladder (mild or moderate pain) with initial use of opioids only in patients with very severe pain (such as a fractured limb) or in patients who have failed to respond to appropriate doses of drugs used for moderate pain. In addition other therapies particularly anti-depressants and anti-epileptic drugs are used in patients with severe or chronic pain.

9. The most important aspect of good pain management is regular review of the patient and identification of adverse effects. Initial use of potent opioid drugs carries a risk particularly in older people of adverse effects with respiratory depression, hypotension, constipation, drowsiness, nausea and vomiting which could be avoided if pain is controlled with mild or moderate analgesics.

Use of opioid medication

10. The most commonly prescribed opioid is morphine and unless patients are unable to swallow initial dosing should be orally. The British National Formulary[2] states that morphine should be given regularly every 4 hours orally with an initial dose of 5-10mg. In frail elderly patients a starting dose of 5mg is preferred. The BNF states *"to reduce doses recommended in elderly or debilitated patients"*. If pain relief is not obtained or is not sustained for 4 hours dose is usually increased by 50%. When pain is controlled it is common practice to switch patients to an oral sustained release preparation to reduce the frequency with which patients need to take medication. Laxatives such as senna or lactulose should be commenced to avoid constipation when morphine or other potent opioids are prescribed, nausea and vomiting should be treated with metoclopramide or haloperidol as required.

11. The parenteral route and that is the administration of opioids by intramuscular intravenous or percutaneous injection is used where more rapid pain relief is required or patients are unable to swallow as is commonly the case in patients who are receiving palliative care and deteriorating. The parenteral route is also used if bowel obstruction is present and absorption may be impaired or if patients express the desire not to take the medication. Diamorphine is the preferred opioid to use for injection[3] because it is more soluble than morphine and can be given in a smaller volume. The equivalent intramuscular or subcutaneous dose is approximately one third of the oral dose of morphine.

12. Syringe drivers are used to give a continuous subcutaneous infusion of a drug or drugs. This avoids the problems of repeated intramuscular or subcutaneous injections which can be a source of discomfort in older cachectic (frail, thin, muscle wasted) patients. The BNF confirms that indications for use of the parenteral route are patients unable to take medicines by mouth because of nausea and vomiting, drowsiness or coma, bowel obstruction and if the patient does not wish to take regular medication by mouth. Incorrect use of syringe drivers are common cause of drug errors therefore it is important that staff using syringe drivers are appropriately trained and the rate settings on syringe drivers are clearly identified and differentiated[2].

13. The BNF reports a number of potential problems with syringe drivers. If an infusion runs too quickly patients may experience considerable toxicity and adverse effects. If an infusion runs too slowly patients will not receive adequate analgesia. There may also be injection site reactions. Infusions can run too quickly if the rate setting is set incorrectly, or drug calculations have been incorrectly performed. Infusions can run too slowly if the start button has not been used correctly, the batteries run out or there are problems with the syringe driver or cannula connections. Use of a syringe driver is an important clinical decision and the reasons why this is done should always be clearly documented in the medical records.

14. The British National Formulary provides clear advice on the process of administering equivalent doses of orally administered morphine and

parentrally administered diamorphine[2]. There are situations where it is appropriate to administer sedative drugs in conjunction with opioid analgesics. However in these circumstances close monitoring is required. Failing to adequately monitor patient may result in life-threatening respiratory depression.

Issues in elderly patients

15. It is well described that older individuals are more sensitive to opioid drugs and older individuals clear the drug less rapidly from the body and studies suggest the duration of pain relief is 50% more in individuals over the age of 70 compared to those under the age of 30 years. It is usual to start with 5 mg rather than 10mg initial oral dose of morphine in frail older people. If an older individual is in considerable acute severe pain or is not frail and above average height and weight is not necessarily unreasonable to start with 10mg dose but patients need to be closely monitored.

16. In the chapter on pain relief in 'Drugs and the Older Person;' Crome writes on the treatment of acute pain; *'Treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patients and the presence of comorbidity will dictate whether to start with a mild analgesic of or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.*

17. The British National Formulary states in the 'Prescribing for the Elderly' section: *'The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and anti parkinsonian drugs, all of which must be used with caution' (BNF 36 1998 page 15).*

Medical Assessment

18. Doctors have a responsibility to provide good standards of care. GMC guidelines on good medical practice (1995) state; *Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."* The section on good clinical care states;

"You must take suitable and prompt action when necessary. This must include:

- *An adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination*
- *providing or arranging investigations or treatment where necessary*
- *Referring the patient to another practitioner, when indicated*

In providing care you must:

- *recognise the limits of your professional competence*
- *be willing to consult colleagues*
- *be competent when making diagnoses and when giving or arranging treatment*
- *keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatment prescribed*
- *keep colleagues informed when sharing the care of patients*
- *pay due regard to efficacy and the use of resources*
- *prescribe only the treatment, drugs, or appliances that serve patients' needs*

The 1995 GMC Guidelines state in the section on delegating care to non-medical staff and students *"You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care."*

19. The 1995 GMC Guidelines state in the section on arranging cover *"You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.'* The 1998 GMC Guidelines on Good Medical Practice which replaced the 1995 guidelines in July 1998 did not change any of the above recommendations.

20. There are important reasons why good medical practice places these responsibilities on doctors. Failing to undertake an adequate assessment of the patient's condition means that an inaccurate diagnosis may be made and inappropriate treatment given. Similarly failing to recognise limits of professional competence results in patients are put at risk from potentially incompetent treatment decisions. Failure to keep clear, accurate and contemporaneous patient records means there is no clear information in the notes concerning the patient's condition for other health professionals to refer to and appropriately base their care. If there are no entries in the medical notes that record the thinking, diagnosis and treatment plan put in place at the time, the doctor relies entirely on their memory for making future treatment decisions and for justifying treatment decisions if these are challenged at a future date. Failure to record any adverse effects of treatment means there is no record in the notes for health care professionals to avoid re-providing this treatment.

21. A medical assessment is generally performed in any patient admitted to hospital shortly after their arrival on a ward. In most cases unless clerical and nursing staff record patient details and nursing assessments before a patient is seen by a doctor. Medical assessment of a patient on arrival to a hospital ward to review their history and current problems, perform a physical

examination, arrange any appropriate investigations and prescribe necessary drug and other treatments. This baseline assessment is important in establishing a diagnosis, and implementing an appropriate management plan. It also provides a baseline assessment against which future symptoms and problems can be assessed.

22. A medical assessment is required when a patient is transferred from one hospital to another for a number of reasons. The patient may develop new problems during transfer. The referring hospital may not have recorded or transferred all necessary information. For older patients transferring from an acute ward to a rehabilitation or continuing care environment a medical assessment is important to confirm they are medically stable and appropriate to stay in a ward environment where there is a lower level of medical and other support services.

23. It is important that the results of an initial medical assessment are recorded in the notes are available for other medical and health care staff to refer to if a patient has new symptoms or problems. On call doctors are called to assess patients and information on their baseline function active problems and level of intervention agreed to be appropriate, is important in helping staff to make appropriate decisions about treatment.

24. A general principle well recognised in medical practice is that if a doctor does not record the results of a history or clinical examination they undertake the assumption is that no such assessment was undertaken. Given the busy nature and multiple patient contacts doctors have, retrospective recall by doctors of the details of the assessment that they took in an individual patients in the absence of a record in the medical notes, either by themselves or another member of the medical team is unlikely to be reliable.

25. GMC guidance in 1995 and 1998 emphasised the importance that doctors recognise limits of their professional competence and be willing to consult colleagues. This is a particularly important for doctors who are trainees or non-specialists working under the supervision of a consultant specialist as was the case with Dr Barton a general practitioner acting as a clinical assistant. In a setting such as Gosport War Memorial Hospital it would be appropriate to discuss and seek advice from the responsible consultant for any patient where the management plan was unclear, where there were complex or difficult management issues where diagnosis or treatment was not clear-cut it would have also been appropriate to seek advice and discuss with the responsible consultants any major change in a patient's medical status particularly if there was unexpected deterioration. If a patient had not been identified and admitted for palliative terminal care I would consider it important any decision about palliative care was discussed with the responsible consultant.

26. When patients deteriorate in a setting such as Gosport War Memorial Hospital where modern diagnostic services and specialist advice is not easily available it may be necessary for patients to return to the main district general hospital for further assessment. It would be appropriate and expected for a clinical assistant to discuss this with the responsible consultant

or another consultant who was acting on behalf of the responsible consultant if he/she was not available.

Medical records and Drug Prescription Charts

27. As previously mentioned GMC guidance places clear emphasis on importance of keeping clear, accurate and contemporaneous patient records. Failing to follow this approach results in the problems already outlined in section 6.

28. Drug charts play and important role in treatment prescribed by doctors the details of the drug dose and time and route through the drug should be administered. It is important that drug charts are clearly completed by medical staff as drugs are generally given by nursing staff who need to be able to clearly identify the drug dose, date and time that drugs should be administered to patients.

29. Many drugs are prescribed at a fixed dose on a regular basis. Sometimes drugs are prescribed as a single dose or written on "as required" basis (often referred to as PRN *pro re nata* meaning as necessary). The administration of drug therapy is recorded in a column on the drug chart relating to a specific day and time usually the initialled signature of the member of nursing staff responsible for administering the medication. Treatment instructions may be given to discontinue treatment on a certain date. This is commonly the case for antibiotic prescriptions. If a drug is discontinued the prescription has a line put through and the date of discontinuation inserted along the initials of the doctor making this treatment change.

30. When drugs are prescribed on an "as required" basis nursing staff are able to use their judgement as to when the drug needs to be administered to the patient and to decide on an appropriate dose if there is a range of doses written. It is common for patients to be written up for a range of opiate doses when requiring potent analgesia. This allows a member of nursing staff to adjust the dose according to a response from previous doses. Usually the range of doses prescribed is small for example 5-10mg of morphine or 2.5mg of diamorphine. If a large dose range is written for a PRN drug there is a risk, unless the drugs are being administered according to a clear protocol understood by all nursing staff, that a patient may be administered an inappropriately high dose of opiate which could lead to respiratory depression, coma and in some cases death.

Standards and Guidelines

31. The British National Formulary is the main reference text doctors should generally refer to in obtaining information about drugs they prescribe to ensure an appropriate drug is chosen for the condition being treated and is given at the correct dose. The BNF has a section on analgesics (4.7 BNF 36,September) with a section on the use of opioid analgesics. This states that a reduced dose is recommended in elderly or debilitated patients. Side effects are listed including respiratory depression, confusion and drowsiness.

Recommended doses for individual drugs are listed. The BNF also contains sections on prescribing in the elderly and the use of syringe drivers in palliative care (see sections 8 and 9 of this report).

32. I have also seen The Palliative care Handbook produced by Portsmouth Healthcare NHS Trust known as the Wessex Protocols, produced to help GPs and other healthcare professionals in managing problems in specialist care. The general principles of symptom management in this document (page 4) state *'Accurate and full assessment is essential for both diagnosis and treatment', 'Be careful that drug side effects to not become worse than the original problem'* and *'continually reassess'*. The WHO analgesic ladder is described. In the use of morphine the recommend starting with a low dose and increase by 30-50% increments each day until pain is controlled or side effects prevent any further increase. In an older patient an appropriate low dose would be 5 mg morphine.

33. The 'Wessex Protocols' recommend that prn doses are prescribed at the same dose as the 4 hourly dose and repeated as often as necessary (hourly if necessary) for breakthrough pain and to review every 24 hours. A syringe drive is recommended when oral administration is not possible because of dysphagia, vomiting or weakness and the conversion of oral morphine to subcutaneous diamorphine should be one third to one half of the morphine dose i.e. a 24 hour oral dose of 30 mg morphine should be replaced with a 10-15 mg diamorphine infusion over 24hr.

34. In the management of anxiety, diazepam is recommended and if a patient is unable to swallow midazolam 10-20mg per 24 hours by continuous subcutaneous infusion. Opioids are not recommended as a treatment for anxiety. For terminal restlessness drug therapy with diazepam (20-60mg per 24 hours orally or rectally), midazolam (10-60mg per 24 hours orally or by subcutaneous infusion) are recommended as possible treatment options.

Matters specific to Gosport War Memorial Hospital

'Clinical Assistant' Position

35. Clinical assistant posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. Theses posts generally work a number of half days (often referred to as sessions) and the person reports to a consultant responsible for the care of the patients. The job description (undated) for the post of clinical assistant to the Geriatric Division in Gosport that was undertaken by Dr Barton states *' This is a new post of 5 sessions a week worked flexibly to provide a 24 hour Medical cover to the Long stay patients in Gosport. The patients are slow stream or slow stream rehabilitation but holiday relief and shared care patients are admitted.'*

36. How many hours Dr Barton should have worked on the ward during the usual working week Monday – Friday 8am -5pm is unclear. I would estimate out of ours calls to the wards would not account for more than 4 hours time in a working week on average so it might be reasonably expected that Dr

Barton in her position as Clinical Assistant was present on the wards for 16 hours a week i.e. about 3 hours per day.

37. The job description suggests the post had responsibility for 11 patients at Gosport War Memorial Hospital, 12 patients at Northcott Annexe and 23 patients at Redclyffe Annexe. However the Commission for Healthcare Improvement report states that in Dr Barton had responsibility for Dryad (20 beds) and Daedalus (24 beds) wards. In 1997/8 there were 169 finished consultant episodes (which equates to admissions) for these wards and in 1998/99 197 finished consultant episodes[5]. Therefore on average Dr Barton would have 3-4 newly admitted patients each week to assess. As many of the patients would be stable continuing care or 'slow stream' rehabilitation patients I would consider this was adequate time to assess new patients (which should take 30-40 minutes per patient to conduct a comprehensive medical assessment) and assess any deterioration or major problems in existing patients, to document such assessments in the medical notes and attend a weekly consultant ward round. It would be insufficient time to see all patients every day or document every contact with patients and relatives.

38. The Duties described include *'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 the 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. To take part in weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant Physicians in Geriatric Medicine. To provide clinical advice and professional support to other members of the caring team.'* The job description states that the sessions may be split between two separate general Practitioners, ideally from the same Practice.

39. Clinical assistants are usually not required to have any specialist training in the specialty they are working in. Many Clinical Assistants would not have had specialist training as a trainee in the area of practice they work in as a general practitioner. My understanding is that Dr Barton had received no specialist training or qualifications in Geriatric Medicine such as the Diploma in Geriatric Medicine that some general practitioners take. Because of the lack of specialist training it is important that they seek advice from Consultant colleagues for any aspect of patient care where they lack specialist expertise or where decisions might be seen to be contentious with patients, relatives or other health care professionals.

Continuing Care, Slow Stream Rehabilitation and Palliative Care at Gosport War Memorial Hospital

40. There appears to have been some lack of clarity of the role of the wards at Gosport War Memorial Hospital. Although the wards were continuing care wards in practice patients who required a period of rehabilitation or further assessment prior or returning to their own home or entering residential or nursing home care were admitted to these wards. Transcribed interviews with nursing staff suggest there may have been insufficient rehabilitation and nursing staff to adequately meet the needs of such patients at all times.

41. A further problem is that having two different groups of elderly patients in the wards, those requiring continuing medical and nursing care with others requiring rehabilitation patients, may lead to confusion amongst staff about the management of individual patients unless patient management plans are very clearly understood by all staff. For some of the patients transferred to Gosport War Memorial Hospital it appears to have been unclear to all staff whether individual patients were for continuing care or a period of rehabilitation. Most elderly care services in the 1990s separated out continuing care from rehabilitation beds and often changed continuing care wards into rehabilitation wards and this process appears to have been eventually completed after 2000 at Gosport War Memorial Hospital.

42. Palliative care is a very important aspect of management in frail older people who develop acute illness they are unlikely to survive or have progressive disabling disease. By definition patients in NHS continuing care beds are very dependent and are expected to die on the ward. A significant number of older frail patients in rehabilitation beds will deteriorate and palliation of symptoms prior to death will be necessary. There is no generally agreed definition of palliative care but palliative care is not confined to end-of life care. NICE has defined palliative care as *'the holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families'*. Many frail older people require and benefit from such an approach.

43. In many frail older patients receiving palliative care a decision will have been made to limit the extent of other medical interventions, for example surgery, ventilation, and antibiotics. However treatment of active medical problems is compatible and often appropriate in patients receiving palliative care. Prediction of death in frail older people is difficult. Experienced clinicians recognise that patients may die and deteriorate more quickly than anticipated or alternatively that patients who are deteriorating may improve. For these reasons management plans need to be reviewed if a patients' condition changes significantly.

Use of Drug Charts in the Gosport War Memorial Hospital

44. The drug charts in use in Gosport War Memorial Hospital have a format used in most hospitals with a section for drugs given as a single dose, a section for regular drug prescriptions, a section for 'prn' drugs to be taken as required and a section for prescribing of infusions and fluid management. Drug therapy for the patients under the care of Consultant Geriatricians at Gosport War Memorial Hospital would usually be written up by Dr Barton in her role as Clinical Assistant and sometimes by one of the consultant physicians with patients on the wards.

45. A legal prescription requires a clear written record usually placed in a drug chart of the drug dose (usually in mg or other units), frequency (e.g.

once, twice daily) and route of administration (oral, intramuscular etc), start and end date to be written with the signature and date of the prescribing doctor. The responsibility for the appropriateness, accuracy and legibility of a prescription lies with the prescribing doctor. When a drug is discontinued the doctor must draw a line through the prescription and sign their initials and date. The drug chart must have the name and hospital number of the patient inserted.

46. The term 'written up' indicates that a drug prescription has been written by a doctor in the notes. The term 'prescribed' means that the drug involved has been written in the drug chart and should be given to the patient as instructed; this may be a drug administered once, regularly or 'as required' where the drug is administered by the nursing staff is specific symptoms are present. A prescription is usually made by the writing up of a prescription by the responsible doctor or sometimes by a verbal order taken by a member of nursing staff. The term administered means that a drug has been given to the patient. This might be through oral, intravenous, intramuscular injection or infusion or other routes of administration.

47. It is the responsibility of registered nursing staff to administer prescribed drugs according to the instructions written in the drug chart. Registered nursing staff work within a code of professional practice and are expected to carry out administration of medicines to certain standards. Nurses are required to act in the best interest of their patients and this may require nursing staff to challenge prescribing decisions by medical staff.

48. As required or prn prescriptions are usually expected to include a specific instruction by doctors as to the circumstances under which the prescribed drug should be administered including how frequently the drug may be administered e.g. paracetamol up to 4g /24 hours. A prn prescription of GTN might include an instruction 'for angina' or for chest pain'. Prn prescriptions do not always include instructions for drugs which have a good safety profile where it would be expected nursing staff would understand the circumstances under which drugs should be administered e.g. senna or paracetamol where it would be expected nursing staff would understand that the drugs are indicated for constipation and mild pain respectively.

49. It is important that prn "as required" prescriptions for controlled drugs, such as opioids, and other drugs with potentially severe adverse effects, such as midazolam and haloperidol, include clear instructions of the circumstances under which the drugs should be administered. This can be done through the prescriber writing instructions such as 'for severe pain' for diamorphine or by nurses using an agreed protocols or policies for the drugs or the symptoms being managed. There were no unit policies or protocols for the use of opioids and other drugs or the management of pain in the late 1990s at Gosport War Memorial Hospital. Staff at the hospital did refer to the 'Wessex protocols' but these did not appear to be followed in all patients.

50. It is possible Dr Barton trusted nursing staff to know the circumstances under which prescriptions for morphine, diamorphine and midazolam were appropriately administered and the appropriate dose that should be used.

However this appears not to have been clear to nursing staff in some patients. For example patient F was prescribed prn morphine without any instructions that this was for pain. Patient F was then administered oral morphine for anxiety and distress when not in pain by nursing staff when this is not an appropriate indication.

51. If wide dose ranges are prescribe for prn drugs there needs to be clear instructions or a policy in place to ensure an appropriate starting dose is commenced by nursing staff. In many patients prn prescriptions of diamorphine and midazolam were very wide e.g. 20-200 mg/24 hr and 20-80mg/24hr. Without clear instructions in the medical notes and drug chart or a policy in place which details appropriate staring dose there is a risk that patients will be administered an inappropriately high dose of a prn drug by nursing staff.

52. Out of hours or when Dr Barton was on leave, other general practitioners covering the hospital would be expected to write up any drugs required out of hours. It is not clear how often on call doctors visited the wards out of hours and in some cases drugs were prescribed by a 'verbal order'. In such a system the nurse writes down the drug prescribed over the phone by the doctor and this is usually confirmed by a second nurse to reduce the chances of any error on the drug or dose prescribed. The potential problem with 'verbal orders' for drug prescriptions is that they involve the prescription of a drug for a problem that may not have been assessed by a doctor taking a history, examining and investigating the patient where this might be required.

53. Review of the notes and interviews suggest that 'anticipatory prescribing' was undertaken where drugs were prescribed for problems that patients might develop. This is sometimes done to avoid the need for a doctor to come to a ward out of hours to prescribe for a simple complaint that does not require urgent medical evaluation.

54. It was common practice in many wards in the 1980s and 1990s for mild analgesics such as paracetamol, laxatives and hypnotic drugs such as temazepam. In recent years anticipatory prescribing of hypnotic drugs in patients who are not already receiving them is now not advised because of the risk of patients developing long term dependence on benzodiazepines as these may be continued after discharge. Because the use of benzodiazepines in older people is associated with falls and hip fracture, and may produce confusion and cognitive impairment, many geriatricians avoid and limit the use of benzodiazepines in older people.

55. Anticipatory prescribing of powerful opioids and sedatives in patients who do not require them when assessed is potentially highly dangerous as the prescribing of such drugs requires careful evaluation of the patient because of the risk of serious adverse effects such as respiratory depression and coma.

56. In the late 1990s the General Medical Council had not produced guidance on prescribing. However Good Practice in Prescribing Medicines was published by the GMC in 2006 and the principles applied in the 1990s.

The Guidance refers to the importance of ensuring familiarity with guidance published in the BNF, the need to be in possession of or take an adequate history from the patient, to reach agreement with the patient on the use of any proposed medication, establishing the patient's priorities, preference and concerns, to satisfy oneself that the patient has been given appropriate information in a way they can understand about drug therapy. The guidance also states that doses should be prescribed appropriate for the patient and their condition and that there must be a clear, accurate, legible and contemporaneous record of all medicines prescribed.

57. **Declaration**

a) I understand that my overriding duty is to the panel, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.

b) I have set out in my report what I understand from those instructing me to the questions in respect of which my opinions as an expert are required.

c) 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.

d) I have drawn to the attention of the court all matters, of which I am aware which might adversely affect my opinion.

e) Wherever I have no personal knowledge, I have indicated the source of factual information.

f) 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.

g) Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

h) 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 correction or qualification.

i) I understand that the 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.

j) I have included in this and the supplementary reports a statement setting out the substance of al acts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

k) I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Statement of Truth

I confirm 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.

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BNF 36

SEPTEMBER 1998

Changes to this edition see page viii

BRITISH NATIONAL FORMULARY

British Medical Association

Royal Pharmaceutical Society of Great Britain

Prescribing in palliative care

Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount to provide the best quality of life for patients and their families. Careful assessment of symptoms and needs of the patient should be undertaken by a multidisciplinary team.

Specialist palliative care is available in most areas as day hospice care, home care teams (often known as Macmillan teams), in-patient hospice care, and hospital teams. Many acute hospitals and teaching centres now have consultative, hospital-based teams.

Hospice care of terminally ill patients has shown the importance of symptom control and psychosocial support of the patient and family. Families should be included in the care of the patient if they wish.

Many patients wish to remain at home with their families. Although some families may at first be afraid of caring for the patient at home, support can be provided by community nursing services, social services, voluntary agencies and hospices together with the general practitioner. The family may be reassured by the knowledge that the patient will be admitted to a hospital or hospice if the family cannot cope.

DRUG TREATMENT. The number of drugs should be as few as possible, for even the taking of medicine may be an effort. Oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma, in which case parenteral medication may be necessary.

Pain

Analgesics are more effective if started at the earliest stage in the development of pain than if used for the relief of established pain.

The non-opioid analgesics **aspirin** or **paracetamol** given regularly will often make the use of opioids unnecessary. Aspirin[1] (or other NSAIDs if preferred) may also control the pain of *bone secondaries*; naproxen, flurbiprofen, and indomethacin (section 10.1.1) are valuable and if necessary can be given rectally. Radiotherapy, radioactive isotopes of **strontium** (*Metastron*® available from Amersham) and bisphosphonates (section 6.6.2) may also be useful for pain due to bone metastases.

An opioid such as **codeine** or **dextropropoxyphene**, alone or in combination with a non-opioid analgesic at adequate dosage, may be helpful in the control of moderate pain if non-opioids alone are not sufficient. If these preparations are not controlling the pain, **morphine** is the most useful opioid analgesic. Alternative strong analgesics are **hydromorphone** (section 4.7.2) and transdermal **fentanyl** (see below and section 4.7.2).

ORAL ROUTE. Morphine is given *by mouth* as an oral solution regularly every 4 hours, the initial dose depending largely on the patient's previous treatment. A dose of 5–10 mg is enough to replace a weaker analgesic (such as paracetamol or co-proxamol), but 10–20 mg or more is required to replace a strong one (comparable to morphine itself). If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50%, the aim being to choose the lowest dose which prevents pain. Although a dose of 5–20 mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100 mg or occasionally up to 500 mg or higher if necessary. If pain occurs between doses the next dose due is increased; in the interim an additional dose is given. The dose should be adjusted with careful assessment of the pain and the use of other drugs (such as NSAIDs) should also be considered.

Modified-release preparations of morphine are an alternative to the oral solution. Depending on the formulation of the modified-release preparation, the total daily morphine requirement may be given in two equal doses or as a single dose.

Preparations suitable for twice daily administration include *MST Continus*® tablets or suspension, *Oramorph*® *SR* tablets, and *Zomorph*® capsules. Preparations that allow administration of the total daily morphine requirement as a single dose include *MXL*® capsules. *Morcap SR*® capsules may be given either twice daily or as a single daily dose.

The starting dose of modified-release preparations designed for twice daily administration is usually 10–20 mg every 12 hours if no other analgesic (or only paracetamol) has been taken previously, but to replace a weaker opioid analgesic (such as co-proxamol) the starting dose is usually 20–30 mg every 12 hours. Increments should be made to the dose, not to the frequency of administration, which should remain at every 12 hours.

The effective dose of modified-release preparations can alternatively be determined by giving the oral solution of morphine every 4 hours in increasing doses until the pain has been controlled, and then transferring the patient to the same total 24-hour dose of morphine given as the modified-release preparation (divided into two portions for 12-hourly administration). The first dose of the modified-release preparation is given 4 hours after the last dose of the oral solution.[1]

Morphine, as oral solution or standard formulation tablets, should be prescribed for breakthrough pain.

PARENTERAL ROUTE. If the patient becomes unable to swallow, the equivalent intramuscular dose of morphine is half the oral solution dose; in the case of the modified-release tablets it is half the total 24-hour dose (which is then divided into 6 portions to be given every 4 hours). **Diamorphine** is preferred for injection because being more soluble it can be given in a smaller volume. The equivalent intramuscular (or subcutaneous) dose of diamorphine is only about a quarter to a third of the oral dose of morphine; *subcutaneous infusion via syringe driver* can be useful (for details, see p. 13).

1. Studies have indicated that administration of the last dose of the *oral solution* with the first dose of the *modified-release tablets* is not necessary.

RECTAL ROUTE. Morphine is also available for *rectal administration* as suppositories; alternatively **oxycodone** suppositories can be obtained on special order.

TRANSDERMAL ROUTE. Transdermal preparations of fentanyl are available (section 4.7.2). Careful conversion from oral morphine to transdermal fentanyl is necessary; a 25 micrograms/hr patch is equivalent to a total dose of morphine up to 135 mg/24 hours

GASTRO-INTESTINAL PAIN. The pain of *bowel colic* may be reduced by loperamide 2–4 mg 4 times daily. Hyoscine hydrobromide may also be helpful, given sublingually at a dose of 300 micrograms 3 times daily as *Kwells*® (Roche Consumer Health) tablets. For the dose by subcutaneous infusion using a syringe driver, see p. 13.

Gastric distension pain due to pressure on the stomach may be helped by a preparation incorporating an antacid with an antiflatulent (section 1.1.1) and by domperidone 10 mg 3 times daily before meals.

MUSCLE SPASM. The pain of muscle spasm can be helped by a muscle relaxant such as diazepam 5–10 mg daily or baclofen 5–10 mg 3 times daily.

NEUROPATHIC PAIN. Neuropathic pain occurs when nerves are damaged; the pain may be described as burning, stabbing or stinging. Pain due to nerve compression may be reduced by a corticosteroid such as dexamethasone 8 mg daily, which reduces oedema around the tumour, thus reducing compression.

Tricyclic antidepressants can be useful; amitriptyline may be given initially at 10–25 mg daily at night and the dose increased gradually. If pain persists, an anticonvulsant such as *either* sodium valproate initially 200 mg twice daily increased to 1.6 g daily in divided doses *or* carbamazepine initially 200 mg at night increased to 400 mg twice daily, may be added or substituted.

Nerve blocks may be considered when pain is localised to a specific area. **Transcutaneous electrical nerve stimulation** (TENS) may also provide useful relief of pain.

Miscellaneous conditions

Non-licensed indications or routes

Several recommendations in this section involve non-licensed indications or routes.

RAISED INTRACRANIAL PRESSURE. Headache due to raised intracranial pressure often responds to a high dose of a corticosteroid, such as dexamethasone 16 mg daily for 4 to 5 days, subsequently reduced to 4–6 mg daily if possible; dexamethasone should be given before 6 p.m. to reduce the risk of insomnia.

INTRACTABLE COUGH. Intractable cough may be relieved by moist inhalations or may require regular administration of an oral morphine hydrochloride (or sulphate) solution in an initial dose of 5 mg every 4 hours. Methadone linctus should be avoided as it has a long duration of action and tends to accumulate.

DYSPNOEA. Dyspnoea may be relieved by regular oral morphine hydrochloride (or sulphate) solution in carefully titrated doses, starting at 5 mg every 4 hours. Diazepam 5–10 mg daily may be helpful; a corticosteroid, such as dexamethasone 4–8 mg daily, may also be helpful if there is bronchospasm or partial obstruction.

EXCESSIVE RESPIRATORY SECRETION. Excessive respiratory secretion (death rattle) may be reduced by subcutaneous injection of hyoscine hydrobromide 400–600 micrograms every 4 to 8 hours; care must however be taken to avoid the discomfort of dry mouth. For the dose by subcutaneous infusion using a syringe driver, see next page.

RESTLESSNESS AND CONFUSION. Restlessness and confusion may require treatment with haloperidol 1–3 mg by mouth every 8 hours. Chlorpromazine 25–50 mg by mouth every 8 hours is an alternative, but causes more sedation. Methotrimeprazine is also used occasionally for restlessness. For the dose by subcutaneous infusion using a syringe driver, see next page

HICCUP. Hiccup due to gastric distension may be helped by a preparation incorporating an antacid with an antiflatulent (section 1.1). If this fails, metoclopramide 10 mg every 6 to 8 hours by mouth or by intramuscular injection can be added; if this also fails, chlorpromazine 10–25 mg every 6 to 8 hours can be tried.

ANOREXIA. Anorexia may be helped by prednisolone 15–30 mg daily or dexamethasone 2–4 mg daily.

CONSTIPATION. Constipation is a very common cause of distress and is almost invariable after administration of an opioid. It should be prevented if possible by the regular administration of laxatives; a faecal softener with a peristaltic stimulant (e.g. co-danthramer), or lactulose solution with a senna preparation should be used (section 1.6.2 and section 1.6.3).

FUNGATING GROWTH. Fungating growth may be treated by cleansing with a mixture of 1 part of 4% povidone–iodine skin cleanser solution and 4 parts of liquid paraffin. Oral administration of metronidazole (section 5.1.11) may eradicate the anaerobic bacteria responsible for the odour of fungating tumours; topical application (section 13.10.1.2) is also used.

CAPILLARY BLEEDING. Capillary bleeding may be reduced by applying gauze soaked in adrenaline solution 1 mg/mL (1 in 1000).

DRY MOUTH. Dry mouth may be relieved by good mouth care and measures such as the sucking of ice or pineapple chunks or the use of artificial saliva (section 12.3.5); dry mouth associated with candidiasis can be treated by oral preparations of nystatin or miconazole (section 12.3.2); alternatively, fluconazole can be given by mouth (section 5.2). Dry

mouth may be caused by certain medication including opioids, antimuscarinic drugs (e.g. hyoscine), antidepressants and some anti-emetics; if possible, an alternative preparation should be considered.

PRURITUS. Pruritus, even when associated with obstructive jaundice, often responds to simple measures such as emollients. In the case of obstructive jaundice, further measures include administration of cholestyramine or an anabolic steroid, such as stanozolol 5–10 mg daily; antihistamines can be helpful (section 3.4.1).

CONVULSIONS. Patients with cerebral tumours or uraemia may be susceptible to convulsions. Prophylactic treatment with phenytoin or carbamazepine (section 4.8.1) should be considered. When oral medication is no longer possible, diazepam as suppositories 10–20 mg every 4 to 8 hours, or phenobarbitone by injection 50–200 mg twice daily is continued as prophylaxis. For the use of midazolam by subcutaneous infusion using a syringe driver, see below.

DYSPHAGIA. A corticosteroid such as dexamethasone 8 mg daily may help, temporarily, if there is an obstruction due to tumour. See also under Dry Mouth.

NAUSEA AND VOMITING. Nausea and vomiting are very common in patients with advanced cancer. The cause should be diagnosed before treatment with anti-emetics (section 4.6) is started. Octreotide (section 8.3.4.3), which stimulates water and electrolyte absorption and inhibits water secretion in the small bowel, can be used by subcutaneous infusion, in a dose of 300–600 micrograms/24 hours to reduce intestinal secretions and vomiting.

Nausea and vomiting may also occur in the initial stages of morphine therapy but can be prevented by giving an anti-emetic such as haloperidol 1.5 mg daily (or twice daily if nausea continues) or metoclopramide 10 mg 3 times daily (section 4.6). An anti-emetic is usually only necessary for the first 4 or 5 days therefore fixed-combination opioid preparations containing an anti-emetic are not recommended since they lead to unnecessary anti-emetic therapy (often with undesirable drowsiness). For the administration of anti-emetics by subcutaneous infusion using a syringe driver, see below.

For the treatment of nausea and vomiting associated with cancer chemotherapy, see section 8.1.

INSOMNIA. Patients with advanced cancer may not sleep because of discomfort, cramps, night sweats, joint stiffness, or fear. There should be appropriate treatment of these problems before hypnotics are used. Benzodiazepines, such as temazepam, may be useful (section 4.1.1).

HYPERCALCAEMIA. See section 9.5.1.2.

Syringe drivers

Although drugs can usually be administered *by mouth* to control the symptoms of advanced cancer, the parenteral route may sometimes be necessary. If the parenteral route is necessary, repeated administration of *intramuscular injections* can be difficult in a cachectic patient. This has led to the use of a portable syringe driver to give a *continuous subcutaneous infusion*, which can provide good control of symptoms with little discomfort or inconvenience to the patient.

Indications for the **parenteral route** are:

- the patient is unable to take medicines by mouth owing to *nausea and vomiting, dysphagia, severe weakness,* or *coma;*
- there is *malignant bowel obstruction* in patients for whom further surgery is inappropriate (avoiding the need for an intravenous infusion or for insertion of a nasogastric tube);
- occasionally when the patient *does not wish* to take regular medication by mouth.

NAUSEA AND VOMITING. **Haloperidol** is given in a *subcutaneous infusion* dose of 2.5–10 mg/24 hours.

Methotrimeprazine causes sedation in about 50% of patients; it is given in a *subcutaneous infusion dose* of 25–200 mg/24 hours, although lower doses of 5–25 mg/24 hours may be effective with less sedation.

Cyclizine is particularly liable to precipitate if mixed with diamorphine or other drugs (see under Mixing and Compatibility, below); it is given in a *subcutaneous infusion dose* of 150 mg/24 hours.

Metoclopramide may cause skin reactions; it is given in a *subcutaneous infusion dose* of 30–60 mg/24 hours.

BOWEL COLIC AND EXCESSIVE RESPIRATORY SECRETIONS. **Hyoscine hydrobromide** effectively reduces respiratory secretions and is sedative (but occasionally causes paradoxical agitation); it is given in a *subcutaneous infusion dose* of 0.6–2.4 mg/24 hours.

Hyoscine butylbromide is effective in bowel colic, is less sedative than hyoscine hydrobromide, but is not always adequate for the control of respiratory secretions; it is given in a *subcutaneous infusion dose* of 20–60 mg/24 hours (**important:** this dose of *hyoscine butylbromide* must not be confused with the much lower dose of *hyoscine hydrobromide*, above).

RESTLESSNESS AND CONFUSION. **Haloperidol** has little sedative effect; it is given in a *subcutaneous infusion dose* of 5–30 mg/24 hours.

Methotrimeprazine has a sedative effect; it is given in a *subcutaneous infusion dose* of 50–200 mg/24 hours.

Midazolam is a sedative and an antiepileptic, and is therefore suitable for a very restless patient; it is given in a *subcutaneous infusion dose* of 20–100 mg/24 hours.

CONVULSIONS. If a patient has previously been receiving an antiepileptic *or* has a primary or secondary cerebral tumour *or* is at risk of convulsion (e.g. owing to uraemia) antiepileptic medication should not be stopped. **Midazolam** is the benzodiazepine antiepileptic of choice for *continuous subcutaneous infusion*, and is given in a dose of 20–40 mg/24 hours.

Syringe driver rate settings. Staff using syringe drivers should be **adequately trained** and different rate settings should be **clearly identified** and **differentiated;** incorrect use of syringe drivers is a common cause of drug errors.

PAIN CONTROL. **Diamorphine** is the preferred opioid since its high solubility permits a large dose to be given in a small volume (see under Mixing and Compatibility, below). The table below gives the approximate doses of *morphine by mouth* (as oral solution or standard tablets or as modified-release tablets) equivalent to *diamorphine by injection* (intramuscularly or by subcutaneous infusion).

MIXING AND COMPATIBILITY. The general principle that injections should be given into separate sites (and should not be mixed) does not apply to the use of syringe drivers in palliative care. Provided that there is evidence of compatibility, selected injections can be mixed in syringe drivers. Not all types of medication can be used in a subcutaneous infusion. In particular, **chlorpromazine, prochlorperazine** and **diazepam** are **contra-indicated** as they cause skin reactions at the injection site; to a lesser extent **cyclizine** and **methotrimeprazine** may also sometimes cause local irritation.

In theory injections dissolved in **water for injections** are more likely to be associated with pain (possibly owing to their hypotonicity). The use of **physiological saline** (sodium chloride 0.9%) however increases the likelihood of precipitation when more than one drug is used; moreover subcutaneous infusion rates are so slow (0.1–0.3 mL/hour) that pain is not usually a problem when water is used as a diluent.

Diamorphine can be given by subcutaneous infusion in a strength of up to 250 mg/mL; up to a strength of 40 mg/mL either *water for injections* or *physiological saline* (sodium chloride 0.9%) is a suitable diluent—above that strength only *water for injections* is used (to avoid precipitation).

The following can be mixed with *diamorphine:*

Cyclizine[1]	Hyoscine hydrobromide
Dexamethasone[2]	Methotrimeprazine
Haloperidol[3]	Metoclopramide[4]
Hyoscine butylbromide	Midazolam

Subcutaneous infusion solution should be monitored regularly both to check for precipitation (and discoloration) and to ensure that the infusion is running at the correct rate.

PROBLEMS ENCOUNTERED WITH SYRINGE DRIVERS. The following are problems that may be encountered with syringe drivers and the action that should be taken:

if the subcutaneous infusion runs *too quickly* check the rate setting and the calculation;

if the subcutaneous infusion runs *too slowly* check the start button, the battery, the syringe driver, the cannula, and make sure that the injection site is not inflamed;

if there is an *injection site reaction* make sure that the site does not need to be changed—firmness or swelling at the site of injection is not in itself an indication for change, but pain or obvious inflammation is.

1. Cyclizine may precipitate at concentrations above 10 mg/mL *or* in the presence of physiological saline *or* as the concentration of diamorphine relative to cyclizine increases; mixtures of diamorphine and cyclizine are also liable to precipitate after 24 hours.
2. Special care is needed to avoid precipitation of dexamethasone when preparing.
3. Mixtures of haloperidol and diamorphine are liable to precipitate after 24 hours if haloperidol concentration is above 2 mg/mL.
4. Under some conditions metoclopramide may become discoloured; such solutions should be discarded.

Equivalent doses of morphine sulphate by mouth (as oral solution or standard tablets *or* as modified-release tablets) *or* of diamorphine hydrochloride by intramuscular injection *or by* subcutaneous infusion
These equivalences are approximate only and may need to be adjusted according to response

ORAL MORPHINE		PARENTERAL DIAMORPHINE	
Morphine sulphate oral solution or standard tablets	Morphine sulphate modified-release tablets	Diamorphine hydrochloride by intramuscular injection	Diamorphine hydrochloride by subcutaneous infusion
every 4 hours	**every 12 hours**	**every 4 hours**	**every 24 hours**
5 mg	20 mg	2.5 mg	15 mg
10 mg	30 mg	5 mg	20 mg
15 mg	50 mg	5 mg	30 mg
20 mg	60 mg	7.5 mg	45 mg
30 mg	90 mg	10 mg	60 mg
40 mg	120 mg	15 mg	90 mg
60 mg	180 mg	20 mg	120 mg
80 mg	240 mg	30 mg	180 mg
100 mg	300 mg	40 mg	240 mg
130 mg	400 mg	50 mg	300 mg
160 mg	500 mg	60 mg	360 mg
200 mg	600 mg	70 mg	400 mg

If breakthrough pain occurs give a subcutaneous (preferable) or intramuscular injection of diamorphine equivalent to one-sixth of the total 24-hour subcutaneous infusion dose. It is kinder to give an intermittent bolus injection *subcutaneously*—absorption is smoother so that the risk of adverse effects at peak absorption is avoided (an even better method is to use a subcutaneous butterfly needle).

To minimise the risk of infection no individual subcutaneous infusion solution should be used for longer than 24 hours.

Prescribing for the elderly

Old people, especially the very old, require special care and consideration from prescribers.

POLYPHARMACY. Elderly patients often receive multiple drugs for their multiple diseases. This greatly increases the risk of drug interactions as well as other adverse reactions. Moreover, symptoms such as headache, sleeplessness, and lightheadedness which may be associated with social stress, as in widowhood, loneliness, and family dispersal can lead to further prescribing, especially of psychotropics. The use of drugs in such cases can at best be a poor substitute for effective social measures and at worst pose a serious threat from adverse reactions.

