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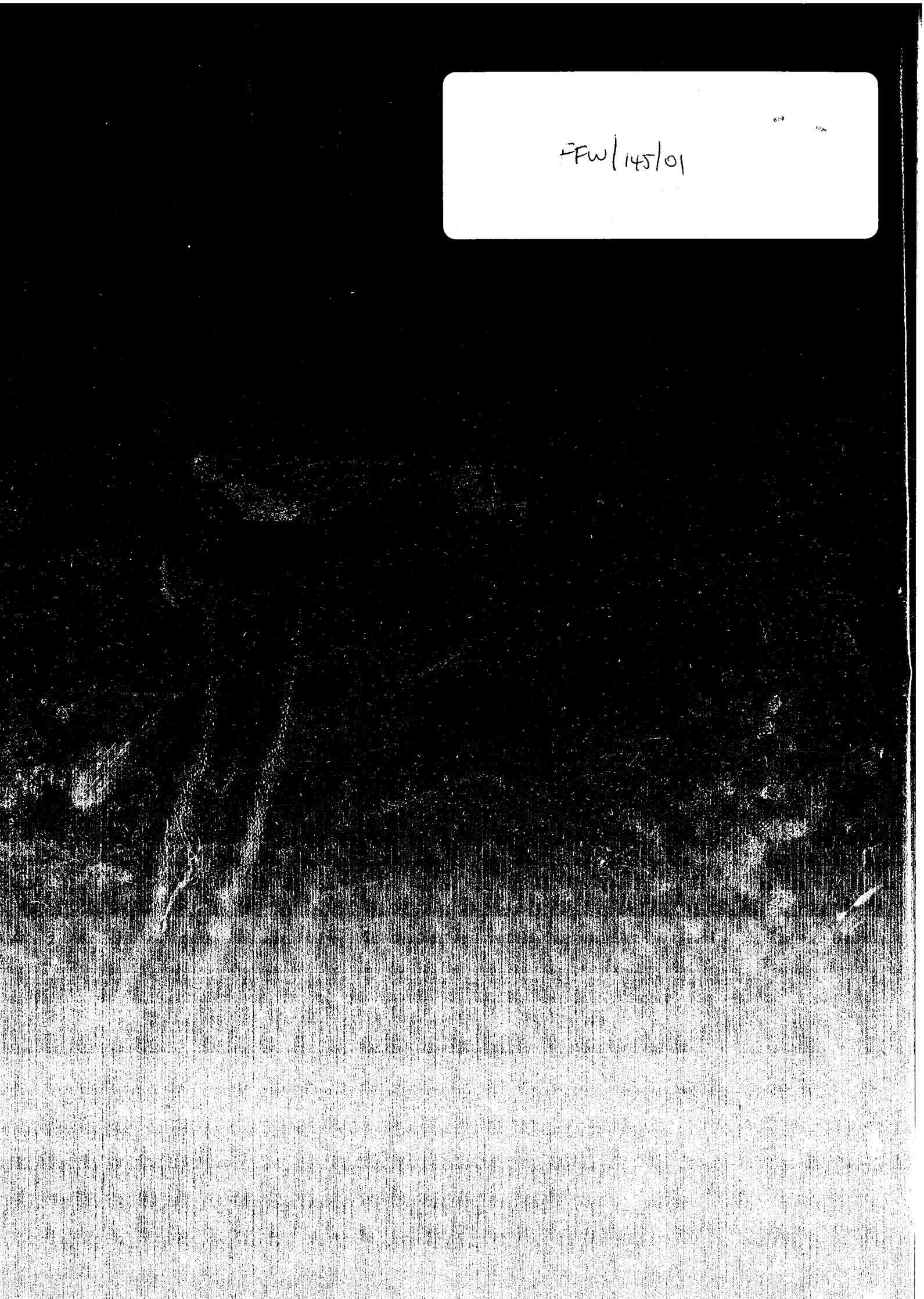

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE (INTERIM ORDERS PANEL)

Monday, 22 December 2008.

350 Euston Road, London.

Chairman - Mr. Roger Thompson

Case of:

DR. BARTON, Jane Anne

Transcript from the stenograph notes of T A Reed & Co
Tel No: 01992-465900

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Case of:

DR. BARTON, Jane Anne

Panel Members

Sir James Perowne
Mr. Alan Wood

Legal Assessor: Ms Julia Oakford

MR. I. BAKER, instructed by the Medical Defence Union, appeared on behalf of the doctor.

MR. S. BRASSINGTON, of counsel, instructed by solicitors to the General Medical Council, appeared on behalf of the Council.

T A REED & CO

(The proceedings convened at 09.35)

CHAIRMAN: Good morning, everybody. This is a meeting of the Interim Orders Panel on Monday December 22, 2008. The panel this morning will commence with the case of Dr. Jane Anne Barton who is present and is represented by Mr. Ian Barker of the Medical Defence Union. Mr. Brassington, counsel, represents the General Medical Council. Doctor, normal practice is for the doctor to give your full name and registration number, please. I would be grateful if you would do so.

DR. BARTON: My name is Dr. Jane Anne Barton, and my General Medical Council number is 1587920.

CHAIRMAN: Thank you very much. I think you have been here before, in front of a panel before, Dr. Barton, I think that is correct, is it?

DR. BARTON: Yes.

CHAIRMAN: I think you know the procedure and process as to what is to happen today. I will just introduce the panel members so you know who we are.

(The chairman then introduced the members of the panel and all parties present)

CHAIRMAN: You know the process; I will no got through it again.

DR. BARTON: Yes.

CHAIRMAN: I will go straight to you, please, Mr. Brassington.

MR. BRASSINGTON: Thank you, sir; good morning. This is a review of an order imposed by the Interim Orders Panel on 11 July 2008 when the panel on that occasion determined to make and order imposing conditions on the doctor's registration for a period of 18 months. Enclosed within your bundle at page 293 is a copy of the transcript of that hearing. Between pages 297 and 309 you will find the opening that I made in relation to this case, which took some considerable time and went into considerable detail as to the previous history of this case and the up-to-date position, and you would have discerned from your reading of the papers that this is long standing case which is on-going. The doctor appeared previously before four Interim Orders Committees before the order was made in July of this year. You will also find contained within that transcript the detailed submissions made by my learned friend Mr. Langdale on behalf of Dr. Barton. I rely, for the purposes of this hearing, on the opening that I made, and I do not intend to repeat or rehearse it to you unless you invite me so to do. In the same vein I encourage you of course again to have regard to the submissions made by Mr. Langdale on that occasion.

Can I ask you please to turn to the transcript so that you can have regard to the conditions that were imposed upon the doctor's registration by the Interim Orders Panel. At page 319 you will see that the first condition was that she was required to notify the General Medical Council promptly of any professional appointment she accepts for which registration with the General Medical Council is required, and

provide the contact details of her employer and the Primary Care Trust upon whose list she was entered. You will see from your brief reading of the papers that at page 329, in compliance with that condition, the doctor wrote to the General Medical Council informing them of her present employment and the Primary Care Trust she is on.

On page 320, condition 5, that she must not prescribe diamorphine and must restrict her prescribing of diazepam in line with BNF guidance. Number 6, she was to provide evidence of her compliance with condition number 5 to the General Medical Council prior to any review of this hearing. Sir, you have what is described as addenda 2, which is two letters; firstly from Hazel Bagshaw -- I think I got the name right -- yes, Hazel Bagshaw, who is the Community Pharmacy Development Manager at the Hampshire National Health Primary Care Trust indicating that, as far as she is concerned, she is content that Dr. Barton has complied with the condition that was imposed upon her by the General Medical Council, and you have a letter at page 342 from Mr. Barker explaining in a little more detail the contents of that letter. It's a matter for you always of course, but you may think that there is evidence of compliance with condition number 5, and the doctor has complied with condition number 6 also.

What has happened since the imposition of those conditions, if you turn to page 331, you will find a letter from the Coroner's officer dated 4 November received on the 5th to Field Fisher Waterhouse indicating that this Coroner's inquest has now been listed for 18 March. It was hoped that it was to take place in autumn of this year, but it did not, and it is now fixed for March. It is going to take place at the Combined Court Centre in Portsmouth. The consequence of that inquest being adjourned is that the General Medical Council's fitness to practise panel, applying PCC rules, which was due to hear Dr. Barton's case in September 2008, has now been adjourned until the conclusion of this Coroner's inquest, and I understand that it has now been listed, or relisted, for 8 June, and it is expected to last some 55 days.

Sir, there is apparent compliance with the conditions and, in those circumstances, the submission that I make is that, for the reasons previously given, it is a proportionate order for conditions that has been placed upon the doctor's registration and the need for it persists, and I invite you to review it and maintain it.

Unless I can assist you further, those are my submissions.

CHAIRMAN: Thank you very much, Mr. Brassington. I will see if any members of the panel have any questions. (Conferred) There are none. Can I go to you, Mr. Barker.

MR. BARKER: Mr. Chairman, thank you. The only point of additional detail I would add if I may is that, in spite of the letter from the Coroner, I think in fact the inquest is on 9 March, that is the date in my diary, maybe because I need booking early to avoid disappointment, but that is the date that I have.

Can I start by saying that, as Mr. Brassington has kindly indicated to you, you might wish to have regard of what Mr. Langdale said on behalf of Dr. Barton on that

last occasion. I essentially adopt the representation that Mr. Langdale made at that last hearing. The essence of this is that Dr. Barton's case is now less serious than it was when it was considered on the four occasions, up to and including 7 October 2004. I say that because at that stage Dr. Barton was under police investigation. She is no longer under that police investigation and she was not on the last occasion. And it is because she is no longer under that investigation that the Coroner is able now to proceed to hold those very inquests.