FORM OF MEDICINE. Elderly patients may have difficulty swallowing tablets; if left in the mouth, ulceration may develop. They should always be encouraged to take their tablets or capsules with enough fluid, and in some cases it may be advisable to prescribe the drug as a liquid if available.

MANIFESTATIONS OF AGEING. In very old subjects, manifestations of normal ageing may be mistaken for disease and lead to inappropriate prescribing. For example, drugs such as prochlorperazine are commonly misprescribed for giddiness due to age-related loss of postural stability. Not only is such treatment ineffective but the patient may experience serious side-effects such as parkinsonism, postural hypotension, and confusion.

SELF-MEDICATION. Self-medication with over-the-counter products or with drugs prescribed for a previous illness (or even for another person) may be an added complication. Discussion with relatives and a home visit may be needed to establish exactly what is being taken.

SUSCEPTIBILITY. The ageing nervous system shows increased *susceptibility* to many commonly used drugs, such as opioid analgesics, benzodiazepines, and antiparkinsonian drugs, all of which must be used with caution.

Pharmacokinetics

While drug distribution and metabolism may be significantly altered, the most important effect of age is reduction in renal clearance, frequently aggravated by the effects of prostatism or chronic urinary tract infection. Many aged patients thus possess only *limited reserves of renal function, excrete drugs slowly*, and are *highly susceptible to nephrotoxic drugs*. Acute illness may lead to rapid reduction in renal clearance, especially if accompanied by dehydration. Hence, a patient stabilised on a drug with a narrow margin between the therapeutic and the toxic dose (e.g. digoxin) may rapidly develop adverse effects in the aftermath of a myocardial infarction or a respiratory tract infection.

The net result of pharmacokinetic changes is that the tissue concentration of a drug is commonly increased by over 50%, and aged and debilitated patients may show even larger changes.

Adverse reactions

Adverse reactions often present in the elderly in a vague and non-specific fashion. *Mental confusion* is often the presenting symptom (caused by almost any of the commonly used drugs). Other common manifestations are *constipation* (with antimuscarinics and many tranquillisers) and postural *hypotension* and *falls* (with diuretics and many psychotropics).

HYPNOTICS. Many hypnotics with long half-lives have serious hangover effects of drowsiness, unsteady gait, and even slurred speech and confusion. Those with short half-lives should be used but they too can present problems (section 4.1.1). Short courses of hypnotics are occasionally useful for helping a patient through an acute illness or some other crisis but every effort must be made to avoid dependence.

DIURETICS. Diuretics are overprescribed in old age and should **not** be used on a long-term basis to treat simple gravitational oedema which will usually respond to increased movement, raising the legs, and support stockings. A few days of diuretic treatment may speed the clearing of the oedema but it should rarely need continued drug therapy.

NSAIDs. Bleeding associated with *aspirin* and *other NSAIDs* is more common in the elderly who are more likely to have a fatal or serious outcome. NSAIDs are also a special hazard in patients with cardiac disease or renal impairment which may again place the elderly at particular risk.

Owing to the *increased susceptibilty of the elderly* to the *side-effects of NSAIDs* the following recommendations are made:

- for *osteoarthritis, soft-tissue lesions and back pain* first try measures such as weight reduction, warmth, exercise and use of a walking stick;
- for *osteoarthritis, soft tissue lesions, back pain and rheumatoid arthritis* avoid giving an NSAID unless *paracetamol* (alone or with a *low dose* of an opioid analgesic as in co-codamol 8/500 or co-dydramol 10/500) has failed to relieve the pain adequately;
- where a paracetamol preparation has failed to relieve the pain adequately *add a very low dose of an NSAID* to the paracetamol preparation (starting with ibuprofen). For advice on prophylaxis of NSAID-induced peptic ulcers (where continued treatment with NSAIDs is necessary), see section 1.3.
- if an NSAID is considered necessary monitor the patient for gastro-intestinal bleeding for 4 weeks (and for a similar time on switching to another NSAID). For the management of NSAID-associated peptic ulcers, see section 1.3.
- do not give two NSAIDs at the same time.

OTHER DRUGS. Other drugs which commonly cause adverse reactions are *antiparkinsonian drugs, antihypertensives, psychotropics*, and *digoxin*; the usual maintenance dose of digoxin in very old patients is 125 micrograms daily (62.5 micrograms is often inadequate, and toxicity is common in those given 250 micrograms).

Drug-induced blood disorders are much more common in the elderly. Therefore drugs with a tendency to cause bone marrow depression (e.g. *co-trimoxazole, mianserin*) should be avoided unless there is no acceptable alternative.

The elderly generally require a lower maintenance dose of *warfarin* than younger adults; once again, the outcome of bleeding tends to be more serious.

Guidelines

First always question whether a drug is indicated at all.

LIMIT RANGE. It is a sensible policy to prescribe from a limited range of drugs and to be thoroughly familiar with their effects in the elderly.

REDUCE DOSE. Dosage should generally be substantially lower than for younger patients and it is common to start with about 50% of the adult dose. Some drugs (e.g. chlorpropamide) should be avoided altogether.

REVIEW REGULARLY. Review repeat prescriptions regularly. It may be possible to stop the drug (e.g. digoxin can often be withdrawn) or it may be necessary to reduce the dose to match diminishing renal function.

SIMPLIFY REGIMENS. Elderly patients cannot normally cope with more than three different drugs and, ideally, these should not be given more than twice daily. In particular, regimens which call for a confusing array of dosage intervals should be avoided.

EXPLAIN CLEARLY. Write full instructions on every prescription (*including* repeat prescriptions) so that containers can be properly labelled with full directions. Avoid imprecisions like 'as directed'. Child-resistant containers may be unsuitable.

REPEATS AND DISPOSAL. Instruct patients what to do when drugs run out, and also how to dispose of any that are no longer necessary. Try to prescribe matching quantities.

If these guidelines are followed most elderly people will cope adequately with their own medicines. If not then it is essential to enrol the help of a third party, usually a relative or a friend.

Acupan® (3M) PoM
Tablets, f/c, nefopam hydrochloride 30 mg. Net price 90-tab pack = £11.44. Label: 2, 14
Injection, nefopam hydrochloride 20 mg/mL. Net price 1-mL amp = 73p

4.7.2 Opioid analgesics

Opioid analgesics are used to relieve moderate to severe pain particularly of visceral origin. Repeated administration may cause dependence and tolerance, but this is no deterrent in the control of pain in terminal illness, for guidelines see Prescribing in Palliative Care, p. 11.

SIDE-EFFECTS. Opioid analgesics share many side-effects though qualitative and quantitative differences exist. The most common include nausea, vomiting, constipation, and drowsiness. Larger doses produce respiratory depression and hypotension. **Overdosage**, see Emergency Treatment of Poisoning, p. 22.

INTERACTIONS. See Appendix 1 (opioid analgesics) (**important:** special hazard with *pethidine and possibly other opioids* and MAOIs).

DRIVING. Drowsiness may affect performance of skilled tasks (e.g. driving); effects of alcohol enhanced.

CHOICE. **Morphine** remains the most valuable opioid analgesic for severe pain although it frequently causes nausea and vomiting. It is the standard against which other opioid analgesics are compared. In addition to relief of pain, morphine also confers a state of euphoria and mental detachment.

Morphine is the opioid of choice for the oral treatment of *severe pain in palliative care*. It is given regularly every 4 hours (or every 12 or 24 hours as modified-release preparations). For guidelines on dosage adjustment in palliative care, see p. 11.

Buprenorphine has both opioid agonist and antagonist properties and may precipitate withdrawal symptoms, including pain, in patients dependent on other opioids. It has abuse potential and may itself cause dependence. It has a much longer duration of action than morphine and sublingually is an effective analgesic for 6 to 8 hours. Vomiting may be a problem. Unlike most opioid analgesics its effects are only partially reversed by naloxone.

Codeine is effective for the relief of mild to moderate pain but is too constipating for long-term use.

Dextromoramide is less sedating than morphine and has a short duration of action.

Diphenoxylate (in combination with atropine, as co-phenotrope) is used in acute diarrhoea (see section 1.4.2).

Dipipanone used alone is less sedating than morphine but the only preparation available contains an anti-emetic and is therefore not suitable for regular regimens in palliative care (see p. 13).

Dextropropoxyphene given alone is a very mild analgesic somewhat less potent than codeine. Combinations of dextropropoxyphene with paracetamol (co-proxamol) or aspirin have little more analgesic effect than paracetamol or aspirin alone. An important disadvantage of co-proxamol is that overdosage (which may be combined with alcohol) is complicated by respiratory depression and acute heart failure due to the dextropropoxyphene and by hepatotoxicity due to the paracetamol. Rapid treatment is essential (see Emergency Treatment of Poisoning, p. 22).

Diamorphine (heroin) is a powerful opioid analgesic. It may cause less nausea and hypotension than morphine. In *palliative care* the greater solubility of diamorphine allows effective doses to be injected in smaller volumes and this is important in the emaciated patient.

Dihydrocodeine has an analgesic efficacy similar to that of codeine. The dose of dihydrocodeine by mouth is usually 30 mg every 4 hours; doubling the dose to 60 mg may provide some additional pain relief but this may be at the cost of more nausea and vomiting. A 40-mg tablet is now also available.

Alfentanil, fentanyl and **remifentanil** are used by injection for intra-operative analgesia (section 15.1.4.3); fentanyl has been introduced recently as a transdermal drug delivery system as a self-adhesive patch which is changed every 72 hours.

Meptazinol is claimed to have a low incidence of respiratory depression. It has a reported length of action of 2 to 7 hours with onset within 15 minutes but there is an incidence of nausea and vomiting.

Methadone is less sedating than morphine and acts for longer periods. In prolonged use, methadone should not be administered more often than twice daily to avoid the risk of accumulation and opioid overdosage. Methadone may be used instead of morphine in the occasional patient who experiences excitation (or exacerbation of pain) with morphine.

Nalbuphine has a similar efficacy to that of morphine for pain relief, but may have fewer side-effects and less abuse potential. Nausea and vomiting occur less than with other opioids but respiratory depression is similar to that with morphine.

Oxycodone is used as the pectinate in suppositories (special order from BCM Specials) for the control of *pain in palliative care*.

Papaveretum is used peri-operatively, see 15.1.4.3.

Pentazocine has both agonist and antagonist properties and precipitates withdrawal symptoms including pain in patients dependent on other opioids. By injection it is more potent than dihydrocodeine or codeine, but hallucinations and thought disturbances may occur. It is not recommended and, in particular, should be avoided after myocardial infarction as it may increase pulmonary and aortic blood pressure as well as cardiac work.

Pethidine produces prompt but short-lasting analgesia; it is less constipating than morphine, but even in high doses is a less potent analgesic. It is not suitable for severe continuing pain. It is used for analgesia in labour, and in the neonate is associated with less respiratory depression than other opioid analgesics (probably because its action is weaker).

Phenazocine is effective in severe pain and has less tendency to increase biliary pressure than other opioid analgesics. It can be administered sublingually if nausea and vomiting are a problem.

Tramadol has been introduced recently and is claimed to produce analgesia by two mech

an opioid effect and an enhancem
gic and adrenergic pathways. It i
fewer of the typical opioid sid
less respiratory depression, less
less addiction potential); psychia
been reported.

ADDICTS. Although caution is
(and ex-addicts) may be treated
the same way as other people w
clinical need. Doctors are remind
require a special licence to pres
gesics for addicts for relief of p
disease or injury.

MORPHINE SALTS

Indications: see notes above;
oedema; peri-operative ar
15.1.4.3)

Cautions: hypotension, hypot
(avoid during attack) and dec
reserve, prostatic hypertroph
breast-feeding; may precipitat
impairment (reduce dose or av
patients tolerate morphine wel
avoid in renal impairment (see
elderly and debilitated (reduce
disorders, dependence (severe
toms if withdrawn abruptly);
pressants containing opioi
generally recommended in chil
avoided altogether in those un
interactions: Appendix 1 (opi
PALLIATIVE CARE. In the control o
ness these cautions should not nec
to the use of opioid analgesics

Contra-indications: avoid ir
depression, acute alcoholism
paralytic ileus; not indicated
also avoid in raised intracrani
injury (in addition to interferi
affect pupillary responses vi
assessment); avoid injection
cytoma (risk of pressor res
release)

Side-effects: nausea and vomi
initial stages), constipation
larger doses produce respirat
hypotension; other side-effec
with micturition, ureteric or
mouth, sweating, headach
vertigo, bradycardia, tachy
postural hypotension, hypo
tions, dysphoria, mood ch
miosis, decreased libido or p
caria and pruritus; overdos
Treatment of Poisoning, p.
opioid-induced respiratory de
15.1.7

Dose: acute pain, *by subcuta*
suitable for oedematous pati
cular injection, 10 mg every
(15 mg for heavier well-mus
up to 1 month 150 microgra
200 micrograms/kg, 1–5 ye
years 5–10 mg
Postoperative pain, see secti

an opioid effect and an enhancement of serotoninergic and adrenergic pathways. It is reported to have fewer of the typical opioid side-effects (notably, less respiratory depression, less constipation and less addiction potential); psychiatric reactions have been reported.

ADDICTS. Although caution is necessary addicts (and ex-addicts) may be treated with analgesics in the same way as other people when there is a real clinical need. Doctors are reminded that they do not require a special licence to prescribe opioid analgesics for addicts for relief of pain due to organic disease or injury.

MORPHINE SALTS

Indications: see notes above; acute pulmonary oedema; peri-operative analgesia (section 15.1.4.3)

Cautions: hypotension, hypothyroidism, asthma (avoid during attack) and decreased respiratory reserve, prostatic hypertrophy; pregnancy and breast-feeding; may precipitate coma in hepatic impairment (reduce dose or avoid but many such patients tolerate morphine well); reduce dose or avoid in renal impairment (see also Appendix 3), elderly and debilitated (reduce dose); convulsive disorders, dependence (severe withdrawal symptoms if withdrawn abruptly); use of cough suppressants containing opioid analgesics not generally recommended in children and should be avoided altogether in those under at least 1 year; **interactions:** Appendix 1 (opioid analgesics)

PALLIATIVE CARE. In the control of pain in terminal illness these cautions should not necessarily be a deterrent to the use of opioid analgesics

Contra-indications: avoid in acute respiratory depression, acute alcoholism and where risk of paralytic ileus; not indicated for acute abdomen; also avoid in raised intracranial pressure or head injury (in addition to interfering with respiration, affect pupillary responses vital for neurological assessment); avoid injection in phaeochromocytoma (risk of pressor response to histamine release)

Side-effects: nausea and vomiting (particularly in initial stages), constipation, and drowsiness; larger doses produce respiratory depression and hypotension; other side-effects include difficulty with micturition, ureteric or biliary spasm, dry mouth, sweating, headache, facial flushing, vertigo, bradycardia, tachycardia, palpitations, postural hypotension, hypothermia, hallucinations, dysphoria, mood changes, dependence, miosis, decreased libido or potency, rashes, urticaria and pruritus; **overdosage:** see Emergency Treatment of Poisoning, p. 22; for reversal of opioid-induced respiratory depression, see section 15.1.7.

Dose: acute pain, *by subcutaneous injection* (not suitable for oedematous patients) *or by intramuscular injection*, 10 mg every 4 hours if necessary (15 mg for heavier well-muscled patients); CHILD up to 1 month 150 micrograms/kg, 1–12 months 200 micrograms/kg, 1–5 years 2.5–5 mg, 6–12 years 5–10 mg

Postoperative pain, see section 15.1.4.3

By slow intravenous injection, quarter to half corresponding intramuscular dose

Patient controlled analgesia (PCA), consult hospital protocols

Myocardial infarction, *by slow intravenous injection* (2 mg/minute), 10 mg followed by a further 5–10 mg if necessary; elderly or frail patients, reduce dose by half

Acute pulmonary oedema, *by slow intravenous injection* (2 mg/minute) 5–10 mg

Chronic pain, *by mouth or by subcutaneous injection* (not suitable for oedematous patients) *or by intramuscular injection*, 5–20 mg regularly every 4 hours; dose may be increased according to needs; oral dose should be approximately double corresponding intramuscular dose and triple to quadruple corresponding intramuscular *diamorphine* dose (see also Prescribing in Palliative Care, p. 11); *by rectum*, as suppositories, 15–30 mg regularly every 4 hours

Note. The doses stated above refer equally to morphine hydrochloride, sulphate, and tartrate; see below for doses of **modified-release** preparations.

■ Oral solutions

Note. For advice on transfer from oral solutions of morphine to modified-release preparations of morphine, see Prescribing in Palliative Care, p. 11

Morphine Oral Solutions PoM or CD

Oral solutions of morphine can be prescribed by writing the formula:

Morphine hydrochloride 5 mg

Chloroform water to 5 mL

Note. The proportion of morphine hydrochloride may be altered when specified by the prescriber; if above 13 mg per 5 mL the solution becomes **CD**. For sample prescription see Controlled Drugs and Drug Dependence, p. 6. It is usual to adjust the strength so that the dose volume is 5 or 10 mL.

Oramorph® (Boehringer Ingelheim)

Oramorph® oral solution PoM, morphine sulphate 10 mg/5 mL. Net price 100-mL pack = £2.31; 250-mL pack = £5.36; 500-mL pack = £9.70. Label: 2

Oramorph® Unit Dose Vials 10 mg PoM (oral vials), sugar-free, morphine sulphate 10 mg/5-mL vial, net price 25 vials = £3.31. Label: 2

Oramorph® Unit Dose Vials 30 mg CD (oral vials), sugar-free, morphine sulphate 30 mg/5-mL vial, net price 25 vials = £9.30. Label: 2

Oramorph® concentrated oral solution CD, sugar-free, morphine sulphate 100 mg/5 mL. Net price 30-mL pack = £6.47; 120-mL pack = £24.15 (both with calibrated dropper). Label: 2

Oramorph® Unit Dose Vials 100 mg CD (oral vials), sugar-free, morphine sulphate 100 mg/5-mL vial, net price 25 vials = £31.00. Label: 2

■ Tablets

Sevredol® (Napp) CD

Tablets, f/c, scored, morphine sulphate 10 mg (blue), net price 56-tab pack = £6.31; 20 mg (pink), 56-tab pack = £12.62; 50 mg (pale green), 56-tab pack = £31.55. Label: 2

Dose: severe pain uncontrolled by weaker opioid, 10–50 mg every 4 hours (dose adjusted according to need and tolerance); CHILD 3–5 years, 5 mg; 6–12 years, 5–10 mg

■ Modified release

Morcap® SR (Sanofi Winthrop) CD

Capsules, m/r, clear enclosing ivory and brown pellets, morphine sulphate 20 mg, net price 30-cap pack = £5.71, 60-cap pack = £11.42; 50 mg, 30-cap pack = £13.84, 60-cap pack = £27.68; 100 mg, 30-cap pack = £27.68, 60-cap pack = £55.37. Label: 2, counselling, see below

Dose: adjusted according to daily morphine requirements, for further advice on determining dose, see Prescribing in Palliative Care, p. 11; dosage requirements may need to be reviewed if the brand is altered

COUNSELLING. Swallow whole or open capsule and sprinkle contents on soft food

Note. Prescription must also specify 'capsules' (i.e. 'Morcap SR capsules')

MST Continus® (Napp) CD

Tablets, m/r, f/c, morphine sulphate 5 mg (white), net price 60-tab pack = £4.50; 10 mg (brown), 60-tab pack = £7.51; 15 mg (green), 60-tab pack = £13.16; 30 mg (purple), 60-tab pack = £18.03; 60 mg (orange), 60-tab pack = £35.16; 100 mg (grey), 60-tab pack = £55.67; 200 mg (green), 60-tab pack = £111.35. Label: 2, 25

Suspension (= sachet of granules to mix with water), m/r, pink, morphine sulphate 20 mg/sachet, net price 30-sachet pack = £28.60; 30 mg/sachet, 30-sachet pack = £29.72; 60 mg/sachet, 30-sachet pack = £59.44; 100 mg/sachet, 30-sachet pack = £99.07; 200 mg/sachet pack, 30-sachet pack = £198.14. Label: 2, 13

Dose: adjusted according to daily morphine requirements, for further advice on determining dose, see Prescribing in Palliative Care, p. 11; dosage requirements may need to be reviewed if the brand is altered

Note. Prescriptions must also specify 'tablets' or 'suspension' (i.e. 'MST Continus tablets' or 'MST Continus suspension').

MXL® (Napp) CD

Capsules, m/r, morphine sulphate 30 mg (light blue), net price 28-cap pack = £12.28; 60 mg (brown), 28-cap pack = £16.83; 90 mg (pink), 28-cap pack = £24.82; 120 mg (green), 28-cap pack = £32.82; 150 mg (blue), 28-cap pack = £41.02; 200 mg (red-brown), 28-cap pack = £51.96. Label: 2, counselling, see below

Dose: adjusted according to daily morphine requirements, for further advice on determining dose, see Prescribing in Palliative Care, p. 11; dosage requirements may need to be reviewed if the brand is altered

COUNSELLING. Swallow whole or open capsule and sprinkle contents on soft food

Note. Prescriptions must also specify 'capsules' (i.e. 'MXL capsules')

Oramorph® SR (Boehringer Ingelheim) CD

Tablets, m/r, f/c, morphine sulphate 10 mg (buff), net price 60-tab pack = £5.75; 30 mg (violet), 60-tab pack = £13.80; 60 mg (orange), 60-tab pack = £26.89; 100 mg (grey), 60-tab pack = £42.59. Label: 2, 25

Dose: adjusted according to daily morphine requirements, for further advice on determining dose, see Prescribing in Palliative Care, p. 11; dosage requirements may need to be reviewed if the brand is altered

Note. Prescriptions must also specify 'tablets' (i.e. 'Oramorph SR tablets')

Zomorph® (Link) CD

Capsules, m/r, morphine sulphate 10 mg (yellow/clear enclosing pale yellow pellets), net price 60-cap pack = £4.51; 30 mg (pink/clear enclosing pale yellow pellets), 60-cap pack = £10.82; 60 mg (orange/clear enclosing pale yellow pellets), 60-cap pack = £21.10; 100 mg (white/clear enclosing pale yellow pellets), 60-cap pack = £33.40; 200 mg (clear enclosing pale yellow pellets), 60-cap pack = £66.80. Label: 2, counselling, see below

Dose: adjusted according to daily morphine requirements, for further advice on determining doses, see Prescribing in Palliative Care, p. 11; dosage requirements may need to be reviewed if the brand is altered

COUNSELLING. Swallow whole or open capsule and sprinkle contents on soft food

Note. Prescriptions must also specify 'capsules' (i.e. 'Zomorph capsules')

■ Injections

Morphine Sulphate (Non-proprietary) CD

Injection, morphine sulphate 10, 15, 20, and 30 mg/mL, net price 1- and 2-mL amp (all) = £1.96p

Intravenous infusion, morphine sulphate 1 mg/mL, net price 50-mL vial = £4.75; 2 mg/mL, 50-mL vial = £4.85

Available from Aurum, Faulding DBL

Min-I-Jet® Morphine Sulphate (IMS) CD

Injection, morphine sulphate 10 mg/mL, net price 2-mL disposable syringe = £10.85

Morphine and Atropine Injection CD

Section 15.1.4.3

Morphine Sulphate Rapiject® (IMS) CD

Injection, morphine sulphate 1 mg/mL, net price 50-mL disposable syringe = £9.50; 2 mg/mL, 5 mL disposable syringe = £10.50

■ Injection with anti-emetic

CAUTION. In myocardial infarction cyclizine may aggravate severe heart failure and counteract the haemodynamic benefits of opioids, see section 4.6. Not recommended in palliative care, see p. 13

Cyclimorph® (GlaxoWellcome) CD

Cyclimorph-10® Injection, morphine tartrate 10 mg, cyclizine tartrate 50 mg/mL. Net price 1-mL amp = £1.28

Dose: by subcutaneous, intramuscular, or intravenous injection, 1 mL, repeated not more often than every 4 hours, with not more than 3 doses in any 24-hour period

CHILD 1–5 years 0.25–0.5 mL as a single dose, 6–12 years 0.5–1 mL as a single dose

Cyclimorph-15® Injection, morphine tartrate 15 mg, cyclizine tartrate 50 mg/mL. Net price 1-mL amp = £1.33

Dose: by subcutaneous, intramuscular, or intravenous injection, 1 mL, repeated not more often than every 4 hours, with not more than 3 doses in any 24-hour period

■ Suppositories

Morphine (Non-proprietary) CD

Suppositories, morphine hydrochloride or sulphate 10 mg, net price 12 = £6.12; 15 mg, 12 = £6.12; 20 mg, 12 = £7.45; 30 mg, 12 = £8.50; 1

Available from Aurum, Martindale, Medeva and

Note. Both the strength of the suppositories and the phine salt contained in them must be specified prescriber

BUPRENORPHINE

Indications: moderate to severe pain tive analgesia (section 15.1.4.5)

Cautions; Contra-indications: see under Morphine Salts and note

give rise to mild withdrawal dependent on opioids; ef reversed by naloxone; **inter** (opioid analgesics)

Dose: *by sublingual administ* 400 micrograms every 8 hou essary to 200–400 microgra CHILD over 6 months, 16–25 25–37.5 kg, 100–200 micro 200–300 micrograms

By intramuscular or slow in 300–600 micrograms every over 6 months 3–6 microg hours (max. 9 micrograms/kg

Temgesic® (R&C) CD

Tablets (sublingual), buprenor chloride), 200 micrograms, ne = £6.00; 400 micrograms, 50- Label: 2, 26

Injection, buprenorphine 300 m hydrochloride)/mL. Net price

CODEINE PHOSPHATE

Indications: mild to moderate

Cautions; Contra-indicatio see under Morphine Salts and cough suppressants containing opioid analgesics not generall children and should be avo those under 1 year; **interact** (opioid analgesics)

Dose: *by mouth*, 30–60 mg ev necessary, to a max. of 240 mg years, 3 mg/kg daily in divided

By intramuscular injection, 30–6 when necessary

Codeine Phosphate (Non-pro

Tablets PoM, codeine phosphat 20 = 35p; 30 mg, 20 = 39p; 60 Label: 2

Note. As for schedule 2 control needing to take codeine phosphate may require a doctor's letter expl necessary

Syrup PoM, codeine phosphate price 100 mL = 87p. Label: 2

Injection CD, codeine phosphat price 1-mL amp = £1.76

Codeine Linctuses

Section 3.9.1

Note. Codeine is an ingredient of som preparations, section 4.7.1 and sect Cyclimorph®)

DEXTROMORAMIDE

Indications: severe pain

Cautions; Contra-indication see under Morphine Salts and short duration of action (2–3 obstetric analgesia (increased depression); **interactions:** Ap analgesics)

Dose: *by mouth*, 5 mg increasin required

By rectum in suppositories, 10 mg

give rise to mild withdrawal symptoms in patients dependent on opioids; effects only partially reversed by naloxone; **interactions:** Appendix 1 (opioid analgesics)

Dose: *by sublingual administration*, initially 200–400 micrograms every 8 hours, increasing if necessary to 200–400 micrograms every 6–8 hours; CHILD over 6 months, 16–25 kg, 100 micrograms; 25–37.5 kg, 100–200 micrograms; 37.5–50 kg, 200–300 micrograms

By intramuscular or slow intravenous injection, 300–600 micrograms every 6–8 hours; CHILD over 6 months 3–6 micrograms/kg every 6–8 hours (max. 9 micrograms/kg)

Temgesic® (R&C) CD

Tablets (sublingual), buprenorphine (as hydrochloride), 200 micrograms, net price 50-tab pack = £6.00; 400 micrograms, 50-tab pack = £12.00. Label: 2, 26

Injection, buprenorphine 300 micrograms (as hydrochloride)/mL. Net price 1-mL amp = 55p

CODEINE PHOSPHATE

Indications: mild to moderate pain

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; use of cough suppressants containing codeine or similar opioid analgesics not generally recommended in children and should be avoided altogether in those under 1 year; **interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth*, 30–60 mg every 4 hours when necessary, to a max. of 240 mg daily; CHILD 1–12 years, 3 mg/kg daily in divided doses

By intramuscular injection, 30–60 mg every 4 hours when necessary

Codeine Phosphate (Non-proprietary)

Tablets PoM, codeine phosphate 15 mg, net price 20 = 35p; 30 mg, 20 = 39p; 60 mg, 20 = 97p. Label: 2

Note. As for schedule 2 controlled drugs, travellers needing to take codeine phosphate preparations abroad may require a doctor's letter explaining why they are necessary

Syrup PoM, codeine phosphate 25 mg/5 mL. Net price 100 mL = 87p. Label: 2

Injection CD, codeine phosphate 60 mg/mL. Net price 1-mL amp = £1.76

Codeine Linctuses

Section 3.9.1

Note. Codeine is an ingredient of some compound analgesic preparations, section 4.7.1 and section 10.1.1 (*Codafen Continus®*)

DEXTROMORAMIDE

Indications: severe pain

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; only short duration of action (2–3 hours); avoid in obstetric analgesia (increased risk of neonatal depression); **interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth*, 5 mg increasing to 20 mg, when required

By rectum in suppositories, 10 mg when required

Palfium® (Boehringer Mannheim) CD

Tablets, both scored, dextromoramide (as tartrate) 5 mg, net price 60-tab pack = £4.66; 10 mg (peach), 60-tab pack = £9.21. Label: 2

Suppositories, dextromoramide 10 mg (as tartrate). Net price 10 = £2.29. Label: 2

DEXTROPROPOXYPHENE HYDROCHLORIDE

Indications: mild to moderate pain

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; occasional hepatotoxicity; porphyria (see section 9.8.2); compound preparations special hazard in overdose, see notes above; convulsions reported in overdose; contra-indicated in those who are suicidal or addiction prone; **interactions:** Appendix 1 (opioid analgesics)

Dose: 65 mg every 6–8 hours when necessary; CHILD not recommended

Note. 65 mg dextropropoxyphene hydrochloride ≡ 100 mg dextropropoxyphene napsylate

Dextropropoxyphene (Non-proprietary) PoM

Capsules, the equivalent of dextropropoxyphene hydrochloride 65 mg (as napsylate). Net price 20 = £1.64. Label: 2

Available from Lilly (NHS Doloxene®)

Note. Dextropropoxyphene is an ingredient of some compound analgesic preparations, section 4.7.1

DIAMORPHINE HYDROCHLORIDE

(Heroin Hydrochloride)

Indications: see notes above; acute pulmonary oedema

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)

Dose: acute pain, *by subcutaneous or intramuscular injection*, 5 mg repeated every 4 hours if necessary (up to 10 mg for heavier well-muscled patients)

By slow intravenous injection, quarter to half corresponding intramuscular dose

Myocardial infarction, *by slow intravenous injection* (1 mg/minute), 5 mg followed by a further 2.5–5 mg if necessary; elderly or frail patients, reduce dose by half

Acute pulmonary oedema, *by slow intravenous injection* (1 mg/minute) 2.5–5 mg

Chronic pain, *by mouth or by subcutaneous or intramuscular injection*, 5–10 mg regularly every 4 hours; dose may be increased according to needs; intramuscular dose should be approximately half corresponding oral dose, and quarter to third corresponding oral *morphine* dose—see also Palliative Care, p. 14; *by subcutaneous infusion* (using syringe driver), see Palliative Care, p. 14

Diamorphine (Non-proprietary) CD

Tablets, diamorphine hydrochloride 10 mg. Net price 100-tab pack = £12.30. Label: 2

Available from Aurum

Injection, powder for reconstitution, diamorphine hydrochloride. Net price 5-mg amp = £1.16, 10-mg amp = £1.34, 30-mg amp = £1.60, 100-mg amp = £4.42, 500-mg amp = £20.68

Available from Berk (Diagesil®), CP, Hillcross, Medeva

Diamorphine Linctus CD
See section 3.9.1

DIHYDROCODEINE TARTRATE

Indications: moderate to severe pain
Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above
Dose: *by mouth*, 30 mg every 4–6 hours when necessary (see also notes above); CHILD over 4 years 0.5–1 mg/kg every 4–6 hours
By deep subcutaneous or intramuscular injection, up to 50 mg repeated every 4–6 hours if necessary; CHILD over 4 years 0.5–1 mg/kg every 4–6 hours

Dihydrocodeine (Non-proprietary)
Tablets PoM, dihydrocodeine tartrate 30 mg. Net price 20 = 56p. Label: 2, 21
Available from most generic manufacturers
Oral solution PoM, dihydrocodeine tartrate 10 mg/5 mL. Net price 150 mL = £2.40. Label: 2, 21
Available from Napp
Injection CD, dihydrocodeine tartrate 50 mg/mL. Net price 1-mL amp = £1.49
Available from Aurum

DF 118 Forte® (Napp) PoM
Tablets, dihydrocodeine tartrate 40 mg. Net price 100-tab pack = £12.05. Label: 2, 21
Dose: severe pain, 40–80 mg 3 times daily; max. 240 mg daily; CHILD not recommended

■ Modified release

DHC Continus® (Napp) PoM
Tablets, m/r, dihydrocodeine tartrate 60 mg, net price 56-tab pack = £6.58; 90 mg, 56-tab pack = £10.36; 120 mg, 56-tab pack = £13.83. Label: 2, 25
Dose: chronic severe pain, 60–120 mg every 12 hours; CHILD not recommended

Note. Dihydrocodeine is an ingredient of some compound analgesic preparations, see section 4.7.1

DIPIPANONE HYDROCHLORIDE

Indications: moderate to severe pain
Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)

Diconal® (GlaxoWellcome) CD
Tablets, pink, scored, dipipanone hydrochloride 10 mg, cyclizine hydrochloride 30 mg. Net price 50-tab pack = £7.59. Label: 2
Dose: 1 tablet gradually increased to 3 tablets every 6 hours; CHILD not recommended
CAUTION. **Not recommended** in palliative care, see p. 13

FENTANYL

Indications: chronic intractable pain due to cancer, see below; other indications (section 15.1.4.3)
Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; local reactions such as rash, erythema and itching reported; **interactions:** Appendix 1 (opioid analgesics)
FEVER OR EXTERNAL HEAT. Monitor patient for increased side-effects if fever present (increased absorption possible); avoid exposing application site to external heat (may also increase absorption)
Administration: see under preparation, below
LONG DURATION OF ACTION. In view of the long duration of action, patients who have experienced serious side-effects should be monitored for up to 24 hours after patch removal

Durogesic® (Janssen-Cilag) ▼ CD
Patches, self-adhesive, transparent, fentanyl '25' patch (releasing approx. 25 micrograms/hour for 72 hours), net price 5 = £28.97; '50' patch (releasing approx. 50 micrograms/hour for 72 hours), 5 = £54.11; '75' patch (releasing approx. 75 micrograms/hour for 72 hours), 5 = £75.43; '100' patch (releasing approx. 100 micrograms/hour for 72 hours), 5 = £92.97. Label: 2
ADMINISTRATION: apply to dry, non-irritated, non-irradiated, non-hairy skin on torso or upper arm, removing after 72 hours and siting replacement patch on a different area (avoid using the same area for several days). Patients who have not previously received a strong opioid analgesic, initial dose, one '25 micrograms/hour' patch replaced after 72 hours; patients who have received a strong opioid analgesic, initial dose based on previous 24-hour opioid requirement (oral morphine sulphate 90 mg over 24 hours = one '25 micrograms/hour' patch, see data sheet for details); CHILD not recommended
Note. When starting initial evaluation of the analgesic effect should **not** be made before the system has been worn for **24 hours** (to allow for the gradual increase in plasma-fentanyl concentration)—previous analgesic therapy should be phased out gradually from time of first patch application; dose adjustment should normally be carried out in 72-hour steps of '25 micrograms/hour'. More than one patch may be used at a time for doses greater than '100 micrograms/hour' (but applied at same *time* to avoid confusion)—consider additional or alternative analgesic therapy if dose required exceeds 300 micrograms/hour (**important:** it may take 17 hours or longer for the plasma-fentanyl concentration to decrease by 50%, therefore replacement opioid therapy should be initiated at a low dose, increasing gradually)

Sublimaze® CD
Section 15.1.4.3

HYDROMORPHONE HYDROCHLORIDE

Indications: severe pain in cancer
Cautions: see Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)
Contra-indications: see Morphine Salts and notes above
Side-effects: see Morphine Salts and notes above
Dose: see under preparations below

Palladone® (Napp) ▼ CD
Capsules, hydromorphone hydrochloride 1.3 mg (orange/clear), net price 56-cap pack = £8.67; 2.6 mg (red/clear), 56-cap pack = £17.34. Label: 2, counselling, see below
Dose: 1.3 mg every 4 hours, increased if necessary according to severity of pain; CHILD under 12 years not recommended
COUNSELLING. Swallow whole or open capsule and sprinkle contents on soft food

Palladone® SR (Napp) ▼ CD
Capsules, m/r, hydromorphone hydrochl
2 mg (yellow/clear), net price 56-cap pa
£18.42; 4 mg (pale blue/clear), 56-cap p
£25.24; 8 mg (pink/clear), 56-cap pack
16 mg (brown/clear), 56-cap pack = £9
24 mg (dark blue/clear), 56-cap pack =
Label: 2, counselling, see below
Dose: 4 mg every 12 hours, increased if nec
according to severity of pain; CHILD under
recommended
COUNSELLING. Swallow whole or open
sprinkle contents on soft food

MEPTAZINOL

Indications: moderate to severe pain
postoperative and obstetric pain and
peri-operative analgesia, see section 1
Cautions; Contra-indications; Si
see under Morphine Salts and notes at
only partially reversed by naloxone
Dose: *by mouth*, 200 mg every 3–
required; CHILD not recommended
By intramuscular injection, 75–100 m
hours if necessary; obstetric anal
150 mg according to patient's weigh
CHILD not recommended
By slow intravenous injection, 50–100
4 hours if necessary; CHILD not recor

Meptid® (Monmouth) PoM
Tablets, orange, f/c, meptazinol 200 m
20 = £4.39. Label: 2
Injection, meptazinol 100 mg (as hyd
mL. Net price 1-mL amp = £1.92

METHADONE HYDROCHLO

Indications: severe pain, see notes a
in treatment of opioid dependence,
Cautions; Contra-indications;
see under Morphine Salts and notes
actions: Appendix 1 (opioid analge
Dose: *by mouth or by subcutaneous*
lar injection, 5–10 mg every 6–8 h
according to response; CHILD not re

Methadone (Non-proprietary) CD
Tablets, scored, methadone hydroch
Net price 50 = £3.11. Label: 2
Available from GlaxoWellcome (*Physep*
Injection, methadone hydrochloride
net price 1-mL amp = 86p, 2-mL a
3.5-mL amp = £1.78, 5-mL amp =
Available from CP, Martindale, GlaxoW
(*Physeptone®*)
Linctus, section 3.9.1
Mixture 1 mg/mL, section 4.10

NALBUPHINE HYDROCH

Indications: moderate to severe
tive analgesia, see section 15.1.4.
Cautions; Contra-indications;
see under Morphine Salts and no
actions: Appendix 1 (opioid anal
Dose: *by subcutaneous, intramu*
venous injection, 10–20 mg fo
every 3–6 hours, adjusted as re

Palladone® SR (Napp) ▼ CD

Capsules, m/r, hydromorphone hydrochloride 2 mg (yellow/clear), net price 56-cap pack = £18.42; 4 mg (pale blue/clear), 56-cap pack = £25.24; 8 mg (pink/clear), 56-cap pack = £49.22; 16 mg (brown/clear), 56-cap pack = £93.52; 24 mg (dark blue/clear), 56-cap pack = £140.30. Label: 2, counselling, see below

Dose: 4 mg every 12 hours, increased if necessary according to severity of pain; CHILD under 12 years not recommended

COUNSELLING. Swallow whole or open capsule and sprinkle contents on soft food

MEPTAZINOL

Indications: moderate to severe pain, including postoperative and obstetric pain and renal colic; peri-operative analgesia, see section 15.1.4.3

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; effects only partially reversed by naloxone

Dose: *by mouth*, 200 mg every 3–6 hours as required; CHILD not recommended

By intramuscular injection, 75–100 mg every 2–4 hours if necessary; obstetric analgesia, 100–150 mg according to patient's weight (2 mg/kg); CHILD not recommended

By slow intravenous injection, 50–100 mg every 2–4 hours if necessary; CHILD not recommended

Meptid® (Monmouth) PoM

Tablets, orange, f/c, meptazinol 200 mg. Net price 20 = £4.39. Label: 2

Injection, meptazinol 100 mg (as hydrochloride)/mL. Net price 1-mL amp = £1.92

METHADONE HYDROCHLORIDE

Indications: severe pain, see notes above; adjunct in treatment of opioid dependence, section 4.10

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth or by subcutaneous or intramuscular injection*, 5–10 mg every 6–8 hours, adjusted according to response; CHILD not recommended

Methadone (Non-proprietary) CD

Tablets, scored, methadone hydrochloride 5 mg. Net price 50 = £3.11. Label: 2

Available from GlaxoWellcome (*Physeptone®*)

Injection, methadone hydrochloride, 10 mg/mL, net price 1-mL amp = 86p, 2-mL amp = £1.55, 3.5-mL amp = £1.78, 5-mL amp = £1.92

Available from CP, Martindale, GlaxoWellcome (*Physeptone®*)

Linctus, section 3.9.1

Mixture 1 mg/mL, section 4.10

NALBUPHINE HYDROCHLORIDE

Indications: moderate to severe pain; peri-operative analgesia, see section 15.1.4.3

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)

Dose: *by subcutaneous, intramuscular, or intravenous injection*, 10–20 mg for 70 kg patient every 3–6 hours, adjusted as required; CHILD up to 300 micrograms/kg repeated once or twice as necessary

Myocardial infarction, *by slow intravenous injection*, 10–20 mg repeated after 30 minutes if necessary

Preparations

Section 15.1.4.3

PENTAZOCINE

Indications: moderate to severe pain, but see notes above

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; occasional hallucinations; avoid in patients dependent on opioids and in arterial or pulmonary hypertension and heart failure; porphyria (see section 9.8.2); **interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth*, pentazocine hydrochloride 50 mg every 3–4 hours preferably after food (range 25–100 mg); CHILD 6–12 years 25 mg

By subcutaneous, intramuscular, or intravenous injection, moderate pain, pentazocine 30 mg, severe pain 45–60 mg every 3–4 hours when necessary; CHILD over 1 year, *by subcutaneous or intramuscular injection*, up to 1 mg/kg, *by intravenous injection* up to 500 micrograms/kg

By rectum in suppositories, pentazocine 50 mg up to 4 times daily; CHILD not recommended

Pentazocine (Non-proprietary) CD

Capsules, pentazocine hydrochloride 50 mg. Net price 20 = £3.68. Label: 2, 21

Tablets, pentazocine hydrochloride 25 mg. Net price 20 = £1.58. Label: 2, 21

Injection, pentazocine 30 mg (as lactate)/mL. Net price 1-mL amp = £1.45; 2-mL amp = £2.80

Suppositories, pentazocine 50 mg (as lactate). Net price 20 = £17.33. Label: 2

Note. The brand name *Fortral®* NHS (Sanofi Winthrop) is used for all the above preparations of pentazocine

PETHIDINE HYDROCHLORIDE

Indications: moderate to severe pain, obstetric analgesia; peri-operative analgesia (section 15.1.4.3)

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; avoid in severe renal impairment; not suitable for severe continuing pain; convulsions reported in **overdosage; interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth*, 50–150 mg every 4 hours; CHILD 0.5–2 mg/kg

By subcutaneous or intramuscular injection, 25–100 mg, repeated after 4 hours; CHILD, *by intramuscular injection*, 0.5–2 mg/kg

By slow intravenous injection, 25–50 mg, repeated after 4 hours

Obstetric analgesia, *by subcutaneous or intramuscular injection*, 50–100 mg, repeated 1–3 hours later if necessary; max. 400 mg in 24 hours

Postoperative pain, see section 15.1.4.3

Pethidine (Non-proprietary) CD

Tablets, pethidine hydrochloride 50 mg, net price 20 = £1.91. Label: 2

Available from Roche

Injection, pethidine hydrochloride 50 mg/mL. Net price 1-mL amp = 39p; 2-mL amp = 42p. 10 mg/mL see section 15.1.4.3

Various strengths available from Martindale

Pamergan P100® (Martindale) CD

Injection, pethidine hydrochloride 50 mg, promethazine hydrochloride 25 mg/mL. Net price 2-mL amp = 69p

Dose: by intramuscular injection, for obstetric analgesia, 1–2 mL every 4 hours if necessary; severe pain, 1–2 mL every 4–6 hours if necessary; premedication, see section 15.1.4.3

Note. Although usually given intramuscularly, may be given intravenously after dilution to at least 10 mL with water for injections

PHENAZOCINE HYDROBROMIDE

Indications: severe pain

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; **interactions:** Appendix 1 (opioid analgesics)

Dose: *by mouth or sublingually*, 5 mg every 4–6 hours when necessary; single doses may be increased to 20 mg; CHILD not recommended

Narphen® (Napp) CD

Tablets, phenazocine hydrobromide 5 mg. Net price 100-tab pack = £28.51. Label: 2

TRAMADOL HYDROCHLORIDE

Indications: moderate to severe pain

Cautions; Contra-indications; Side-effects: see under Morphine Salts and notes above; in addition to hypotension, hypertension also occasionally reported; anaphylaxis, hallucinations and confusion also reported; caution if history of epilepsy (convulsions reported, usually after rapid intravenous injection); avoid in pregnancy and breast-feeding; not suitable as substitute in opioid-dependent patients; **interactions:** Appendix 1 (opioid analgesics)

GENERAL ANAESTHESIA. Not recommended for analgesia during potentially very light planes of general anaesthesia (possibly increased operative recall reported)

Dose: *by mouth*, 50–100 mg not more often than every 4 hours; total of more than 400 mg daily by mouth not usually required; CHILD not recommended

By intramuscular injection or by intravenous injection (over 2–3 minutes) *or by intravenous infusion*, 50–100 mg every 4–6 hours

Postoperative pain, 100 mg initially then 50 mg every 10–20 minutes if necessary during first hour to total max. 250 mg (including initial dose) in first hour, *then* 50–100 mg every 4–6 hours; max. 600 mg daily; CHILD not recommended

Tramadol Hydrochloride (Non-proprietary) ▼ PoM

Capsules, tramadol hydrochloride 50 mg. Net price 100-cap pack = £15.20. Label: 2

Available from Cox, Ethical Generics Ltd, Galen (*Tramake®*), Norton

Tramake Insts® (Galen) ▼ PoM

Sachets, effervescent powder, sugar-free, lemon-flavoured, tramadol hydrochloride 50 mg (contains 9.7 mmol Na^+/sachet), net price 60-sachet pack = £8.95; 100 mg (contains 14.6 mmol Na^+/sachet), 60-sachet pack = £17.90. Label: 2, 13

Excipients: include aspartame (section 9.4.1)

Zamadol® (ASTA Medica) ▼ PoM

Capsules, tramadol hydrochloride 50 mg. Net price 100-cap pack = £15.20. Label: 2

Zydol® (Searle) ▼ PoM

Capsules, green/yellow, tramadol hydrochloride 50 mg. Net price 100-cap pack = £17.71. Label: 2

Soluble tablets, tramadol hydrochloride 50 mg, net price 20-tab pack = £3.19, 100-tab pack = £15.95. Label: 2, 13

Injection, tramadol hydrochloride 50 mg/mL. Net price 2-mL amp = £1.30

■ Modified release

Zamadol® SR (ASTA Medica) ▼ PoM

Capsules, m/r, tramadol hydrochloride 50 mg (green), net price 60-cap pack = £8.60; 100 mg, net price 60-cap pack = £17.20; 150 mg (dark green), 60-cap pack = £25.80; 200 mg (yellow), 60-cap pack = £34.40. Label: 2

Dose: 50–100 mg twice daily increased if necessary to 150–200 mg twice daily; total of more than 400 mg daily not usually required; CHILD under 12 years not recommended

COUNSELLING. Swallow whole or open capsule and swallow contents immediately without chewing

Zydol SR® (Searle) ▼ PoM

Tablets, m/r, f/c, tramadol hydrochloride 100 mg, net price 60-tab pack = £19.12; 150 mg (beige), 60-tab pack = £28.68; 200 mg (orange), 60-tab pack = £38.24. Label: 2, 25

Dose: 100 mg twice daily increased if necessary to 150–200 mg twice daily; total of more than 400 mg daily by mouth not usually required; CHILD not recommended

4.7.3 Trigeminal neuralgia

Carbamazepine (section 4.8.1), taken during the acute stages of trigeminal neuralgia, reduces the frequency and severity of attacks. It has no effect on other forms of headache. A dose of 100 mg once or twice a day should be given initially and the dose slowly increased until the best response is obtained; most patients require 200 mg 3–4 times daily but a few may require an increased total daily dosage of up to 1.6 g. Plasma-carbamazepine concentration should be monitored when high doses are given. Occasionally extreme dizziness is encountered which is a further reason for starting treatment with a small dose and increasing it slowly.