Dr. Barton, as you will appreciate from the papers, has had a suitable voluntary arrangement in place with the Primary Care Trust since 2002, and essentially conditions placed upon her by the Interim Orders Panel on the last occasion mirror that voluntary arrangement. There was no suggestion at any stage that Dr. Barton has ever been in breach of that voluntary arrangement that she has with the Primary Care Trust. The fact that the panel on the last occasion considered it appropriate to impose conditions of course does not mean that that panel is obliged to continue them. Dr. Barton obviously has demonstrated continuing compliance with the voluntary agreement that she had with the Primary Care Trust, essentially with the conditions on the last occasion. Obviously to continue with the conditions as they are would mean that this panel will have to consider it necessary, in accordance with section 41A of the Medical Act, for the protection of members of the public, in the public interest or in the Dr. Barton's interest for the order to be made in circumstances in which no complaint is made about Dr. Barton's behaviour or professional performance for a period of almost ten years now, where she has abided by the appropriate voluntary arrangement with the Primary Care Trust for the last six, and in which I've got no doubt the Primary Care Trust would inform General Medical Council swiftly were there to be any failure to comply with that arrangement. We would maintain that the panel could reasonably conclude that it is not necessary for this order to remain in place. Sir I have nothing else to say unless there is anything you think I can specifically assist you with.

CHAIRMAN: So your submission to the panel, Mr. Barker, is that there is no necessity for an order now, is that what you are saying?

MR. BARKER: Sir, it is. In circumstances in which Dr. Barton has demonstrated a continuing regard to the voluntary arrangement, and indeed the conditions that were placed on her on the last occasion, and bearing in mind that these matters are profoundly historic, and perhaps I should add in a different context. Or course you will appreciate that Dr. Barton is a general practitioner, and has been for many years and. The allegations against her relate to a period when she was in addition a clinical assistant in geriatrics, and she has not held that position for some very long time.

CHAIRMAN: Thank you very much. I will just see if any member of the panel has any questions. (Conferred) There are not. I will ask Ms Oakford the legal assessor to give her advice to the panel.

LEGAL ASSESSOR: I would remind the panel that, in reviewing the order, you can maintain the order, vary, replace or revoke it. You must have regard to the principle of proportionality. Of course you must consider all the circumstances relating to the case, including any new information that is before you since the last Interim Orders

Panel. And I will remind you that in order to make an order in all the circumstances there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public or adversely affect the public interest, or the interest of the practitioner and, after balancing the interests of the doctor and the interests of the public, the interim order is necessary to guard against such a risk, the appropriate order should be made. If you feel that an order should be made, you first have regard to consider conditions. If you think that is not appropriate and proportionate, then you move on to suspension.

CHAIRMAN: Thank you very much. We will go into private session.

(The panel retired to deliberate in camera 09.50 - 10.15)

DETERMINATION OF THE PANEL

CHAIRMAN: Dr. Barton, when the Interim Orders Committee considered your case on 21 June 2001, it determined that it was not necessary for the protection of members of the public, in the public interest and in your own interest to make an order on your registration. Your case was reviewed and no order imposed on a further four occasions. On 11 July 2008, the Interim Orders Panel considered it necessary to impose conditions on your registration.

The Panel has comprehensively reviewed the order today and, in doing so, has considered the information before it previously, the transcripts of the previous hearings and the further information received today, including Mr. Brassington's submissions on behalf of the General Medical Council (GMC) who submits that your registration should remain subject to conditional registration. Mr. Barker on your behalf submits that, as you are no longer subject to police investigation, there should no longer be an interim order imposed.

The Panel is satisfied that it continues to be necessary for the protection of members of the public, in the public interest and in your own interests for your registration to remain subject to conditions. The Panel has therefore directed that for the remainder of the duration of the order your registration should remain subject to the following conditions:

1. You must notify the GMC promptly of any professional appointment you accept for which registration with the GMC is required and provide the contact details of your employer and the PCT on whose Medical Performers List you are included.

2. You must allow the GMC to exchange information with your employer or any organisation for which you provide medical services.

3. You must inform the GMC of any formal disciplinary proceedings taken against you, from the date of this determination.

4. You must inform the GMC if you apply for medical employment outside the UK.

5. You must not prescribe diamorphine, and you must restrict your prescribing of diazepam in line with BNF guidance.

6. You must provide evidence of your compliance with condition number 5 to the GMC prior to any review hearing of this Panel.

7. You must inform the following parties that your registration is subject to the conditions, listed at (1) to (6), above:

a. Any organisation or person employing or contracting with you to undertake medical work;

b. Any locum agency or out-of-hours service you are registered with, or apply to be registered with (at the time of application);

c. Any prospective employer (at the time of application);

d. The PCT in whose Medical Performers List you are included, or seeking inclusion (at the time of application);

e. Your Regional Director of Public Health.

In reaching its decision to place conditions on your registration, the Panel bore in mind that it is not its function to make findings of fact or to decide on the veracity of the allegations. The Panel has, however, given such weight as it considers to be appropriate to the allegations that you face.

In reaching this determination, the Panel has considered the information received initially from the Hampshire Constabulary concerning your alleged inappropriate prescribing for a number of patients at Gosport War Memorial Hospital and the investigations into their deaths. The Panel has noted, from the overview of the Police investigation contained in the statement of Detective Superintendent Williams dated 16 January 2007, that the Crown Prosecution Service has decided not to proceed with a criminal prosecution. However, the Panel has noted the criticisms in respect of your prescribing and record keeping contained in the report by Professor Black, an expert commissioned by the GMC.

The Panel has also taken account of the information that the GMC has referred your case for a hearing by the Fitness to Practise Panel into allegations that your prescribing in relation to 12 patients at Gosport War Memorial Hospital was inappropriate. The Panel has noted that the GMC has decided to postpone the Fitness to Practise hearing until the outcome of the Coroners inquest into the deaths of 10 patients at Gosport War Memorial Hospital, eight of which are the subject of the Fitness to Practise hearing. The Panel notes that the inquest is to be held in March 2009, and the Fitness to Practise Hearing is provisionally listed for June 2009.

Mr. Brassington submitted that, in view of the serious concerns raised in relation to your prescribing, the potential for risk to members of the public, and in the public interest, it would be appropriate for the Panel to maintain the conditions on your

registration. Mr. Brassington submitted that the public interest includes the maintenance of public confidence in the profession.

The Panel had regard to the information that you entered voluntarily into an agreement with the Fareham and Gosport Healthcare Trust (the Trust) in which you gave an undertaking that you would not prescribe benzodiazepines or opiate analgesics with effect from 1 October 2002. The Panel has received a letter dated 3 December 2008 from Hazel Bagshaw, Community Pharmacy Development Manager at the Hampshire NHS Primary Care Trust (Hampshire PCT), who states that she continues to monitor closely your prescribing of benzodiazepines and opioid analgesics since your undertaking to restrict your prescribing of diazepam and diamorphine, and confirms that you have maintained your compliance with the voluntary agreement since October 2002.

While the Panel notes your compliance, it is concerned that the agreement is voluntary and that there are no formal arrangements in place to monitor your continued compliance. Given that your prescribing has been queried and there is to be an inquest in respect of ten of the patients concerned, public confidence in the profession could be undermined if you were left in unrestricted practice in the meantime. The Panel considers that it is necessary for the maintenance of public confidence in the medical profession for the GMC to exercise control over your compliance with restrictions on your prescribing.

The Panel is satisfied that in all the circumstances there may be impairment of your fitness to practise which poses a real risk to members of the public or may adversely affect the public interest or your own interests and, after balancing your own interests and the interests of the public, an interim order is necessary to guard against such a risk.

The Panel has also taken account of the principle of proportionality, and has balanced the need to protect members of the public, the public interest and your own interests against the consequences for you of the imposition of conditions on your registration. Whilst it notes that its order has placed restrictions on your ability to practise medicine, the Panel is satisfied that these conditions are a proportionate response to the risk posed by you remaining in unrestricted practice.

Notification of this decision will be served upon you in accordance with the Medical Act 1983, as amended.

Code A
For TA REED & CO LTD
22 Dec 2008

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GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Regents Place,
Euston Road,
London NW1 3JN.

Chairman: Mr Manny Devaux

Case of:

BARTON, Jane Ann

Transcript of the shorthand notes of T A Reed & Co
Tel No: 01992 465900

T A REED & CO

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Chairman: Mr Manny Devaux

Panel Members: Dr Eve Miller
Mr John Walsh

Legal Assessor: Mr Nigel Seed QC

CASE OF:

BARTON, Jane Ann

MR STEPHEN BRASSINGTON of counsel, instructed by the GMC Legal Team, appeared on behalf of the Council.

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

(Transcript of the shorthand notes of TA Reed & Co
Tel No: 01992 465900)

T A REED & CO

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THE CHAIRMAN: Good morning Dr Barton and Mr Langdale. This is the Interim Orders Panel sitting on Friday 11 July 2008. Dr Jane Barton is present and is represented by Mr Timothy Langdale QC, instructed by the MDU. Mr Brassington of counsel, instructed by the GMC Legal Team, represents the GMC.

Mrs Barton, I thought your husband was coming. Is he waiting outside? Does he wish to come in?

DR BARTON: That would be lovely.

THE CHAIRMAN: It is your husband and it is your hearing and if you think it would be nice for you I have no problem with that. Mr Brassington, there is no objection?

MR BRASSINGTON: I have no problem with that.

THE CHAIRMAN: Please ask him to come in. He can sit at the back. (Mr Barton entered the room)

Dr Barton, can you confirm for the Panel your full name and your GMC number?

DR BARTON: Dr Jane Ann Barton and my GMC number is 1587920.

THE CHAIRMAN: Thank you very much. I know you have been to the Interim Orders Committee before and I think you probably remember me sitting on one of the Panels, but I will introduce you to this hearing today. This is the Interim Orders Panel – the previous panel was the Interim Orders Committee, which goes back to a little while ago. I am Manny Devaux, the Chairman of the Panel – a lay person. To my right is Nigel Seed QC, who is our Legal Assessor. Mr Seed gives independent legal advice to the Panel. To my left is Christine Challis who is Secretary to the Panel today. The Panel members are, to my right is Dr Eve Miller, who is a medical member, and to my left is John Walsh, who is a lay person. Mr Brassington, for the General Medical Council sits right opposite you and next to him at the far end is the shorthand writer.

In terms of our procedure today I will invite Mr Brassington to address the Panel on the matters that we have to consider, bearing in mind that this is an Interim Orders Panel. Thereafter there might be questions for him for clarification. Then we will move on to Mr Langdale, who will address the Panel on your behalf as obviously he is here to represent you today. If there is a matter you wish to raise for him quietly you can either write it down for him or his solicitor; and again we might have questions for him at the end of his presentation. Then we will go into private session following the advice of the Legal Assessor and then we will call you back.