Some cases of trigeminal neuralgia respond to **phenytoin** (section 4.8.1) given alone or in conjunction with carbamazepine. A combination of phenytoin and carbamazepine is only required in refractory cases or in those unable to tolerate high doses of carbamazepine.

Although **tricyclic antidepressants** are not indicated for true trigeminal neuralgia they are more effective than carbamazepine in *post-herpetic neuralgia* and may also be useful in *oral and facial pain*, particularly if it is associated with depression.

4.7.4 Mig

4.7.4.1 Treatn

4.7.4.2 Proph

4.7.4.1 Treat migr

Acute attacks of mi gesics or a specific 5HT$_1$ agonist or er also be given if naus

Analgesics

Most migraine hea such as **aspirin** or **p** since peristalsis is attacks the medicatic absorbed to be effect preparations should t

The NSAID **tolfen** cally for the treatmer

5HT$_1$ agonists

Sumatriptan is a 5H ble value in the treatn be used during the est attack and should be ment in those who fa analgesics. Sumatript headache.

Naratriptan and **z** duced recently; both absorption than sumat

CAUTIONS. 5HT$_1$ a caution in conditions artery disease (pre-e Contra-indications bel Appendix 2); pregnan agonists are recomm should not be taken c migraine therapies.

CONTRA-INDICATIC not be used for prophyl in ischaemic heart dise arction; coronary va metal's angina); uncont

SIDE-EFFECTS. Side-ef include sensations of tir sure, or tightness of an throat and chest—disc due to coronary vasoco see also CSM advice u dizziness, feeling of we vomiting also reported.

Ergotamine

The value of ergotamir in absorption and by it

Atropine (Non-proprietary) PoM
Injection, atropine sulphate 600 micrograms/mL. Net price 1-mL amp = 32p
Note. Other strengths also available
Injection, prefilled disposable syringe, atropine sulphate 100 micrograms/mL, net price 5 mL = £3.78, 10 mL = £4.24, 30 mL = £7.75
Available from IMS (*Min-I-Jet*®)
Injection, prefilled disposable syringe, atropine sulphate 200 micrograms/mL, net price 5 mL = £4.24; 300 micrograms/mL, 10 mL = £4.32
Available from Aurum
Morphine and Atropine Injection CD see under Morphine Salts (section 15.1.4.3)

GLYCOPYRRONIUM BROMIDE

Indications; Cautions; Side-effects: see under Atropine Sulphate
Dos[redacted]medication, *by intramuscular or intra-*[redacted]*injection*, 200–400 micrograms, *or* 4-[redacted]grams/kg to a max. of 400 micrograms; [redacted]*by intramuscular or intravenous injection*, 4–8 micrograms/kg to a max. of 200 micrograms. Intra-operative use, *by intravenous injection*, as for premedication, repeated if necessary
Control of muscarinic side-effects of neostigmine in reversal of competitive neuromuscular block, *by intravenous injection*, 10–15 micrograms/kg with neostigmine 50 micrograms/kg; CHILD 10 micrograms/kg with neostigmine 50 micrograms/kg

ıbinul® (Anpharm) PoM
jection, glycopyrronium bromide
:00 micrograms/mL. Net price 1-mL amp = 63p; -mL amp = £1.06
'ailable as a generic from Antigen
binul-Neostigmine® PoM see under Neostigmine Methylsulphate (section 15.1.6)

'OSCINE HYDROBROMIDE

)polamine Hydrobromide)
'cations: drying secretions, amnesia; other lications, see section 4.6
tions; Side-effects: see under Atropine Sulate; may slow heart; avoid in the elderly (see :es above); porphyria (see section 9.8.2)
e: [redacted]ication, *by subcutaneous or intra-*[redacted]*jection*, 200–600 micrograms 30–nin[redacted] before induction of anaesthesia, usu- with papaveretum

cine (Non-proprietary) PoM
tion, hyoscine hydrobromide
micrograms/mL, net price 1-mL amp = .
7; 600 micrograms/mL, 1-mL amp = £2.73
'eretum and Hyoscine Injection CD see r Papaveretum (section 15.1.4.3)

1 Sedative and analgesic peri-operative drugs

1.1 Anxiolytics and neuroleptics
1.2 Non-opioid analgesics
1.3 Opioid analgesics

rugs are given to allay the apprehension of ent in the pre-operative period (including t before operation), to relieve pain and discomfort when present, and to augment the action of subsequent anaesthetic agents. A number of the drugs used also provide some degree of pre-operative amnesia. The choice will vary with the individual patient, the nature of the operative procedure, the anaesthetic to be used and other prevailing circumstances such as outpatients, obstetrics, recovery facilities etc. The choice would also vary in elective and emergency operations.

PREMEDICATION IN CHILDREN. Oral administration is preferred to injections where possible but is not altogether satisfactory; the rectal route should only be used in exceptional circumstances. Oral trimeprazine is still used but when given alone it may cause postoperative restlessness when pain is present.

Atropine or hyoscine is often given orally to children, but may be given intravenously immediately before induction.

ANAESTHESIA AND DRIVING. See section 15.1.

15.1.4.1 Anxiolytics and neuroleptics

Anxiolytic benzodiazepines are widely used whereas neuroleptics (e.g. chlorpromazine) are now rarely used.

Benzodiazepines

Oral premedication with benzodiazepines is increasing in popularity, a short-acting oral benzodiazepine now being the most common premedicant.

Benzodiazepines are also of particular value for the production of light sedation during unpleasant procedures or during operations under local anaesthesia (including dentistry). The resultant amnesia is such that the patient is unlikely to have any unpleasant memories of the procedure (however, benzodiazepines, particularly when used for deep sedation, can sometimes induce sexual fantasies).

Benzodiazepines are also of particular value for sedation of patients in intensive care units, particularly those having assisted ventilation. Since they have no analgesic action they are often given in conjunction with opioid analgesics.

Benzodiazepines may on occasion cause marked respiratory depression and facilities for treatment of this are essential.

Diazepam is used to produce light sedation with amnesia. The 'sleep' dose shows too great an individual variation to recommend it for induction of anaesthesia. It is a long-acting drug with active metabolites, and a second period of drowsiness can occur 4–6 hours after its administration. Peri-operative use of diazepam in children is not generally recommended; its effect and timing of response are unreliable and paradoxical effects may occur.

Diazepam is relatively insoluble in water and preparations formulated in organic solvents are painful on intravenous injection and followed by a high incidence of venous thrombosis (which may not be noticed until a week after the injection); they are also painful on intramuscular injection, and absorption from the injection site is erratic. An emulsion preparation for intravenous injection is less irritant and is followed by a negligible incidence of venous thrombosis; it is not suitable for intramuscular injection. Diazepam is also available as a rectal solution.

Temazepam is given by mouth and has a shorter action and a relatively more rapid onset than diazepam by mouth. Used as a premedicant, anxiolytic and sedative effects are produced which continue for one and a half hours, but there may be residual drowsiness. It has proved useful as a premedicant in inpatient and day-case surgery.

Lorazepam produces more prolonged sedation than temazepam. In addition amnesia is commonplace. It is used as a premedicant the night before major surgery. A further, smaller, dose may be required the following morning if any delay in starting surgery is anticipated. Alternatively the first dose may be given in the early morning of the day of operation.

Midazolam is a water-soluble benzodiazepine which is often used in preference to intravenous diazepam. Recovery is faster than with diazepam. The incidence of side-effects is low but the CSM has received reports of respiratory depression (sometimes associated with severe hypotension) following intravenous administration. It is also associated with some major interactions (see below).

DIAZEPAM

Indications: premedication; sedation with amnesia, and in conjunction with local anaesthesia; other indications, see sections 4.1.2, 4.8.2, 10.2.2
Cautions; Contra-indications; Side-effects: see notes above and sections 4.1.2, 4.8.2
Dose: *by mouth*, 5 mg on night before minor or dental surgery then 5 mg 2 hours before procedure
By intravenous injection, into a large vein 10–20 mg over 2–4 minutes as sedative cover for minor surgical and medical procedures; premedication 100–200 micrograms/kg
By rectum in solution, 10 mg; ELDERLY 5 mg; CHILD not recommended (see notes above)
Note. Diazepam rectal solution doses in the BNF may differ from those in the product literature

Preparations
Section 4.1.2

LORAZEPAM

Indications: sedation with amnesia; as premedication; other indications, see sections 4.1.2, 4.8.2
Cautions; Contra-indications; Side-effects: see under Diazepam
Dose: *by mouth*, 2–3 mg the night before operation; 2–4 mg 1–2 hours before operation
By slow intravenous injection, preferably diluted with an equal volume of sodium chloride intravenous infusion 0.9% or water for injections, 50 micrograms/kg 30–45 minutes before operation
By intramuscular injection, diluted as above, 50 micrograms/kg 1–1½ hours before operation

Preparations
Section 4.1.2

MIDAZOLAM

Indications: sedation with amnesia, and in conjunction with local anaesthesia; premedication, induction

Cautions; Contra-indications; Side-effects: see under Diazepam; see notes above for CSM warning; **important:** profound sedation with erythromycin and possibly other drugs, see **interactions:** Appendix 1 (anxiolytics and hypnotics)

Dose: sedation, *by intravenous injection* over 30 seconds, 2 mg (elderly 1–1.5 mg) followed after 2 minutes by increments of 0.5–1 mg if sedation not adequate; usual range 2.5–7.5 mg (about 70 micrograms/kg), elderly 1–2 mg

Premedication, *by intramuscular injection*, 70–100 micrograms/kg 30–60 minutes before surgery; usual dose 5 mg (2.5 mg in elderly)

Induction, *by slow intravenous injection*, 200–300 micrograms/kg (elderly 100–200 micrograms/kg); CHILD over 7 years, 150 micrograms/kg

Sedation of patients receiving intensive care, *by intravenous infusion*, initially 30–300 micrograms/kg given over 5 minutes, then 30–200 micrograms/kg/hour; reduce dose (or omit initial dose) in hypovolaemia, vasoconstriction, or hypothermia; low doses may be adequate if opioid analgesic also used; avoid abrupt withdrawal after prolonged administration (safety after more than 14 days not established)

Midazolam (Non-proprietary) PoM

Injection, midazolam (as hydrochloride) 1 mg/mL, net price 50-mL vial = £6.00

Available from Aurum

Hypnovel® (Roche) PoM

Injection, midazolam (as hydrochloride) 2 mg/mL, net price 5-mL amp = £1.01; 5 mg/mL; 2-mL amp = 85p

TEMAZEPAM

Indications: premedication before minor surgery; anxiety before investigatory procedures; hypnotic, (section 4.1.1)

Cautions; Contra-indications; Side-effects: see under Diazepam

Dose: *by mouth*, premedication, 20–40 mg (elderly, 10–20 mg) 1 hour before operation; CHILD 1 mg/kg (max. 30 mg)

Preparations

Section 4.1.1

Chlormethiazole

Chlormethiazole (clomethiazole) is licensed for use as an intravenous infusion to maintain sleep during surgery carried out under regional anaesthesia, but is no longer in current use for this purpose.

CHLORMETHIAZOLE

(Clomethiazole)

Indications: sedative during regional anaesthesia (but see also notes above); other indications (section 4.1.1, section 4.8.2, and section 4.10)

Cautions; Contra-indications; Side-effects: see section 4.1.1

Dose: *by intravenous infusion*; as a 0.8% solution of chlormethiazole edisylate, induction 25 mL (200 mg)/minute for 1–2 minutes; maintenance 1–4 mL (8–32 mg)/minute

IMPORTANT. See special cautions for intravenous infusion, section 4.1.1

Preparations

See section 4.1.1

denotes preparations that are considered to be less suitable for prescribing (see p. vi)

Phenothiazines and related drugs

Neuroleptics such as **chlorpromazine** and **droperidol** (section 4.2.1) are rarely used in the UK for premedication; although chlorpromazine is licensed to prevent shivering in induction of hypothermia, it is no longer in current use for this purpose. **Trimeprazine** is used as a premedicant for children.

PROMETHAZINE HYDROCHLORIDE

Indications: pre-operative sedative and antimuscarinic; anti-emetic (section 4.6); other indications (section 3.4.1 and section 3.4.3)

Cautions; Contra-indications; Side-effects: see section 4.6

Dose: premedication, *by mouth*, CHILD under 2 years not recommended, 2–5 years 15–20 mg, 5–10 years 20–25 mg

By deep intramuscular injection, 25–50 mg 1 hour before operation; CHILD 5–10 years, 6.25–12.5 mg

Preparations

Section 3.4.1 and section 15.1.4.3 (with pethidine)

TRIMEPRAZINE TARTRATE

(Alimemazine Tartrate)

Indications: pre-operative sedation, anti-emetic, other indications (section 3.4.1)

Cautions; Contra-indications; Side-effects: see notes above and section 3.4.1

Dose: *by mouth*, premedication, CHILD 2–7 years up to 2 mg/kg 1–2 hours before operation

Preparations

Section 3.4.1

15.1.4.2 Non-opioid analgesics

Since non-steroidal anti-inflammatory drugs (NSAIDs) do not depress respiration, do not impair gastro-intestinal motility, and do not cause dependence, they may be useful alternatives (or adjuncts) to the use of opioids for the relief of postoperative pain. NSAIDs may be inadequate for the relief of severe pain.

Diclofenac, flurbiprofen, ketoprofen (section 10.1.1), and **ketorolac** are licensed for postoperative use. Diclofenac, ketoprofen and ketorolac can be given by injection as well as by mouth. Intramuscular injections of diclofenac and ketoprofen

are given deep into the gluteal mus
pain and tissue damage; diclofena
given by intravenous infusion for t
prevention of postoperative pain. K
irritant on intramuscular injection bu
reported; it can also be given by int
tion.

Suppositories of diclofenac and k
be effective alternatives to the pa
these drugs. Flurbiprofen is also av
positories.

KETOROLAC TROMETAMC

Indications: short-term manageme
to severe acute postoperative pain

Cautions: reduce dose in elderly
weighing less than 50 kg; reduce d
tor in mild renal impairment (avoid
severe); heart failure, hepatic in
other conditions leading to reduc
volume or in renal blood flow (ir
taking diuretics); cardiac decompen
tension or similar conditions (fluid
oedema reported); **interactions:**
(NSAIDs)

GASTRO-INTESTINAL EFFECTS. Elderly
more prone to risk of gastro-intestin
increases with increased dose and dur
under Contra-indications and Side-effect

Contra-indications: history of hype
aspirin or any other NSAID (severe
reactions reported), history of asth
or partial syndrome of nasal polyps
or bronchospasm; history of peptic
gastro-intestinal bleeding; haemorr
ses (including coagulation disorder
tions with high risk of haemorrhage
haemostasis; confirmed or suspec
vascular bleeding; moderate or
impairment; hypovolaemia or
pregnancy (including labour and
breast-feeding

Side-effects: side-effects reported inc
laxis (with rash, bronchospasm, laryn
and hypotension), fluid retention (s
nausea, dyspepsia, abdominal disco
changes, peptic ulceration, gas
bleeding (elderly at greater risk, see
pancreatitis, drowsiness, dizziness
sweating, dry mouth, excessive thirs
sensory changes, convulsions, mya
meningitis, hyponatraemia, hyperkal
blood urea and creatinine, urinary s
acute renal failure, flushing or pallor,
hypertension, purpura, thrombocyt
longed bleeding time, dyspnoea an
oedema, skin reactions (some seve
Stevens-Johnson and Lyell's syndr
operative wound haemorrhage,
epistaxis, oedema, liver function char
tinue if clinical symptoms); pain at i
for general side-effects of NSAIDs,
10.1.1

Dose: *by mouth*, PATIENT over 16
every 4–6 hours (ELDERLY every 6–8
40 mg daily; max. duration of treatr
CHILD under 16 years, not recommen

investigation

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

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- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

Quality of care and the patient experience (Chapter 5)

- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

9. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

10. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

12. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patients and their relatives in the care process, including care planning.

3.3 National standards called *Essence of Care*, published by the Department of Health in 2001, provide standards for assessing nursing practice against fundamental aspects of care such as nutrition, preventing pressure sores and privacy and dignity. These are designed to act as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT.

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

Inpatient services for older people at the Gosport War Memorial Hospital 1998-2002

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that the patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

3.15 Although not part of the CHI investigation, older patients are also cared for on Mulberry ward, a 40 bed assessment unit comprising Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

KEY FINDINGS

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation that had not been fulfilled.

RECOMMENDATIONS

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

4.1 CHI's terms of reference for its investigation in part reflected those of the earlier preliminary inquiry by the police, whose reports were made available to CHI.

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

Medicine usage

4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)

Figure 4.1 Diamorphine use – Daedalus ward

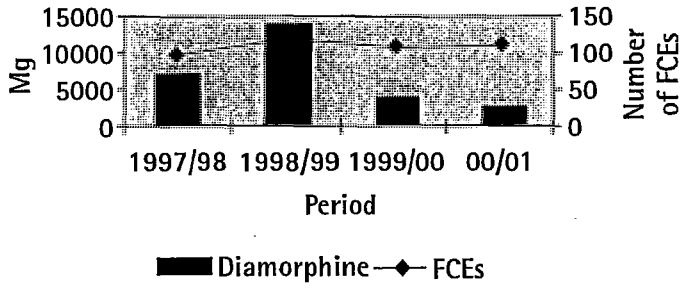


Figure 4.2 Haloperidol use – Daedalus ward

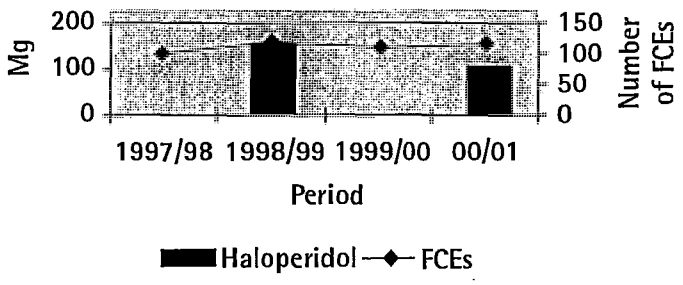


Figure 4.3 Midazolam use – Daedalus ward

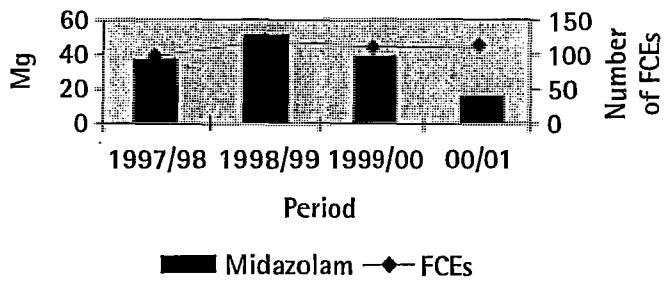


Figure 4.4 Diamorphine use – Dryad ward

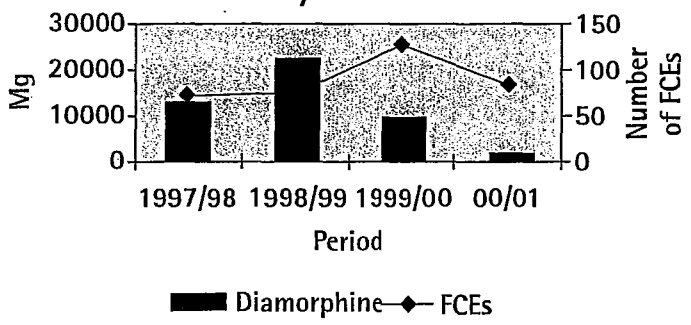


Figure 4.5 Haloperidol use – Dryad ward

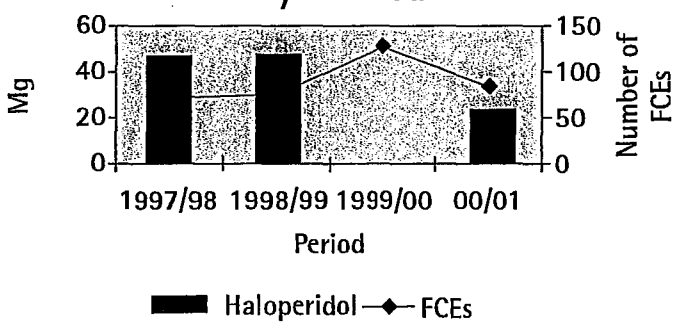


Figure 4.6 Midazolam use – Dryad ward

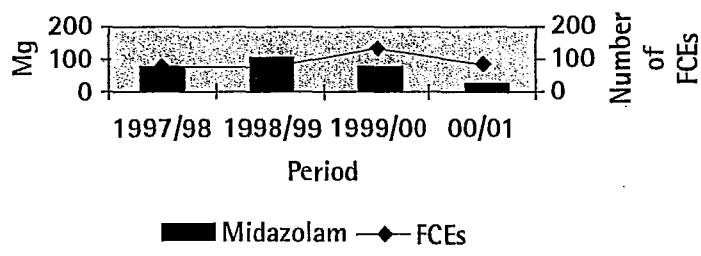


Figure 4.7 Diamorphine use – Sultan ward

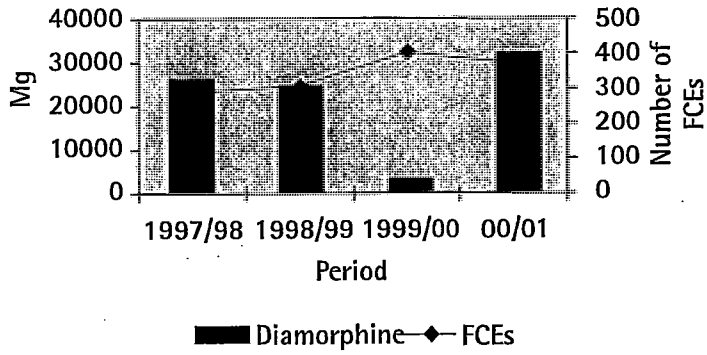


Figure 4.8 Haloperidol use – Sultan ward

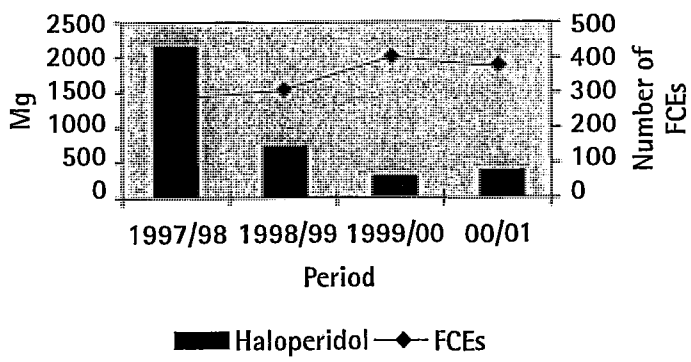
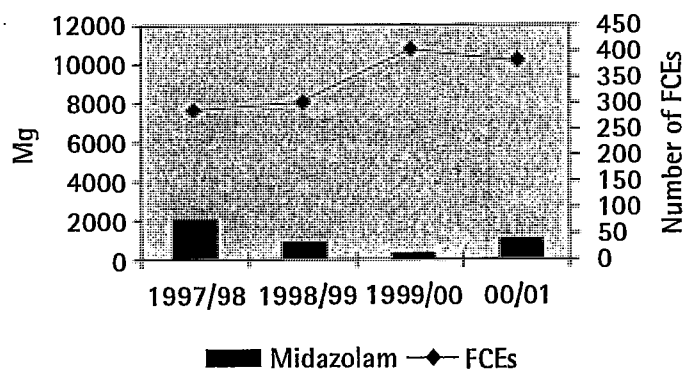


Figure 4.9 Midazolam use – Sultan ward



Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001, in collaboration with Portsmouth Hospitals NHS Trust, and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver), the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

Prescription writing policy

4.12 This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covered the purpose, scope, responsibilities and requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of intravenous medicines.

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

4.16 Information provided by the trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from Dryad or Daedalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

4.18 Underpinning all of the regulations that govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

5.8 A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards had been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced throughout the service.

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

5.18 All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders, who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

5.23 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

5.24 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff handed out the medicines while the other oversaw the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

KEY FINDINGS

1. Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

3. The ward environments and patient surroundings are good.

4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

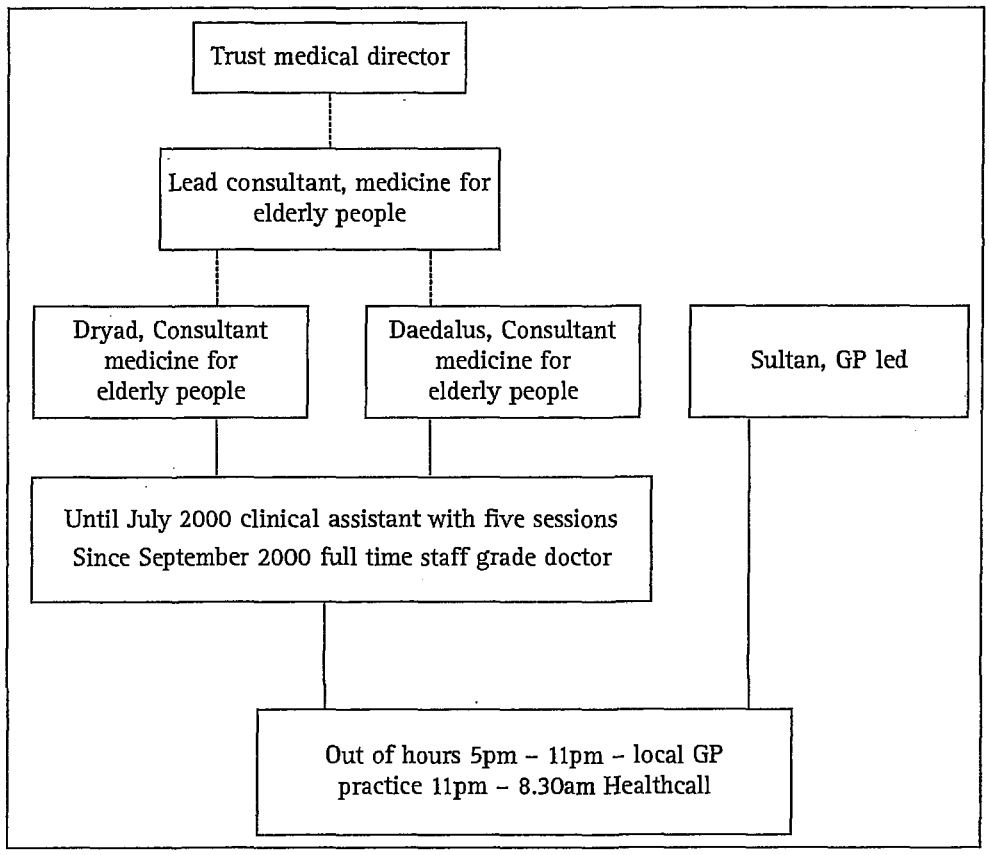
Medical responsibility

6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

Figure 6.1 Line management accountabilities



(*---------- this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

6.11 GPs managing their own patients on Sultan ward could be subject to the health authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

6.15 All qualified nurses are personally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments that promote high quality nursing care.

6.16 On each ward, a G grade clinical manager, who reports to a senior H grade nurse, manages the ward nurses. The H grade nurse covers all wards caring for older people and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 The trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

6.23 Allied health professionals are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

6.25 Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion groups and clinical observation groups.

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

6.27 In November 2000, in preparation for the change of use of beds in Dryad and Daedalus wards from continuing care to intermediate care, the trust undertook an undated resource requirement analysis and identified three risk issues:

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation

programme between the elderly medicine and elderly mental health wards. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

6.31 CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

6.34 Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

KEY FINDINGS

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure.* A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

7.12 Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation which it was aware of in late 1998.

2. Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

8 | Clinical governance

Introduction

8.1 Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

Clinical governance structures

8.3 The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. In September 1998, a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit, was patchy.

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescriping of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

A) NATIONAL DOCUMENTS

1. Modern Standards and Service Models, Older People, National Service Framework for Older People, Department of Health, March 2001
2. 'Measuring disability a critical analysis of the Barthel Index', British Journal of Therapy and Rehabilitation, April 2000, Vol 7, No 4
3. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999
4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
5. Extension of independent nursing prescribing, items prescribable by nurses under the extended scheme, Department of Health, February 2002
6. Essence of Care: patient-focused benchmarking for healthcare practitioners, Department of Health, February 2001
7. Caring for older people: A nursing priority, integrated knowledge, practice and values, The nursing and midwifery advisory committee, March 2001
8. British National Formulary 41, British Medical Association, Royal Pharmaceutical Society of Great Britiain, 2001
9. Consent – What you have a right to expect: a guide for relatives and carers, Department of Health, July 2001
10. Making a Difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Summary, The Department for Health, July 1999
11. Improving Working Lives Standard, NHS employers commited to improving the working lives of people who work in the NHS, Department of Health, September 2000
12. The NHS plan, a plan for investment, a plan for reform, Chapter 15, dignity, security and independence in old age, The Department of Health, July 2000
13. Standards for health and social care services for older people, The Health Advisory Service 2000, May 2000
14. Reforming the NHS Complaints Procedure: a listening document, The Department of Health, September 2001

B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

1. Our work, our values – a guide to Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, undated
2. Annual reports, Portsmouth Healthcare NHS Trust, 2000-2001, 2000, 1998-1999
3. Local health, local decisions – proposals for the transfer of management responsibility for local health services in Portsmouth and south east Hampshire from Portsmouth

Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust, South East regional office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Hampshire Health Authority, September 2001

4. Dissolution project proposal, Portsmouth Healthcare Trust, undated

5. Trust dissolution: summary of meeting to agree the future management arrangements for risk and clinical governance systems and groups, Portsmouth Healthcare NHS Trust, 1 November 2001

6. Looking forward... the next five years 1995-2000, Portsmouth Healthcare NHS Trust, September 1994

7. Business plans 2000-2001, 1999-2000, 1998-1999, 1997-1998, Portsmouth Healthcare NHS Trust

8. Health improvement programme 2000-2003, Portsmouth and south east Hampshire, Isle of Wight, Portsmouth and South East Hampshire, April 2000

9. Fareham health improvement programme 2000-2002, Fareham and Gosport Primary Care Groups, undated

10. A report on a future Patient Advice Liaison Service for Fareham & Gosport Primary Care Trust, Portsmouth Healthcare NHS Trust, November 2001

11. Gosport War Memorial Patient Survey results, Portsmouth Healthcare NHS Trust, November 2001, October 2001, July 2001.

12. 2001/2002 Services and Financial Framework (SAFF) cost and service pressures, Portsmouth Healthcare NHS Trust, undated

13. Gosport War Memorial Hospital outpatient clinics rota, 9 July 2001

14. User involvement in service development: A framework, Portsmouth Healthcare NHS Trust, undated

15. Isle of Wight, Portsmouth & South East Hampshire Health Authority joint investment plan for older people 2001-2002, Isle of Wight, Portsmouth & South East Hampshire Health Authority, undated

16. Portsmouth Healthcare NHS Trust, trust board agendas and strategic briefing documents:

    Trust board strategic briefing 18 October 2001, 19 July 2001, 21 June 2001,18 January 2001, 19 October 2000, 20 July 2000, 15 June 2000, 20 April 2000, 20 January 2000, 21 October 1999, 15 July 1999, 17 June 1999, 15 April 1999, 21 January 1999, 22 October 1998, 24 September 1998

    Public meeting of the trust board 20 September 2001, 17 May 2001,15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998

    Agenda for part two of meeting of trust board 20 September 2001, 17 May 2001, 15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998, 24 September 1998

17. Divisional review 2000 Gosport and Fareham division, Portsmouth Healthcare NHS Trust, 8 February 2000, 10 August 2000, 16 May 2000, 11 November 1999

18. National service framework: older people steering group (district wide implementation team) documents, Isle of Wight, Portsmouth and South East Hampshire health authority, undated

19. Correspondence: re Healthcall data 2001 analysis, Knapman practice, 22 June 2002

20. Correspondence: re Healthcall regarding contract for 2002, Healthcall business manager, March 2002

21. Patient environment assessment and action plan, Portsmouth Healthcare NHS Trust, August and September 2000

22. Combined five year capital programme 2001/2002-2005/2006, Portsmouth Healthcare NHS Trust, Portsmouth City Primary Care Trust, East Hampshire NHS Primary Care Trust, 8 November 2001

23. Portsmouth Healthcare NHS Trust: Investors in People report, Western Training and Enterprise Council, July 1999

24. Portsmouth Healthcare NHS Trust, Quality report – governance indicators, quarter ending 30 June 2001, 31 March 2001, 31 December 2000, 30 September 2000, 30 June 2000, 31 March 2000, 31 December 1999, 30 September 1999, 30 June 1999, 31 March 1999, 31 December 1998, 30 September 1998, 30 June 1998, 31 March 1998, 31 December 1997, 30 September 1997, 30 June 1997

25. Annual quality report to Portsmouth and South East Hampshire Health Authority (quarter 3 2000/2001), Portsmouth Healthcare NHS Trust, 27 February 2001

26. Improving quality – steps towards a First class service, Portsmouth Healthcare NHS Trust September 1998

27. Infection control services, Portsmouth Hospitals NHS Trust and Portsmouth Healthcare NHS Trust, Nursing practice audit, Portsmouth Healthcare NHS Trust, 9 May 2001

28. Emergency incidents originating at Gosport War Memorial Hospital, Hampshire Ambulance Service NHS Trust, April 2000-February 2002

29. Staff handbook, Portsmouth Healthcare NHS Trust, undated

30. Junior doctors' accreditation information, pack supplied by Portsmouth Healthcare NHS Trust, undated

31. GP contracts for trust working, Portsmouth Healthcare NHS Trust, December 1979-May 2001

32. GP contracts for trust working, Out of hours GP contract, Portsmouth Healthcare NHS Trust, April 1999-March 2000, June 2001-March 2002

33. Strategy for employing locum medical staff, Portsmouth Healthcare NHS Trust, undated

34. The development of clinical supervision for nurses, nurse consultant, adult mental health services, Portsmouth Healthcare NHS Trust undated

35. Correspondence/memorandum re: staff opinion survey results, Portsmouth Healthcare NHS Trust, 18 December 2001

36. Staff opinion survey 2000, Portsmouth Healthcare NHS Trust undated

37. Common actions arising from staff opinion survey results, personnel department, 19 October 2001

38. Memorandum re: senior managers on call, Portsmouth Healthcare NHS Trust, 29 September 2000

39. Personnel and human resources/management strategy and action plan, Portsmouth Healthcare NHS Trust, personnel director, October 2001

40. Strategy for human resource management and important human resource issues, Portsmouth Healthcare NHS Trust, personnel director, October 1996

41. Human resource management, Portsmouth and South East Hampshire Health Authority Community Health Care Services, November 1991

42. Audit of standards of oral hygiene within the stroke service, Portsmouth Healthcare NHS Trust November 1999-April 2000

43. Clinical Stroke service guidelines, Department of medicine for elderly people, undated

44. Reaudit evaluation of compliance with revised handling assessment guidelines, Portsmouth Healthcare NHS Trust, June 1998-November 1998

45. Feeding people, trust wide reaudit of nutritional standards, Portsmouth Healthcare NHS Trust, November 2001

46. Trust records strategy, records project manager, Portsmouth Healthcare NHS Trust March 2001

47. A guide to medical records, a pocket guide to all medical staff, Portsmouth Healthcare NHS Trust, June 2000

48. Health records all specialities core standards and procedures, Portsmouth Healthcare NHS Trust (incorporating East Hants Primary Care Trust and Portsmouth City Primary Care Trust), December 1998 updated February 2000 and May 2001

49. Referral to old age psychiatry form, Portsmouth Healthcare NHS Trust, undated

50. Patients affairs procedure – death certification and post mortems, department of medicine for elderly people, Queen Alexandra Hospital, (undated)

51. Audit of compliance with bed rails guidelines in community hospitals, Portsmouth Healthcare NHS Trust, August 2001

52. Patient flows, organisational chart, 24 October 2001

53. Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts Joint Generic Transfer Document: Protocol for the transfer to GP step down beds, Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts, November 2000

54. Discharge summary form, guidance notes for completion, Portsmouth Healthcare NHS Trust, 21 November 2001

55. Audit of patient records, December 1997-July 1998, Portsmouth Healthcare NHS Trust

56. Audit of nutritional standards, October 1997-April 1998, Portsmouth Healthcare NHS Trust, undated

57. Falls policy development - strategy to reduce the number of falls in community hospitals, Portsmouth Healthcare NHS Trust, undated

58. Minutes of falls meetings held on 26 July 2001,13 June 2001, 26 February 2001, 18 January 2001, 23 November 2000, 5 October 2000, Portsmouth Healthcare NHS Trust