To make sure we have the same papers, Mr Langdale and Mr Brassington. We have the bundle and then there is one addendum which is an employer details form and also a letter from Dr Barton saying that she will be here today.

MR BRASSINGTON: That is all the papers that we have.

THE CHAIRMAN: In that case we can move on. Can I make it clear before we start that we have had this bundle for a little while; we have read all the papers in advance and I know something of the background of the case because I was involved before a little while ago. Having said that, this is a new hearing but we have read all the papers.

MR BRASSINGTON: Sir, this is a re-referral of Dr Barton's case to the Interim Orders Panel and it is the first time she has appeared before it but has previously appeared before the Interim Orders Committee, as you say, on four previous occasions. Firstly, on 21 June 2001 when no order was made; on 21 March 2002 when no order was made; 19 September 2002, again no order; and 7 October 2004 is the most recent appearance – again no order was made.

Either the transcripts or partial transcripts are available in the bundle that you have, which I know that you have read and in due course I will make reference to them if I may.

The matter has been referred to the Interim Orders Panel because there is fresh material, say the GMC, available to you that was unavailable to previous Committees who considered the imposition of an interim order. It being the first appearance before the IOP and there being a slightly different test to that which was applied in the IOC can I begin, for the benefit of the doctor, by reading out the test that we say applies to your deliberations today. It is this: that if you are satisfied in all the circumstances that there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public, or which may adversely affect the public interest or indeed the interests of the doctor; and that after balancing the interests of the doctor as against the interests of the public if you consider that an interim order is necessary to guard against any risk that you have identified, then you will move on to make the appropriate and proportionate interim order in all the circumstances of the case.

The bundles contain, as I say, the transcripts and that will give you an understanding of the material that was previously available to the Interim Orders Committee.

On 27 July 2000 the Hampshire Constabulary wrote to the GMC in a letter which you see at page 1 of your bundle, indicating that they were conducting an investigation into the death of a patient, GR, at the Gosport War Memorial Hospital, in August 2998. Dr Barton at that stage was thought to have been the doctor responsible primarily for the care of Patient GR.

Pausing there for a moment, I should have mentioned at the outset that my learned friend Mr Langdale has invited me to allow him during the course of my opening to draw your attention to any part of a document that I have not drawn to your attention in the course of my opening, to save time; and I am quite content that that be done as we go along. So if Mr Langdale speaks it is with the consent of all the parties.

MR LANGDALE: Sir, I am grateful for that. I think it may save time so that the Panel does not have to hear the facts twice.

THE CHAIRMAN: If that is the procedure I am happy with that. As I say, it is an Interim Orders Panel and not a full fitness to practise hearing.

MR BRASSINGTON: At that time in 1998 Dr Barton was a general practitioner practising in Gosport. She was additionally engaged as a visiting clinical assistant at the Gosport Hospital, employed by the Portsmouth Healthcare NHS Trust.

As I say, on 21 June 2001 Dr Barton was referred to the Interim Orders Committee and at that time the only case before the Panel was that of the investigation into the alleged unlawful death of GR. The transcript for that hearing appears in your bundle at pages 4 through to 10. It was made clear to that Committee that there had already been one police investigation into the death of GR, which had concluded with the Gosport CID submitting their evidence to the Crown Prosecution Service who had decided that no criminal proceedings should follow.

Subsequently a complaint was made by the family of GR as to the quality of the original police investigation and following that complaint a decision was taken to reinvestigate.

On 14 August 2001 – we see at page 14 of the bundle – Hampshire Police wrote to inform the GMC that whilst a decision had been taken that there was insufficient evidence to support a viable prosecution against Dr Barton in respect of GR there had been concerns expressed by other families of patients who had died at Gosport, and preliminary inquiries were being made as to whether a more intensive police investigation should commence into the care given by Dr Barton to patients at that hospital.

On 6 February 2002 the GMC were told in a letter at page 16 that expert advice had been sought regarding the deaths of four further patients at the Gosport Hospital, but following review of that information no further police investigation at that stage was thought appropriate. However, the reports did raise, said the police, serious concerns over the standard of clinical care of patients, particularly given by Dr Barton, which raised concern as to her professional conduct. There was disclosure by the police of the reports that had been prepared.

On 21 March 2002, following receipt of that letter and that information, the GMC referred the case again to the Interim Orders Committee on the basis of the new material that had been provided. You have in your bundle only a partial transcript of the hearing that took place in March 2002 and indeed that was submitted by the doctor as part of her response to the appearance of her case before the Preliminary Proceedings Committee. Nevertheless, you do have evidence give by Dr Barton on that occasion and it runs from page 32 through to page 50. It covers her evidence and the submissions made by my learned friend Mr Jenkins, who appeared on her behalf on that occasion.

Again, on the basis of the material presented to the Committee they were not satisfied that it was necessary in the circumstances to impose an order and no order was made.