59. Stepping stones: how the need for stepping stones came about, Portsmouth Healthcare NHS Trust, undated

60. Portsmouth Healthcare NHS Trust Policies: Resuscitation status policy, April 2000; Whistleblowing policy, February 2001; Risk management policy, January 2001; Recording and reviewing risk events policy, May 2001; Control and administration of medicines by nursing staff policy, January 1997; Prescription writing policy, July 2000; Policy for assessment and management of pain, May 2001; Training and education policy, April 2001; Bleep holder policy review, 15 May 2001; Prevention and management of pressure ulcers policy, May 2001; Prevention and management of malnutrition within trust residential and hospital services, November 2000; Client records and record keeping policy, December 2000; Trust corporate policies, guidance for staff, revised August 2000;

Psychiatric involvement policy, November 2001; Induction training policy, October 1999 Handling patient related complaints policy, Portsmouth Healthcare NHS Trust, January 2000; Domestic abuse in the workplace policy, July 2000

61. Medicines policy incorporating the IV policy, final draft – version 3.5, Portsmouth Hospitals NHS Trust, Royal Hospital Haslar, Portsmouth Healthcare NHS Trust, August 2001

62. Non emergency patient transport request form, Portsmouth Hospitals and Healthcare NHS Trust, undated

63. Patient transport – standards of service, Portsmouth Healthcare NHS Trust, Development Directorate, March 2001

64. Booking criteria and standards of service – criteria for use of non emergency patient transport, Portsmouth Hospitals and Healthcare NHS Trust and Hampshire Ambulance Trust, undated

65. Prescribing formulary, Portsmouth District October 2001, Portsmouth Hospitals NHS Trust, Portsmouth Healthcare NHS Trust, General Medical Practitioners, Portsmouth and South East Hampshire Health Authorities and Royal Hospital Haslar (not complete)

66. Wessex palliative care handbook: guidelines on clinical management, fourth edition, Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, The Rowans (Portsmouth Area Hospice), undated

67. National sentinel clinical audit, evidence based prescribing for older people: Report of national and local results, Portsmouth Healthcare NHS Trust, undated

68. Compendium of drug therapy guidelines 1998 (for adult patients only), Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998

69. Draft protocol for prescription and administration of diamorphine by subcutaneous infusion, medical director, Portsmouth Healthcare NHS Trust, 15 December 1999

70. Medicines and prescribing committee meeting: agendas 3 February 2000, 4 May 2001, 6 April 2000, 6 July 2000, 3 November 2000

71. Medicines and prescribing committee meeting: minutes 3 November 2000, 5 January 2001

72. Correspondence: protocol for prescription administration of diamorphine by subcutaneous infusion, Portsmouth Healthcare NHS Trust, 7 February 2000, 11 February 2000

73. Correspondence: Portsmouth Healthcare NHS Trust syringe driver control, Portsmouth Healthcare NHS Trust, 21 February 2000

74. Correspondence: diamorphine guidelines, Portsmouth Healthcare NHS Trust, 21 February 2000

75. Audit of prescribing charts: questionnaire Portsmouth Healthcare NHS Trust, undated

76. Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers, Portsmouth Healthcare NHS Trust, February 1997

77. Scoresheet – medicines management standard 2001/2002, Portsmouth Healthcare NHS Trust, undated

78. Organisational controls standards, action plan 2000/2001, Portsmouth Healthcare NHS Trust, November 2001

79. Diagram of Medicines Management Structure, Portsmouth Healthcare NHS Trust, 16 October 2000

80. Summary medicines use 1997/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan, Portsmouth Hospitals NHS Trust pharmacy service, April 2002

81. Training on demand: working in partnership, Portsmouth Healthcare NHS Trust, undated

82. Programme of training events 2001-2002, Portsmouth Healthcare NHS Trust, undated

83. Sultan ward leaflet, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust

84. Post mortem information for relatives and hospital post mortem consent form, Portsmouth Healthcare NHS Trust, January 2000

85. Proposal for Portsmouth Healthcare NHS Trust: the provision of an employee assistance programme for Portsmouth Healthcare NHS Trust, Corecare, 16 March 2000

86. Gosport War Memorial Hospital chaplains' leaflet, Portsmouth Healthcare NHS Trust, undated

87. Gosport War Memorial Hospital, chaplains and Portsmouth Healthcare NHS Trust: because we care, community health services – leaflets, Portsmouth Healthcare NHS Trust, undated

88. Talking with dying patients, loss death and bereavement, staff handout, no author, undated

89. Multidisciplinary post registration development programme, 2001

90. Gerontological nursing programme: proposal for an integrated work based learning and practice development project between the RCN's gerontological nursing programme, Portsmouth Health Care NHS Trust, PCTs and Portsmouth University: COMMUNITY HOSPITALS, Royal College of Nursing, version 2.0 2001

91. Multidisciplinary post registration year 2000-2001: lecture programme, Portsmouth Healthcare NHS Trust, November 2001

92. Training programme 2002 and in service training: list of lectures, Portsmouth Healthcare NHS Trust, undated

93. Occupational therapy service – supervision manual, Portsmouth Healthcare NHS Trust, Portsmouth City Council, Hampshire County Council Social Service department, undated

94. Acute life threatening events recognition and treatment (ALERT): A multiprofessional University of Portsmouth course in care of the acutely ill patient, October 2000

95. Training and development for nursing staff in Portsmouth Healthcare NHS Trust community hospitals relating to intermediate care: Progress report, Portsmouth Healthcare NHS Trust, 12 February 2001

96. E-learning at St James's: catalogue of interactive training programmes, November 2001

97. Valuing diversity pamphlet: diversity matters, Portsmouth Healthcare NHS Trust, undated

98. Procedural statement – individual performance review: recommended documentation and guidance notes, personnel director, Portsmouth Healthcare NHS Trust, April 2001

99. IPR audit results 2000, community hospitals service lead group, 22 March 2001

100. Clinical nursing development, promoting the best practice in Portsmouth Healthcare, Portsmouth Healthcare NHS Trust, January 1998

101. An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, December 1999

102. Your views matter: making comments or complaints about our services, Portsmouth Healthcare NHS Trust, undated

103. Anonymised correspondence on complaints relating to Gosport War Memorial Hospital since 1998

104. Learning from experience: action from complaints and patient based incidents, 1998-2001, Portsmouth Healthcare NHS Trust

105. Handling complaints course facilitators notes, Portsmouth Healthcare NHS Trust, 21 May 1999

106. Community hospitals governance framework, January 2001

107. Community hospitals and Portsmouth Healthcare NHS Trust clinical governance development plan, 2001- 2002

108. General rehabilitation clinical governance group, minutes of meeting 6 September 2001

109. Stroke service clinical governance meeting, minutes of meeting 12 October 2001

110. Continuing care clinical governance group, minutes of meeting 7 November 2001, Portsmouth Healthcare NHS Trust

111. Community hospitals clinical leadership programme update, Portsmouth Healthcare NHS Trust, 19 November 2001

112. Practice development programme: community hospitals clinical governance, Portsmouth Healthcare NHS Trust, March 1999

113. Third quarter quality/clinical governance report, community hospitals service lead group, Portsmouth Healthcare NHS Trust, January 2000

114. Community hospitals clinical governance baseline assessment action plan, September 1999

115. Clinical governance: minimum expectations of NHS trusts and primary care trusts from April 2000. Action plan – review March 2001, Portsmouth Healthcare NHS Trust, undated

116. Clinical governance annual report 2000/2001 and 1999/2000, Portsmouth Healthcare NHS Trust

117. Risk event forms and instructions, Portsmouth Healthcare NHS Trust, undated

118. Clinical governance baseline assessment trust wide report, 1999, Portsmouth Healthcare NHS Trust, undated

119. Trust clinical governance panel meeting minutes on 16 May 2001, Portsmouth Healthcare NHS Trust

120. Memorandum re: implementation of clinical governance, Portsmouth Healthcare NHS Trust, 11 June 1999

121. Risk management strategy 2000/2003, 1999/2002 and 1998/2001, Portsmouth Healthcare NHS Trust

122. Gosport War Memorial Hospital patient survey action plan, Portsmouth Healthcare NHS Trust, (undated)

C) DOCUMENTS RELATING TO THE DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE AT THE GOSPORT WAR MEMORIAL HOSPITAL

1. Dryad ward away day notes, Gosport War Memorial Hospital, 22 January 2001, 18 May 1998
2. Community hospital service plan 2001/2002, Portsmouth Healthcare NHS Trust, undated
3. Community hospitals GP bed service plan 2000/2001, Portsmouth Healthcare NHS Trust, 30 November 1999
4. Intermediate care and rehabilitation services proposal, Fareham and Gosport primary care groups, May 2000.
5. Team objectives 1999/2000 – Sultan ward, Portsmouth Healthcare NHS Trust, 21 November 2001
6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
7. Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
8. Gosport health improvement programme (HIMP) 2000-2002, Fareham and Gosport primary care groups, undated
9. Fareham and Gosport primary care groups intermediate care and rehabilitation services, Fareham and Gosport primary care groups, undated
10. Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998 – 2000/2001, Fareham and Gosport primary care groups, April 2002
11. Fareham and Gosport staff management structure, community hospitals, Portsmouth Healthcare NHS Trust, 25 October 2001
13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
14. Fareham and Gosport older persons' locality implementation group progress report. Isle of Wight, Portsmouth and South East Hants Health Authority, Fareham and Gosport primary care groups, undated
15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
16. Correspondence from department of medicine for elderly people re: national sentinel audit of stroke 1999, Portsmouth Healthcare NHS Trust, 8 March 2000
17. Job description: Lead consultant department of medicine for elderly people (draft 4), Portsmouth Healthcare NHS Trust, February 1999
18. Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
19. Job description: service manager (H Grade) department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 29 August 2000
20. Job description: Service manager, community hospitals Fareham and Gosport, Portsmouth Healthcare NHS Trust, February 2000
21. University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development, Portsmouth Healthcare NHS Trust and Portsmouth University, May 2000

22. One year on: aspects of clinical nursing governance in the department of elderly medicine, Portsmouth Healthcare NHS Trust, September 2001

23. Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health, Portsmouth Healthcare NHS Trust, 1 May 2001

24. Job description: full time staff grade physician, Gosport War Memorial Hospital department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 5 July 2000

25. Correspondence re: staff grade physician contract - Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 26 September 2001

26. Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992

27. Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated

28. Department of medicine for elderly people, consultant timetables August 1997-November 2001, Portsmouth Healthcare NHS Trust

29. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated

30. Information for supervision arrangements for Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, November 2001

31. Clinical managers meeting minutes, Portsmouth Healthcare NHS Trust, 12 November 2001

32. Notes of action learning meeting, Portsmouth Healthcare NHS Trust, 11 June 2001

33. Notes from team leader meetings for the Daedalus ward, Portsmouth Healthcare NHS Trust, 5 April 2001

34. Notes of Daedalus ward meeting, Portsmouth Healthcare NHS Trust, 6 August 2001

35. Fareham & Gosport locality division, nursing accountability pathway, Portsmouth Healthcare NHS Trust, 25 October 2001

36. Medical accountability structure for Gosport War Memorial Hospital, undated

37. Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998-2001, Portsmouth Healthcare NHS Trust

38. Night skill mix review Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 28 March 2001

39. Vacancy levels 1998-2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001

40. Sickness absence statistics for Daedalus Ward, Gosport War Memorial Hospital, 2000-2001, undated

41. Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998-2001, undated

42. Wastage for qualified nurses - Daedalus, Dryad and Sultan Ward, undated

43. Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated

44. Audit of detection of depression in elderly rehabilitation patients, January-November 1998, Portsmouth Healthcare NHS Trust, undated

45. District audit review of rehabilitation service for older people 2000/2001, Portsmouth Healthcare NHS Trust, January 2001

46. Memorandum to all medical staff re: rapid tranquillisation and attached protocol – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 23 February 2001

47. Correspondence re: guidelines on management of acute confusion from general manager – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 18 October 2001

48. Memorandum to all consultants from consultant geriatrician re: management of acute confusion elderly medicine, Queen Alexandra Hospital Portsmouth Healthcare NHS Trust, 30 April 2001

49. Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998, review date May 1999

50. Memorandum: Guidelines for admission to Daedalus and Dryad ward, Portsmouth Healthcare NHS Trust, 4 October 2000

51. Clinical policy, admission and discharge policy, Portsmouth Healthcare NHS Trust, September 2000

52. Urgent notice for all medical and nursing staff in the event of a suspected fracture and/or dislocation of a patient on the above ward, Daedalus and Dryad wards, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 16 November 2001

53. Procedure for the initial management of medical emergencies in Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 15 January 2001

54. Audit of neuroleptic prescribing in elderly medicine, Portsmouth Healthcare NHS Trust, January-November 1999, November 1998-July 1999, September–December 2001

55. Administration of medicines, community hospitals – programme for updating qualified staff, Portsmouth Healthcare NHS Trust, 13 March 1997

56. Memorandum re: seminar – osteoporosis and falls, 14 November 2001, clinical assistant teaching elderly medicine, Portsmouth Healthcare NHS Trust, 19 October 2001

57. Introduction to Gosport War Memorial Hospital for staff, Portsmouth Healthcare NHS Trust, undated

58. Competence record and development for qualified nurses 1998-2001, Sultan, Dryad and Daedalus wards

59. Fareham and Gosport induction programme, 9 November 2001, Portsmouth Healthcare NHS Trust, undated

60. Training and development in community hospitals workshops – practice development facilitators (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital), East Hampshire Primary Care Trust, undated

61. Occupational therapy service – continuous professional development and training, Fareham and Gosport locality, occupational therapy professional advisor, 23 November 2001

62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

63. Fareham and Gosport Primary Care Groups: Proposal to establish a primary care trust for Fareham and Gosport, Isle of Wight, Portsmouth and South East Hampshire Health Authority, July 2001

64. March 2001 Final monitoring report intermediate care, Portsmouth Healthcare NHS Trust, May 2001

D) DOCUMENTS RELATING TO HAMPSHIRE CONSTABULARY INVESTIGATIONS

1. Police expert witness report, Professor B Livesley, MD, FRCP, 9 November 2000
2. Police expert witness report, Professor G Ford, MA, FRCP, 12 December 2001
3. Police expert witness report, Dr K Mundy, FRCP, 18 October 2001

E) OTHER DOCUMENTS RELATING TO GOSPORT WAR MEMORIAL HOSPITAL

1. A local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern, Isle of Wight, Portsmouth and South East Hampshire Health Authority and local medical committee, undated
2. Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

ii. CHI sought to obtain views about the service through a range of methods. People were invited to:

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the stakeholders contact.

Figure B.1 Concerns about care raised by stakeholders by ward and date

	Dryad	Daedalus	Sultan	GWMH	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
GWMH				2	2
TOTAL	1	17	3	6	27

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received nine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

iii. The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "one lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "as a whole the ward was lovely and there was no complaints against the staff". The environment was described as being tidy and clean with good decor. Another comment recognised the ward's attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. One stakeholder commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

APPENDIX C

Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Barker, D, Staff Nurse
- Barker, M, Enrolled Nurse
- Barrett, L, Staff Nurse
- Beed, P, Clinical Manager
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Hamblin, G, Senior Staff Nurse
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Joice, C, Staff Nurse (until 4 October 1999)
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M, Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose, B, Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- Neville, J, Staff Nurse (until 1 January 2001)
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- Portsmouth Hospitals NHS Trust

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- Hampshire Ambulance Service NHS Trust

  Alan Lyford, Patient Transport Service Manager

- Isle of Wight, Portsmouth & South East Hampshire Health Authority

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- NHS Executive south east regional office

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

- Portsmouth and South East Hampshire Community Health Council

  Joyce Knight, Chairman

  Christine Wilkes, Vice Chair

  Margaret Lovell, Chief Officer

- Hampshire Constabulary

  Detective Superintendent John James

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

- Local representative for Unison

  Patrick Carroll, Branch Chair

- Local general practitioners

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

The group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHI's investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

The group will review 15 anonymised clinical notes supplied by the trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The group will reach its conclusions by 31 March 2002 at the latest.

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)

- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)

- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital

- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital

- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

Department	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS Trust
Elderly medicine		●		
Elderly mental health		●		
Community paediatrics	●			
Adult mental health services	● For Portsmouth patients			● For Hampshire patients
Learning disability services			●	
Substance misuse	●			
Clinical pyschology	●			
Primary care counselling				●
Specialist family planning	●			
Palliative care		●		

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

APPENDIX I

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998-2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			0	37	0	0
Diamorphine injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	0
	Sultan	500mg	5	1	1	0	4
	Total			1	4	0	4
Haloperidol injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total			44	19	6	0
Haloperidol injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total			0	0	0	21
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total			133	168	116	47

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

APPENDIX J

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc.
Non clinical relates to management, administration, catering, portering etc.

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

clinical governance refers to the quality of health care offered within an organisation.
The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN institute.

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

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CHI
COMMISSION FOR HEALTH IMPROVEMENT

Commission for Health Improvement
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

Telephone: 020 7448 9200
Fax: 020 7448 9222
Text phone: 020 7448 9292
Web: www.chi.nhs.uk

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General Medical Council and Dr Jane Barton
Report on Mr Lesley Pittock (Patient A)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient A

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC panel in determining whether Dr Barton has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that Dr Barton prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; that the prescriptions of nozinan in combination with other drugs were excessive to his needs; and that Dr Barton's prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient A; statement of Dr Jane Barton re Patient A; witness statements of Lynda Wiles, Dr Jane Tandy, Tina Douglas, Dr Victoria Banks, Freda Shaw, Lynn Barrett, Gillian Hamblin, Dr Althea Lord, Fiona Walker; statement made by Dr Barton in relation to Patient A, interview of Dr Barton dated 23 March 2005.

5. Course of events.

5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152) and died on 24 January 1996. His past medical history was notable for recurrent

depression which had been treated with electro convulsive therapy 1992. He was admitted under the care of Dr Banks consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.

5.2 Patient A was admitted under Dr Banks' care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December the notes record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated with antibiotics. On the 27 December the notes record (p66) a ward round by Dr Banks and that Patient A was *"chesty, poorly, abusive, not himself at all'*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

5.3 On 2 January a referral was made by Dr Bank's team to Dr Lord consultant geriatrician (page 67) states *'his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die'*. The referral says *"this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health"*.

5.4 On the 3 January on a ward round by Dr Banks the notes record that Patient A *"needs more time to convalesce"* and that he would probably need a nursing home. On the 4 January the notes record Patient A was seen by Dr Lord (page 68). Dr Lord noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) Dr Lord states that his prognosis is poor and that she understood Patient A's wife was aware of the poor prognosis. The nursing records at psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.

5.5 On the 5 January (page 196) an entry by Dr Barton in the medical notes at Gosport War Memorial Hospital states *'Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L*

ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself, long standing depression on lithium and sertraline'. The next entry in the medical notes is on the 9 January by Dr Barton and states *'Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs opiates.'*

5.6 On Friday 10 January an entry by Dr Tandy states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w wife – agrees .....(illegible)..... TLC'.* The next entry in the medical notes on 18th January 1996 is By Dr Barton and states *'Further deterioration, sc analgesia continues, ...(illegible)..... symptoms try nozinan.*

5.7 The next entry in the medical notes is dated 20 January (p198) and is unsigned but as it refers to a verbal order is likely to be by a member of nursing staff. *Has been unsettled on haloperidol in syringe drive diamorphine (illegible) to higher dose (illegible words), nozinan 50mg to 100m in 24 hrs (verbal order).* There is an entry the following day dated 21 January 1996 (signature unclear) *'much more settled, quiet breathing, respiratory rate 6 / minute, not distressed continue'.* There is an entry in the notes on 24 January 1996 confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.

5.8 Nursing assessment on the 5 January at Gosport on Dryad ward record Patient A had a poor physical condition with broken pressure areas to his buttocks and hip, and broken skin on scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).

5.9 An entry in the nursing notes on the 10 January states *'condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on oramorph4 hourly this evening'.* A nursing entry on the 15 January states *'Seen by Dr Barton has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug'.* A second entry that day states his daughter was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet. On the 16 January the nursing notes record *'Condition remains very poor, some agitation was noticed when being attended to. Seen by Dr Barton haloperidol 5-10mg to be added to the driver'.*

5.10 An entry later that day at 1300h states *'previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly'.* There was a note to nurse him on his back and left side only. An entry in the nursing note on 17 January indicates Patient A was seen by Dr Barton and that his medication was increased as he remained *'tense and agitated, chest very "bubbly"'.* On the same day at 14:30h the nursing notes records Patient A was again seen by Dr Barton (page 210) his medication reviewed and altered, and that his syringe driver renewed

at 15:30 with two drivers. Further deterioration is noted at 2030h. On the 17 January he appears more settled.

5.11 An entry on the 18 January in the nursing notes record that he appears comfortable. On 19 January *'marked deterioration in already poor condition'* is reported. Over the next 3 days the notes record he is settled and that an infusion of diamorphine, midazolam, nozinan, haloperidol and hyoscine was continuing.

5.12 The drug charts indicate on the 5 January that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195). There is an undated prescription by Dr Barton (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear to me if these drugs were prescribed by Dr Barton on the 5 January 1996. Regular oramorph (5mg 5 times a day) was prescribed on 10 January. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January the prescription is changed to 2ml (4mg) 4 hourly with 5ml (10mg) at 2000 at this dose regimen of morphine is given until the morning of 15 January 1996 with a last dose administered at 0600h with Patient A receiving a total of 26mg morphine daily (page 202).

5.13 On 11 January Dr Barton prescribed diamorphine 80-120mg subcutaneous 24 hours, hysoscine 200-400ug subcutaneous 24 hours, midazolam 40-80mg subcutaneous 24 hours , 80 mg of diamorphine, hyoscine 400ug, midazolam 60mg are then administered over 24 hour periods during the 15, 16 and 17 January (page 201).

5.14 On 16 January, haloperidol 5-10mg/24hr was prescribed. Haloperidol was administered on the 16 January (5mg/24hr) and 17 January (10mg/24hr). On the 17 January the dosage of all drugs were increased by Dr Barton to diamorphine 120mg/24hr, midazolam 80mg/24hr, hyoscine 1200ucg/24hr, haloperidol 20mg 24 hours and these were administered from 17 January onwards, until Patient A's death with the exception of haloperidol which was stopped on 20 January. On 18 January nozinan 50mg was prescribed by Dr Barton and 2 doses administered (dates unclear) this was then increased to 100mg on 20 January and this appears to be administered subcutaneously each 24 hours over the following 3 days. An entry in the nursing notes on 20 January (page 211) states *'verbal order taken to double nozinan and omit halopeirdol'*.

5.15 There is a prescription for diamorphine 120mg and hyoscine 600ug over 24 hours dated 18 January although the nursing entries on the drug chart suggest these were administered on 17 January. I cannot find the drug charts for the period 18-24 January in the copies of the medical records provided to me.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 189-191 and 199-204
All prescriptions written by Dr Barton unless otherwise marked.

Regular Prescrptions

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)	
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)	
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)	
Thyroxine 50ucg od	5 Jan – 15 Jan (dose not administered after 15 Jan)	
Illegible prescription	*tick mark 7 Jan*	
Arthrotec one tab bd	8 Jan – 10 Jan (discontinued after 0900 10 Jan)	
Oramorph (10mg/5ml) 5mg nocte	10 Jan	5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan	Four 5mg doses
Oramoprh (10mg/5ml) 10 mg nocte	11 Jan	10mg nocte
	12 Jan	Four 5 mg doses
	12 Jan	10mg nocte
	13 Jan	Four 5mg doses
	13 Jan	10mg nocte
	14 Jan	Four 5 mg doses
	14 Jan	10mg nocte
	15 Jan	one 5mg dose then discontinued
Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan	120 mg/24hr
Hyoscine subcut via syringe driver 600ucg/24hr Prescribed 18 Jan	17 Jan	600ucg/24hr
Haloperidol subcut via syringe driver 5-10mg/24hr Prescribed 16 Jan	16 Jan	5mg/24hr
	17 Jan	10 mg/24hr
Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan	120 mg/24hr
	18 Jan	120 mg/24hr
	19 Jan	120 mg/24hr
	20 Jan	120 mg/24hr
	21 Jan	120 mg/24hr
	22 Jan	120 mg/24hr
	23 Jan	120 mg/24hr
Midazolam subcut via syringe driver 80mg/24hr Prescribed 18 Jan	17 Jan	80 mg/24hr
	18 Jan	80 mg/24hr
	19 Jan	80 mg/24hr
	20 Jan	80 mg/24hr

	21 Jan	80 mg/24hr
	22 Jan	80 mg/24hr
	23 Jan	80 mg/24hr

Hyoscine subcut via syringe driver	17 Jan	1200ucg/24hr
1200ucg/24hr	18 Jan	1200ucg/24hr
Prescribed ? Jan	19 Jan	1200ucg/24hr
	20 Jan	1200ucg/24hr
	21 Jan	1200ucg/24hr
	22 Jan	1200ucg/24hr
	23 Jan	1200ucg/24hr

Haloperidol subcut via syringe driver	17 Jan	20 mg/24hr
20mg/24hr	18 Jan	20 mg/24hr
Prescribed 16 Jan	19 Jan	20mg /24hr
	20 Jan	20 mg/24hr discontinued

Nozinan subcut	23 Jan	100mg/24hr
100mg/24hr		
Prescribed 22 Jan		

As required prescriptions

Diamorphine subcut via syringe driver	15 Jan	80mg/24hr
80-120mg/24hr	16 Jan	80mg/24hr
Prescribed 11 Jan	17 Jan	80mg/24hr

Hysoscine subcut via syringe driver	15 Jan	400 ucg/24hr
200-400 ucg/24hr	16 Jan	400 ucg/24hr
Prescribed 11 Jan	17 Jan	400 ucg/24hr

Midazolam subcut via syringe driver	15 Jan	60mg/24hr
40-80mg/24hr	16 Jan	60mg/24hr
Prescribed 11 Jan	17 Jan	60 mg/24hr
	18 Jan	80 mg/24hr

Midazolam subcut via syringe driver	None administered
80mg/24hr	
Prescribed 16 Jan	

Nozinan subcut via syringe driver	18 Jan	50mg/24hr
50mg/24hr	19 Jan	50mg/24hr
Prescribed 18 Jan		

Nozinan subcut via syringe driver	20 Jan	100mg/24hr
100mg/24hr	21 Jan	100mg/24hr
Prescribed Dr Brigg	?	100mg/24hr

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission

to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction and had become immobile with malnutrition and bedsores. Dr Lord's assessment indicates he was very ill and would possibly not survive to leave hospital. Dr Lord appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and unstable enough that he should continue to be managed in a continuing care bed.

8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by Dr Barton at regular intervals during this period. On admission Dr Barton summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether Dr Barton considered Patient A was for palliative care only.

9. The previous assessment by Dr Lord and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with Dr Tandy as the responsible consultant. Day to day medical care was the responsibility of Dr Barton and during out of hours the on call doctors.

10. Despite the limited medical documentation the decision of Dr Barton to prescribe 5mg of oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates Dr Tandy considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.

11. I consider the discontinuation of sertaline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.

12. The change on 15 January from regular oral doses of morphine to syringe driver subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion is not justified by any information recorded in the medical notes. The nursing notes suggest Patient A was agitated at times but there is no record that he was in pain.

13. The diamorphine dose prescribed was not justified and was excessively high. Patient A was receiving 30mg oral morphine/24 hour on 14 January. The equivalent dose of subcutaneous diamorphine would have been 15-20mg/24hr. The prescription of diamorphine 80-120mg/24hr was at least a four-fold increase in the equivalent opioid dose he had been receiving. An appropriate dose to commence with if a diamorphine infusion had been justified would have been 15-20mg/24hr and up to 30mg/hr if Patient A was showing signs of still being in pain. The prescribed dose of midazolam of 40-80mg/24hr was excessively high and the notes contain no entry from Dr Barton justifying such a high starting dose. An appropriate starting dose in a frail older man if a subcutaneous infusion had been indicated would have been 10mg/24hr particularly when a diamorphine infusion was also being administered. The prescription of diamorphine at an infusion rate of 80mg/24hr with midazolam at an infusion rate of 60 mg/24hr on 15 January carried a very high risk of producing respiratory depression and/or coma.

14. It would have been appropriate for Dr Barton to perform a clinical assessment at this stage but there is no evidence in the notes that this took place. Dr Barton does not appear to have considered the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think Dr Barton need necessarily have discussed Patient A's problems with the consultant Dr Tandy but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam, haloperidol and nozinan. The medical notes contain no justification for the commencement of haloperidol and then nozinan, a more sedating neuroleptic drug. However the prescription of haloperidol would have been reasonable if agitation was a continuing problem in Patient A.

15. The prescription of nozinan on 18 January was not justified by any information presented in the nursing or medical records as at this point as Patient A was reported to be comfortable. The combination of diamorphine midazolam, haloperidol and nozinan very likely shortened Patient A's life although he would not have been expected to live more than a few week following his admission to Dryad ward.

16. In my opinion the infusions of diamorphine, midazolam and haloperidol and then nozinan, very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs.

Summary of Conclusions

17. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by Dr Barton as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam. The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. There was no justification in the medical or nursing notes for the prescription of nozinan by Dr Barton. However the very poor quality of the medical and nursing notes make it difficult for me to be certain that these drugs were not justified given Patient A's clinical condition and reported pain and agitation.

18. In my opinion Dr Barton in her care of Patient A failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GMC and Dr Barton
Report on Elsie Lavender (Patient B)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient B

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient B commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practise Panel that the prescriptions for diamorphine on 26 February and for diamorphine and midazolam on 5 March were too wide; that the lowest commencing dose of diamorphine on 5 March of 100mg per 24 hours was excessive to Patient B's needs; that these prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her needs; that these prescriptions and the prescription of Morphine Slow Release (MST) tables on 24 February were inappropriate, potentially hazardous and not in the best interests of Patient B; that Dr Barton did not perform an appropriate examination or assessment of Patient B on admission or an adequate assessment when Patient B's condition deteriorated; did not provide a plan treatment or obtain the advice of a specialist when Patient B's condition deteriorated and that Dr Barton's actions and omissions in relation to Patient B were therefore inadequate and not in the best interests of Patient B.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient B; statements of Alan Lavender, Sheelagh Joines, Margaret Couchman, Dr Althea Lord, Elizabeth Thomas, Fiona Walker; statement made by Dr Barton in relation to Patient B; Dr Barton's police interview 24 March 2005.

5. **Course of events**

5.1 Patient B was 83 years of age when she was admitted to the Royal Hospital Haslar on 5 February 1996 following a fall, was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996. Patient B died on Daedalus Ward, Gosport War Memorial Hospital on 6 March 1996. Prior to her fall and admission on 5 February 1996, Patient B lived alone at home with her bed downstairs. She had a history of long-standing insulin dependent diabetes and was registered blind due to cataracts (page 79). The admission clerking notes (page 127) record she could walk about 10 yards with a stick, that her son did her shopping and she was supported with daily home help and nurse visits to administer her insulin.

5.2 On 5 February 1996, Patient B had been found at home, lying at the bottom of her stairs by her home help. Patient B was unable to recall events but it seemed clear that she had fallen down the stairs as she was complaining of pain in both shoulders and a sore head. She was taken to the Accident & Emergency Department at Royal Hospital Haslar where she was found to have a laceration on the scalp, laceration on the right lower leg and tenderness over the acromioclavicular region of the right shoulder and tenderness over the left humerus (page 130). X-rays were obtained of the skull and left and right shoulder. The notes record (page 134) that there was no bony injury evident. I could not find a formal report of these x-rays in the medical notes. On neurological examination she was found to have general weakness and was unable to move her right fingers. The impression of the assessing doctor in Accident & Emergency was that she had had a fall either due to a slip or stroke (CVA). She noted she was a little drowsy and arranged for admission.

5.3 On admission (page 140) the admitting doctor noted she looked frail but was fully alert and orientated. No focal arm or leg weakness was noted although power was generally weak throughout and an upgoing right plantar reflex was observed. Other findings were of a laceration (now sutured) and cut on the right leg with a small ulcer over the left tibia. Blood tests on admission were unremarkable and the electrocardiogram (ECG) showed atrial fibrillation (p143). Further enquiry into her history indicated she had had an episode of hypoglycaemia one month previously (page 143). The notes record (page 144) that she was independent but could only walk a few yards and went out of the house once a week when taken out by her son.

5.4 On 6 February the medical notes record that Patient B was complaining of pain in the right arm and had tenderness over the humerus and that the x-rays were not on the ward. Later that evening the medical notes record (page 145) that Patient B developed a temperature of 38.5°C. Examination reports chest and abdomen were normal and there was no obvious source of infection, however she was commenced on amoxicillin most likely to cover the possibility of a chest or urinary tract infection.

5.5 On 7 February the notes record that she still had left shoulder and upper arm pain and her hands were a problem (p145). On 8 February she was seen by Code A physiotherapist (page 146) who noted that Patient B was complaining of shoulder/upper limb tenderness and abdominal pain that she

required the assistance of two people to move from sitting to standing with full support for a few steps. She noted the pain Patient B was having in her shoulder was a major problem leading her to require assistance with feeding, washing and dressing when she had previously been independent in these activities. An entry later that day indicates the need for analgesia. On 12 February the medical records note Patient B's shoulder was still very painful. On 13 February a referral was made to Dr Lord, Consultant in Elderly Medicine. I have not been able to find a record of the analgesia and other drug therapy Patient B received at Royal Hospital Haslar in the medical notes.

5.6 The referral to Dr Lord (page 146) state that x-rays showed no fractures, that her diabetes was under control, that she was not able to do anything for herself and that she needed help to walk. The medical records on 14 February record that *"Patient B was still not able to do much for herself because of pain in her arms"* (page 150).

5.7 On 16 February Patient B was seen by Dr Tandy, Consultant Geriatrician in response to the referral made to Dr Lord. Dr Tandy noted the history of the fall on 5 February. That her full blood count suggested the presence of iron deficient anaemia and that Patient B still had pain in her arms and shoulders. At this stage she was walking a few steps with a physiotherapist, required two people to transfer and had no problems eating or drinking. Dr Tandy noted (page 151) that she had been unable to use her fingers since admission, but this was improving.

5.8 Dr Tandy's examination of Patient B at this time indicated she had 4/5 weakness of the fingers and wrists in both arms and a decreased measurement in both shoulders. On sensory examination there was a possible loss of sensation in the median nerve territory of the right hand which Dr Tandy thought was long-standing. Reflexes were generally decreased, right plantar reflex was equivocal and left plantar was upgoing. Dr Tandy's impression was of a probable brain stem stroke (b. stem CVA page 152). Dr Tandy stated in the medical notes *"she had her neck x-rayed – I assume it was normal"*. Her notes record *"sounds as though only just managing at home prior – but would like to get back. Therefore to Daedalus GWMH"*. She requested (page 153) that notes and x-rays be sent with Patient B when a bed was available on the ward. Dr Tandy stated at the end of her assessment *"I am not sure whether we'll be able to get her home, but we will try"*.

5.9 An entry in the medical notes on 20 February stating mobility was improving in her arms and Patient B was now able to feed herself but was still unable to use cutlery. Dr Tandy's assessment is summarised in a letter dated 16 February 1996 (pages 242, 244).

5.10 Patient B was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996, under the care of Dr Lord, Consultant Geriatrician. An entry from Dr Barton in the medical notes on 22 February 1996 (p175) states *"Transfer to Daedalus Ward, GWMH. Past medical history fall at home top to bottom of stairs, laceration on head. Leg ulcers. Severe incontinence, needs a catheter. Insulin dependent diabetes mellitus. Needs Mixtard insulin bd. Regular series blood sugar. Transfers with two. Incontinent of urine. Help to*

feed and dress. Barthel 2. Assess general mobility. ? suitable rest home if home found for cat".

5.11 The next entry from Dr Barton in the medical notes on 23 February states *"catheterised last night. 500ml residue. Blood and protein. Trimethoprim".* The next entry in the medical notes is on 26 February by Dr Barton *"not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress. Institute subcutaneous analgesia if necessary".* As required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800ucg/24hr were written by Dr Barton on 26 February but none administered.

5.12 The next entry is on 5 March 1996 by Dr Barton in the medical notes and states *"has deteriorated over last few days. Not eating or drinking. In some pain therefore start subcutaneous analgesia. Let family know".* On 6 March 1996 Dr Barton writes in the medical notes (page 975) *"further deterioration. Subcutaneous analgesia commenced. Comfortable and peaceful. I am happy for medical staff to confirm death".* There is an entry in the medical records on 6 March 1996 at 2128h confirming death by a member of nursing staff. The death certificate records cause of death as 'CVA' with diabetes mellitus as a contributory factor (CVA is an abbreviation for cerebrovascular accident i.e. stroke).

5.13 The nursing summary records (page 1021) state *"patient having problems with grip in both hands and pain in her arms and shoulders".* On 20 February the nursing summary states she was referred to physiotherapy. On 24 February the nursing notes state *"Patient B's pain was not controlled by DF118, that the patient was seen by Dr Barton and commenced on morphine (MST 10mg bd)"* (Page 1021). On 26 February 1996 the nursing notes record that Patient B was seen by Dr Barton and the MST morphine dose increased to 20mg bd (page 1022). The nursing notes later that day (1430h) indicate the son of Patient B and his wife were seen by Dr Barton, that the prognosis was discussed and *"son is happy for us to just make Patient B comfortable and pain-free. Syringe driver explained".*

5.14 On 4 March 1996 the notes record patient B was complaining of pain and of having extra as required doses of analgesia. Morphine sustained release tablets were increased to 30mg twice daily by Dr Barton. On 5 March the nursing summary records Patient's B pain was uncontrolled and a syringe driver was commenced at 0930h with diamorphine 100mg/24hr and midazolam 40mg/24hr. On 6 March 1996 the nursing records state that patient B was seen by Dr Barton and that medication other than that through the syringe driver was discontinued as Patient B was not unrousable.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 832-848. All prescriptions written by Dr Barton unless otherwise marked.

Regular prescriptions

Digoxin 125ug od Prescribed 22 Feb	23 Feb – 4 Mar then discontinued

Digoxin 125ug od 5 Mar no further doses
Prescribed 4 Mar
Co-amilofruse 1 tablet once daily 23 Feb – 4 Mar then discontinued
Prescribed 22 Feb
Co-amilofruse 1 tablet once daily 4 Mar then no further doses
Prescribed 4 Mar
Ferrous sulphate 200mg bd 23 Feb – 4 Mar then discontinued
Prescribed 22 Feb and further continuation prescription 4 Mar
Beclomethasone inhaler 2 puffs twice daily
Prescribed 22 Feb 22 Feb – 4 Mar then discontinued
Salbutamol inhaler 2 puffs four times daily
Prescribed 22 Feb 22 Feb – 4 Mar then discontinued

Insulin mixtard 50 units once daily 0730h
Prescribed 22 February 1996 23-26 Feb
Insulin mixtard 50 units once daily 1800h
Prescribed 22 February 1996 22-25 Feb
Insulin mixtard dose unclear 23 Feb – 4 Mar (omitted 28 Feb)
Insulin mixtard dose unclear
Insulin mixtard 30 units morning 4-5 March
Prescribed 4 March
Insulin mixtard 20 units evening No doses administered
Prescribed 4 March
Trimethoprim 200mg bd 23-27 Feb then discontinued.
Prescribed 23 Feb

MST 10mg bd 0600h, 1800h 24-26 Feb discontinued after morning dose
Prescribed 24 Feb
MST 20mg bd 26 Feb 2200h – 3 Mar 2200h then discontinued
Prescribed date unclear
MST 30mg bd 4 Mar 2 doses then discontinued
Prescribed 4 Mar

Diamorphine subcut via syringe driver 5 Mar 100mg/24hr
100-200mg/24hr 6 Mar 100mg/24hr
Prescribed 5 Mar

Midazolam subcut via syringe driver 5 Mar 40mg/24hr
40-80mg/24h 6 Mar 40mg/24hr
Prescribed 5 March 1996

As required prescriptions
Dihydrocodeine ? dose 9 doses, 2 tablets received dates and times unclear
Prescribed 22 Feb

Diamorphine subcut via syringe driver None administered
80-160mg/24hr
Prescribed 26 Feb

Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 26 Feb	None administered
Hyoscine sub-cut via syringe driver 400-800ug/24hr Prescribed 26 Feb	None administered

Opinion on Patient Management

7. Patient B was an elderly lady with long standing diabetes who had significant impairments and comorbidites prior to her fall and admission to hospital in February 1996. Although she was registered blind and had previous falls at home she was living alone at home with support. Following the fall her functional abilities were significantly impaired because she was unable to use her hands. This was attributed to a brain stem stroke although I consider the clinical evidence does not support this diagnosis. Bilateral hand weakness and arm and shoulder pain would be an unusual presentation for a brain stem stroke. No radiological brain imaging was undertaken which might have helped confirm the diagnosis. However as Dr Tandy rightly commented CT brain imaging at the time she assessed the patient would be unlikely to have demonstrated a brain stem stroke.

8. In a patient who has had a significant fall downstairs it is crucial to exclude injury to the head or cervical spine and in particular in patients with neurological deficits to exclude cervical cord compression. Dr Tandy recognised the importance of this through her comment asking whether the medical team responsible for her care had obtained and reviewed neck X-rays. I have been unable to find a record of any X-rays of Patient B's neck in the medical records and it is not clear that any X-rays of Patient B's cervical spine were obtained. In this context I think it is much more likely Patient B's symptoms were related to cervical spine cord injury. Her clinical symptoms are more in keeping with this diagnosis than a stroke. Ideally MR scanning of the brain and cervical spine would have been requested to assess whether this was present and consideration given to obtaining a neurological or neurosurgical opinion. Not withstanding the possible presence of cervical spine and cord injury Patient B eventually started to gain improved function of her hands although her general function was significantly reduced to that prior to her fall.

9. At the time of her transfer to Daedalus Ward the plan was to attempt to mobilise Patient B. The initial assessment of Patient B by Dr Barton was in my view inadequate. There was no assessment of her pain and no neurological examination. The latter should have been performed because of the continuing arm weakness and the working diagnosis of a possible brain stem stroke. There was no record of the analgesia she had received prior to transfer to Daedalus Ward. The prescription of mild opioid drug dihydrocodeine for her pain was in my view reasonable and appropriate. It seems likely that her pain was attributed to musculoskeletal injuries although this is not stated by Dr Barton. In my view continuing pain in the absence of

fracture more than two weeks after a fall should have prompted a clinical review including a detailed history and re-examination of the patient with consideration of alternative causes of the pain.

10. The prescription by Dr Barton of MST (sustained release morphine) on 24 February was in my view not justified or best practice by the information available in the medical records. The response to dihydrocodeine was not recorded. It would have been more appropriate to prescribe as required oral morphine before prescribing a sustained release preparation. Both the medical and nursing notes lack information on Patient B's symptoms of pain although it seems likely that she was having persisting pain as the MST dose was increased to a total of 60mg daily. However the medical and records do not record that Patient B remained in pain on the initial dose of MST and do not provide any justification for the increase in dose to 60 mg daily over the following days.