On 11 July 2002 Dr Barton was notified by the General Medical Council that they had determined to refer her case to the Preliminary Proceedings Committee to determine

whether or not the case should be referred onwards to the Professional Conduct Committee, and you see a copy of the letter notifying her of that at page 19 of your bundle. The matters referred to the PPC were the five patients that had been identified and investigated at that stage by the Hampshire Constabulary. The allegations relate to Patient EP, Patient AW, Patient GR, Patient AC and Patient RW. The patients were all inpatients at the Gosport Hospital between February 1998 and October 1998, and without taking you through the allegations in any detail they assert, amongst other things, inappropriate and unprofessional prescribing of opiates and other sedative drugs by Dr Barton, in the knowledge that the amounts and combinations of drugs prescribed were excessive and potentially hazardous, and the doctor's management of the patients was unprofessional in that she paid insufficient regard to their rehabilitation needs.

As I said, Dr Barton provided fairly detailed written representations to the PPC in a letter that appears in your bundle at pages 23 to 31, together with a transcript of her evidence and the submissions of Mr Jenkins. In essence, what the doctor was asserting at that stage was that she was overworked and under-supported; that she was covering many patients without appropriate consultant cover, but that she was doing so within a well established nursing team with whom she had a good working relationship. For reasons of expediency she neglected her note taking, stretched as she was. Similarly, she adopted a policy of proactively prescribing – giving nurses in effect a degree of discretion in administering opiates and sedatives within a range of doses of medication.

The doctor moved on in her letter to give more detailed comments on each of the five patients that had been referred to the PPC, but I do not propose, unless invited, to take you through each of those patients and the comments that she made; I am satisfied that you have read this bundle carefully.

On 29 August 2002 you will see at page 51 of your bundle that the PPC determined, having heard evidence or considered the written evidence in the case, that a charge should be formulated against the doctor on the basis of the information that had been provided. They set out in that letter at page 51, dated 12 September 2002, the reasons why they determined it was appropriate to formulate a charge for referral, which were, amongst other things, that there was evidence of an apparently reckless and inappropriate prescribing of the drugs by Dr Barton, appearing to precipitate if not cause death and that patients were being commenced too rapidly on to terminal care drug regimes or being rapidly prescribed excessive doses of those drugs.

As a result of the referral by the PPC to the PCC the matter was again re-referred to the Interim Orders Committee. A transcript of that hearing appears in your bundle at page 53 through to 70, Ms Horlick appearing on behalf of the General Medical Council and Mr Jenkins appearing on behalf of Dr Barton. At that hearing of the Interim Orders Committee it was argued by Mr Jenkins that there was in truth no new material before the Interim Orders Committee which would entitle it to reconsider the necessity for an order. The only possible change that was alluded to by Ms Horlick was that the Crown Prosecution Service were reconsidering the decision to take no further action, and she makes reference to that at page 54 paragraph F.

It was observed later by the Chairperson of the Panel, Mrs Macpherson, that there was in fact no material before the Panel which spoke to that suggestion that the CPS may be considering the position, and that is dealt with at page 66 of your bundle at paragraph C.

The Panel considered, having heard from Mr Jenkins and Ms Horlick, that there was indeed no new material available to it and accordingly did not go on to consider whether it was necessary to make an order in the case.

On 30 September 2004 Detective Chief Superintendent Watts, who was the head of the Hampshire CID, wrote a statement setting out the history of what is described as Operation Rochester, and that appears in your bundle at page 71 onwards. It reviews the progress and evolution of the criminal investigation and at pages 73 to 75 sets out that an expert team, comprising various different healthcare experts, was engaged to conduct reviews and to categorise some 88 patients from Gosport who had been administered opiates prescribed or authorised by Dr Barton. There was categorisation into three different categories, set out at pages 73 and 74 and I do not need to take you through it – you have read it.

The police at that stage were unwilling – for good reason, you might think – to disclose the entirety of the material that they held in relation to Operation Rochester for fear of prejudicing their inquiry, and the statement of the Chief Superintendant goes into some detail as to the reasons why not all of the available material was being provided to the GMC, and that is dealt with at page 76 of the bundle. However, the Chief Superintendant was cognisant of the primacy of public protection and made reference to a voluntary agreement that had been entered into between the doctor and the Fareham and Gosport Heath Care Trust, from apparently October 2002, and reference is made to that at page 78 of the bundle.

The doctor had undertaken not to prescribe benzodiazepines or opiate analgesics from 1 October 2002:

> "All patients ongoing requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.
>
> Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement. Dr Barton also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes."

There is some reference then to the prescription by Dr Barton of diazepam to relatives of deceased patients.

There is then an update provided by the Chief Superintendant as to the five cases that were of particular concern to the GMC and that had been previously considered by the Interim Orders Committee in September 2002. AC had been assessed as a category 3 case and was being investigated accordingly – category 3 being the most serious in

terms of the case against Dr Barton, as was Patient RW. GR, the original complaint, was assessed as a category 2 case by the clinical team:

> "This assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004."

Patient AW, no further police action was to be taken in respect of this particular patient, the medical records not being sufficient to enable an assessment. The Chief Superintendant then makes emphasis on two key points:

> "There is no admissible evidence at this time of criminal culpability in respect of any individual."

And that the information adduced by the investigation and the findings so far justifies the ongoing operation and its use of resources.

The matter in consequence of that statement being received was referred back to the Interim Orders Committee for the fourth time, which sat on 7 October 2004. The reasons obviously are clear. It had come to the GMC's attention that there was a much more wide-ranging investigation being conducted by the Hampshire Constabulary into many more patients than had previously been considered by the General Medical Council.