11. The prescriptions on 26 February of as required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800ucg/24hr were in my opinion, not justified, reckless and potentially very dangerous. In the event none of these were administered by nursing staff. At this time there was no evidence in the notes that Patient B was unable to swallow. She was receiving 40mg oral morphine in a 24 hour period and the equivalent dose of subcutaneous diamorphine would have been approximately 15-20mg/24hr. Had the diamorphine been administered this would have been 4-8 fold increase and would have been highly likely to cause respiratory depression and coma. Had the midazolam infusion been commenced this would have even more powerfully suppressed Patient B's respiration and conscious level.

12. Dr Barton documents on the 5 March that Patient B was deteriorating and was not eating or drinking. No assessment was recorded or appears to have made by Dr Barton as to the cause of this deterioration. In particular she does not appear to have considered that the deterioration in patient B may have been due to adverse effects of the morphine prescribed to her. In this context it is difficult to know whether continuing opioid drugs was appropriate in Patient B. If Patient B's deterioration was not due to opiates it was appropriate to continue an equivalent opioid dose by the subcutaneous route. The equivalent diamorphine subcutaneous dose is one third to one half of the oral morphine dose received over a 24 hour period. Patient B was receiving 60mg/24hr of oral morphine. Therefore an equivalent dose of subcutaneous diamorphine would have been 20-30mg/24hr.

13. The prescription of a subcutaneous infusion of diamorphine that was 3-5 times higher than the oral morphine she had received was in my view reckless and dangerous and highly likely to precipitate respiratory depression and coma in Patient B. The prescription of 40mg/24hr midazolam was in my opinion also not justified as the medical and nursing notes do not record and agitation or other symptoms justifying the prescription of a sedative drug. The dose range prescribed was in my view excessive and reckless and likely to cause further respiratory depression and coma. If agitation or restlessness was present a single dose of haloperidol or other sedative would have been appropriate

initial therapy. Close monitoring of Patient B was required once the combination of diamorphine and midazolam was infused with the nursing and medical staff understanding the high risk of respiratory depression and coma that these drugs can produce.

14. The subsequent deterioration of Patient B on 6 March is in my view most likely due to the combined effects of the diamorphine and midazolam infusions. The description of Patient B being comfortable and peaceful most likely reflects Patient B was in a drug induced coma at this stage. In my opinion the diamorphine infusion was inappropriately high and the midazolam infusion was not indicated in Patient B. I consider these drugs very likely produced respiratory depression and coma in Patient B and hastened her death.

Summary of Conclusions

15. Patient B was an elderly lady with diabetes who developed persisting bilateral hand weakness and shoulder and arm pain following a fall. The underlying cause of her persisting weakness and pain was in my opinion not clearly established. Patient B was transferred to Daedalus ward with the intent to try and mobilise her. The information in the notes suggests there was inadequate assessment of patient B by Dr Barton as the doctor responsible for the day to day medical care of the patient. Dr Barton's prescription of Morphine Slow Release Tablets on 24 February was inappropriate because an adequate clinical assessment had not been performed and the response to paracetamol and moderate analgesia had not been assessed. The prescriptions of subcutaneous diamorphine and midazolam by Dr Barton on 26 February were too wide a dose range and potentially hazardous. The prescriptions of subcutaneous diamorphine and midazolam on 5 March were not justified, reckless and in my opinion led to deterioration in Patient B contributing to her death.

16. In my opinion Dr Barton in her care of Patient B failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

17. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Barton
Report on Eva Page (Patient C)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Patient C

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of patient C, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were made with too wide a dose range and were there inappropriate and potentially hazardous and not in the best interests of Mrs Page.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 30-34 I described the course of events relating to Mrs Page's admission to the Department of Medicine for Elderly People at Queen Alexandra Hospital on 6 February 1998 and subsequent care following her transfer to Dryad Ward at Gosport War Memorial Hospital on 27 February 1998 prior to her death on 3 March 1998.

4. This report is based on my review of the following documents: medical records of patient C; statements of Bernard Page, and various nurse statements.

5. **Course of events**

   I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make to my statement in that report.

6. **Drug therapy prescribed and received at Gosport War Memorial Hospital.**

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 6.9 of my report to Hampshire Constabulary (12 December 2001).

Pages 272 – 284. All prescriptions written by Dr Barton unless otherwise marked.

Once only prescription

Diamorphine im 5mg administered twice. First date unclear, 0800 h
Second date unclear, 1500 h

As required prescriptions

Thioridazine 25mg — 28 Mar 1300h
Prescribed 27 Feb

Oramorph 10mg per 5mls, 5mg — 28 Feb 1620h
Prescribed 27 Feb

Fentanyl '25' patch x 3 days — 2 Mar 0800h
Prescribed 2 Mar

Regular prescriptions

Digoxin 125ug od
Frusemide 40mg od
Ramipril 5mg od
Sotalol 40mg od
Sertraline 50mg od

All 5 drugs above prescribed 27 Feb
No drugs administered, discontinued date unclear

Lactulose 10ml bd — 27 Feb 1 dose
Prescribed 27 Feb — 28 Feb 2 doses
29 Feb 1 dose

Thioridazine dose unclear tds — 1 Mar 2 doses
Prescribed 28 Feb — 2 Mar 1 dose then discontinued

Heminevrin dose unclear nocte — 28 Feb 1 dose
Prescribed 28 Feb — 1 Mar 1 dose then discontinued

Daily review prescriptions

Diamorphine sub cut via syringe driver 20-200mg/24hr — 3 Mar 20mg/24hr 1050h
Prescription date unclear MARKED PRN

Hyoscine subcut via syringe driver 200-800ug/24hr — None administered
Prescription date unclear

Midazolam subcut via syringe driver 3 Mar 20mg/24hr 1050h
20-80mg/24hr
Prescription date unclear

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing.

8. As previously stated I consider the prescription of oral morphine on 28 February was probably appropriate. If this had failed to control her symptoms which the notes suggest was the case by 2 March. Patient C had received oral morphine, thioridazine and heminevrin and was reported to be unsettled following intra-muscular diamorphine and to be spitting out oral medication. I would consider the decision to prescribe a transdermal patch was appropriate. Dr Barton recorded the rationale for prescribing a fentanyl patch in her entry to the medical notes on 2 March.

9. After the fentanyl patch (25ug per hour) was applied Patient C became more drowsy. The fentanyl 25ug patch is equivalent to 90mg of oral morphine (ref BNF 36 September 1998 page 204). Patient C had received substantially less than the equivalent of 90mg oral morphine in the previous 24 hours. It is difficult to determine how much opioid drugs she had received because the dates of two administered 5 mg intramuscular doses of diamorphine are unclear. However if it is assumed these two doses were administered on 1 March this was equivalent to 20-30mg morphine. Dr Barton had therefore prescribed at least a three fold higher dose of opioid, and if the diamorphine doses were administered on separate days the increase in opioid dose was even higher. There was a sigificant risk of adverse effects from the fentanyl patch and this was the most likely cause of Patient C developing drowsiness.

10. The notes record Mrs Page's son was concerned about the deterioration. Dr Lord appeared to recognise the deterioration could be due to adverse affects of opiates although she states in her entry that patient C was receiving diamorphine when she was only receiving a fentanyl patch at this point. It would have been appropriate for the fentanyl patch to be removed although it is not clear if this was done.

11. I cannot find any justification of the subsequent commencement of midazolam and diamorphine as a subcutaneous infusion on 3 March. Dr Barton recorded no indication for this in the medical records. At this time the nursing records do not indicate patient was in any pain or distress. In my view there was no indication to prescribe additional opiates or sedative by continuous syringe driver infusion when patient C had already deteriorated following the application of the fentanyl patch. The infusion of diamorphine and midazolam would be expected to result in further depression of conscious level and respiratory depression. These drugs likely contributed to her death.

12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The medical notes should have recorded clear reasons why these powerful drugs were being prescribed. In the absence of any clear protocol the prescription of such a wide dose range was hazardous in a patient such as Patient C.

Summary of Conclusions

13. Patient C was a frail elderly lady with probable carcinoma of the bronchus who had background problems of depression, dementia, ischaemic heart disease and congestive heart failure. Dr Barton was responsible for her day to day medical care on Dryad Ward. The information recorded in the medical records suggests there was an inadequate medical assessment when she was initially admitted to Dryad ward. The medical records also suggest that an adequate medical assessment was not performed by Dr Barton prior to the prescription of midazolam, diamorphine and hyoscine by subcutaneous infusion using a syringe driver. The dose ranges were inappropriate and potentially hazardous. In my opinion the prescription of these drugs in conjunction with the previous prescription of a fentanyl patch at a much higher equivalent dose then the oral morphine may have contributed to her death. However Patient C was a frail woman with probable carcinoma of the bronchus who was deteriorating prior to her admission to Dryad ward and other medical problems may have caused her deterioration and death.

14. In my opinion, Dr Barton in her care of patient C failed to meet the requirements of good medical practice to:
    - provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
    - prescribe only the treatment drugs or appliances that serve the patient's needs.

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Barton
Report on Alice Wilkie (Patient D)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient D

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient D commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were in too wide a dose range, creating a situation whereby drugs could be administered to Patient D which were excessive to her needs and were inappropriate, potentially hazardous and not in the best interests of Patient D.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 21-24 of that report I describe the course of events relating to Patient D's admission to the Queen Alexandra Hospital on 31 July 1998, transfer to Daedalus Ward Gosport War Memorial Hospital on 6 August 1998 prior to her death on 21 August 1998.

4. This report is based on my review of the following documents; medical records of Patient D; statements of Mrs Marilyn Jackson, Dr Althea Lord, various nurse statements.

5. Course of events

5.1 I have described the course of events in my report to Hampshire Constabulary dated 12 December 2001. A correction I have to that statement relates to section 4.4 where I stated the nursing care plan recorded no significant deterioration until 21 August 1998. The nursing notes record a deterioration in Patient D's condition over the weekend on 17 August 1998 (p635). Otherwise I have no changes or corrections to make to my statement in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 4.5 of my report to Hampshire Constabulary (12 December 2001).

Pages 138-145. All prescriptions written by Dr Barton unless otherwise marked.

Note the drug chart used at Queen Alexandra Hospital was used following transfer on 6 August 1998 to Daedalus Ward with the hospital and ward being changed from 'Q.A. to 'GWMH' and 'Philip' to 'Daedalus' ward.' (p139)

As required prescriptions

Promazine syrup 25mg Prescribed 31 Jul 1998 by Dr Wilson	None administered
Haloperidol subcut 2.5-10mg maximum 60mg in 24 hours Prescribed 1 Aug 1998 by Dr Wilson	1 Aug 2045h 2.5mg
Magnesium hydroxide 10mls Prescribed 4 Aug 1998 Dr Wilson	None administered

Regular prescriptions

Fluoxetine (Prozac) 20mg od Prescribed 31 Jul 1998 Dr Wilson	1-9 Aug then discontinued
Co-danthramer 5-10mls Prescribed 31 Jul 1998 Dr Wilson	31 Jul – 19 Aug
Zopiclone 3.75mg Prescribed 31 Jul 1998 Dr Wilson	3-19 Aug
Lactulose 10mls Prescribed 31 Jul 1998 Dr Wilson	1 - 4 Aug then discontinued
Promazine 25mg od Prescribed 31 Jul 1998 Dr Wilson	None administered
Augmentin1.2 g iv tds Prescribed 1 Aug 1998 Dr Wilson	1 Aug 2 doses Discontinued 2 August
Augmentin elixir 250-62 500mg tds Prescribed 2 Aug 1998 Dr Wilson	2-9 Aug then discontinued

Daily review prescriptions

Diamorphine subcut via syringe driver Prescribed date unclear 20–200mg/24hr	20 Aug 30mg /24hr 1350h 21 Aug 30mg /24hr
Hyoscine subcut via syringe driver 200-800ug/24hr Prescribed date unclear	None administered
Midazolam subcut syringe driver 20-80mg/24hr	20 Aug 20mg /24hr 1350h 21 Aug 20mg /24hr

Prescribed date unclear

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing.

8. Patient D was a frail elderly woman with dementia resident in a psychogeriatric care home (Addenbrooke's) prior to her admission to hospital. Dr Lord had outlined the management plan for Patient D on 4 Aug 1998 (p99A) with continuation of oral antibiotics to treat her urinary tract infection, administration of subcutaneous fluids and transfer to Daedalus NHS Continuing Care Ward for 4-6 weeks for observation prior to a decision about placement. At this stage Patient D could not return to her bed at Addenbrooke's care home but her bed was to be kept there until it became clear whether she would recover sufficiently to return to the care home. A decision was made that Patient D was not for resuscitation in the event of a cardiac arrest but active treatment was continuing. I would consider both these decisions were appropriate and reasonable.

9. There are very few medical records following Patient D's transfer to Daedalus ward. There is a brief entry on 6 August by Dr Peters documenting her transfer and plan for 4-6 weeks observation. The entry in the medical notes by Dr Lord on 10 August indicates Patient D had shown some improvement and was eating and drinking better but remained confused and slow (page 99B). Dr Lord made a decision that the place at Addenbrooke's care home should be given and Patient D reviewed in one month time to assess if she continued to have specialist medical or nursing problems which would have meant long term care in an NHS continuing care bed was appropriate.

10. The nursing notes indicated on 17 August that Patient D's condition had deteriorated over the weekend (p635). The nursing notes do not record Patient D was in pain or distress. The next entry in the nursing records on 21 August after Patient D had been commenced on diamorphine and midazolam by Dr Barton do not record Patient D having any pain or distress. Subcutaneous infusions of diamorphine and midazolam were commenced on 20 August by nursing staff. It is unclear when the prescription for these drugs was written by Dr Barton as this section of the drug chart does not have a date box to record the prescribing date. However Dr Barton presumably wrote this prescription on or before Thursday 20 August and later made an entry in the notes on 21 August when she documents subcutaneous analgesia was commenced the previous day.

11. The deterioration that occurred in Patient D required a medical assessment to be performed to determine the cause of the deterioration such as infection or electrolyte disturbance. However the information in the medical records suggests that no such assessment was undertaken by Dr Barton which was necessary to meet the requirements of good medical practice. In my opinion Dr Barton's failure to record any indication for the commencement of

subcutaneous infusions of diamorphine and midazolam was not good medical practice and the decision to commence these drugs was not justified or appropriate.

12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The prescription of large dose ranges of these drugs in the absence of a clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs, doses to be used and monitoring undertaken, placed Patient D at high risk of being administered an inappropriately high dose of opiate. In my opinion it is likely that the administration of the diamorphine and midazolam infusions produced depression of her respiration and conscious level. However as there are no clear observations of Patient D's respiratory rate it is difficult to assess whether significant deterioration occurred before or after administration of the diamorphine and midazolam and whether these drugs hastened death.

Summary of Conclusions

13. Patient D was a frail elderly woman with dementia who was transferred to Daedalus ward for observation prior to a decision about appropriate long term placement. After initial improvement following admissions to the ward Patient D deteriorated and was prescribed and commenced on diamorphine and midazolam subcutaneous infusions and died the following day. The information in the notes suggests there was an inadequate assessment of patient D by Dr Barton when the deterioration occurred. In my opinion the prescriptions of diamorphine and midazolam by subcutaneous infusion were not justified by the information recorded in the medical records, were in too wide a dose range and were potentially hazardous.

14. In my opinion Dr Barton in her care of Patient D failed to meet the requirements of good medical practice to:
    - Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
    - Prescribe only the treatment, drugs or appliances that serve the patient's need

13. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

GMC and Dr Barton
Report on Gladys Richards (Patient E)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient E

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient E, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegations presented to the Fitness to Practice Panel that prescriptions by Dr Barton on 11 August 1998 of diamorphine and midazolam were in too wide a dose range and created a situation whereby drugs could be administered to patient E which were excessive to her needs; that prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient E.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 4-13 I described the course of events relating to Patient E's admission to the Royal Hospital Haslar on 29 July 1998 subsequent care following her transfer to Daedalus ward, Gosport War Memorial Hospital on 11 August prior to her death on 21 August 1998.

4. This report is based on my review of the following documents: medical records of Patient E; statements of Lesley Richards, Philip Beed, Margaret Couchman, Gillian Hamblin, Fiona Walker, Dr Richard Reid, Gillian McKenzie Dr Althea Lord, Anita Tubbritt; police statements of Dr Barton; statement made by Dr Barton in relation to patient E.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no changes or corrections to make to my statement of the course of events as outlined in that report.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In the next section I list all drug therapy received providing more detail of Dr Barton's prescribing previously outlined in section 2.11 of my report to Hampshire Constabulary (12 December 2001).

Pages 62-All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Oramorphine 10mg/5ml	11 Aug	1115h	10mg
2.5-5ml		1145h	10mg
Prescribed 11 Aug	12 Aug	0615h	10mg
	13 Aug	2050h	10mg
	14 Aug	1150h	10mg
	17 Aug	1300h	5mg
		?	5mg
		1645h	5mg
		2030h	10mg
	18 Aug	0230h	10mg
		?	10mg

Diamorphine subcut via syringe driver	None administered	
20-200mg/24hr		
Prescribed 11 Aug		

Hyoscine subcut via syringe driver	19 Aug 1120h	200ucg/24hr ? *400*
200-800 ucg/24hr	20 Aug 1045h	400ucg/24hr
Prescribed 11 Aug	21 Aug 1155h	40ucg/24hr

Midazolam subcut via syringe driver	18 Aug 1145h	20mg/24hr
20-80mg / 24 hr	19 Aug 1120h	20mg/24hr
Prescribed 11 Aug	20 Aug 1045h	20mg/24hr
	21 Aug 1155h	20mg/24hr

Regular prescriptions

Haloperidol 2mg/ml oral	13 Aug	One dose administered
0.5ml 'If noisy'		

Heading 'REGULAR PRESCRIPTION' crossed out and replaced with 'PRN' for this prescription

Haloperidol 2mg/ml, I mg twice daily	11 -14 Aug
Prescribed 11 Aug	17 Aug then none administered

Oramorphine 10mg/5ml	None administered
2.5 ml four time daily	
Prescribed 12 Aug. Marked 'PRN'	
Oramorphine 10mg/5ml	None administered
5ml nocte	
Prescribed 12 Aug. Marked 'PRN'	

Diamorphine subcut via syringe driver	18 Aug 1145h	40mg/24hr
40-200mg/24hr	19 Aug 1120h	40mg/24hr

Prescribed 17 Aug	20 Aug 1045h	40mg/24hr	
	21 Aug 1155h	40mg/24hr	
Haloperidol subcut via syringe driver	18 Aug	1145h	5mg/24hr
5-10mg/24hr	19 Aug 1120h		5mg/24hr
Prescribed 17 Aug	20 Aug 1045h		5mg/24hr
	21 Aug	1155h	5mg/24hr
Lactulose 10ml twice daily	11-14 Aug		
Prescribed 11 Aug	17 Aug then none administered		

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing. I have the following corrections to make to my report to Hampshire Constabulary:
   i) 2.26 line 11 *'The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate'* is incorrect as Dr Barton had prescribed two sedative drugs diamorphine and midazolam on 11th August. In this report I comment on the initial prescription of the two drugs in this report and the prescription of haloperidol by subcutaneous infusion on 17 August.
   ii) 2.30 line 13 *'In the absence of post-mortem. Radiological data (chest Xray) or recordings of Mr _____ respiratory rate...'* should read *''In the absence of post-mortem. Radiological data (chest Xray) or recordings of Patient E's respiratory rate...'.*

8. Patient E was a frail elderly woman with dementia who was living in a nursing home prior to admission following a fractured hip secondary to a fall. Following assessment by Dr Reid (page 24,26 letter summarising assessment) on 3 Aug 1998 she was transferred to Daedalus Ward, Gosport War Memorial Hospital with the aim to improve her mobility. Prior to her transfer to Daedalus ward the orthopaedic nursing team documented on the 10 August that she was fully weight bearing and walking with the aid of two nurses and a Zimmer Frame.

9. The medical notes record a limited assessment by Dr Barton of patient E on 11 August following her admission to Daedalus ward but indicate she was *'not obviously in pain'*. The nursing records on 12 August also state that patient E did not appear to be in pain when she awoke from sleep very agitated. Prior to her transfer to Daedalus ward patient E had been taking cocodamol (paracetamol and codeine) as required. As I have previously commented (section 2.21 report to Hampshire Constabulary) I do not consider it was appropriate to prescribe oramorphine and a subcutaneous diamorphine infusion to patient E on 11 August. The medical records contain no information suggesting patient E's pain would not be controlled by as required or regular cocodamol which she had already been receiving.

10. The oramorphine patient E received between 11-13 August may have contributed to her confusion and agitation following admission to Daedalus ward and to her fall on 13 August leading to dislocation of the hip. However she had dementia, had been agitated prior to receiving the oramorphine and was also taking haloperidol, all of which increase the risk of falls and hip dislocation.

11. The prescription by Dr Barton of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient E at a high risk of developing respiratory depression and coma if a higher infusion rate had been commenced. In my opinion from the information available in the notes the prescriptions on 11 August of as required oramorphine and diamorphine by subcutaneous infusion by Dr Barton were inappropriate and potentially hazardous to patient E. The recorded clinical assessment of patient E undertaken by Dr Barton did not justify the prescription of powerful opioid drugs at this stage, and no instructions were recorded in the medical or nursing records as to the circumstances under which oramorphine or diamorphine should be administered.

12. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion prescribed by Dr Barton to patient E on 11 August. Patient E had intermittent episodes of agitation and regular haloperidol with additional as required doses was appropriate to manage these symptoms. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. None of these applied to patient E.

13. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. In an older frail patient in whom a midazolam infusion as indicated an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr unacceptably high. The prescribed dose range of midazolam particularly in conjunction with the diamorphine prescribed placed Patient E at risk of developing life threatening complications if these doses were administered by nursing staff.

14. Following patient E's readmission to Daedalus ward on 17 August the medical and nursing notes document that Patient E had hip pain. I consider the administration of opioids at this point was reasonable and appropriate. The cause of the hip pain was unclear and it would have been good practice for Dr Barton to discuss patient E with the responsible consultant and/or the orthopaedic team. However as no dislocation was present on the repeat XRay the focus would have been on the provision of effective pain relief. The medical and nursing notes Patient E was deteriorating rapidly at this stage. Hip fracture is often a pre-terminal event in frail patients with dementia. I would consider the focus of care was appropriately on palliating Patient E's symptoms of pain and agitation.

15. Oral morphine was initially used and a total of 45 mg morphine was administered to patient E between 17 August 1300h and 18 August 1145h when a diamorphine infusion was commenced. The medical notes do not record the justification for commencing a subcutaneous infusion rather than continuing to administer drugs by the oral route. The equivalent dose of subcutaneous diamorphine is one third to one half of the total oral morphine dose received which would have equated to 15-23mg/24hr. Patient E was still in pain so a further 50% increase in dose was reasonable which would equate to about 35mg/24hr subcutaneous diamorphine. I would consider the dose of diamorphine infused was high but not unreasonably so, although careful monitoring of patient E's conscious level and respiratory rate was required.

16. The nursing and medical notes indicate patient E was in pain and distressed on 17 August and it was appropriate to continue to administer haloperidol via a syringe driver which was commenced on 18 August at an equivalent dose to that she had been receiving orally. On 16 August patient E received 6 mg oral haloperidol (section 2.10 report to Hampshire Constabulary) whilst at Royal Hospital Haslar. Patient E received one dose of haloperidol on 17 August after transfer back to Daedalus ward and the medical notes record she was in pain and distress. I consider the prescription of haloperidol 5mg/24hr by syringe driver on 17 August was reasonable as this equated to the total oral dose received on 16 August. The administration of diamorphine and haloperidol required careful monitoring because these drugs alone or in combination may produce coma and/or respiratory depression.

17. In my view it was appropriate to prescribe opioid analgesia for pain and haloperidol for distress and agitation on 18 August. The medical notes do not record a clear indication for using subcutaneous infusion rather than continuing oral adminstration. However the doses of morphine and haloperidol that were commenced by subcutaneous infusion on 18 August were in my view reasonable.

18. The medical notes provide no justification for the administration of midazolam to patient E on 18 August. It would have been appropriate to observe the response of patient E to the infusion of diamorphine and haloperidol. If patient E remained agitated and distressed and this was not thought to be due to pain it would have been appropriate to increase the dose of haloperidol infused to 10mg/24hr the upper limit of the haloperidol infusion dose range. If this did not relieve Patient E's symptoms it would have been appropriate to consider replacing the haloperidol with midazolam. However as outlined in my report to Hampshire Constabulary II consider the prescription and administration of midazolam with haloperidol and diamorphine in the doses prescribed to be inappropriate and highly risky because of the combined risk of these three drugs to produce respiratory depression and coma. If patient E had remained highly distressed on adequate doses of diamorphine analgesia and haloperidol and substitution of midazolam for haloperidol had not improved control of symptoms of distress and restlessness it would then have been reasonable to consider administering both

haloperidol and midazolam to patient E with careful monitoring to ensure patient E's symptoms were controlled without unnecessary adverse effects.

19. Dr Barton stated that she used midazolam in patient E as a muscle relaxant (section 2.27 report to Hampshire Constabulary). This is not an appropriate use. The medical and nursing notes at the time of the midazolam prescription and administration do not contain any record of an assessment of tone or muscle stiffness in patient E. In my opinion the dose range of subcutaneous midazolam prescribed by Dr Barton was in excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older frail patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The dose of 40mg/24hr hat was administered was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine and haloperidol prescribed placed Patient E at high risk of developing life threatening complications.

20. I consider it likely that the diamorphine, midazolam and haloperidol infusions commenced on 18 August very likely produced respiratory depression and coma that led to her dying earlier than she would have done. However patient E required palliative care following her and was likely to die within a few days or weeks after her transfer back to Daedalus ward on 17 August and was likely to die within a short time period. The doses of subcutaneous diamorphine and haloperidol infusions administered were in my view appropriate but there was no justification in the medical notes for the prescription and administration of midazolam in addition to these drugs.

Summary of Conclusions

21. Patient E was a frail older lady with dementia who sustained a fractured neck of femur, which was successfully surgically treated but then complicated by dislocation and continuing pain following successful manipulation. She had a high risk of dying in hospital following these events. She was initially transferred to Daedalus ward with the aim of improving her mobility before discharging her back to the nursing home she lived in. The information in the notes suggest there was inadequate assessment of patient E by Dr Barton as the doctor responsible for the day to day medical care of the patient when transferred to Deadalus ward on 11 August 1998. The medical notes record no evidence of hip pain at this time and no justification was provided for the prescriptions of oramorphine and subcutaneous diamorphine and midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

22. Patient E deteriorated rapidly after dislocating her hip on 14 August and treatment with opioids and haloperidol was appropriate. The medical records do not provide any justification for the prescription of midazolam by subcutaneous infusion or is administration on 18 August until Patient E's death on 21 August. In my opinion the midazolam infusion at the dose infused very

likely led to respiratory depression and shortened patient E's life although at this stage she required palliative care and was likely to die within a few days or weeks.

23. In my opinion, Dr Barton in her care of Patient E failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

24. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Jane Barton
Report on Ruby Lake (Patient F)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient F

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient F commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions by Dr Barton on 18 August 1998 of oramorphine, and on 19 August 1998 of diamorphine and midazolam were inappropriate, potentially dangerous and not in the best interests of patient F.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient F; statements of Lynne Barnet; Dr David Barrett; Adele Bindloss; Beverly Turnbull; Shirley Hallman; Dr Althea Lord; statement by Dr Barton in relation to Ruby Lake; Dr Barton's police interview 14 July 2005.

5. Course of events

5.1 Patient F was 84 years of age when she was admitted to Royal Hospital Haslar, Ward 3 on 5 August 1998 and transferred to Dryad ward, Gosport War Memorial Hospital on 18 August 1998. Patient Fdied on Dryad ward, Gosport War Memorial Hospital on 21 August 1998. Past medical history prior to this admission included inflammatory arthritis which had been considered to be possibly rheumatoid arthritis. When assessed by a consultant rheumatologist Code A in 1998 the diagnosis was thought to be CREST (Calcinosis, Raynauds, Eosphageal dysfunction, Sclerodactyl, Telangiectasia) syndrome. Other past medical problems were gout, hypertension, renal impairment which had previously been assessed by Dr Lord (p26-33). She had previous admissions for shortness of breath chest pain, atrial fibrillation and a myocardial infarction. In June 1998 she was admitted from home for a

treatment of leg ulcers. The medical records state (p495) she had been *'mobile, independent and self caring'* prior to admission on 5 August 1998.

5.2 Following a fall at home on 5 August 1998 Patient F was admitted to the accident and emergency department at Royal Hospital Haslar and found to have a fractured left neck of femur. She underwent surgery the same day with an insertion of left cemented hemiarthroplasty. A nursing transfer letter by a staff nurse dated 15 August 1998 (page 23-25) summarises her course during her stay Royal Hospital Haslar prior to her transfer Dryad ward, Gosport War Memorial Hospital on 18 August. She had a slow recovery following surgery problems of angina and breathlessness. At the time of the transfer letter she was mobile with a Zimmer frame and supervision and could wash her top half independently. She had bilateral leg ulcers which were present prior to admission and a broken area on her left buttock that was improving. She had a urinary catheter in place, had been occasionally confused at night and her hearing aid had gone missing.

5.3 On 9 August the medical notes (p508) record *"slow progress, nausea, diarrhoea yesterday, poor mobilising, on examination pyrexial, pulse 80, wound fine, urine output good (illegible word) poor "*. On 10 August the medical notes (p509) record *"patient unwell, vomiting, diarrhoea, drowsy, denies pain, orientated in time and place o/e pulse 129 bpm irreg irreg BP 120/60 mmHg. Apyrexial chest clear, oxygen sats on air 94%, plan 1. ECG 2. continue IV fluid, rediscuss with SHO"*. An ECG was noted to show a sinus tachycardia (increased heart rate) ST depression in leads V5 and 6V. Blood tests including cardiac enzymes (p552) were taken at this stage showing a normal creatinine kinase (CK) at 68 (increased if a myocardial infarct occurs) and an elevated white cell count. An entry in the medical notes later that day by a medical SHO documents respiratory crackles in the left base and a possible diagnosis of a chest infection. A further note (p511) states by Surgeon Captain Farquharson Robert states *"for all necessary treatments and resuscitation..."*. A chest x-ray showed left-sided basal chest infection. Antibiotics were commenced.

5.4 On 12 August the medical notes record an entry by the registrar (page 514) *"much improved, has sat out today, not in failure, no further deterioration, developing sacral bedsore"*. A plan was to mobilise with physiotherapy, encourage oral fluid intake and stop antibiotics and intravenous fluids. On 13 August a referral was sent from the orthopaedic team to Dr Lord, consultant geriatrician, requesting assessment from the point of her future management. The referral notes her post-op recovery was slow with periods of confusion and pulmonary oedema and that she suffered vomiting, diarrhoea but that over the last 2 days she had been alert and well and the intention was to improve her immobilisation. The referral notes she lived in a ground floor house and was visited twice daily by the district nurse for the previous four weeks prior to admission.

5.5 On 13 August there is an entry from Dr Lord (p516). She records that Patient F is a frail 85 year old who had problems of a left cemented hemiarthroplasty of the hip, left bundle branch block and left ventricular failure which was improving sick, sinus syndrome/atrial fibrillation, dehydration that was

improving, bilateral buttock ulcers, bilateral leg ulcers, hypokalaemia (low blood potassium), normochromic anaemia, vomiting and diarrhoea ? cause. Dr Lord suggested prescribing potassium supplements, hydrating orally and sending stool for culture and sensitivity if not already sent. Dr Lord states *"it is difficult to know how much she will improve but I will take her to a NHS continuing care bed at Gosport War Memorial Hospital next week"*. There is a letter summarising her assessment dictated 14 August 1998 (p466).

5.6 On 15 August (p 518) an entry by a house officer in the medical notes documents left-sided chest pain *'since being manhandled'*. An electrocardiogram showed no new changes and there was response of the pain to due to GTN. The clinical impression was of a musculoskeletal pain although a pulmonary embolus (clot to the lung) or angina were considered as alternative diagnoses, and a comment was made that further investigation with spiral CT or VQ scanning might be necessary. Codeine phosphate was prescribed as an analgesic. On 17 August an entry in the medical notes (p519) by the SHO notes she is well with no chest pain and was mobilising slowly and was awaiting transfer to Gosport War Memorial Hospital.

5.7 On 18 August Patient F was transferred to Dryad ward and an entry (p78) by Dr Barton states *"HPC fracture neck of femur left 05/08/98 past medical history angina, CCF* (Congestive Cardiac Failure). *catheterised, transferring with 2, needs some help with ADL* (Activities Daily Living), *Barthel 6. Get to know, gentle rehabilitation. I am happy for nursing staff to confirm death"*. There is one other entry in the medical notes on 21st August 1998 by nursing staff confirming death at 1825h that evening (page 78).

5.8 Nursing notes on 18 August (page 394) record Patient F is *"for slow mobilisation"*. There is no documentation of any pain or discomfort in the initial nursing assessment. Another entry on 18 August (p388) states *"Settled and slept well from 2200 until midnight. Woke very distressed and anxious. Says she needs someone with her. Oramorph 10mg given 0015 with little effect. Very anxious during the night. Confused at times"*. An entry on the 19 August states *"Comfortable night. settled well". Drowsy but rousable this am. Sips of oral fluid tolerated. Syringe driver satisfactory"*.

5.9 On 19 August the nursing notes (p394) state *"1150 c/o chest pain. Not radiating down arm - no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg/5ml given r notified'*. A further note states *"pain only relieved for a short period, very anxious. Diamorphine 20mg Midazolam 20mg commenced via syringe driver"*. The next entry in the nursing summary on 20 August 1215h states *'Condition appears to have deteriorated over night driver recharged 1010 diamorphine 20mg, midazolam 20mg, hyoscine 400ug. Family informed of condition. Daughter present a time of report'*. An entry later that night states *'General condition continued to deteriorated very "bubbly" suction attempted without success'*. An entry on 21 August in the nursing notes at 1855h (page 395) states *"Condition continued to deteriorate slowly"*.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

P368–369. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Temazepam 10-20mg	not administered	
Oramorph 10mg/5ml sc 2.5-5mg	18 Aug 1415h	5mg dose
	19 Aug 0015	10mg dose
	19 Aug 1150	10mg dose

Regular prescriptions

Digoxin 62.5ug od	18 -20 Aug
Slow K one tablet bd	18 -19 Aug
Bumetanide 1mg od	19 -20 Aug
Allopurinol 100mg od	18 -20Aug

Daily review prescriptions

Diamorphine sc via syringe driver	19 Aug	20mg/24 hr 1600h
20-200mg/24 hr	20 Aug	20mg/24hr
Prescribed (date unclear)	21 Aug	60mg/24 hr 0735hr
Hyoscine sc via syringe driver	20 Aug	400ug/24hr 0915hr
200-800ug/24hr		increased to 800ug/24hr 1050hr
Prescribed (date unclear)	21 Aug	800ug/24hr 0735hr
Midazolam sc via syringe driver	19 Aug	20mg/24hr 1600hr
20-80mg/24hr	20 Aug	20mg/24hr 0915hr
Prescribed (date unclear)		increased to 40mg/24hr 1015hr
	21 Aug	60 mg/24hr 0735hr

Opinion on Patient Management

7. Patient F was making slow progress at Royal Hospital Haslar following her left hip hemiarthroplasty on 5 August. She had a number of episodes of chest pain. Investigation into these did not reveal any increase in her cardiac enzymes or change in her ECG. Therefore the most likely cause of her episodes of chest pain was angina or possibly musculoskeletal pain. At the time of her transfer she appeared to be stable the assessment by Dr Lord on 13 August is comprehensive and notes a number of problems leading to Dr Lord to include that the rate and level of final of improvement she would achieve following mobilisation was unclear. It is unclear from Dr Lord's assessment whether she thought there was a reasonable possibility she could improve sufficiently to return home. In my opinion from the description of her problems it was appropriate and reasonable to transfer her to an elderly care ward for continued assessment and rehabilitation with a view as to assessing whether she would regain mobility and sufficient independence to be able to return to her home.

8. The medical assessment by Dr Barton on transfer to Dryad ward describes her past medical history and current function. There is no record of any physical

examination being performed. It would be usual to expect a description of any current symptoms or complaints a patient had and for a physical examination to be performed on admission of a patient to rehabilitation ward to establish their baseline problems. Dr Baton's assessment failed to document episodes of chest pain or the problems with diarrhoea. An adequate assessment would have noted these and recorded current blood pressure and recent blood results. There is no documentation that Patient F had pain in this assessment. I find it of concern that there are no further entries in the medical records following this initial entry despite the deterioration in Patient F's condition. In my opinion there was a failure to maintain adequate medical records. Dr Barton was responsible for day to day care of Patient F and this failure must be attributable to her.

9. The failure to document any problems of pain or other indication for opioids make it difficult to justify the prescription by Dr Barton of "as required" oramorphine on 18 August. I would consider this prescription was not appropriate. Patient F was administered morphine later that night when she became distressed and anxious. I do not consider the administration of morphine was appropriate for these symptoms. The notes record that Patient F wished someone to be with her and a more appropriate response would have been for a nurse to sit with Patient F for a while and if her symptoms failed to improve to either to administer temazepam which had been prescribed or arrange for the prescription of another sedative such as a small dose of haloperidol.

10. The lack of clear instructions for the use of "as required" oramorphine may explain why the oramorphine was given for distress and anxiety by nursing staff. Although oramorphine is used by some doctors to treat distress and anxiety in older people it is not an appropriate first line treatment for a patient who develops distress and anxiety shortly after admission to a rehabilitation ward. Although opiates usually more commonly produce drowsiness or sedation that may cause or exacerbate anxiety or distress in older people. The development of anxiety or distress in older people requires medical evaluation and assessment to determine the underlying cause before the administration of any drug but particularly opioids.

11. The prescription of diamorphine and midazolam and hyoscine (undated) by Dr Barton was in my opinion not justified. There is no evidence recorded in the notes that she was experiencing significant pain or distress. The medical records do not record the indication for prescribing diamorphine and midazolam. It is possible this was prescribed as treatment for her chest pain which is recorded in the nursing notes as occurring on the morning of 19 August. An electrocardiogram was not obtained which might have found evidence of changes consistent with angina or a myocardial infarct. I can find no record of any observations of Patient F's pulse or heart rate or examination of her heart and lungs.

12. In my opinion there was an inadequate medical assessment of this problem. An adequate medical assessment would have sought to determine a diagnosis responsible for the chest pain and provided appropriate treatment. If it was musculoskeletal a mild or moderate analgesia therapy such as

paracetamol or a non-steroidal anti- inflammatory drug would have been appropriate. If it was cardiac pain appropriate treatment would have been with a nitrate and possibly a dose of oral morphine if the pain failed to respond to nitrate therapy and there was clear evidence pain was cardiac in nature. A 10mg dose of oramorphine was administered at 1150h. No justification was given for the commencement of a continuous infusion by syringe driver with the combination of diamorphine and midazolam. On 19 August and 20 August Patient F was able to take oral medication as evidenced by the prescription chart recording the administration of oral bumetanide and allopurinol.

13. Patient F's condition deteriorated after the commencement of diamorphine and midazolam. This deterioration should have led to a full medical assessment. It is highly likely her deterioration was due to the combined sedative effects of diamorphine and midazolam and if the infusion had been discontinued her drowsiness may have resolved. However her deterioration was interpreted as requiring further sedative and drugs and the midazolam dose was increased twofold to 40mg over 24 hours and hyoscine was also commenced. These would have further contributed to Patient F's decline in my opinion. In my opinion there is no clear evidence presented to support the diagnosis of a myocardial infarct or cardiogenic shock as the cause of death in Patient F. It is much more likely she died from the sedative and depressant effects of the diamorphine and midazolam infusion that she received. There was no justification provided in the notes for the syringe driver as Patient F was able to swallow medication.

Summary of Conclusions

14. Patient F was a frail older lady who had a number of medical problems. Following her left hip fracture she was making slow progress. When transferred to Dryad ward she was medically stable. Dr Barton was responsible for her day to day medical care there was inadequate medical assessment both when she was initially admitted and then a failure to adequately assess Patient F when she developed agitation and then chest pain. The prescription of opioids was in my opinion not justified and there was no justification provided for the prescription of diamorphine and midazolam by subcutaneous. The prescription and administration of these drugs are the most likely cause of Patient F's subsequent deterioration and her death. There was a failure of adequate assessment by Dr Barton in particular when Patient F developed chest pain there should have been a physical examination and investigations undertaken and recorded in medical notes.

15. In my opinion Dr Barton in her care of Patient F failed to meet the requirements of good medical practice to:

    - Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - Consult colleagues

- Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
- Provide or arranging necessary investigations

- Prescribe only the treatment, drugs or appliances that serve patient's need

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GMC and Dr Barton
Report on Arthur Cunningham (Patient G)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient G

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient G commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that Dr Barton prescribed diamorphine and midazolam subcutaneously over a 24 hour period in a dose range that was too wide, thereby creating a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs; that the prescribing of these drugs was inappropriate, potentially hazardous, not in the best interests of Patient G.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital, and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 14-20 of that report I describe the course of events relating to Patient G's admission to Dryad Ward, Gosport War Memorial Hospital on 21 September 1998 prior to his death on 26 September 1998.

4. This report is based on my review of the following documents; medical records of Patient G; witness statements of Charles Farthing, Shirley Sellwood, Dr Victoria Banks, Dr Joanna Taylor, Gillian Hamblin, Freda Shaw, Beverly Turnbull, Shirley Hallman, Dr Althea Lord; statement made by Dr Barton in relation to Patient G; interview of Dr Barton dated 21 April 2005.

Course of events

5. I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no major changes to make to that report. The statement in course of events *"on 24 September Dr Lord has written "Remains*

unwell. Son has visited again today..." is incorrect. The entry in the medical notes on 24 September was by Dr Barton (page 646). The entry I record by Dr Lord in the medical notes on 21 September 1998 is correct except for the final sentence "*analgesics prn*" which on re-reading the medical notes I believe stated "*prognosis poor*". Otherwise I have no changes to make to the course of events as recorded in my report to Hampshire Constabulary.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list drug therapy received providing more detail of Dr Barton's prescribing in section 3.3 of my report to Hampshire Constabulary.

Pages 753-758 and page 831. All prescriptions written by Dr Barton unless otherwise marked.

Regular Prescriptions

Diamorphine subcut via syringe driver 40-200mg/24hr Prescribed 25 Sep	25 Sep	60mg/24hr	1015h
	26 Sep	80mg/24hr	1150h
Hyoscine subcut via syringe driver 800ug-2mg/24hr Prescribed 25 Sep	25 Sep	1200ucg/24hr	1015h
	26 Sep	1200ucg/24hr	1150h
Midazolam subcut via syringe driver 20-200mg/24hr Prescribed 25 Sep	25 Sep	80mg/24hr	1015h
	26 Sep	100mg/24hr	1150h

As required prescription

Oramorph 2.5-10mg Prescribed 21 Sep (Dr Lord)	21 Sep	1415h	5mg
	21 Sep	2015h	10mg
Actrapid insulin sub-cut 10 units Prescribed date unclear	None administered		

Daily Review Prescriptions (written as prn)

Diamorphine sc via syringe driver 20-200mg/24hr Prescribed date unclear discarded	21 Sep	20mg/24hr	2310h
	22 Sep	20mg/24hr	2029h
	23 Sep	20mg/24hr	0925h
		20mg/24hr	2000h
	24 Sep	40mg/24hr	1055h
	24 Sep	60mg/24hr	time unclear
Midazolam sub-cut via syringe driver 20-80mg/24hr Prescribed date unclear discarded	21 Sep	20mg/24hr	2310h
	22 Sep	20mg/24hr	2020h
	23 Sep	20mg/24hr	0925h
		60mg/24hr	2000h
	24 Sep	80mg/24hr	1055h

Hyoscine sub-cut via syringe driver discarded	23 Sep400ug/24hr	0925h
200-800ug/24hr	400ug/24hr 2000h	
Prescribed date unclear	24 Sep800ug/24hr 1055h	

Opinion on Patient Management

7. I have provided an opinion on the management of Patient G in my report to Hampshire Constabulary. I have no changes to make to my opinions expressed in that report except to correct my statement 3.9 where I state *"when Dr Lord reviewed Patient G on 24 September..."*. This should state *"when Dr Barton reviewed Patient G on 24 September the notes implied that he was much worse than when he had been assessed by Dr Lord three days earlier."*

8. In the following sections I summarise my opinions on the management of Patient G by Dr Barton and other staff and the actions taken particularly with respect to the prescribing of midazolam and diamorphine.

9. Although review of the notes suggests it was clear that Patient G was in pain from his sacral sore, there is little information in the medical and nursing notes that describes the location or severity of his pain. The initial assessment by Dr Barton on 21 September is very brief. Although a reference is made to making Patient G comfortable there is no description of the cause of his pain or its severity. There had been clear instructions from Dr Lord that Patient G was to receive oramorph "as required" for his pain. This prn ('pro re nata') as required instruction had been underlined by Dr Lord.

10. As I have previously outlined in my report to Hampshire Constabulary I consider the decision by Dr Barton to prescribe and administer diamorphine in a very wide dose range (20-200mg/24hr) along with midazolam in a similarly wide dose range (20-80mg/24hr) was not justified by the information recorded in the medical records. The commencement of diamorphine and midazolam by subcutaneous infusion via syringe driver at 2310h on 21 September was in my opinion not justified and highly inappropriate. There is no evidence recorded in the notes that Patient G was unable to swallow oral medication. He had received only two doses or oramorphine which would be an inadequate number of doses over a very short time period to establish the total daily dose of opiate he would need over a 24 hour period to control his pain. Even if the decision had been made that Patient G required sustained administration of an opiate drug this could have been achieved through the prescribing of regular prn doses of morphine that had been prescribed by Dr Lord.

11. Although the nursing notes document that Patient G was agitated until 2330h there was no indication for prescribing subcutaneous midazolam by continuous infusion. Appropriate medication would have been either an oral benzodiazepine such as diazepam or an oral or intramuscular dose of a sedative such as haloperidol. The nursing notes during Patient G's admission

are very limited but do not indicate any problem with swallowing. The nursing care plan of 21 September (page 869) states *"offer hot drink"* which suggests he was able to swallow on admission.

12. For reasons I have previously outlined in my report to Hampshire Constabulary the prescription of diamorphine at a dose of 20mg/24hr in conjunction with midazolam at a dose of 20mg/24hr was unnecessary and potentially highly dangerous in a frail elderly man such as Patient G because of the risk of the combination resulting in profound depression of respiration and/or conscious level. The subsequent deterioration of Patient G on 23 September was in my opinion most likely due to the combined effect of the diamorphine and midazolam infusions he had received. The nursing notes record that Patient G had become *"chesty"* and had possibly developed a chest infection.

13. The nursing notes also record that Patient G was seen by Dr Barton but there was no evidence in the medical records that she undertook an examination of the patient and considered that he may have developed a chest infection that required treatment with antibiotics, or that his deterioration was due to diamorphine and/or midazolam. The decision to increase the midazolam dose on 23 September at 2000h from 20mg/24hr to 60mg/24hr was not justified by any information recorded in the medical notes. The decision to increase the dose three fold appears to have been made by nursing staff as the nursing notes state he Patient G was agitated at 2300h and the syringe driver was boosted "with effect". In my opinion this increase in midazolam does was inappropriate and dangerous and in combination with continuing diamorphine infusion was the most likely cause of his subsequent deterioration.

14. The use of a syringe driver was challenged by relatives of Patient G on 23 September (page 862) and the nursing record records that the consultant would need to give permission for the syringe driver to be discontinued. Given the concerns expressed by relatives and that the commencement of the syringe driver had not been at the instruction of the Responsible Consultant, Dr Lord, and indeed was against a specific direction that Patient G should receive prn analgesia, this should have led the nursing staff to contact Dr Lord or Dr Barton as the doctor responsible for Patient G's day to day care to discuss the management plan with Dr Lord.

15. There is no information presented in the nursing or medical notes to justify the three-fold increase in the diamorphine infusion from 20mg/24hr to 60mg/24hr. The nursing records record that Patient G had pain when attended to, especially in his knees. In my opinion, the three-fold increase in diamorphine dose infused with the very high dose of midazolam infused inevitably led to the further deterioration documented on 26 September.

16. There were a number of time points between 21 and 25 September when the appropriateness of continuing the infusion of diamorphine and midazolam should have been questioned and discussed with the responsible consultant. In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronchopneumonia. In my opinion it is very likely that the administration of midazolam and

diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs.

Summary of Conclusions

17. Patient G was a frail older man with multiple medical problems. He was admitted to Dryad Ward, Gosport War Memorial Hospital for treatment of his sacral sores. The medical and nursing notes following Dr Lord's assessment provide little detail but in my view it was reasonable to commence Patient G on as required oral morphine and then move subsequently to regular administration of an opiate drug to control his pain, at a dose that did not cause undue side effects. I consider the prescription and administration of diamorphine and midazolam by subcutaneous infusion was not justified, and that there was inadequate assessment of Patient G's pain and the cause of his subsequent deterioration by Dr Barton. There was a failure to discuss the management and seek advice from Dr Lord or another Consultant when Patient G deteriorated. In my view the doses of diamorphine and midazolam used were inappropriately high and were increased excessively without good cause. These prescriptions likely led to the shortening of Patient G's life.

18. In my opinion Dr Barton in her care of Patient G failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

    I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GMC and Dr Barton
Supplementary Report on Arthur Cunningham (Patient G)

Professor Gary A Ford, FRCP
Consultant Physician

2 June 2009

GMC and Dr Jane Barton
Patient G

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors.

2. Section 2 line 4" ... service I undertook research into the effects of drugs in older people." changed to "....service. I undertake research into the effects of drugs in older people."

   Section 5 line 1 "I have no major changes to make.." corrected to " I have two changes to make.."

   Section 6 *As required prescription* "Oramorph 2.5-10mg" corrected to "Oramorph 5-10mg"

   Section 9 line 1 "Although review of the notes suggests it was clear that Patient G.." corrected to "Although review of the notes suggests Patient G.."

   Section 14 line 4 "...of the Responsible Consultant,.." corrected to "... of the responsible Consultant, .."

   Section 17 line 5 "I consider the prescription and administration of." changed to "I consider the prescription of...."

3. I have reviewed the witness statement of **Code A** (dated 25 April 2005) in which he recorded the cause of death as bilateral bronchopneumonia and his opinion that Patient G's death was due to natural causes. No post mortem drug analyses were reported as being undertaken. I have not changed my opinion stated in section 16 of my report dated 21 April 2009 which was as follows: *"In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronchopneumonia. In my opinion it is very likely that the administration of midazolam and diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs."*

4. I have been asked to comment on the appropriateness of the prescriptions by Dr Barton on 25 September 1998 of diamorphine 40-200mg/24hr and midazolam 20-200mg/24hr. A previous prescription by Dr Barton had written a prn (as required) prescription for diamorphine 20-200mg/24hr and midazolam 20-80mg/24hr on 21 September. This prescription on 25 September did not change the maximum dose of diamorphine that could be administered but set a lower dose of 40mg/24hr to be administered by nursing staff. The prescription on 25 September set a lower dose of 20mg/24hr midazolam to be administered by nursing staff and increased the maximum dose of midazolam that could be administered from 80mg/24hr to 200mg/24hr.

5. The medical records do not record the reasons why Dr Barton made these changes to the prescription, and it is difficult to understand why the original prescription was changed by Dr Barton. Dr Barton recorded in the notes on 24 September that Patient G's pain was *"just controlled"* when receiving

20mg/24 hr diamorphine. I consider the prescription of diamorphine on 25 September was in too wide a dose range and hazardous. I consider the prescription of midazolam on 25 September was inappropriate, in too wide a dose range and excessively high. The medical and nursing notes do not record that Patient G had uncontrolled restlessness on 24 or 25 September and no justification is recorded in the medical notes for increasing the administered dose of midazolam from 60mg/24hr to 80mg/24hr and then 100mg/24hr. The Wessex Protocols recommended a dose range of 10-60mg/24hr for terminal restlessness. The prescription of midazolam up to a dose of 200mg/24hr was inappropriate and excessively high and not indicated by the information recorded in the medical records. If Patient G was deteriorating and experiencing increasing pain and restlessness this should have led to Dr Barton examining Patient G and recording in the medical notes the cause of any deterioration and the rationale for increasing the dose of diamorphine and midazolam administered by nursing staff. The information in the medical notes does not contain any record of such assessment taking place on 25 or 26 September.

6. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GMC and Dr Barton
Report on Robert Wilson (Patient H)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient H

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient H commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that Patient H was not properly assessed upon admission; that the prescription of oramorphine was inappropriate, potentially hazardous and likely to lead to serious and harmful consequences for Patient H and not in his best interests; that the prescription of diamorphine was in too wide a dose range that created a situation whereby drugs could be administered to Patient H which were excessive to his needs; that the prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient H.

2. I am Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics, and General Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service. I undertake research into the effects of drugs in older people. I am editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 25-29 of that report I describe the course of events relating to Patient H's admission to the Queen Alexandra Hospital on 22 September 1998 and following transfer to Dryad Ward at Gosport War Memorial Hospital on 14 October 1998 prior to his death on 18 October 1998.

4. This report is based on my review of the following documents; medical records of Patient H; statements of Dr Rosie Lusznat, Dr Ewenda Peters, Ruth Clemow, Gillian Kimberley, Dr Arumugam Ravindrane, Fred Shaw, Gill Hamblin, Shirley Hallman, Dr Althea Lord; statement made by Dr Barton in relation to Patient H.

5. Course of events

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make or add to my

statement in that report. In this report I comment on the potential influence of the past diagnosis of alcoholic liver disease on the prescribing of opioid drugs to Patient H, which I did not include in my report to Hampshire Constabulary. The recorded cause of death was congestive cardiac failure, renal failure and liver failure.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 5.4 and 5.5 of my report to Hampshire Constabulary (12 December 2001).
Pages 258-263. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Paracetamol 1g 4 hourly — None administered
Prescribed 14 Oct

Hyoscine subcut 600ug/24 hr — None administered
Prescribed by another doctor

Regular prescriptions

Frusemide 80mg once daily — 15/16 Oct 1 dose
Prescribed 14 Oct

Spironolactone 50mg bd — 14 Oct 1 dose
Prescribed 14 Oct — 15 Oct2 doses then discontinued

Bendrofluazide 2.5mg od — 15 Oct1 dose
Prescribed 14 Oct — 16 Oct1 dose then discontinued

Trazodone 50mg once daily — 14 Oct1 dose
Prescribed 14 Oct — 15 Oct1 dose then discontinued

Thiamine 100mg once daily — 15 Octthen discontinued
Prescribed 14 Oct

Multivitamins 1 tablet — 15 Octthen discontinued
Prescribed 14 Oct

Magnesium hydroxide 1 tablet bd — 14 Oct1 dose
Prescribed 14 Oct — 15 Oct2 doses then discontinued

Senna 2 tablets once daily — 14 Oct2 tablets then discontinued
Prescribed 14 Oct

Oramorph 10mg / 5mls — 15 Oct 3 doses 1000h, 1400h, 1800h
10mg 4 times daily — 16 Oct3 doses 0600h, 1000h, 1400h
Prescribed 15 Oct

Oramorph 10mg / 5mls — 15 Oct1 dose 2200h then discontinued
20mg nocte prescribed 15 Oct
Illegible prescription by another doctor

Daily review prescriptions

THE TYPED HEADING "REGULAR PRESCRIPTION" HAS BEEN CROSSED OUT AND REPLACED WITH THE HANDWRITTEN LETTERS "PRN"

Oramorph 10mg / 5mls 14 Oct1445h 10mg
2.5-5mls 4 hourly 14 Oct 2245h 10mg
Prescription date unclear

Diamorphine subcut via syringe driver 16 Oct1610h 20mg/24 hr
20–200mg/24hr 17 Oct 0515h 20mg/24 hr
Prescription date unclear 1550h increased to 40mg/24hr
18 Oct1450h 60mg/24 hr

Hyoscine subcut via syringe driver16 Oct1610 400ug / 24 hr
200-800ug/24hr 17 Oct0515 600ug / 24 hrs
Prescription date unclear 1550h increased to 800ug/24hr

Midazolam subcut via syringe driver 17 Oct1550h 20 mg/24hr
20-80mg/24hr 18 Oct1450h 40 mg/24hr
Prescription date unclear

Hyoscine subcut 1200ug/24hr 18 Oct 1450 1200ug / 24 hours
Verbal prescription Dr Peters 18 Oct

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's assessment and prescribing.

8. Patient H **Code A** had previously presented with ascites and had signs of chronic liver disease suggesting he had cirrhosis due to **Code A** liver disease (admission in January 1997). Ultrasound of the abdomen produced at that time (page153) had shown a smallish bright liver consistent with cirrhosis. Reduced dose of opioid analgesics is recommended in patients with hepatic and renal impairment with recommendations to avoid if severe hepatic impairment is present (BNF 55 page 229). Opioid analgesics may precipitate hepatic encephalopathy and coma in patients with cirrhosis. However when patients are in severe pain it may still be necessary to use opiates. In older people a lower dose should be used and patients need to be carefully monitored.

9. In 1997 Patient H had a low albumin indicating he had at least moderately severe liver disease. Prior to Patient H's admission to Dryad Ward he was receiving paracetamol 1g qds for analgesia and the transfer letter (page 81) notes he still had a lot of pain from the fractured left humerus. He had been receiving a combination of paracetamol and dihydrocodeine as codydramol until the 30 September when this was changed to paracetamol alone. After Dr Barton had assessed Patient H on 14 October she prescribed paracetamol four hourly prn and oramorphine 2.5-5mg four hourly.

10. Dr Barton does not provide any justification in the medical records for moving from paracetamol to the use of a strong opioid morphine, although the prescription of "as required" oral morphine controlled Patient H's pain without undue adverse effects initially on the 14 October. A more appropriate response to manage his continuing arm pain would have been to prescribe paracetamol with a mild opioid such as codeine or dihydrocodeine which he had previously been prescribed. He was prescribed 5-10mg morphine prn and then administered two doses of 10mg morphine. Given his age and chronic liver disease a lower 5mg dose would have been a more appropriate cautious response if opioid drugs were needed. The nursing notes report on 15 October that he had slept well.

11. On 15 October Dr Barton prescribed regular oramorphine at a dose of 10mg 4 times daily and 20mg nocte (60mg morphine daily). This was a high dose of morphine for an elderly man with chronic liver disease. Dr Barton had not undertaken a physical examination of Patient H when transferred to Dryad Ward on 14 October and may not have been aware of his diagnosis of chronic liver disease, as this was not described in his recent medical notes, or taken into consideration the potential impact of this on his response to opiate drugs.

12. The nursing notes suggested he had had symptomatic improvement and control of his pain with the previous prn doses of morphine (20mg received over the 12 hour period) without any obvious problems. Although a more cautious and appropriate response would have been to increase his opiate dose to 40mg oral morphine over 24 hours, the prescription of regular oramorphine at the doses prescribed (60 mg/24hr) after he had experienced pain control from prn doses of morphine equate to a 50% increase in the 24 hour dose equivalent, would have been reasonable if Patient H did not have liver disease and he was monitored for adverse effects of opioids. However this is a large increase in an older patient with chronic liver disease who has only received two "as required' doses of morphine, and there was a significant risk the increased dose of morphine could precipitate liver failure.

13. On 16 October there was a clear deterioration after Patient H had received three 10mg doses and a 20mg night-time dose (total 50mg) of morphine. Dr Knapman who assessed Patient H appears not to have considered that the deterioration in conscious level could have been secondary to the oral morphine he had received and nursing staff administered further doses of oral morphine at 0600h, 1000h and 1400h on 16 October. It would have been appropriate for Dr Knapman to discuss Patient H's deterioration with a senior colleague.

14. Later that afternoon on 16 October, Dr Barton prescribed diamorphine by subcutaneous infusion to a syringe driver with a dose range of 20-200mg with midazolam in the dose range of 20-80mg and hyoscine in the dose range of 200-800ug per 24 hours. There is no evidence in the medical records that Dr Barton examined Patient H at this stage. Dr Barton was presumably informed of Patient H's deterioration and did not appear to have considered that the oral morphine he had received was the likely cause of the deterioration due

to both its depressive effects on conscious level and ability to precipitate a hepatic encephalopathy in patients with chronic liver disease.

15. At this stage as Patient H was unresponsive it is likely he was unable to take oral medication and this may explain the decision of Dr Barton to prescribe opioids and other drugs by subcutaneous route. However, the lack of medical assessment and failure to consider that Patient H's deterioration was secondary to the morphine he had received was not consistent with good medical practice. If Dr Barton was uncertain as to the cause of Patient H's deterioration she should have discussed this with the responsible medical consultant. If Dr Barton was aware Patient H had chronic liver disease it would have been particularly important for her to assess Patient H to determine if he had developed liver failure secondary to morphine. If Dr Barton had taken a full history from Patient H when he was admitted she might have obtained a history of ascites and chronic liver disease from Patient H.

16. The prescription of diamorphine and midazolam was inappropriate and not justified by any information presented in the notes. There is no evidence at this stage that Patient H was in pain. When his conscious level deteriorated an appropriate response would have been to discontinue opiates, and assess the cause of his deterioration. I can find no evidence of any symptoms which required the prescription of the midazolam, which can precipitate hepatic encephalopathy in patients with chronic liver disease. The dose range prescribed was highly inappropriate and potentially dangerous given Patient H's age, clinical condition with a depressed conscious level and presence of chronic liver disease. The subsequent escalation of diamorphine and midazolam dose on 17 October inevitably led to his further deterioration and in my view contributed to his death through depression of his conscious level and respiration. The nursing notes of 15 October record no symptoms of pain and no justification is given for the prescribing of diamorphine and midazolam or the escalation in dose to diamorphine 60 mg/24hr and midazolam 40mg/24hr.

Summary of conclusions

17. Patient H was a frail older man with depression, **Code A** liver disease and a painful fracture of the left humerus transferred to Dryad ward for rehabilitation. Oral opioid drugs were an appropriate treatment for Patient H if his pain had been uncontrolled on mild opioid drugs and paracetamol but this combination was not first prescribed. Dr Barton failed to undertake or record an adequate clinical assessment of Patient H when he was admitted to Dryad ward or adequately assess his subsequent deterioration. The prescription by Dr Barton of subcutaneous diamorphine and midazolam infusions was not justified and the dose ranges used were inappropriately wide. The subsequent increase in diamorphine and midazolam doses that were infused were not justified. In my opinion the doses of diamorphine and midazolam received by Patient H led to his subsequent deterioration and most likely led to Patient H's death through producing respiratory depression.

18. In my opinion Dr Barton in her care of Patient H failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

    I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

General Medical Council and Dr Barton
Report on Enid Spurgin (Patient I)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient I

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient I, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the assessment of Patient I on admission was inadequate and not in her best interests, that the prescriptions of midazolam and diamorphine were in too wide a dose range and created a situation whereby drugs could be administered to Patient I that were excessive to her needs, and that actions in prescribing these drugs were inappropriate and potentially hazardous; and that the prescription of 80mg of diamorphine and 20mg of midazolam over 24 hours was excessive to Patient I's needs and was inappropriate, potentially hazardous and not in her best interests.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient I; witness statements of Carl Jewell, Freda Shaw, Gillian Hamblin, Beverley Turnbull, Lynne Barrett, Anita Tubbritt, Fiona Walker; statement made by Dr Barton in relation to Patient I; interview of Dr Barton dated 15 September 2005.

5. Course of events

5.1 Patient I was 92 years of age when she was admitted to Royal Hospital Haslar on 19 March 1999 following a fall, was transferred to Dryad Ward, Gosport War Memorial Hospital on 20 March 1999. Patient I died on Dryad Ward, Gosport War Memorial Hospital on 13 April 1999. Prior to her admission on 19 March the admission notes to the orthopaedic service at Royal Hospital Haslar state *"lives alone, self caring, independent"* (page 356). There were no

significant problems in her past medical history. A letter by Dr Reid, Consultant Physician in Geriatrics on 26 March states *"Before her fall, Patient I had been very active and had been in good health"* (page 464).

5.2 The orthopaedic medical notes record Patient I had sustained a right sub-trochanteric femur fracture (page 356) which had occurred after she had been pulled over by her dog and landed on her right hip. The notes record she underwent an anaesthetic pre-operative assessment on 20 March at 1200 hours (page 358) and was given Voltarol (diclofenac) 15mg and paracetamol 1gm for analgesia. A further entry at 1400 hours (page359) indicates she had been given intravenous fluids, cyclizine 50mg and morphine 2mg IV. Following the 2mg morphine she had had hallucinations and the notes by an SHO anaesthetist state *"nil further opiates"*.

5.3 She underwent surgery under spinal anaesthesia on 20 March 1999 with insertion of a right dynamic hip screw. An entry by an SHO post-operative review on 20 March 1999 at 2130 hours (page 359) notes *"oozing from the wound with swelling of the right thigh."* The impression was of a potential bleeding vessel in the wound with risk of a compartment syndrome and hypovolaemia developing. She was monitored and received a blood transfusion. On 21 March 1999 at 2300h(page 371) the notes record a review by **Code A** records *"R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor"*.

5.4 On 22 March the notes record a ward round and comment that she has poor oral fluid intake and required her haemoglobin to be checked. Her haemoglobin was 11.1 when checked. The next entry in the medical notes 24 March notes *"her skin is very thin and fragile on the lower legs"* and that Patient I would benefit from assessment by Dr Lord with a view to rehabilitation. The referral to Dr Lord notes that she was transfused with 3 units of blood but was otherwise making an unremarkable post-operative recovery (page 373). The referral letter stated *"was proving difficult to mobilise her and that the skin on her legs was at risk of breaking down"*. The referral states Surgeon Commander Scott would appreciate advice regarding her rehabilitation and consideration for a place at Gosport War Memorial Hospital (page 374).

5.5 An entry in the notes by Dr Reid Consultant in Elderly Medicine is dated 23 March states *"a delightful 92 year old lady, previously well, with sub-trochanteric fracture right femur. She is still in a lot of pain which is the main barrier to mobilisation at present. Could her analgesia be reviewed? I'd be happy to take her to GWMH provided you are satisfied that orthopaedically all is well with the right hip. Please let me know."*

5.6 The drug charts (pages 326-331) at Royal Hospital Haslar indicate Patient I had received 2mg of morphine intravenously on 20 March, diclofenac 50mg once only on 19 March, paracetamol 1g seven doses between 19-25 March, and three doses of 5mg morphine on 20 March and on two doses of 5mg morphine on 21 March. I can find no record of other analgesia being administered during her admission at Royal Hospital Haslar.

5.7 A transfer letter (undated) (page 23) indicates that at a time prior transfer to Dryad Ward, Patient I was mobile, walking short distances with a zimmer frame, that she required the assistance of two nurses to transfer from bed to chair, that she was continent during the day but incontinent at night. Her only medication on transfer was paracetamol. On 26 March Patient I was transferred to Dryad Ward, Gosport War Memorial Hospital. An entry by Dr Barton (page 27) states *"transfer to Dryad Ward HPC fracture neck of femur right 19.3.1999. PMH nil of significance, Barthel, no weight bearing, tissue paper skin, not continent, plan sort out analgesia."*

5.8 The next entry in the medical notes is dated 7 April by Dr Reid and states *"still in a lot of pain and very apprehensive. MST Increased to 20mg bd yesterday. Try adding fluphenthixol for x-ray right hip as movement still quite painful also about 2 inch shortening right leg"*. The next entry following this is dated 12 April again by Dr Reid and states *"now v drowsy (since diamorphine infusion established) reduced to 40mg/24 hours. If pain recurs increase to 60mg. Able to move legs without pain but patient not rousable."* The final entry in the medical notes is 13 April at 0115 hours stating the patient died peacefully and death had been confirmed by nursing staff.

5.9 The nursing notes relating to admission to Dryad Ward note on 20 March that Patient I required assistance to settle for the night (page 89) and that she had pain in her hips (page 91). The nursing care plan (page 95) states *"..... is experiencing a lot of pain on movement"*. On 27 March state *"is having regular oramorph but still in pain"*. On 28 March *"has been vomiting with oramorph, advised by Dr Barton to stop oramorph. Is now having metoclopramide tds and co-dydramol. Vomited this afternoon after using commode"*. An entry in the nursing notes dated 29 March (page 97) states *"please review pain relief this morning"*. The next entry on 31 March states *"now commence on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain"*. A further entry on 3 April states *"MST 10mg bd continued. Still continues to complain of pain on movement"*. On 8 April *"MST increased to 20mg bd"*.

5.10 The nursing summary relating to Patient I's admission to Dryad Ward states on 26 March 1999 (page 132) *"admitted to Dryad Ward for rehabilitation and gentle mobilisation. In Haslar she was mobile with a zimmer frame and two nurses for short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. She has complained a lot of pain for which she is receiving oramorph regularly now, with effect"*. An entry on 6 April 1999 states *"seen by Dr Barton, MST increased to 20mg. Nephew has visited. If necessary once Enid is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in"*.

5.11 An entry on 11 April (page 134) states *"nephew telephoned at 1910 hours as Enid's condition has deteriorated during this afternoon. She is very drowsy, unrousable at times and refusing food and drink and asking to be left alone. Asked about her pain, Enid denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that ..... be kept as comfortable as possible. Seen by Dr Barton to commence syringe driver"*. An entry on 12 April (page 136) states *"seen by Dr*

Reid. Diamorphine to be reduced to 40mg over 24 hours. If pain recurs the dose can be gradually increased as and when necessary".

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Pages 157-179. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Oramorph 10mg/5ml sc 2.5-5mg	31 Mar	2.5mg
Prescribed 26 March	11 Apr	2.5mg

Regular prescriptions

Oramorph 10mg/5ml, 2.5mg four x day	26 Mar	3 doses received
	27 Mar	1 dose 0600h then discontinued
Oramorph 10mg/5ml, 5mg nocte	26 Mar	1 dose then discontinued

Oramorph 10mg/5mls, 5mg four x day	27 Mar	2 doses received 1800h dose not administered
	28 Mar	2 doses received then discontinued
Oramorph 10mg/5mls, 10mg nocte	27 Mar	1 dose
	28 Mar	not administered

Codydramol 2 tablets 4 x day	28 Mar – 31 Mar	
Prescribed 27 March 1999		

Metoclopramide 10mg tds	28 Mar	2 doses
Prescription date unclear	29-30 Mar	3 doses per day
pp Dr Barton and then	31 Mar	1 dose
counter-signed by Dr Barton	1-6 Apr	None
administered	7/8 Apr	2 doses
	9-11 Apr	3 doses per day

Morphine MST 10mg bd	6 Apr	1 dose received then discontinued
Prescribed 31 Mar		

Morphine MST 20mg bd	6 Apr	1 dose administered
Prescribed 6 Apr	7-11 Apr	2 doses daily

Diamorphine sc via syringe driver 20-200mg /24 hr	12 Apr	80mg / 24hr 0800h
Prescribed 12 Apr		

Hyoscine subcut via syringe driver 200-800 ucg/24hr	Not administered
Prescribed 12 Apr. Marked PRN	

Midazolam subcut via syringe driver 20-80mg/24hr Prescribed 12 Apr	12 Apr	30mg/24hr 0900h
Cyclizine sc via syringe driver 50-?600mg (unclear) per 24 hours Prescribed 12 Apr. Marked PRN	Not administered	
Ciprofloxacin 100mg bd	7-11 Apr	
Metronidazole 400mg bd	7-11 Apr	
Lactulose 10mls bd	26 Mar-11 Apr	
Senna 2 tablets once daily	29 Mar-10 Apr 2 tablets	
	11/12 April	Not administered

Opinion on Patient Management

7. Patient I was an elderly independent lady with no active medical problems prior to admission with a hip fracture. This was repaired surgically on 19 March and over the following seven days she made slow progress with mobilisation but was walking with a zimmer frame prior to her transfer. She was referred to the Geriatrics Team for further rehabilitation and following assessment by Dr Reid transferred to Dryad Ward on 26 March.

8. The medical assessment by Dr Barton on 26 March following admission to Dryad Ward is very limited. It describes her having a fractured neck of femur and no significant past medical history. There is no record of a physical examination. There is no record of her having any pain although there is a comment that she is not weight bearing. As the transfer letter from Royal Hospital Haslar had indicated she was mobilising this would suggest there had been a change in her mobility and functional and a physical examination particularly of the right hip was indicated. There should have been an assessment of whether the right hip was causing any pain at this stage. There is no record of the drug she is taking at this stage but there is a comment *"sort out analgesia"* which I would take to indicate Dr Barton considered she had pain which was not controlled. The nursing notes record on a number of occasions that Patient I had hip pain.

9. Dr Barton prescribed oramorphine on an as required basis on 26 March 1999 but no regular analgesia until the 27 March when codydramol (dihydrocodeine and paracetamol) was prescribed. This was signed as a pp signature suggesting this was commenced as a telephone order and subsequently counter-signed by Dr Barton. I would consider the prescription of codydramol was appropriate as an initial analgesic. Initially prescribing a regular combination of paracetamol and mild opioid drugs would have been appropriate before prescribing oramorphine. If pain was uncontrolled on the codydramol which appears to have been the case, the subsequent regular prescription of regular morphine (initially as oral morphine and then as sustained release preparation morphine MST) was reasonable and appropriate. However, there are no medical notes from Dr Barton which record her assessment or reasons for prescribing the drugs she did during this

period. In this respect I would consider the medical notes are inadequate and Dr Barton failed to maintain adequate medical records as the doctor responsible for the day to day care of Patient I.

10. As Patient I's pain was not controlled on either mild or regular prescriptions of morphine there should have been re-examination of her hip to ascertain the cause of the hip pain and an x-ray of the hip should have been arranged to determine whether there was any mechanical problem with the dynamic hip screw which might account for the pain. It would not be usual for a patient to have severe pain at this stage following a hip fracture if there was no mechanical or other complication.

11. On 6 April Dr Barton increased the dose of morphine (MST) to 20mg twice daily after Dr Reid records this and suggested adding fluphenthixol but I can find no record that this was prescribed. However as the main problem appeared to be pain I think it was appropriate to first increase her analgesia. His assessment suggested there may have been a problem with the right hip dynamic hip screw as the right leg was 2 inches shorter and he requested an x-ray of the right hip be arranged. I can find no record of this x-ray of the right hip being requested by Dr Barton or any reason why it was not requested. I would consider the failure to arrange an x-ray of the hip when this had been recommended by Dr Reid was a failure of Dr Barton to provide and arrange a necessary investigation for Patient I.

12. On 11 April Patient I became very drowsy. This is likely to have been due to the increased dose of oral morphine (40mg daily) that she was receiving. The nursing notes indicate she was not in pain when left alone but complained of pain when moved. I consider the prescription of diamorphine in the dose range 20-200mg/24 hr was inappropriate and reckless. The 40mg or oral morphine Patient I was receiving every 24 hr would be equivalent to approximately 15-20 mg diamorphine administered by subcutaneous infusion over 24 hours. Patient I was already drowsy so increasing the opioid dose would have been expected to produce further depression in her conscious level. However as she was still in pain when being moved it would have been reasonable to consider an increase of 50% in the dose and monitor Patient I closely. An appropriate dose of diamorphine to prescribe over 24 hours would therefore have been 20-30mg/24hr. The prescription of 20-200mg was dangerous because if a dose greater than 30mg/24 hr was administered it was highly likely to produce coma and respiratory depression. In the event an infusion was commenced at 80mg/24hr four times greater than the equivalent dose received orally in the previous 24 hours.

13. In my opinion the additional prescription of midazolam 20-80mg/24hr was also reckless and inappropriate. No justification was given in the medical notes by Dr Barton for the prescription of midazolam. The 20mg/24hr midazolam infusion further contributed to respiratory depression and depressed conscious level. I consider the diamorphine and midazolam infusions directly contributed to Patient I's death on 13 April 1999. The reduction in dose by Dr Reid on 12 March was not sufficient to prevent the toxicity of these drugs and it would have been more appropriate to temporarily discontinue both the diamophine and midazolam infusions

Summary of Conclusions

14. Patient I was an elderly independent lady who sustained a fractured hip who underwent surgery and was referred for rehabilitation. Patient I experienced persistent pain in the right hip after transfer to Dryad Ward, Gosport War Memorial Hospital. Good medical practice required appropriate investigation to determine the cause of the hip pain and the administration and monitoring of analgesia. There was inadequate investigation of patient I's hip pain. Specifically there is no record of an adequate examination of the hip by Dr Barton as the doctor responsible for her day to day care, and an X-ray of the right hip was not obtained. In my opinion the prescriptions of diamorphine and midazolam by Dr Barton were dangerous and reckless and the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.

15. In my opinion, Dr Barton in her care of Patient I failed to meet the requirements of good medical practice to:

    - provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
    - prescribe only the treatment drugs or appliances that serve the patient's needs.

16. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

    I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

General Medical Council and Dr Jane Barton
Report on Geoffrey Packman (Patient J)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient J

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Dr Barton in relation to patient J to assist the GMC panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that; the verbal prescribing of diamorphine, prescriptions of diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interest of patient J; that the failure to obtain medical advice and/or undertake further investigation on 26 August was inappropriate and not n the best interests of Patient J.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. Documents reviewed this report is based on my review of the following documents; medical records of patient J, statements of Victoria Packman, Betty Packman, Dr Arumugam, Shirley Hallman, Gillian Hamblin, Beverley Turnbull, Anita Tubbritt, statement made by Dr Barton in relation to patient J, Interview of Dr Barton dated 17 November 2005, interview of Dr Barton dated 6 April 2006.

5. **Course of Events**

   5.1 Patient J was 67 years old when admitted to Dryad Ward on 23 August 1999. In July 1999 he was seen at the out-patient clinic of **Code A**, Consultant Dermatologist describe him having bilateral severe leg oedema (swelling) secondary to venous hypertension and secondary skin problems (p30). His wife describes him as having being overweight for many years and his legs being a *'constant problem to him'* because of weeping fluid (p2 BP1).

5.2 On 6 August he had a fall at home and was admitted to the Accident and Emergency department by his general practitioner (p43). The notes in A&E indicate problems of bilateral leg oedema, obesity and not coping. He was admitted to Anne Ward which I assume was a general medical ward.

5.3 The admission clerking on 6 August by a Senior House Officer describes the primary problem as decreased mobility (p44) with problems of obesity and bilateral lower leg oedema with ulcers and erythema (redness) in the groin. Other medical problems listed were hypertension and arthritis. Drug therapy on admission was doxazosin, bendrofluazide and felodipine (all blood pressure lowering drugs). On examination there was a slight temperature, pulse was 80 irregular, BP was 128/81 mm Hg, erythema was seen in both groins, bilateral swelling of both legs. The left lower leg was noted to be swollen and erythematous. The examination notes nursing staff had reported blistering on buttocks. Problems were considered to be: bilateral leg oedema, cellulitis of the groin and left lower leg, decreased mobility due to obesity/oedema/infection and atrial fibrillation.

5.4 A number of investigations were performed at this stage. An ECG confirmed the presence of atrial fibrillation (irregular heart beat). A Chest X-ray, blood tests and swabs from the groin and leg ulcers were obtained. Blood tests showed a normal haemoglobin (Hb 15.7 g/dl) and an elevated white cell count 25.7 consistent with a bacterial skin infection in the groin and legs. Intravenous antibiotics were commenced to treat infection and diuretics were changed from bendrofluazide to frusemide.

5.5 Patient J was reviewed later the same afternoon by a Registrar, Dr Code A who agreed with the diagnoses and suggested stopping felodipine and doxazosin since they could be exacerbating his oedema. He indicated an echocardiogram might be obtained to assess his cardiac function. A separate note (signature unclear) at the bottom of the page (p47) states *'In view of premorbid sate and multiple medical problems not for CPR in event of arrest'*.

5.6 The following day 7 August, there is an entry from a different registrar (name unclear) (p48) noting that the patient has been seen by Dr Grunstein (I would assume this was the responsible consultant physician). The notes record he has 'morbid obesity' (the nursing notes record his weight was 148.6 Kg p108) and says Patient J reported *'walking till about a week before'*. The recorded plan was to obtain a good history from the next of kin, continue intravenous antibiotics over the weekend and considered his problems were mainly nursing. Renal impairment (creatinine 173) was also noted. There is a comment *"Agree not for 555"* (meaning not for attempted resuscitation).

5.7 On the 9 August the medical notes record the cellulitis of the left leg was improving and he should be switched to oral antibiotics. On the

11 August the notes record he was well and the cellulitis improved and physiotherapy should continue. On the 12 August a further entry states 'continue nursing care and try to mobilise'. The felodipine was stopped to try and improve his oedema. Again a note is made 'Not for 555'. On the 13 August the medical notes document the white cell count has fallen to 12.4 and the Hb is 13.5. Antibiotics were to continue for a total of 10 days and there is a comment to *'Transfer to Dryad ward on 16 August 1999'*. On the 16 August the notes state *'Dryad when bed available'*. On 18 August the medical notes record antibiotics were to be stopped the following day. A further entry on 18 August is by Dr Jane Tandy, Consultant Geriatrician, states *' P sores extensive, feed himself, not mobilising, black stool overnight – nil says bowels looser than usual, no pain. Abdomen soft, BS /, PR – normal brown stool. Check Hb R/O bleed. ? antibiotic related diarrhoea 'stool chart.'*

5.8 On 20 August the medical notes record *'no further black motion, nausea or epigastric pain, epigastric tenderness, BP 140/80 m Hg'*. The full blood count was checked with no significant change in Hb at 12.9. The notes record transfer to Gosport Hospital was to take place on 23 August (p54).

5.9 On Monday 23 August the medical notes (doctors name unclear) record problems of obesity, arthritis bilateral knees, immobility, pressure sores and note he is on a high protein diet and *'? Melaena 13/8/99 Hb stable, alb 29 '*. There is a further note *'MTS very good'. Clinical examination records a normal cardiovascular and respiratory systems, obese, legs slightly ....., chronic skin disease, ulcers dressed yesterday. Needs review later this week'*. MTS is an abbreviation for Mental Test Score and the comment indicates he had no significant cognitive impairment. There is a note that Haemoglobin (Hb) and other blood tests are to be repeated on Friday.

5.10 On Wednesday 25 August the nursing notes (p63) record *'Passing fresh blood PR ?Clexane'. Verbal message from Dr Beasley to withhold 1500 dose and review with Dr Barton mane. Lunch also vomiting – metoclopramide 10 mg given im at 1755h. Good effect.'*

5.11 On 26 August the nursing notes state *'Fairly good morning no further vomiting, Dr Rabi contacted re Cleaxane, advised to discontinue and repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, c/o feeling unwell. Seen by Dr Barton this afternoon, await results of Hb, Further deterioration c/o indigestion – pain in throat not radiating – vomited again this evening. Verbal order from Dr Barton. Diamorphine 10 mg stat – same given at 1800. Metoclopramide 10mg given im.'* A blood sample was sent on 26 August. The notes include a laboratory report that the Hb was 7.7 g/dl (p210) and there is a comment on the report *'Many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard'*. The previous Haemoglobin was 12.0 g/dl from a sample taken on 24 August and analysed on the 25 August.

5.12 There is an entry in the medical notes on 26 August by Dr Barton which states *'Called to see. Pale, clammy, unwell. Suggests ?MI treat stat diamorph and oramorph overnight. Alternative possibility GI bleed but no haematemesis. Not well enough to transfer to acute unit, keep comfortable. I am happy for nursing staff to confirm death.'* I can find no records of any pulse, BP observations in the notes at this point or at any time relating to Patient J's admission on Dryad ward. A further entry in the nursing notes on 26h August 1900 (p63) states *'Dr Barton here. For Oramorph 4 hourly. Wife seen by Dr Barton, explained Patient Js condition and medication used.'*

5.13 On the 27 August the nursing notes state *'Some marked improvement since yesterday'. Seen by Dr Barton this am – to continue Diamorph 4 hourly same given tolerated well. Some discomfort this afternoon – especially when dressings being done'.* The next entry in the medical notes is on 28 August from Dr Barton and state *'remains poorly, but uncomfortable, please continue opiates over weekend.'*

5.14 On 30 August the nursing notes state *'condition remains poor. Syringe driver commenced at 1445 Diamorphine 40mg, midazolam 20mg no further complaints of abdominal pain. Very small amount diet taken.'*

5.15 On 1 September there is an entry from the Dr Reid, consultant Geriatrician, which states *'Rather drowsy, but comfortable. Passing melaena stools. Abdomen huge but quite soft. Pressure sores over buttock and across the posterior aspects of both thighs. Remains confused. For T.L.C – stop frusemide and doxazosin, wife aware of poor prognosis'.* Death was confirmed on 3 September at 1350h. I understand the death certificate stated he died from myocardial infarction.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 167-172. All prescriptions written by Dr Barton unless otherwise marked.