The Interim Orders Committee on 7 October 2004 – the transcript is at page 80 – considered those five patients that had previously been considered in September. There appears in the transcript to be passing reference – and I emphasises the "passing reference" to six further patients. Passing reference because Mr Henderson, Queen's Counsel, who appeared for the General Medical Council on that occasion, at page 105 of your bundle, introduces those patients and says that in truth little weight should be attached to the reports and the material surrounding them, some of the material having been received recently and some of its provenance being uncertain; and he invited the Committee to have little regard to that evidence.

So when the Interim Orders Committee sat in October 2004 in truth what they were looking at was pretty much the same picture as that which they looked at in September 2002. The expert reports in relation to the other patients were not relied upon to any great extent and the export reports dealt mainly with the five original patients.

That position is borne out by the submissions made by my learned friend Mr Foster on that occasion who appeared for Dr Barton, because in his submissions he said that there was nothing new before the Interim Orders Committee over and beyond that which they had considered in September 2002. Beyond the fact that there was an ongoing police investigation which had been prayed in aid by my learned friend Mr Henderson and Mr Foster said of that, "That amounts to nothing new, there has been a longstanding ongoing police investigation of this case in any event."

The determination of the Interim Orders Committee, which is set out in your bundle at page 118 was that there was no need for an interim order; the Panel were not satisfied that it was necessary in all the circumstances of the case.

What has passed since that Interim Orders Committee in 2004? A great deal and you are not provided with all of the material which is in the possession of the General Medical Council in relation to the proposed fitness to practise hearing, which was listed for September of this year. Can I take you through some of the documentation that is in your bundle? You have at page 119 what is termed an investigation overview between 1998 and 2006, a document which has been prepared by a Detective Superintendant Williams from the Hampshire Constabulary. It is a useful document; it gives a helpful guide to the history of the case and goes into a little more detail than I have done in rehearsing the history. It develops the categorisation of the different cases which occurred during the investigation, and on page 125 it tells you that in fact 92 cases were investigated, and at the foot of page 125 records that 78 of those cases failed to meet the threshold of negligence required to conduct a full criminal investigation, and accordingly were referred to the General Medical Council and the Nursing & Midwifery Council for their information and attention.

Fourteen category three cases – the most serious – were therefore referred for further investigation by the police.

> "Of those 14 cases four presented as matters that although potentially negligent in terms of standard of care were causes where the cause of death was assessed as entirely natural. Under the circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.
>
> Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant geriatrician Professor Black, who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.
>
> Accordingly the four cases were released from the police investigation in 2006."

Those were patients CH, TJ, EC and NW.

> "The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is today outside the bounds of acceptable clinical practice, and cause of death unclear.'"

You are then given some indication of who it is that looked at the particular cases. On page 127 you learn that Dr Barton was interviewed under caution in respect of those allegations and the interviews were conducted in two phases – at the initial phase designed, it says, to obtain an account from Dr Barton in respect of care delivered to individual patients.

> "Dr Barton responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.
>
> During the second interview challenge phase (following the provision of expert witness reports to the investigation team) Dr Barton exercised her right of silence and declined to answer questions."

The ten category three cases that were investigated by the police are set out on page 128 to page 129.

Page 130 records:

> "There was however little consensus between the two principal experts Doctors Black and Wilcock as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death."

The opinion of Treasury Counsel was sought and that opinion was considered by the Crown Prosecution Service and in December 2006, having regard to the overall expert evidence, it was determined that it could not be proved that doctors were negligent to the criminal standard.

> "Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.
>
> Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction."

That summary from Mr Williams is dated 16 January 2007.

Nevertheless the General Medical Council then commenced or continued its investigation into the professional misconduct alleged against Dr Barton and in March 2008 the General Medical Council served its draft notice of hearing, which you will find at page 133. Accompanying that draft notice of hearing were the expert reports that had been prepared by the now Professor Black in relation to each of the individual patients.

The allegations run from page 133 through to page 146. There is an additional set of allegations relating to a further patient which appear in the bundle at page 265, Patient L, and it is much in the same form as those that appear at page 133. Again, I hope not inappropriately, I summarise what the allegations amount to, and it is this: inappropriate and potentially hazardous prescribing by Dr Barton of opium and sedatives together with poor record keeping by her of those prescriptions and of the clinical care offered to those 12 patients.

The expert reports prepared by Professor Black, which appear in an unsigned form in your bundle, but of which I have received signed copies – and my learned friend is aware of that – begin in your bundle at page 147 and individual reports are provided for each of the different patients that are the subject of the notice of hearing. I do not

propose to take you in any great detail through those reports – I am sure that you have read them carefully – and I remind myself that this is not a fact finding Panel.

The opinions of Professor Black are set out at the end of those reports. You will see from having read them that there is a table within each which describes the medication that was dispensed or prescribed for these patients, and Dr Barton is the principal prescriber of the opiates and sedatives that were administered to these 12 patients. Professor Black has engaged in an exercise of looking at whether the standard of care afforded to the patient in the days leading up to their deaths was in keeping with the acceptable standard of the day, and if the care was found to be sub-optimal what treatment should normally have been preferred in that case.