Once only drugs

Diamorphine im 10mg 26 Aug 1800h
Verbal message, subsequent prescription by Dr Barton date unclear

As required prescriptions

Gaviscon 10ml 25 Aug 1200h
Prescription date unclear (Doctor other than Dr Barton)

Temazepam 10-20mg 24 Aug 2210h 10mg
Prescribed 24 Aug 25 Aug 2205h 20mg

Regular prescriptions

Doxazosin 4mg od 24 Aug -31 Aug
Frusemide 80mg od 24 Aug -31 Aug
Clexane 40mg sc bd 24 Aug -25 Aug (morning dose only received 25 Aug)

Paracetamol 1 g qds 23 Aug -26 Aug
None of above 4 drugs prescribed by Dr Barton

Daily review prescriptions
Metoclopramide 10 mg im 8hrly 25 Aug 1755h
Verbal order 25 Aug Dr Beasley 26 Aug 1740h

Oramorph 10mg 4hrly None administered
Prescribed 26 Aug

Oramorph 10mg/5ml (10-20mg) qds 26 Aug 20 mg nocte
Oramorph 10 mg/5ml 20mg nocte 27 Aug 4 doses administered unclear if 10 or 20 mg
Prescribed 26 Aug 20 mg nocte
28 Aug 4 doses administered unclear if 10 or 20 mg
20 mg nocte
29 Aug 4 doses administered unclear if 10 or 20 mg
20 mg nocte
30 Aug 2 doses administered unclear if 10 or 20 mg

Diamorphine sc via syringe driver 30 Aug 1445h 40mg/24hr
40-200mg/24hr 31 Aug 1545h 40mg/24hr
Prescription date not written 1 Sep 1545h 40mg/24hr
1915h increased to 60mg/24hr
2 Sep 1540h 90mg/24hr

Midazolam subcut via syringe driver 30 Aug 1445h 20 mg/24hr
20-80mg/24hr 31 Aug 1540h 20 mg/24hr
Prescription date not written 1 Sep 1545h 40 mg/24hr
1915h increased to 60 mg/24hr
2 Sep 1540h 80mg/24hr

Hyoscine subcut via syringe driver No doses administered
800-2000ucg/24hr
Prescribed 2 Sep

Opinion on Patient Management

7. The initial assessment and management of patient J during his admission to Anne Ward was in my view competent. The information in the medical records suggests appropriate clinical assessments were undertaken, investigations obtained and management initiated. The main initial problem was cellulitis (skin infection) of the groin and legs in the setting of chronic leg swelling. Secondary skin infections are a common problem in patients with chronic leg oedema. He responded to antibiotics and was commenced on subcutaneous heparin (Clexane) to reduce his risk of developing a deep vein thrombosis. There was a clear plan to mobilise patient J with the intention of him then being able to return home.

8. Dr Jane Tandy assessed patient J presumably at the request of the responsible medical team. She identified a possible episode of melaena (black stool due to bleeding from the gut). It is not uncommon for nursing staff to see dark stools and for it to be unclear if these are due to melaena. Dr Tandy examined patient J and performed a rectal examination to see if there was any evidence of bleeding from the gut. She gave clear instructions to check the haemoglobin and rule out a gastro intestinal bleed. This was done prior to his transfer to Dryad ward. I consider the management on Anne ward and Dr Tandy's assessment were competent.

9. The one aspect of his management on Anne Ward that could be questioned was the decision to make patient J not for attempted resuscitation without this being discussed with him or his next of kin and without a clear statement of the level of medical intervention that was appropriate. The decision that patient J was not for attempted resuscitation appears to have influenced subsequent management decisions on Dryad ward. The decision was not necessarily inappropriate since if he had experienced a cardiac or respiratory arrest he would have been unlikely to survive this.

10. Current medical practice is for decisions about resuscitation status to be discussed with patients or their next of kin. In 1999 such decisions were not always discussed with older patients or their relatives. There is no evidence from the medical notes or relative statements that patient J expressed any wishes that he did not want any medical intervention that might prolong his life. A very important principle in the medical care of patients, particularly for older people, is that the decision not for attempted resuscitation is separate from other decisions about other medical interventions. The majority of patients where a decision has been made that attempted resuscitation should not be undertaken in cardiac or respiratory arrest occurs still receive active medical treatment including surgery, antibiotic and other medical treatments.

11. A key principle of decision making about active treatment is that that treatments should be given that serve the patients needs. Therefore unless patients express or have expressed a wish not to receive certain treatments, these should be provided by doctors unless other barriers, such as resource limitations prevent this. In the case of patient J there are no entries in the medical records to suggest that the medical team or Dr Tandy intended patient J should not receive treatment that might prevent early death or further disability. Dr Tandy's assessment and investigation of patient J suggest if he had been identified to have a gastrointestinal bleed he would have received further investigation (such as gastroscopy), treatment with blood transfusion and to be considered for surgery.

12. Primary responsibility for the medical care of patient J whilst he was on Dryad ward lay with Dr Reid the consultant responsible of his care. Day to day medical care was the responsibility of Dr Barton as clinical assistant and during out of hours period on call medical staff. Ward nursing staff were responsible for assessing, monitoring, and administering treatment to patient J and informing medical staff of any significant deterioration.

13. I consider there are many aspects of patient J's management that were of concern. Review of the medical and nursing notes indicates that patient J died from massive gastrointestinal haemorrhage most likely contributed to in part by the Clexane (enoxaparin) he received to reduce his risk of developing a deep vein thrombosis, and possibly opiate and sedative induced respiratory depression. There was no evidence to support a diagnosis of myocardial infarction (such as ECG changes, cardiac enzyme changes) which was given as the cause of his death.

14. Had patient J been readmitted to an acute hospital unit alternative actions would have been taken including blood transfusion and possibly therapeutic endoscopy (if available) or surgery and he might have survived the gastrointestinal bleed. Although his severe obesity would be expected to place him at risk of a number of complications, he was not dying or expected to die prior to his deterioration on Dryad ward on 26 August. His pressure sores were treatable and there was a reasonable possibility that he might regain limited mobility. The available evidence suggests patient J's had a reasonable quality of life and would wish to be treated. Patient J's wife states that they were told patient J was to be transferred to Gosport War Memorial Hospital for recuperation and rehabilitation (p4 BP/1).

15. Dr Barton as the doctor responsible for the day to day management of patient J had a responsibility to obtain, review and act upon the results of blood tests. The medical notes on 23 August indicated repeat blood tests were to be performed. The nursing notes indicate the haemoglobin result was to be reviewed by Dr Barton. On 26 August Dr Barton was called to see patient J as he was unwell and she had recognised that patient J might have had a gastrointestinal bleed. Had this result been obtained it would have indicated that patient J had experienced a large bleed and required blood transfusion and transfer to an acute medical unit for further care. I find the comment by Dr Barton that patient J was too unwell to transfer to an acute unit difficult to understand when at no point had it been suggested that patient J was for palliative care. On the contrary it was clear he was too unwell to be safely investigated and managed at Gosport War Memorial Hospital. This decision was not appropriately made by a clinical assistant without discussion with a consultant colleague and Dr Barton should have discussed patient J with a consultant Geriatrician or the on call Acute Medical Team.

16. The medical notes suggest the medical assessment of patient J by Dr Barton on 26 August were in my view inadequate. The standard of note keeping falls below the expected level of documentation on a continuing care of rehabilitation ward. Dr Barton describes patient J as being clammy and unwell but does not appear to have performed a physical examination of his chest and abdomen, recorded the results of any examination and did not instruct nurses or obtain herself his pulse rate and blood pressure. She did not obtain appropriate further investigations such as an electrocardiogram and blood tests to obtain further information supporting a diagnosis of a myocardial infarct. Had she done this and discussed the results with a consultant colleague it is likely patient J would have been transferred to an

acute medical unit at another hospital. Dr Barton's own provisional diagnosis of a myocardial infarct should have prompted her to discuss transferring patient J to a coronary care unit or acute medical unit so that he could be assessed and be in an appropriate environment where complications of a myocardial infarct such as cardiac arrhythmias could be monitored and treated. For these reasons I consider Dr Barton failed to provide appropriate medical care to patient J.

17. The verbal message by Dr Barton to administer diamorphine to patient J on 26 August before she had seen and assessed patient J was inappropriate as no medical assessment was undertaken and no clear diagnosis had been made. If the pain was considered severe enough to require diamorphine patient J should have been assessed immediately by Dr Barton or another doctor to establish whether he had experienced a myocardial infarction or other serious problem.

18. The rationale for commencement of regular oral morphine is not recorded in the medical notes on 26 August by Dr Barton. On the 28 August Dr Barton records that patient J is uncomfortable but does not record the site of pain or justification for continuing morphine. There is no record in the medical notes explaining why diamorphine and midazolam were administered by syringe driver on 30 August or why the doses of diamorphine were increased from 40mg/24hr to 90mg/24hr and midazolam from 20mg/24hr to 80mg/24hr between 31 and 2 September.

19. The medical records contain no information indicating why patient J required midazolam as neither the medical or nursing notes record that he had symptoms of restlessness or agitation requiring administration of a sedative drug. Dr Barton did not record the reasons why the diamorphine and midazolam doses were increased on the 1 and 2 September.

20. The dose ranges of diamorphine and midazolam prescribed were inappropriate and hazardous. After the commencement of diamorphine and midazolam patient J became drowsy. There are no records of his respiratory rate or detailed assessments of his conscious level but the progressive increase in diamorphine and midazolam doses after 1 September may have led to respiratory depression and contributed to his death, although he primary cause of death appears to be due to massive gastrointestinal haemorrhage. The medical records do not contain a record of an adequate medical assessment by Dr Barton or record the reasons for her treatment decisions. In my opinion the prescriptions of oramorphine, diamorphine and midazolam were inappropriate and hazardous.

21. Dr Reid assessed patient J on 1 September. At this stage it was clear patient J had bleeding from the gut and was drowsy. The notes suggest Dr Reid did not review the full blood count results and did not consider the possibility that his drowsiness and confusion might be secondary to the diamorphine infusion. The notes suggest Dr Reid did not consider transferring patient J to an acute medical unit. This was possibly because Dr Reid considered Patient J would inevitably die whatever actions were taken.

Summary of Conclusions

22. Patient J was a man with severe obesity and long standing leg oedema who was admitted to hospital because of mobility problems and difficulties managing at home. He was transferred to Dryad ward for rehabilitation. Shortly after transfer he deteriorated on the 26 August 1999 and died on 3 September 1999 from gastrointestinal bleeding and possibly diamorphine and midazolam induced respiratory depression. In my opinion the information in the medical records indicates an adequate medical assessment was not performed by Dr Barton when patient J deteriorated on 26 August and the verbal order to administer diamorphine before a medical assessment was not justified. The prescriptions of diamorphine and midazolam and the reasons for increasing the doses infused were not justified by the information in the medical records.

23. In my opinion Dr Barton in her care of patient J failed to meet the requirements of good medical practice to:
    - Provide an adequate assessment of the patients condition based on the history and clinical findings and including where necessary an appropriate examination
    - Consult colleagues
    - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
    - Provide or arranging necessary investigations
    - Prescribe only the treatment, drugs or appliances that serve patient's need

20. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

    I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GMC and Dr Barton
Report on Elsie Devine (Patient K)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient K

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient K commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that the prescription by Dr Barton of morphine solution was not justified by the patient's presenting symptoms; that the prescription of diamorphine and midazolam by subcutaneous infusion was in too wide a dose range and created a situation whereby drugs could be excessive to the patient's need; that the prescription of morphine solution, fentanyl 25 patch and diamorphine with midazolam infusions were inappropriate, potentially hazardous and not in the best interests of Patient K.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient K; statements of Ann Reeves, Dr Ian Reckless, Dr Walter Jayawardena, Dr Judith Stevens, Dr Tanja Cranfield, Dr Ravindrane, Dr Joanna Taylor, Freda Shaw, Lynn Barrett, Gillian Hamblin, Anita Tubbritt, Dr Richard Reid, Dr Althea Lord, Fiona Walker; statement made by Dr Barton in relation to Patient K; interview of Dr Barton dated 4 November 2004 (three transcripts).

5. Course of events

5.1 Patient K was an 88 year old lady who was admitted to Queen Alexandra Hospital, Ward 3 on 9 October 1999 with an episode of acute confusion. Some of the medical records relating to this admission appear not to be in the copy of medical notes provided to me but a letter by Dr Taylor, Clinical

Assistant in Old Age Psychiatry summarises Patient K's problems at this time (page 29, 30). Dr Taylor saw Patient K on behalf of Dr Lusznat, Consultant in Old Age Psychiatry, at the request of the responsible Consultant Physician, Dr Duncan. Prior to her admission, her daughter indicated Patient K had been wandering and aggressive.

5.2 Patient K remained confused following admission to the Ward, had tried to get out of windows and was possibly hallucinating. Her behaviour had settled but she remained confused and disorientated. Until January 1999 Patient K had been able to look after herself but her family had noticed a decline in her memory since that time and she was no longer able to cook. She had background medical problems of hypothyroidism, treated with thyroxine, chronic renal failure and an IgA paraprotein. A bone marrow biopsy had shown a 6% plasma cell infiltrate. On assessment in June 1999 by Dr Cranfield, Consultant Haematologist (page 63) she did not consider there was sufficient evidence to make diagnosis of myeloma. Patient K also had a diagnosis of nephrotic syndrome (renal impairment with loss of protein through the kidneys). Examination of Patient K's skeletal system in May 1999 (page 75) had not shown any bone lesions due to plasma cell infiltration.

5.3 Dr Taylor's letter indicated that Patient K's daughter was currently unable to provide support to her mother due to other family illness. On the ward Patient K was mobile, able to wash with prompting and independent in her self-care but did tend to get lost on the ward. At this time Patient K was sleeping well and settled during the day but had been aggressive at times towards her daughter. Dr Taylor found Patient K had hearing difficulties and scored low (9/30) on the mini-mental state examination – an assessment of cognitive function. Dr Taylor considered Patient K had a diagnosis of dementia and that she would not be able to return home and recommended referring her to Social Services for consideration for residential care in a home with experience dealing with memory problems. As her behaviour was settled, Dr Taylor did not think she required an EMI (Elderly Mental Infirm) home.

5.4 On 15 October the notes record a discussion with Dr Smith, Patient K's GP, and a plan to transfer her to St Christopher's. This appears to have been planned as a temporary transfer prior to placement in a suitable home in the community. A referral was made to Dr Jay, Consultant Geriatrician who saw Patient K on 19 October and stated in the notes that she was suitable for rehabilitation and had arranged a transfer to Gosport War Memorial Hospital (page 169). A letter relating to that assessment dated 20 October (page 21) stated she was alert, could stand but was unsteady on walking. A transfer letter dated 20 October 1999 summarises Patient K's admission prior to transfer to Gosport War Memorial Hospital and states *"Patient admitted with increasing confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her crp* (C reactive protein) *we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and now she needs temporary placement with you until a permanent place is..."*

5.5 The medical notes record Patient K's transfer to Dryad Ward on 21 October and an entry by Dr Barton states *"transfer to Dryad Ward, continuing care. HPC acute confusion, admitted to Mulberry → Dryad. Past medical history dementia, myeloma, hypothyroidism, Barthel transfers with one. So far continent. Needs some help with ADL MMSE 9/30. Barthel 8. Plan get to know. Assess rehab potential probably for rest home in due course".*

5.6 The next entry in the medical notes is by Dr Reid, Consultant Geriatrician on 25 October. This states *"mobile unaided. Washes with supervision. Dresses self. Continent. Mildly confused. BP 110/70. Normochromic anaemia-chronic renal failure. Was living with daughter and son-in-law. ?Son-in-law awaiting bone marrow transplant. Need to find out more [illegible] etc".* A further entry by Dr Reid on 1 November states *"physically independent but needs supervision with W and D help with bathing, continent. Quite confused and disorientated e.g. wandering during the day. Unlikely to get much social support at home therefore try home visit to see if functions better in own home".*

5.7 There is a further unsigned entry in the medical notes dated 15 November indicating Patient K had been aggressive at times and restless and that needed thioridazine. She was on treatment for a urinary tract infection after a urine specimen had shown blood and protein. Examination at this time showed Patient K was apyrexial, had some peripheral oedema but had a clear chest. The notes state that a request would go to Dr Lusznat to review Patient K.

5.8 There is then an entry by Dr Barton dated 16 November which states *"Dear* Code A *Thank you so much for seeing Patient K. I gather she is well known to you. Her confusional state has increased in the last few days to the point where we are using thioridazine. Her renal function is decreasing. Her MSU showed no growth. Can you help? Many thanks."*

5.9 Patient K was seen by Dr Taylor on 18 November. The medical notes record *"this lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward".* The next entry is on 19 November 1999 by Dr Barton and records *"marked deterioration over-night. Confused aggressive, creatinine 300, fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs sc analgesia with midzolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death".* A final entry in the medical notes on 21 November records Patient K had died at 2030h (page 157).

5.10 The nursing summary notes (page 223) record on 21 October 1999 Patient K was admitted with increasing confusion and aggression which had resolved. The notes state *"a very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet".* An entry on 19 November which is difficult to read states *"Extremely aggressive..... Two staff to special. Syringe driver commenced at 0925h diamorphine 40mg +*

midazolam 40m. fentanyl patch removed". The nursing notes record Patient K was seen by Dr Barton at 1300h (page 224). An entry on 21 November records that her condition had continued to deteriorate slowly. I can find no record in the nursing notes indicating Patient K was at any time in pain.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 279 -281. All prescriptions written by Dr Barton unless otherwise marked.

Once only drugs

Chlorpromazine 50mg im	Date unclear November 0830h

Regular prescriptions

Thyroxine 100ug od Prescribed 21 Oct	22 Oct-17 Nov. Not administered 2 Nov or 18 Nov onwards
Frusemide 40mg od Prescribed 21 Oct	22 Oct – 17 Nov. Not administered 18 Nov onwards
Amiloride 5 mg od Prescribed 1 Nov	2 Nov-18 Nov. Not administered 19 Nov onwards
Trimethoprim 200mg bd Prescribed 11 Nov	11 Nov – 15 Nov. Then discontinued
Fentanyl 25ug skin (every three days) Prescribed 18 Nov	18 Nov 0915h

Diamorphine subcut via syringe driver 40-80mg/24hr Prescribed 19 Nov	19 Nov 40mg/24hr 20 Nov 40mg/24hr 21 Nov 40mg/24hr
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 19 Nov	19 Nov 40mg/24hr 20 Nov 40mg/24hr 21 Nov 40mg/24hr

As required prescriptions

Temazepam 10mg nocte Prescribed 21 October 1999	11 Nov
Oramorph 10mg/5ml 2.5-5ml Prescribed 21 Oct	None administered
Thiordiazine 10mg tds Prescribed 11 Nov	11 Nov 0830h 12 Nov 1320h 13 Nov 0825h, 1800h 14 Nov 0825h, 1945h 15 Nov 0830h, 2130h 16 Nov 0845h 17 Nov 1740h

Opinion on Patient Management

7. Patient K was an elderly woman with dementia who prior to admission to hospital in October 1999 had been living at home with increasing difficulties and was likely to move into a residential care home. She had been admitted to Queen Alexandra Hospital after being found wandering and aggressive and continued to exhibit some behavioural difficulties. These were not judged sufficiently severe to merit moving into an Elderly Mental Infirm home rather than a residential home. She was referred to Gosport War Memorial Hospital for temporary placement prior to a suitable residential home being found for her to move into.

8. Following transfer to Dryad ward Dr Reid had suggested Patient K be taken on a home visit to see if she functioned better in her own home than on the ward. This is common and good practice in elderly care medicine as some patients function better in their own homes than when observed in a ward environment. Observation of the patient in their own home allows a decision to be made as to whether they can continue to manage at home and what level of support services might be required to support this. At this point Patient K was independently mobile, continent, able to wash with supervision and dress herself. It was reasonable to consider the possibility that Patient K might be able to manage to live in the community with support from her family and social services.

9. Patient K was intermittently aggressive on the ward. Aggression is a well recognised and troublesome symptom in some patients with dementia and is often worse when patients are in a new environment such as a hospital ward. It can also be precipitated or worsened by other medical problems particularly chest or urinary tract infections. Thiordiazine had been prescribed on 11 November. Neuroleptic drugs such as thioridazine are commonly used to try and improve symptoms of aggressions in people with dementia. I would consider this was an appropriate treatment approach.

10. When her aggressive behaviour persisted a request for consultation was sent to Dr Lusznat, Consultant Old Age Psychiatrist who had previously assessed Patient K. This was appropriate and good medical practice. Dr Taylor, a member of Dr Lusznat's team assessed Patient K and noted she was refusing medication and not eating well. Dr Taylor made plans to transfer her to an Old Age Psychiatry ward for further assessment and management. This suggests that Dr Taylor considered Patient K's main problems were related to her dementia and she had no other significant active medical problems.

11. On 18 November when Dr Taylor saw Patient K Dr Barton prescribed a fentanyl patch to Patient K. Dr Barton's entry in the medical records on 19 November indicates Patient K deteriorated the day before. The medical and nursing notes contain no evidence that Patient K was in pain and the indication for prescribing the fentanyl patch is not recorded. Good medical practice requires the reasons for commencement of any drug but particularly a controlled drug such as an opiate to be recorded in the medical notes. If Patient K was in pain the details of the pain should have been recorded in the medical notes and a physical examination should have been performed to further assess the pain. Patients with dementia may not always communicate

they are in pain, but may become confused and aggressive because of pain. Examination may reveal a patient has a musculoskeletal injury, such as a hip fracture, or other problem such as a distended bladder or other acute painful condition which require specific treatments.

12. Nursing and medical review of Patient K was indicated when she deteriorated on the 18 November. There is no evidence in the medical and nursing notes that Dr Barton examined Patient K. In my opinion the prescription of fentanyl by Dr Barton was not justified as there is no evidence Patient K was in pain. I consider Dr Barton failed to meet the requirements of good medical practice to adequately assess Patient K, keep contemporaneous patient records and provide appropriate treatment.

13. A medical assessment was also indicated when she became very aggressive, which appears to have been on the 19 November but could have been on the 18 November. The nursing and medical notes lack sufficient information to be clear when she became aggressive. Dr Barton's notes document that Patient K deteriorated overnight but she does not record what the cause of this deterioration in her condition was due to. One key issue that should have been considered at this stage was that Patient K's further deterioration and aggression might have been related in part to adverse effects of the fentanyl patch that had been commenced. Opioid drugs commonly cause sedation but can precipitate confusion and aggression in some older people.

14. When Patient K deteriorated Dr Barton's notes document an increased blood creatinine concentration suggesting her renal function had deteriorated. This was possibly due to dehydration but could have been also due to a urinary tract or other infection. There is also a comment that Patient K needed subcutaneous analgesia with midazolam but her notes do not record why. The specific reference to analgesia suggests Dr Barton considered Patient K was in pain but neither the medical or nursing notes record any information suggesting she was in pain. As Patient K was not able to swallow use of the transdermal or subcutaneous route to administer analgesia and/or sedation if she required this would have been appropriate if these treatments were indicated.

15. The prescription of subcutaneous diamorphine by Dr Baton on 19 November was in my opinion not appropriate or justified as there was no evidence she was in pain. The dose prescribed was also in my opinion excessively high if she had been in pain. In an older frail patient an appropriate dose would have been 10mg/24hr or 20mg/24 hr particularly when midazolam was also prescribed. The prescription of diamorphine 40-80mg/24hr placed Patient K at risk of developing respiratory depression and coma.

16. The prescription of subcutaneous midazolam by Dr Barton on 19 November was in my opinion not justified by the information recorded in the medical recotrds. The Wessex Protocols list midazolam by subcutaneous infusion as a treatment option for agitation (10 mg im stat then 10-100mg/24hr) in patients receiving palliative care who have a syringe driver for other reasons. The notes indicate patient K was extremely aggressive. In my opinion midazolam by subcutaneous infusion was not the optimal initial treatment for her

aggression. She had previously been receiving thioridazine until 17 November and it would have been appropriate to administer thrioridazine by intramuscular injection or use an alternative neuroleptic drug such as haloperidol.

17. In patients who are very aggressive single doses of drugs, repeated as necessary if aggression continues without significant adverse effects from the drugs administered, are a more appropriate approach to controlling symptoms. This is rationale for the Wessex Protocols recommend an initial loading dose by intramuscular midazolam to treat agitation. Commencing a midazolam infusion without an initial loading dose leads to the maximal effect of the drug not being observed until 'steady state' concentrations are reached which may be more than 24 hours later. Therefore the initial response may be inadequate and there may be adverse effects that occur much later as the drug accumulates in the patient.

18. If Dr Barton considered Patient K was terminally ill her medical records do not indicate why this was the case. Given that the day before the plan had been to transfer Patient K for further assessment on an Old Age Psychiatry ward it would have been appropriate for Dr Barton, as the doctor responsible for Patient K's day to day care, to discuss the sudden deterioration in Patient K with Dr Reid the responsible consultant or another senior colleague.

19. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-100mg/24hr. In an older frail patient an appropriate dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 40mg/24hr was therefore inappropriately high. The prescribed dose range of midazolam with an upper limit of 80mg/24hr particularly in conjunction with the diamorphine prescribed placed patient K at high risk of developing life threatening complications.

20. In my opinion the subsequent deterioration in Patient K after 19 November until her death on 21 November was very likely due to diamorphine and midazolam leading to respiratory depression and coma.

Summary of Conclusions

21. Patient K was an elderly lady with dementia who developed aggressive behavioural problems whilst on Dryad ward and awaiting transfer to an Old Age Psychiatry ward. The notes do not suggest that Dr Barton conducted an adequate assessment of patient K before prescribing the opiate fentanyl and then subcutaneous infusions of diamorphine and midazolam. In my opinion fentanyl and diamorphine were not indicated. The prescription of a midazolam infusion without an initial loading dose was not in my view optimal management, but if this had been administered alone without diamorphine would not in my opinion have been a breach of a duty of care if there had been an adequate clinical assessment. The doses of diamorphine and midazlolam prescribed by Dr Barton were excessive, dangerous and reckless.

In my opinion the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.

22. In my opinion Dr Barton in her care of Patient K failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

23. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

General Medical Council and Dr Barton
Report on Jean Stevens (Patient L)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient L

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient L commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that; Dr Barton did not properly assess patient L on admission; the prescriptions by Dr Barton of oramorphine, diamorphine and midazolam were not clinically justified and created a situation whereby drugs could be administered which were excessive to patient L's need; that the prescriptions were inappropriate, potentially hazardous and not in the best interests of Patient L.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient L; statements of Ernest Stevens, June Bailey and various nurse statements.

5. Course of events

5.1 Patient L was a 73 years old when admitted to Royal Hospital Haslar on 26 April 1999 after experiencing chest pain and then collapsed at home after developing left arm and leg weakness. She was transferred to Daedalus ward, Gosport War Memorial Hospital on 20 May and died on that ward on 22 May 1999. Prior to this admission she was living at home with her husband. Her past medical history (page 174) included ischaemic heart disease and previous myocardial infarction, atrial fibrillation, asthma and chronic airways disease, and surgery for diverticular disease and a stricture. She had problems with recurrent lower abdominal pain thought to be due

to adhesions (page 129) or irritable bowel syndrome (page 125). She had rated her health as poor in October 1997 (page 150).

5.2 The admission clerking to Royal Hospital Haslar documents she had developed new left face, arm and leg weakness and slurred speech. She was complaining of a headache and was thought to have had a stroke. A CT brain scan was obtained on 26 April (page 177) and demonstrated infarction in the right parietal lobe indicating she had a stroke due to cerebral infarction (blocked blood vessel). The notes state that an ECG showed atrial fibrillation and ischaemic changes. Cardiac enzymes were elevated (CKMB 65) suggesting she had possibly sustained a myocardial infarction as the cause of her chest pain.

5.3 The notes record on 27 April (page 178) that she was alert and had left sided neglect. A nasogastric tube was paced to commence feeding as to swallow was unsafe. On 28 April the notes record she was experiencing continuing chest pain thought to be due to angina (page 180). An ECG showed ST elevation and she was transferred to the coronary care unit (CCU) and treated with a nitrate infusion (page 182). An entry in the medical notes on 30 April states that ECGs had confirmed she had experienced an anterior myocardial infarct. Later that day she developed increasing shortness of breath (page 183). The notes record she was hypoxic (low oxygen in the blood) and had signs on examination suggesting she had either a chest infection or pulmonary oedema due to fluid overload. A chest XRay found the nasogastric tube was not in the stomach and feed had been passed into the nasopharynx suggesting she had developed an aspiration pneumonia. Antibiotics were commenced (Page 184).

5.4 On 5 May 1999 the notes record patient L was able to start taking food (page 190). A referral was made by the medical team to Dr Lord, Consultant Geriatrician (page 190) stating that she was improving and requesting Dr Lord's opinion on the provision of rehabilitation. Later that day the notes record she was less well (page 191) and was in respiratory failure. She was treated with oxygen and small doses of diamorphine. The notes record patient L had a reasonable quality of life prior to her stroke (page 192). After discussion with the family a decision was made that she was for active treatment but not for ventilation if she deteriorated. An entry in the notes the following day records a discussion with the consultant and a decision that she was not for resuscitation.

5.5 Dr Lord assessed patient L on 6 May (page 194). Dr Lord records in the notes that patient L was extremely unwell with problems of a dense left hemiparesis due to stroke, myocardial infarction, atrial fibrillation, and aspiration pneumonia. The notes document she was *'chesty, flushed and tachypnoeic'*. Dr Lord's assessment was that she was not well enough to transfer to Gosport War Memorial Hospital and she thought she was unlikely to survive. She recommended patient L be given intravenous fluids, salbutamol nebulisers, and diamorphine if distressed. Dr Lord states *'If stable early next week for transfer to slow stream stroke care GWMH later in the week'*.

5.6 On 10 May the notes record patient L was improving and nasogastric feeding was recommenced. Dr Tandy, consultant Geriatrician reviewed patient L on 10 May (page 196-198) and noted that she was experiencing chest pain and had an elevated blood sodium (Na 165). Dr Tandy states *'If...(illegible) will take to GWMH. Please normalise Na+(has had 5% dextrose). Rule out MI ensure angina reasonable 'sable'. Make sure tolerating ng. If above OK, please transfer to GWMH next week'.* A letter dated 12 May also summarises her assessment (page 68)

5.7 Later on 10 May the notes record patient L had a further episode of central chest pain which was relieved by GTN spray and her pain settled. On 12 May the notes record Captain Code A spoke to patient L's family and explained her poor prognosis and the rationale for making her not for resuscitation or care on an intensive care unit if she deteriorated (p200). On 14 May she was reviewed by an orthopaedic specialist as it was thought she might have dislocated her left shoulder. This was found to be subluxation of the shoulder and no active intervention was needed (page 202). On 18 May the notes record the medical team liaised with Gosport War Memorial Hospital (page 204) and that she was tolerating her nasogastric feeding, was recovering from her aspiration pneumonia and showing improvement in her orientation, speech and strength, but was faecally incontinent and had a urinary catheter in place. The transfer note states that patient L was for rehabilitation (p70). On transfer she was taking prescribed aspirin, enalapril, digoxin, isosorbide mononitrate (Imdur) and "as required" subcutaneous diamorphine 5mg.

5.8 Patient L was transferred to Daedalus ward on 20 May. The medical records do not state the time patient L arrived on Daedalus ward. The first timed entry is at 1340h in the nursing summary. The medical notes (Vol 3 page 20) contain an entry from Dr Barton which states *'Transfer to Daedalus ward S.S.S.R* (Slow Stream Stroke Rehabilitation) *HPC. R CVA 26-4-99. Dense L Hemi. Aspiration pneumonia and MI 28-4-99. P.M.H. IHD MI x 2. AF, COPD asthma, sigmoid resection due to diverticular disease. Barthel needs help c ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.'* There are no further medical entries in the notes. The notes record in an entry by staff nurse Tubbritt that patient L died at 2230h on 22 May.

5.9 Mr Stevens states in his statement of 5 April 2008 that Dr Barton did not see patient L whilst at Gosport War Memorial Hospital. In his statement dated 16 April 2004 Mr Stevens states he arrived on Daedalus Ward at 1330h on 20 May and had to wait to see patient L as the nurses were attending to her.

5.10 The nursing note summary on 20 May records *'.... Appears quite alert and aware of surroundings'.* The notes do not record that patient L appeared distressed or in pain (vol 3 page 26). However the nursing records record *'c/o abdo pain. Due to Hx bowel problems. Oramorph given o/a* (on arrival)' (Vol 3 page 28). An entry in the nursing night care plan on 20 May (Vol 3 page 60) states *'oramoprh 2.5 ml given as per kardex. c/o pain in stomach and arm. Condition poor'.* On 21 May the nursing records state that isosorbide was discontinued and patient L was to have GTN spray "as

required". A separate entry that day states *'now on regular (4 hourly) Oramorph 10mg/5ml'.*

5.11 At 1800h on 21 May the nursing records (Vol 3 page 34) state *'uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen and care discussed. Very upset. Agreed to commence syringe driver for pain at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.'* An entry at 1945h records a syringe driver was commenced at 1945h with 20mg oramorphine and 20mg midazolam over 24 hours. On 22 May 0800h the nursing notes state *'condition has deteriorated. Very bubbly. 800mcg hyoscine, 20 mg diamorphine, 20 mg midazolam commenced via syringe driver at 8am'.* A further entry at 1020h states *'Dr Beasley contacted and verbal order to increase hyoscine to 1600mcg.'*

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 64 - 69. All prescriptions written by Dr Barton unless otherwise marked.

Regular prescriptions

Digoxin elixir 1.2 ml od — 21 May 1 dose
Prescribed 20 May

Enalapril 5mg od — 21 May 1 dose
Prescribed 20 May

Aspirin 75mg od — 21 May 1 dose
Prescribed 20 May

Isosorbide Mononitrate 60mg — None administered. Discontinued (date unclear)
Prescribed 20 May

Suby C — None administered
Prescribed 20 May

GTN spray 2 puffs (prn) — None administered
Prescribed 21 May

Hyoscine subcut via syringe driver 22 May 1030h 1600mcg/24hr
1600ucg/24hr
Prescribed 22 May (verbal message D Beasley)

Oramorph 10mg/5ml — 21 May 2 doses 1000h, 1400h
10 mg 4 times a day
Prescribed 21 May

Oramorph 10mg/5ml — None administered
20mg nocte
Prescribed 21 May

Daily review prescriptions

Liquid .....? ng tube 4mg qds — None administered
No prescription date

As required prescriptions

Oramorphine 10mg/5ml — 20 May 1430h — 5mg

2.5-5ml		1830h	2.5mg
Prescribed 20 May		2245h	2.5mg
	21 May	0735h	2.5mg

Diamorphine subcut via syringe driver	21 May	1920h	20mg/24hr
20-200mg/24hr	22 May	0800h	20mg/24hr
Prescribed 20 May	22 May	1030h	20mg/24hr

Hyoscine subcut via syringe driver	22 May	0800h	800ucg/24hr
200-800 ucg/24hr			
Prescribed 20 May			

Midazolam subcut via syringe driver	21 May	1920h	20mg/24hr
20-80mg/24 hr	22 May	0800h	20mg/24hr
Prescribed 20 May	22 May	1030h	20mg/24hr

Opinion on Patient Management

7. Patient L was a 73 year old woman with pre-existing cardiac disease and chronic abdominal pain who was living at home independently prior to being admitted with cardiac chest pain and a stroke in April 1999. Her stroke was severe leaving her with significant problems of left sided weakness, swallowing difficulties and inattention, which would almost certainly have left her with long term disabilities requiring care and support, either at home with the support of her husband and carers or in a nursing home. Following her admission she had continuing problems from a myocardial infarction, aspiration pneumonia and hypernatraemia (high blood sodium). Her problems were clearly summarised by Dr Lord following her assessment 10 days after admission. She considered patient L was unlikely to survive and I agree with this assessment. A patient aged over 70 years of age with a severe stroke, myocardial infarction and these complications would have a high likelihood of dying from these problems.

8. Dr Lord recommended a treatment plan for patient L including diamorphine if distressed. I consider this was an appropriate recommendation. Patient L had cardiac chest pain and evidence of pulmonary odema both of which are appropriately treated with diamorphine. I have been unable to find the prescription chart in the medical records during her admission to Royal Hospital Haslar to determine the amount of opioid analgesia patient L received during this admission. Despite her poor state at this time Dr Lord recognised that patient L might improve and indicated that if she became medically stable she would be suitable to transfer to slow stream stroke care at Gosport War Memorial Hospital. In my opinion this was an appropriate plan.

9. Slow stream stroke care or rehabilitation is a commonly used term used to describe a period of rehabilitation over a few months required for patients with severe strokes, who are often elderly and/or have other medical complications, such as in the case of patient L. Such rehabilitation often takes place in rehabilitation wards that are not on acute hospital sites. It is important that patients are medically stable before transfer to such units

which usually do not have a resident on site doctor or facilities to investigate patients if they develop new medical problems.

10. Patient L was still very unwell when seen four days later on 10 May by Dr Tandy who summarised the ongoing medical problems that needed to be stabilised before transfer to Gosport War Memorial Hospital could be considered. One week later patient L had improved and her ongoing medical problems had stabilised with normalisation of her blood sodium, stabilisation of her chest pain and her pneumonia was resolving. She was judged to be sufficiently stable for her to be transferred to Daedalus ward for rehabilitation. At this point she had an ongoing prescription for 5mg diamorphine "as required" but I have not been able to establish how many doses she had received. From the information available in the medical notes I consider patient L was sufficiently stable on 20 May for her to be transferred to Daedalus ward, although she was at risk of developing further medical complications.

11. The nursing notes state that patient L was complaining of abdominal pain and was administered oramorphine on arrival at Daedalus ward. The drug chart indicates that the first dose of oramoprhine was administered at 1430h. I would estimate that patient L arrived at Daedalus ward shortly around 1300h as the first entry on the nursing notes was timed at 1340h. Dr Barton was the doctor responsible for the initial assessment of patient L. She prescribed oral morphine to patient L which was administered shortly after patient L's arrival. I would expect the nurse who initially assessed patient L and documented she had abdominal pain on arrival at the ward would have informed Dr Barton of this. It is routine practice for nursing staff to admit and assess a patient before the admitting doctor sees a patient arriving on a ward. Even if the nurse had not informed Dr Barton that patient L was complaining of abdominal pain I would have expected Dr Barton to assess patient L as a new patient arriving on the ward, and note any current symptoms and examine the patient L. Given the medical problems patient L had recently experienced it would be particularly important that Dr Barton undertook such an assessment of patient L.

12. Dr Barton's entry on 20 May makes no mention of patient L being in pain and contains no record of a physical examination of patient L. As patient L was complaining of abdominal pain, it would have been appropriate for Dr Barton to have recorded the patient's account of pain if she was able to give such an account, or that the nursing staff had noted she was in pain. The medical notes suggest abdominal pain was a new complaint of patient L's since her admission to hospital although she had a history of chronic abdominal pain. It would have been appropriate for Dr Barton to undertake a clinical assessment of patient L including examining her abdomen. There is no evidence in the notes that Dr Barton undertook such a clinical assessment. The information recorded by Dr Barton could have been obtained entirely from the information contained in the Royal Hospital Haslar notes and transfer letter, and from the nursing assessment. In my opinion the information available in the notes suggests Dr Barton failed to undertake an adequate clinical assessment of patient L after she arrived on the ward on 20 May.

13. On 20 May Dr Barton prescribed oramorphine and also subcutaneous infusions of diamorphine, hyoscine and midazolam. It is not clear if the last three prescriptions for subcutaneous drug infusions were written at the same time as the oramorphine. Dr Barton did not record in the records why she prescribed oramorphine to patient L. It is unclear if this was to replace the diamorphine "as required" prescription that was in place or was commenced for the treatment of the abdominal pain patient L was complaining of on admission to Daedalus ward.

14. I consider the prescription by Dr Barton of oramorphine to replace the "as required "diamorphine for chest pain or distress related to pulmonary oedema if this occurred in patient L would not be optimal because when patient are acutely unwell with such symptoms the oral route for administering opiates leads to slower absorption and patients may be too unwell or nauseated to take oral medication. It would have been preferable to continue the prn subcutaneous diamorphine prescription which had been in place for patient L at Royal Hospital Haslar. The "as required" prescription for oramorphine should have specified the symptoms that Dr Barton intended the oramorphine be given for. In my opinion the prescription of oramorphine was not optimal practice if it was a replacement for the diamorphine prescription.

15. However if Dr Barton had given clear written instructions to nursing staff, in either the drug chart or in the medical notes I would not consider such an action constituted a failure of good medical practice. If Dr Barton had given clear verbal instructions to the nursing staff that the oramorphine was replacing the "as required" diamorphine prescription and the circumstances under which it should be administered there would be a risk of nursing staff misunderstanding the reasons oramorphine was prescribed. The nursing records state that the initial dose of oramorphine was given to patient L for abdominal pain. On the basis of the information available in the medical records Dr Barton failed to either record or inform the nursing staff that the oramorphine was replacing the "as required" diamorphine and the circumstances under which the oramorphine should be given if this had been her intention. Therefore if the oramorphine was intended to replace the diamorphine prescription I consider the oramorphine prescription was not appropriately prescribed and potentially hazardous, as the oramorphine could have been given for other symptoms for which it was not intended such as abdominal pain.

16. If Dr Barton prescribed the "as required" oramorphine to relieve abdominal pain in patient L, I consider this was inappropriate and potentially hazardous, since there is no record in the medical notes that Dr Barton performed a clinical assessment, or considered whether any investigations, such as an abdominal Xray and blood tests were required, or discussion with a senior colleague was required. If as seems possible the abdominal pain was a recurrence of her chronic abdominal pain, opioids were not an appropriate treatment. Opioid drugs had not been prescribed to patient L for abdominal pain in the past when patient L had been assessed by consultant specialists. In my opinion from the information available in the notes the prescription on 20 May of "as required" oramorphine by Dr Barton was inappropriate and

potentially hazardous to patient L, as the oramoprhine was administered for abdominal pain and there had not been an adequate clinical assessment of patient L undertaken by Dr Barton, and no instructions had been given as to the circumstances under which oramorphine should be administered.

17. It is unclear who made the decision that diamorphine and midazolam infusions should be administered to patient L on 21 May. The nursing notes record this was discussed with patient L's husband that evening and the infusion commenced at 1945h. The notes do not record if the decision to commence these infusions was discussed with Dr Barton or another member of medical staff. The nursing notes suggest that these were commenced because patient L was uncomfortable despite 4 hourly oramorphine. Dr Barton had commenced regular oramorphine the morning of 21 May, although the notes do not record the symptoms being treated or the underlying diagnosis considered responsible for the pain. Before prescribing a diamorphine infusion there should have been a clinical assessment of the cause of the pain and response to oramorphine and the reasons why a subcutaneous infusion was necessary, but there is no evidence in the notes that this took place.

18. Patient L was able to receive oramorphine through the nasogastric tube she was being fed through. This had been pulled out on the morning of 20 May. If the nasogastric tube was not in place and patient L was unable to swallow oral medication, this might have been a reason to consider administering opioids by a subcutaneous infusion if they were indicated. The nursing notes do not record there was a problem with administering oramorphine and she had received two doses at 1000h and 1400h before the diamorphine infusion was commenced at 1920h.

19. In the preceding 24 hours patient L had received 27.5 mg oramorphine (2.5+2.5+25+10+10). An equivalent dose of subcutaneous diamorphine would be one third to a half of the dose of morphine received i.e. 9mg-14mg over 24 hours. The diamorphine infusion was commenced at 20mg/24hr was within an acceptable starting dose if continuing opioid drugs by using a subcutaneous infusion as appropriate and patient L's pain was uncontrolled on the oramorphine and this would be 50% greater than the equivalent dose. The prescription by Dr Barton of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient L at risk of developing respiratory depression and coma if a higher infusion rate had been commenced.

20. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion. Patient L was medically stable and transferred for rehabilitation on 20 May when Dr Barton wrote the prescription for midazolam. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. The notes contain no information which suggests patient L was restless or agitated. If patient L had been agitated or restless a clinical assessment was indicated to establish the cause, but there is no evidence in the notes that this occurred.

21. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine prescribed placed Patient L at high risk of developing life threatening complications.

22. On the morning of 22 May, a Saturday, the on call doctor Dr Beasley was contacted because patient L had deteriorated and was experiencing increasing secretions from her chest and airways. Ideally a clinical assessment should have taken place at this time point and the cause of the deterioration and possible contributory role of the drugs she was receiving considered. However if Dr Beasley had been told by ward nursing staff that patient L had been assessed by the medical team and was terminally ill, and for palliative care I would not consider there was a duty of care for Dr Beasley to visit Daedalus ward and assess patient L unless the nursing staff had very clearly requested this.

23. In my opinion the subsequent deterioration in Patient L on 21 May until her death the following was very likely due to diamorphine and midazolam leading to respiratory depression and coma. However because of the limited detail in the nursing and medical notes and lack of a clinical assessment I cannot exclude the possibility that patient L died from another undiagnosed problem that developed immediately after she was transferred to Daedalus ward.

24. Although patient L had been seriously ill and was not expected to survive 10-14 days prior to her transfer this was not the case when she was transferred to Daedalus ward. Patient L and was not expected to die within a few days or weeks from a progressive non curable condition. I cannot determine from the medical records whether Dr Barton considered patient L had deteriorated and was dying, but if this was her view she should have assessed patient L and discussed the change in her status with the responsible consultant or another senior colleague.

25. Patient L was transferred from Royal Hospital Haslar for rehabilitation and was considered medically stable on the morning of 20 May. Within 24 hours of transfer she was receiving diamorphine and midazolam infusions and died within 48 hours of transfer. This dramatic change in her condition should have led to a detailed medical assessment by Dr Barton, discussion with the consultant responsible for Daedalus ward and the referring medical team but there is no evidence in the notes that any of these took place. The reference in the nursing records to patient L's husband not wishing the medications should shorten her life also indicates he wished appropriate active measures to be taken to enable her to survive.

Summary of Conclusions

26. Patient L was a 73 year old woman with a disabling stroke and recent myocardial infarct transferred to Daedalus ward for stroke rehabilitation. She was considered medically stable for transfer and was not expected to die within a few days unless new complications developed. The information in the notes suggest there was inadequate assessment of patient L by Dr Barton as the doctor responsible for the day to day medical care of the patient with no clinical findings recorded of an assessment of patient L's abdominal pain, or justification for the prescriptions of oramorphine and subcutaneous diamorphine and midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

27. In my opinion the combination of diamorphine and midazolam very likely shorten Patient L's life. However the very limited content of the medical notes make it difficult to exclude the possibility that patient L developed a new medical problem on transfer to Daedalus ward that led to her deterioration and death.

28. In my opinion Dr Barton in her care of Patient L failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

29. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

    I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

5

v. eminent cancer researcher
No Geriatric Experience except in a cancer setting
current clinical practice.

MEDICAL REPORT

Dr JANE BARTON

Prepared for MDU Services Ltd.
230 Blackfriars Rd.
London SE1 8PJ

Professor Karol Sikora MA PhD FRCR FRCP FFPM

Code A

JUNE 2009

Karol Sikora MA, MBBChir, PhD, MD, FRCR, FRCP, FFPM

Karol Sikora is Medical Director of CancerPartnersUK which is creating the largest independent UK cancer network. He was Professor and Chairman of the Department of Cancer Medicine at Imperial College School of Medicine and is still honorary Consultant Oncologist at Hammersmith Hospital, London. He is Chair of the Scientific Advisory Board of SourceBioscience PLC, Britain's leading cancer diagnostic company. He is Dean and Professor of Medicine at Britain's first independent Medical School at the University of Buckingham and Fellow of Corpus Christi College, Cambridge.

He studied medical science and biochemistry at Cambridge, where he obtained a double first. After clinical training he became a house physician at The Middlesex Hospital and registrar in oncology at St Bartholomew's Hospital. He then became a research student at the MRC Laboratory for Molecular Biology in Cambridge working with Nobel Prize winner, Dr. Sydney Brenner. He obtained his PhD and became a clinical fellow at Stanford University, California before returning to direct the Ludwig Institute in Cambridge. He has been Clinical Director for Cancer Services at Hammersmith for 12 years and established a major cancer research laboratory there funded by the Imperial Cancer Research Fund. He chaired Help Hammer Cancer, an appeal that raised £8m towards the construction of the new Cancer Centre at Hammersmith. He became Deputy Director (Clinical Research) of the ICRF. From 1997 to 1999 he was Chief of the WHO Cancer Programme and from 1999 to 2002, Vice President, Global Clinical Research (Oncology) at Pharmacia Corporation.

He has published over 300 papers and written or edited 20 books including *Treatment of Cancer* - the standard British postgraduate textbook now in its fifth edition and most recently *The Economics of Cancer Care*. He is on the editorial board of several journals and is the founding editor of *Gene Therapy* and *Cancer Strategy*. He was a member of the UK Health Department's Expert Advisory Group on Cancer (the Calman-Hine Committee), the Committee on Safety of Medicines and remains an adviser to the WHO.

Contact:

Tel:
Fax:
Email: Code A

Address: Code A

PA:
Mob: Code A

This report has been prepared after reviewing the following documents:

- *GMC Fitness to Practice Panel Hearing Notice of Inquiry Revised Version 12.06.09*
- *Commission for Health Improvement Investigation July 2002*
- *Reports from Professor Gary Ford*
- *General Police statement of Dr. Jane Barton*
- *Statements of Dr. Jane Barton on 12 patients*

Dr. Barton's post at Gosport

Dr. Jane Barton was contracted as a Clinical Assistant for 4-5 sessions a week at Gosport War Memorial Hospital between 1988 and April 2000. The hours were flexible to allow her and her general practice to provide 24 hour cover to the patients at Gosport. There were a total of 48 beds designed for the long term care of elderly patients. However, the nature of the clinical case-mix changed during the 1990's to include patients transferred from the acute sector for rehabilitation. There was, however, no increase in medical or nursing time and no enhancement of social services, physiotherapy, occupational therapy or support staff to help meet this new function effectively. Dr. Barton also worked as a part time GP locally with a personal list of approximately 1,500 patients.

Dr. Barton had no specific training or postgraduate qualifications in internal medicine, care of the elderly or rehabilitation. This is normally the case with Clinical Assistant posts. Her work was supervised by two consultants Drs Lord and Tandy with Dr Reid replacing Dr Tandy in 1999. They all had major clinical responsibilities elsewhere and their contribution to the care of the Gosport patients was apparently limited to a weekly ward round which did not always take place. During April 1998 Dr Tandy was away on maternity leave and the Trust made the decision not to provide any locum cover for her until she returned in February 1999.

Dr Barton's work pattern (which I believe was devised by her and not part of a formal job plan) consisted of an early morning visit between 07.30-09.00; a lunchtime visit on most days to clerk in any new patients and an evening visit around 7pm if she had any patients or relatives to see. In 1998 Dr Barton raised the increasing workload issue with the Trust management, but no changes were implemented. At no time during her 12 years at Gosport were any changes suggested to Dr Barton's mode of work, her prescription habits or her abbreviated style of note keeping. There seems to have been no formal appraisal system in place. Her rapport with the nursing staff appears to have been excellent and the unit dealt efficiently with a huge patient volume with minimal staff.

Expert criticisms of Dr Barton's work

Despite the volume of text available to me the exact details of where Dr Barton's care fell below a reasonable standard is not explicit in the various reports. The common themes in the accusations against her are described in the Fitness to Practice document as:

1. the lowest doses in the sliding scales of her prescriptions for diamorphine and midazolam were too high
2. the dose range of these drugs was too wide
3. the prescription created a situation where by drugs could be administered that were excessive to the patients' needs
4. adequate assessment of patients was not made and properly recorded
5. advice from a senior colleague was not obtained when patients deteriorated

The CHI investigation is not at all specific on these issues although it does on page 36 address items of corrective action on the prescribing of opiates and the documentation of their use together with the keeping of an effective record of communications with patients' relatives. Most of the report covers general governance issues. However on page 12 it lists five concerns on the prescription system in place.

1. no evidence of Trust policy
2. inappropriate combination of drugs (diamorphine, midazolam and haloperidol) given subcutaneously
3. no distinction between patients for palliative care or rehabilitation
4. failure to recognise adverse effects of prescribed drugs
5. failure by management to supervise care

The report, however, is careful to avoid any apportionment of the blame for these concerns.

The report by Professor Ford examines in an academic way the generic issues around the use of pain control medication. In reality the only way to judge accurately a patient's need for analgesics would be by careful clinical observation over time at the bedside. It is not possible to judge this by the study of abbreviated medical records alone. Professor Ford examines the specific issues pertaining to Gosport including:

1. wide dose ranges of opiates
2. use of p.r.n. prescriptions
3. multiple drug combinations
4. widespread use of subcutaneous infusions
5. use of anticipatory prescribing

All these issues were clearly the responsibility of Dr Barton as the physician responsible for the Gosport site. However Dr Barton was only one member of a team. Professor Ford's report fails to address any practical solution for the circumstances that Dr Barton found herself in during the late 1990's. Furthermore it does not address the wide individual variation between patients to opiate need nor the balance between effective psychological support through good nursing care and drug therapy to relieve anxiety and distress.

Clinical opinion

My area of expertise is cancer medicine and I have been a consultant in this discipline for nearly 30 years. This includes the palliative care of elderly patients with cancer. I have worked as a consultant in two teaching hospitals – Addenbrookes Hospital, Cambridge and Hammersmith Hospital, London where I have had excellent support from more junior colleagues. I have never had to practice in an isolated clinical environment. I was Clinical Director for Cancer Services from 1986-1998 of the Hammersmith Hospitals NHS Trust and this included the management of the palliative care services.

I believe that Dr Barton took on the Gosport work believing it to be a commitment that could initially be managed within the time constraints of her limited sessions. I also believe the nature of the clinical workload at Gosport changed very significantly indeed during her tenure and that she strove to do the best she could under difficult circumstances. As Dr Barton writes in the statement re Enid Spurgin:

"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 as I could, or making more detailed notes about those I did see, but potentially neglecting other patients."

There is clear evidence that she had inadequate clinical consultant support and that the staffing model at Gosport continued to be based on the low dependency care of elderly patients despite the radical change in case-mix over the 1990's.

Drugs form an important part of good palliative care to relieve pain, anxiety and distress. Another important component is good nursing care with adequate staffing ratios and regular patient supervision. Where this is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and their loved ones. I believe this to have been the situation pertaining at Gosport. There was no possibility of a patient, however distressed, being cared for one on one by a nurse or auxiliary to continuously monitor their need for analgesics and sedation.

There is no doubt that opiates were prescribed at wide dose ranges with an effective minimal dose and complete discretion to dose selection given to the

nursing staff. Doctors in palliative care teams vary in their philosophy on the actual level of the starting dose of diamorphine for symptom control based on their past experience and the level of observation maintained over their patients. A range of starting doses between 10mg to 20mg subcutaneously delivered by a syringe driver over 24 hours would in my opinion be reasonable. The plasma levels of active drug achieved over a 24 hour period at these doses would be low and unlikely to lead to any dangerous side effects. On review of the 12 cases I note the maximum dose of 200mg that had been written up was never in fact given. The maximum doses actually achieved in the 12 patients were: 120, 100, 90, 80, 80, 60, 60, 40, 40, 30, 20 and 20 mgs. It is well recognised that the dose of analgesic and anxiolytic needed to allay symptoms in an individual is increased by fear, isolation and an unfamiliar environment.

As the workload pattern changed the clinical team found the intensity of care difficult to cope with and this led to complaints and ultimately three police enquiries. Until then no corrective action was taken by the consultants, pharmacists or the management.

It is impossible to determine in advance the opiate dose required to control pain in an individual. The WHO pain control ladder is a widely used tool to enhance effective pain control. A key feature is the administration of analgesics by the clock to avoid the intermittent onset of pain as the drug levels in the circulation fall. In dying patients there is no risk of drug dependency and large doses of opiates are sometimes required. Only by careful patient assessment can the dose be effectively titrated against symptoms.

Pain and distress are enormously variable. The severity of pain depends on the clinical situation and its perception varies with anxiety, fear, other symptoms and whether the patient has come to terms with the fact they are dying. It is impossible to determine clinically the causes of deterioration in elderly patients with multiple co-morbidities. The only certain way to determine the contribution from symptom control medication is to stop it completely for at least 24 hours. Clearly this would be unethical in this patient group. When there are serious staff shortages, proper assessment and care becomes difficult and more reliance on pharmacological intervention is inevitable.

The use of parenteral fluids is a difficult area in patients such as those admitted to Gosport. Our policy at Hammersmith is to only use the intravenous route if such hydration is required. Subcutaneous infusion of the 2 litres of fluid required over 24 hours is impossible without causing discomfort in elderly patients and its absorption is variable. I understand that facilities for intravenous fluid administration were not available at Gosport and if required the patient would need to be transferred back to an acute facility.

Diamorphine and other opiates are extremely useful not only for pain control but for relieving the secondary anxiety and distress caused by the fear of death. It is

valid to combine anxiolitics such as midazolam and haloperidol even given in the same syringe driver if necessary. Hyoscine – an anti-muscarinic agent which dries up bronchial secretions is also applicable especially with distressing respiratory symptoms that may occur as a terminal event. Only careful assessment can determine the drug requirement in a dying patient and if this is not possible then erring on a higher dose of drug is a kinder way to relieve suffering. At no time do I believe Dr. Barton was prescribing drugs to hasten a patients' demise but to relieve pain and suffering. In her statement she says:

"I felt obliged to adopt a policy of pro-active prescribing, giving the nurses a degree of discretion and administering within a range of medication. As a result, if the patients' condition deteriorated such that they required further medication to ease pain and suffering, the medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient....prescriptions of this nature were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate."

Although Dr. Barton was very much part of this process of anticipatory prescribing, I do not believe she was its cause. In fact she did her best to implement policies to reduce the level of suffering in the patients under her care. As the staff levels could not be increased she used the pharmacological route to improve symptom control. Dr Barton's protocols were apparently in place with the approval of the consultants, nursing staff and the pharmacist who was a regular ward visitor to review the drug charts. Although these protocols may have been devised by Dr Barton, there was at no time any recorded dissent to the use of anticipatory prescribing of the variable dosages of diamorphine, midazolam or haloperidol. Dr Barton received no negative feedback whatsoever. She was subsequently placed in an impossible situation which was only reversed after her resignation.

Dr Barton was only a small cog working part-time in a large machine. She was a member of a team of consultants, nurses, pharmacists and support staff responsible for patient care at Gosport. I cannot see how any doctor placed in a similar position who cares for their patients could have done anything different than Dr Barton. She was the victim of circumstances in a very isolated and vulnerable part of the National Health Service. I believe she is simply a convenient scapegoat for a more widespread system failure that resulted in inadequate numbers of medical and nursing staff to ensure optimal care being delivered to patients at Gosport during the period of her tenure.

Karol Sikora

Code A

Palliative Medicine

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The treatment of terminally ill geriatric patients

JA Wilson, PM Lawson and RG Smith

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The treatment of terminally ill geriatric patients

JA Wilson Senior Registrar, City Hospital, Edinburgh, **PM Lawson** Consultant Geriatrician, Bridge of Weir Hospital, Strathclyde and **RG Smith** Senior Lecturer and Honorary Consultant Physician, City Hospital, Edinburgh

Key words: dehydration, dyspnoea, opiates, pain, palliative treatment, psychomotor agitation

A retrospective study was carried out on 150 patients who died in assessment and long stay wards in a geriatric unit to assess problems during their terminal illness. Thirty-two per cent of the long stay and 41% of the assessment patients were considered to have been distressed during the last week of their life. Agitation was the commonest form of distress. Patients with a respiratory diagnosis were particularly distressed as were those with pulmonary oedema, suggesting that breathing problems are more difficult to manage. No concern was recorded as being expressed by relatives about the treatment patients received but eight relatives were distressed within the last week of the patient's life. A raised urea was more often found in distressed patients. Opiates were used in 56% of all patients but in low doses (2.5–5 mgs diamorphine orally 4-hourly) in the majority. More attention to comfort is required for those who are dehydrated and distressed in terminal care.

Introduction

There has been much concern in the recent literature concerning the treatment of terminally ill elderly patients.[1–3] In particular, general physicians have been criticised for adopting aggressive care regimes involving painful and expensive investigations and treatments resulting in prolonged patient suffering. Such measures may also cause distress and alienation in relatives who witness the prolonged suffering. A recent survey of American physicians showed that 75% would routinely administer intravenous fluids to the terminally ill.[4]

In our wards we try to manage such patients conservatively, attempting to avoid intravenous fluids and unnecessary drugs, minimise investigations and concentrate on patient comfort. In order to determine whether such management was appropriate for such patients and their relatives and to highlight areas of difficulty, we retrospectively examined the care of the last 156 patients dying in our assessmment and long stay wards. It was felt that retrospective analysis would be preferable to a prospective study as it would give the best representation of usual patient management and

Address for correspondence: Dr JA Wilson, City Hospital, Greenbank Drive, Edinburgh, UK.

avoid further imposition on both patients and relatives at a time of considerable distress.

Methods

The consecutive medical and nursing case records of 102 patients dying in our assessment wards and 54 who died in long stay care were examined. The following features were recorded: cause of death, length of stay, duration of predeath dependency (i.e., bedbound, not eating, tolerating only minimal fluids if at all), drug treatment at the time of death and the results from investigations performed in the last week of life. The medical and nursing notes were scrutinised for evidence that the patient experienced distress. Symptoms recorded under the heading of 'distress' were agitation, pain, breathlessness, discomfort, as well as distress itself. Similarly, any record in the medical and nursing notes indicating a relative experiencing distress within the last week of the patient's life was recorded. An opiate for the purpose of this study is defined as a drug containing morphine or diamorphine. Average results are presented as the mean value ± the standard error of the mean if the distribution is normal, otherwise the median along with the range is given. Results are compared using the students t-test or Chi squared analysis.

Results

The standard of note keeping was high, with only six patients excluded due to inadequate notes, proving a sample of 100 patients who died in the assessment wards and 50 in long stay care.

Age

As expected, the patients who died in long stay care were slightly older than those in the assessment wards (mean 85.2 ± 1.0 years compared with 81.4 ± 0.7 years, n.s.).

Diagnosis

Table 1 shows the different diagnoses of patients and the numbers considered to have suffered distress. Dementia and strokes were the most common diagnoses in both long stay care and assessment wards. Heart disease (both ischaemic heart disease and congestive cardiac failure) was a frequent diagnosis in the assessment patients but less common in the long stay wards. The most common certification of death was bronchopneumonia (78% in long stay wards and 41% in the assessment wards). Almost all the remainder died of vascular disease or cancer.

Distress

Each particular diagnosis was associated with distress in 42% of cases (most patients had more

Table 1 Percentages distressed with each diagnosis at death

	Assessment patients (n = 100)		Long stay patients (n = 50)	
	% of patients	% distressed	% of patients	% distressed
Dementia	30	43.3	76	31.6
Cerebrovascular accident	31	35.5	36	33.3
Ischaemic heart disease	30	43.3	20	20
Congestive cardiac failure	20	55	16	25
Respiratory disorder	11	72.7	–	–
Parkinson's disease	10	40	20	20
Locomotor disorders	10	50	18	33.3
Renal disorders	10	60	–	–
Haematological disorders	6	16.6	–	–
GI tract disorders	3	–	–	–
Depression	3	66.7	4	50
Others	25	28	8	25

Some patients had more than one diagnosis

than one diagnosis) but 72.7% of patients with a respiratory diagnosis were distressed ($p < 0.01$). Patients with chronic renal failure (60%) and congestive cardiac failure (55%) were also distressed. 50% with chronic renal failure and 54.6% with congestive cardiac failure had pulmonary oedema.

Although 119 patients had regular visitors, none of the visitors of the long stay patients were recorded as expressing any distress. Of the visitors to the assessment wards, two expressed feelings of guilt, three were distressed at the rapid deterioration of the patient and three were distressed at the patient's condition.

Of the 50 patients in long stay care 16 (32%) were recorded as being distressed in the last week of life. In 88.7% of these distress was due to agitation. Of the 100 assessment ward patients 41% were distressed, with 46.3% of the distress attributable to agitation, 24.4% to breathlessness and 19.5% to pain.

Length of stay

Median length of stay prior to death was nine months (range 2–87 months) for long stay care and 16 days (range 1–140 days) for those in assessment wards. The duration of predeath dependency was similar in long stay and assessment wards (median two days, range 0–14 days compared with two days, range 0–10 days).

Drug therapy

The patients received a median of three drugs per person per day (range 0–10) in the assessment wards compared with three drugs per person per day in long stay care (range 1–9 (Table 2)). Only four patients were receiving no drugs at the time of death (all on the assessment wards). Overall, laxatives (51%) and diuretics (25%) were the most commonly prescribed drugs excluding opiates which were prescribed in 57% of assessment patients and 56% of the long stay care group (Table 3). Regular opiate use orally was the most common mode of administration in the assessment wards but there was no obvious pattern in the long stay wards. Of the distressed patients in long stay care, 87.5% received opiates compared with 61% in the assessment wards. The doses of opiates used were low (89.3% in long stay care and 77.2% in assessment wards received diamorphine 2.5 or 5 mg 4-hourly orally). Patients in assessment wards received opiates for a median of two days (range 1–41 days) compared with three days (range 1–43 days) in long stay care, excluding four patients with chronic locomotor disorders who received opiates for 4, 12, 22 and 27 months respectively. Of these patients receiving opiates only 12 (14%) also received antiemetic drugs, 43 (50.6%) received regular laxatives with opiates and 14 (16.1%) received opiates alone.

Table 2 Drugs prescribed just prior to death

	Assessment patients (n = 100)	Long stay patients (n = 50)
Opiates	57	28
Laxatives	51	27
Diuretics	25	12
Antibiotics	21	6
Hypnotic	18	11
Tranquiliser	17	7
Analgesic	12	20
Anti-Parkinsonian	11	7
Antidepressant	8	5
Other drugs	62	30
No drug	4	0

Table 3 Patients receiving opiates and their route of administration

	Assessment patients (n = 100)		Long stay patients (n = 50)	
	% of patients	% distressed	% of patients	% distressed
Oral	28	50	20	60
IM	14	21.4	18	55.5
Both	15	53.3	19	33.3
Regular	29	37.9	22	36.3
prn	13	38.4	12	50
Both	15	60	22	63

Dehydration

None of the long stay patients received intravenous fluids or had any investigations performed in the last week of life. Twenty of the assessment ward patients received IV fluids, but in 18 cases this was discontinued prior to death. Forty-four patients had their urea and electrolytes checked

in the last week of life; only five were normal. Six of the remainder were not dependent at this time and so this abnormality could possibly have been reversed prior to death. The mean urea overall was 19.1 ± 1.5 mmol/1 but was 29.2 ± 3.6 mmol/1 in those patients noted to be distressed compared with 17.2 ± 1.7 mmol/1 in undistressed patients ($p < 0.025$).

Discussion

Most of the distress suffered in this group of terminally ill elderly patients was due to agitation which confirms the typical absence of specific symptoms in disease of the elderly. Although rather nonspecific, we felt that a trained nurse noting agitation represented a significant symptom which should ideally be treated.

A significantly higher proportion of patients with a respiratory diagnosis were distressed ($p < 0.01$). Although not statistically significant more patients than average with congestive cardiac failure or renal failure (most of whom had pulmonary oedema) were also distressed. Hence breathing problems were particularly difficult to manage. This has been confirmed by other workers[5,6]: Exton Smith found dyspnoea associated with respiratory disorders to be a particularly intractable problem in terminally ill geriatric patients,[5] and Willis noted that in 262 patients dying at home and in hospital dyspnoea was the most commonly reported symptom and was uncontrolled in 83%.[6]

Most patients were prescribed three drugs per day, some receiving many more, despite their dependent condition and consequent poor compliance. In some cases this may have been justified, such as laxatives to relieve constipation, but 25% received diuretics and most of these patients did not have cardiac failure or renal failure. Hence such drugs would worsen their inevitable tendency to dehydration. This indicates a need for close supervision of unnecessary and potentially harmful medications especially when the terminally ill patient enters the dependent stage, opiates perhaps being commenced.

Exton-Smith has noted that patients with chronic locomotor disorders suffer extensively for long periods prior to death,[5] mainly due to opiates being withheld in the mistaken belief that they are addictive in such patients.[6] Our four long stay patients with chronic locomotor disorders received opiates, eventually in high doses, for a mean period of 16 months prior to death. The recent pharmacological literature, although stressing great individual variation, suggests the average daily dose of diamorphine should be between 5 and 20 mg 4-hourly.[7,8] Hence our patients generally received low doses of opiates: overall 81.2% received 2.5–5 mg of diamorphine orally 4-hourly. Although a routine antiemetic is usually recommended with opiates[7,8] only 12% receiving opiates in our study also received an antiemetic drug. Hillier suggests this is only necessary when the dose of diamorphine exceeds 20 mg 4-hourly.[9]

The provision of intravenous fluids for terminally ill patients is a very controversial ethical issue. Some see it merely as an extension of the patient's drug treatment, that is, 'alimentation', whereas others see it as a basic human right, that is, 'feeding', and thus feel that withdrawal of such treatment amounts to active euthanasia. On a more practical level, however, terminal dehydration is thought to cause only thirst (a sensation which diminishes with age) and a dry mouth. These symptoms can be relieved by regular sips of water, ice cubes to suck and meticulous attention to oral hygiene.[11] It has been suggested that most terminally ill patients do not become dehydrated[12] but we found a mean urea of 19.2 mmol/1 in the patients who had their biochemistry checked in the last week of life and mean urea amongst those noted to be distressed was statistically significantly higher than in those not distressed. We should be aware of this possibility and be prepared to treat symptoms of dehydration providing more attention to oral hygiene and comfort. The decision not to give intravenous fluids can impose great strain on the nursing staff. They feel obliged to force fluids to prevent dehydration, but usually in so doing at this stage they cause the patient great distress.[13] They clearly require strong reassurance from senior members of the nursing and medical staff at this time.

Although only 20 of the patients received intravenous fluids this was not criticised by relatives, suggesting that relatives often find it easier to resist such measures than care staff, as has been shown by Erricson-Person.[14]

It can be seen therefore that the policy of

conservative care of the elderly terminally ill can be applied and is acceptable to patient, relatives and care staff. We have identified a few problem areas such as the potential for dehydration, the prescription of unnecessary drugs and the importance of respiratory symptoms in causing distress, demonstrating that perhaps especially in the pre-death state meticulous medical and nursing care is required.

References

1 Lawson IR. Ordinary versus extraordinary measures in care of the elderly. In: Cape RDT, Coe RM, Rossman J eds. *Fundamentals of geriatric medicine*, New York: Raven Press, 1982: 312–28.

2 Fulop M. The teaching hospital's modern death bed ritual. *N Eng J Med* 1985; **312**: 125–26.

3 Dunea G. When to stop treatment. *Br Med J* 1983; **287**: 1056–57.

4 Micetich KC, Steinecker PM, Thomasma DC. Are intravenous fluids morally required for a dying patient? *Arch Intern Med* 1983; **143**: 975–78.

5 Exton-Smith AN. Terminal illness in the aged. *Lancet* 1961; **ii**: 305–308.

6 Wilkes E. Dying now. *Lancet* 1984; **i**: 950–52.

7 Baines M. Drug control of common symptoms. *World Medicine* 1981; **14**: 47–60.

8 Anonymous. Narcotic analgesics in terminal care. *Drug and Therapeutics Bulletin* 1980; **18**: 69–72.

9 Hiller ER. Oral narcotic mixtures. *Br Med J* 1983; **297**: 701.

10 Miles S. The terminally ill elderly: dealing with the ethics of feeding. *Geriatrics* 1985; **40**: 112–20.

11 Baines MJ. Control of other symptoms. In: Saunders C ed. *The management of terminal malignant disease*. Second edition. London: Edward Arnold, 1984: 101.

12 Oliver D. Terminal dehydration. *Lancet* 1984; **ii**: 631.

13 Norberg A, Norberg B, Bexell G. Ethical problems in feeding patients with advanced dementia. *Br Med J* **281**: 847–48.

14 Ericsson-Persson B, Norberg A, Bexell G. Care of senile demented patients in the final stage of the disease as experienced by their close relatives. *J Clin Expt Gerontology* 1984; **6(1)**: 17–26.

fao: Rachel Cooper

Code A

GMC - Dr Jane Barton Case

General Conclusions Report

Prepared by Dr Julian Neal

Senior Partner, Portsdown Group Practice

Brief Curriculum Vitae

Code A

Code A

Review of Evidence

I have spent more than 16 months carefully reviewing all the evidence relating to the 12 cases currently being reviewed by the Fitness to Practice Panel of the GMC. This evidence includes all the clinical notes relating to all 12 cases during the period from 1996 to 1999, the Commission for Heath Improvement Investigation of 2002, transcripts of hundreds of police interviews of doctors, nurses, relatives and managers, many hundred witness statements, reports from Drs Black, Wilcox, Dudley and Professors Livesley, Ford and Sikora and, most recently, transcripts of evidence given to the GMC's Fitness to Practice Panel by Dr Ian Reid.

My own experience in a similar unit

I believe that I am the only medical practitioner to prepare a report relating to the 12 cases under review, who has had any significance experience of the kind of work that Dr Barton undertook while she was the sole Clinical Assistant at Gosport War Memorial Hospital. My experience has been gained from being the main provider of in house medical services to Jubilee House since 1985. Jubilee House is a 25 bed NHS Continuing Care Unit in the Portsmouth area which over the years has changed from being a nurse-led long stay ward in the mid 1980's to a busy step down continuing care assessment unit for the last 15 years.

The parallels with Daedalus and Dryad Wards are striking, especially as the activity on Jubilee House has continued to increase since the mid 1990's. For over a decade an increasing proportion of patients require active intervention on a daily basis due to their complex medical and nursing needs. Also, a significant proportion of the patients are admitted for end of life care, though this is not always apparent at the time of transfer to Jubilee House from acute wards in Queen Alexandra Hospital due to a combination of poor record keeping by doctors at Queen Alexandra Hospital and unrealistic expectations of hospital doctors who are under increasing pressure to discharge patients earlier in the course of their post operative care or illness.

I respectively suggest that my understanding of the pressures on a General Practitioner acting as a Clinical Assistant on Daedalus and Dryad Ward are considerably greater that those of Professor Ford who is shortly to be called by the GMC to give evidence to the GMC's Fitness to Practice Panel.

Conclusions

I believe that it is now generally accepted that when judged by today's standards of note keeping, Dr Barton's note keeping in all 12 cases was poor. However, it is also clear to me that Dr Barton felt under great pressure and she has suggested that she had a choice between attending to her patients and making notes as best she could, or making more detailed notes about those patients she did see but potentially neglecting other patients. I have some sympathy with this view especially as senior Primary Care Trust management were made aware of the pressures on Dr Barton but chose not to take any action to lessen them.

It is noteworthy that in my experience note keeping by General Practitioners working in Community Hospitals in the mid to late 1990s was often of a poor standard, especially within respect to clerking of patients admitted directly to GP led beds. It is also the case that in my experience note keeping by GPs acting as Clinical Assistants or Hospital Practitioners in Community Hospitals was also often poor. In these twelve cases it is also noteworthy that Dr Barton's partners' standard of note keeping was no better than that of Dr Barton, a fact that supports my contention that note keeping by GPs was often of a poor standard. Statements by supervising consultants appear especially relevant. Dr Tandy states that although she recalls at the time that Dr Barton's note keeping could have been more extensive, it was, from her own experience from other cottage hospitals in the health district, certainly no better in some other similar hospitals at the time. In her witness statement Dr Lord, while admitting to concerns about the very brief nature of Dr Barton's note keeping, did nothing at the time to encourage Dr Barton to improve her note keeping. Dr Reid has stated that although at the time he felt that Dr Barton's notes were brief she did actually record significant changes in the either the patient's condition or the significant changes in the management plan at the time. Dr Reid has also stated that

he was very conscious that Dr Barton was working very hard at the time and although he knew that Dr Barton's notes were not entirely adequate he did not want to add to her burden of responsibility by picking up on her note keeping.

I am thus led to the conclusion that when assessed by today's standards of note keeping, I would have thought that a great many GPs in the 1990's would have been open to similar criticism of poor note keeping, a fact that I believe should be acknowledged by the GMC's Fitness to Practice Panel. However, I am also very clear that Dr Barton reviewed patients on a regular basis even though many of these reviews were not documented in the medical notes. Furthermore I have concluded that Dr Barton always visited patients when asked to do so and was always ready to give advice on the phone when required. Given her other commitments I believe that her efforts to help all twelve cases were genuine and that despite time pressures she never failed in her obligation to visit and assess.

Dr Barton appears to have felt obliged to adopt a policy of 'proactive prescribing' given constraints on her time. Another reason for adopting 'proactive prescribing' was, I believe, to reduce the likelihood of an on-call doctor having to visit Gosport War Memorial Hospital. I have come to the conclusion that at all times Dr Barton's adoption of proactive prescribing was based on a fundamental desire to relieve distressing symptoms in all 12 cases. It is also highly significant that at no time in any of the 12 cases was the maximum dose of either Diamorphine or Midazolam ever given, a fact that supports the view that both Dr Barton and the senior nurses on both Dryad and Daedalus Ward were exercising professional judgement.

I have come to the conclusion that Dr Barton did not receive adequate consultant supervision at any time during the period from 1996 to 1999. A number of consultants were involved in the management of these twelve cases, including Dr Lord, Dr Tandy and Dr Reid. Each of these consultants had, at some time, supervisory responsibilities with respect to Dr Barton. Their witness statements are revealing.

Dr Lord carried out ward rounds on alternate weeks between Dryad and Daedalus wards. Dr Barton would only accompany Dr Lord on Monday afternoons. Dr Lord

has stated that on ward rounds she and Dr Barton would carry our any relevant examination. Dr Lord suggests that "anticipatory prescribing" was increasingly used because patients admitted to Gosport War Memorial Hospital were increasingly frail and as Dr Barton did not carry out regular duties on weekends it was necessary to ensure that patients were comfortable over weekends.

Dr Lord also states that between 1998 and 2000 there were no official policies regarding "as required prescribing". Furthermore she has also stated that at the time she did not experience any problems or difficulties with "as required prescribing" and that on ward rounds she would look at the whole drug chart, including "as required" drugs. These statements from Dr Lord suggest to me that at the time she was working in a supervisory role with respect to Dr Barton, yet Dr Lord took no steps to change Dr Barton's prescribing practice as she did not believe it needed changing.

Dr Tandy has stated that she does not remember seeing large quantities of morphine being used on a routine basis. She also states that she remembers going through the drug charts quite carefully and if she had seen excessive use of morphine then she was sure that she would have corrected it. Dr Tandy has also stated that Dr Barton had considerable experience of palliative and long term care and had been attached to the ward for a long time and thus in these areas Dr Barton had more experience than she did as a newly appointed consultant.

Dr Reid has stated that at most he would see Dr Barton once a fortnight. Dr Reid has stated that he spoke to Dr Barton on one occasion about a large dose range and that Dr Barton had stated by way of explanation that her partners were unhelpful in coming out when she was not there and that Dr Reid accepted this explanation at the time. Dr Reid has also stated that he does not recollect Dr Barton frequently prescribing drugs in advance.

Relating to a number of different consultants may have proved difficult for Dr Barton. However, my main point here is that there was ample opportunity for a number of consultants to have questioned, intervened, and ultimately stopped Dr Barton's practice of 'proactive prescribing'. None chose to do this, although in one case medication was significantly reduced by Dr Reid. In my opinion all three Consultants

had an opportunity to discuss with Dr Barton a number of other pharmacological issues including the precise indications for prescribing opiates. Midazolam, and Hyoscine. Wessex protocols, local drug protocols and the analgesic ladder but none chose to do so. I am thus led to the conclusion that it is unreasonable to concentrate on Dr Barton's prescribing habits and to subject only hers to intense criticism when she was just one of many doctors who were responsible for the care of patients in Gosport War Memorial Hospital during the period from 1996 – 1999.

Dr Barton's job description defines a five session a week post. Dr Barton has suggested that one and a half of these sessions were apportioned to out of hours cover and commitment. I do know that Dr Barton's commitment to her own General Practice was eight sessions a week. I also know that Dr Barton's post at the Gosport War Memorial Hospital included being responsible for the day to day care of 48 beds. Even disregarding the increased intensity of cases being admitted during the time between 1996 -1999, this represents an unreasonably excessive workload for Dr Barton, who was the sole GP Clinical Assistant providing support to Gosport War Memorial Hospital at the time in question. I have come to this conclusion from my own experience of providing similar medical cover to a similar unit of only 25 beds.

I note that Dr Barton had raised this issue of excessive workload on more than one occasion with the management of the hospital but that no action was taken to lessen her workload. In my opinion it is clear that Dr Barton was a very busy and dedicated doctor who was struggling to balance all her commitments. Dr Reid has stated that he and his colleagues were extremely grateful to Dr Barton for the care she provided to patients and that not many other GPs would have worked as hard as she had. It is not surprising that this excessive workload led to some suboptimal practice.

I note that when Dr Barton resigned from her post at Gosport War Memorial Hospital a full time staff grade physician was appointment and that an associate specialist and three Senior House Officers were put in post at the hospital. This suggest a belated acceptance on the part of those who had overall management responsibility at the Gosport War Memorial Hospital that Dr Barton's contracted hours at Gosport War Memorial Hospital were significantly inadequate.

I would now like to address the matter of Professor's Ford's evidence in some detail. From my long experience of dealing with complaints in the NHS I am led to the conclusion that when examining a doctor's alleged poor performance it is vital that an independent assessment of the alleged poor performance is undertaken by a doctor from the same speciality and who has similar clinical experience. I suggest that Professor Ford has no such experience and thus the generality of his evidence therefore lacks credibility.

But it is not only in general terms that I find much of Professor Ford's evidence questionable, for compared with all the other expert witness statements that I have read, the tone that Professor Ford has chosen to adopt in all his reports is unhelpful and, at times, borders on the intemperate. The general thrust of his reports reveals a failure to understand and appreciate Dr Barton's role as an experienced GP working as a sole Clinical Assistant, her dedication, work ethic and unacceptable work load.

Too often Professor Ford makes statements that reveal an unfortunate bias of hindsight. Too often Professor Ford has chosen to concentrate on the academic and the theoretical without regard to the fact that the practice of good medicine is based upon a careful synthesis of science and art by an experienced doctor who was often the only clinician to have been in a position to make valid clinical judgements at the time. This failing of Professor Ford's evidence is unfortunate and, in my opinion from the perspective of an experienced GP working in a similar environment, significantly undermines many of his conclusions.

Professor Ford's evidence is also questionable for a number of very specific reasons.

First, Professor Ford repeatedly takes what I believe is both an unrealistic and naive view of the need for experienced GPs working as Clinical Assistants, to consult with more senior colleagues. Unlike Professor Ford, I believe that in only one case can it be argued that Dr Barton failed to consult with a more senior colleague when such a consultation was probably indicated (Case J: Geoffrey Packman).

Second, Professor Ford assumes, incorrectly in my opinion, that the lack of documentation of a clinical assessment and examination always means that no such

assessment took place. As suggested earlier, GPs in the mid 1990's would often fail to document examinations.

Third, Professor Ford seems to be unaware of the possibility of doctors on acute wards either overstating patients' clinical abilities and potential for rehabilitation or, possibly more frequently and significantly, understating patients' post operative pain. Ask any experienced GP about this and you will have no trouble confirming that pain is often under recognised and under treated on acute hospital wards. In my long experience working in Jubilee House I can recall many instances when pain has been undertreated on acute wards at Queen Alexandra Hospital.

Fourth, too often Professor Ford's evidence appears to reveal a somewhat blinkered analysis of the role of drugs in causing deteriorations in the clinical states of the 12 cases in question thereby closing his mind to the reasonable possibilities that significant and progressive co-morbidities contributed to worsening clinical states.

Fifth, and this follows from the fourth point immediately above, Professor Ford's evidence is too often a counsel of perfection, rather than an analysis of all the possibilities open to Dr Barton in each if the 12 cases. I suppose being first and foremost an educationalist and professor of Clinical Pharmacology rather than a practising generalist, this is understandable but it is, nonetheless, unfortunate. In my long experience of caring for patients in Jubilee House I have come to the conclusion that no matter how firmly one's practice is based upon the science of clinical pharmacology, including well understood concepts such as "analgesic ladders", individual patient's responses to opiates (for example Morphine and Diamorphine) and benzodiazepines (for example Midazolam), is often idiosyncratic and unpredictable. Furthermore, experience gained from over 25 years of caring for patients who are terminally ill has taught me that a slavish adherence to guidelines and protocols can at best delay the relief of suffering by hours, and, at worst, by many days.

Sixth, I find it bordering on the perverse that Professor Ford has taken the view that on occasions subcutaneous infusions should actually have been taken down. I have only once in my entire career, in which I have developed considerable skill and

experience in delivering palliative care, ever felt the need to stop a continuous subcutaneous infusion.

Seventh, on the face of it, Professor Ford's statement about the lack of toxicology studies having been undertaken at post mortem in some of the 12 cases, could be interpreted as a failure to understand fully the widely understood principle of "Double effect" in relation to symptom control during the terminal stages of a patient's life. The principle of double effect states that "*If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient*". The logical extension of this principle is that toxic doses of drugs and their metabolites could well be present at the time of death in patients who have been appropriately treated. Yet Professor Ford's evidence repeatedly seems to fail to appreciate this.

Eighth, Professor Ford's evidence repeatedly fails to accept that in reality, the only way to judge accurately a patient's need for analgesics is by careful clinical observation over time at the bedside. Professor Ford, in my opinion, has failed to accept that it is not possible to make such a judgement based solely on the examination of medical records alone.

From my detailed examination of all the evidence presented to me regarding the 12 cases in question, I can understand the actions taken by Dr Barton in all 12 cases.

Code A

5 July 2009.

6

General Medical Council

Dr Jane Barton

Please see separate file

7

General Medical Council

In the matter of Dr Barton

Press Release (29.01.10)

Responding to the decision, Niall Dickson Chief Executive of the General Medical Council said:

"We are surprised by the decision to apply conditions in this case. Our view was the doctor's name should have been erased from the medical register following the Panel's finding of Serious Professional Misconduct. We will be carefully reviewing the decision before deciding what further action, if any, may be necessary."

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