Of particular importance for your consideration today, you might think, are the opinions expressed. Can I take you to the first of those opinions at page 154? There is a short rehearsal by Professor Black of the patient's history and then he indicates where it is appropriate in his judgment that there were significant failings in the medical care provided to each patient. In relation to the first, Mr P:

> "The failure to undertake a physical examination of the patient on admission to the medical ward at Gosport, or if it was undertaken a failure to record it in the notes.
>
> The prescription of a high dose of diamorphine, 40 to 80 milligrams by Dr Barton on the PRN part of the drug chart on admission, without explanation.
>
> The failure to document a detailed assessment of his pain and distress in the notes prior to starting regular opioid treatment.
>
> The use of approximately three times the usual expected daily does of diamorphine when starting the syringe driver, together with a dose of 60 milligrams of Midazolam, without any explanation in the notes, in my view negligent clinical practice."

He goes on then to describe deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, over the page. So it follows in each of the reports that you have a similar pattern.

Can I invite you when you retire to consider each of those opinions, unless the Panel wish me to read through each of them now? I am in your hands. It would seem a laborious exercise for me to undertake. Can I, if that finds favour, invite you to go to page 219, which is the report provided in relation to the patient RW. The drugs prescribed and administered are set out in tabular form at page 224 of the bundle and over the page to 225. It records at 4.6 that:

> "He is transferred on 14 October for ongoing assessment, possible rehabilitation and decisions about long-term care arrangements. No examination has been recorded on admission by the medical staff. Not even a basic clinical examination has been undertaken or, if it has, was not recorded."

A Over the page at 4.8:

> "The decision to give morphine on 14 and then the regular morphine, at this dose, on 15 October is crucial to the understanding of this case."

This was a patient who had a long history of alcohol abuse.

B

> "'The effects of hepatitis or cirrhosis on drug deposition range from impaired to increased drug clearance in an unpredictable fashion ... the oral availability for high first class drugs such as morphine ... is almost double in patients with cirrhosis compared to those with normal liver function. Therefore the size of the oral dose of such drugs should be reduced in this setting.'"

Professor Black says:

C

> "In my view the decision to give the significant doses of morphine on 14 then the regular high oral doses of strong opiates on 15 was negligent. The appropriate use of weaker analgesics had not been used, though these had apparently controlled his symptoms the previous week in the Queen Alexandra Hospital as he had not received strong opioid analgesia after 5 October. The dose of morphine used, particularly in the presence of severe liver disease, was very likely to have serious implications."

D

There is criticism in 4.9 of a failure by Dr Barton to seek senior medical opinion in relation to this patient when seen on 15 October.

On the afternoon of 16 Patient RW was started on a syringe driver. Although prescribed by Dr Barton there is nothing in the notes to document that the decision to start is a medical or nursing decision.

E

4.11:

> "In my view the regular prescription and dosage of Oramorphine was unnecessary and inappropriate on 14 and 15 October and in a patient with serious hepatocellular dysfunction was likely the major cause of the deterioration, in particular in mental stage, on 15 and 16 October. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of RW."

F

Then the opinions of Professor Black are expressed at paragraph 5.1, 5.2 and 5.3.

Can I take you to the summary of conclusions in relation to Patient ES, which begins at page 231? Again you will see that there are prescriptions given by Dr Barton on page 234, set out for you in tabular form.

G

Paragraph 4.4:

> "The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary ..."

H

– from the hospital from which the patient was transferred:

> "... which says that Mrs S is purely on intermittent Paracetamol."

From intermittent Paracetamol you can see the range of opiates and sedatives that were prescribed to her by Dr Barton, all on page 234.

Paragraph 2.12 on page 237:

> "In my view the dose of diamorphine used on 11th was inappropriately high. However, I cannot satisfy myself to the standard of 'beyond reasonable doubt' that this had the definite effect of shortening her life in more than a minor fashion of a few hours. I understand the cause of death on the death certificate was Cerebrovascular Accident. There is nothing in the medical notes to substantiate this diagnosis which is misleading and probably inaccurate."

The doctor does not face any allegations in relation to the final part of that paragraph but she does in relation to the inappropriate use of diamorphine. I am bound to read that paragraph out to you to illustrate that the judgment of Professor Black was that he could not be satisfied beyond a reasonable doubt, and no doubt that is the type of opinion evidence that has influenced the decision by the police not to prosecute this matter criminally; but it does not preclude the General Medical Council, we say, from having regard to the inappropriateness of the high doses of morphine and diamorphine that were being prescribed to this patient in particular and to others.

THE LEGAL ASSESSOR: It might give rise, though, at the substantive hearing to an abuse argument, might it not, that the police conclusion came shortly before the standard of proof was changed by the General Medical Council; it is now different, of course, since April of this year. Mr Langdale will no doubt be keeping his powder dry, but I would have thought there is a ready made abuse argument here.

MR BRASSINGTON: I will not ask him to develop it today and it may be that it is not something that is contentious – I know not. The reason that I raise it is that it is one thing to say, "I cannot be satisfied beyond a reasonable doubt that it hastened death", which is entirely different from him saying it was inappropriately high; and that is the distinction I am drawing between the criminal allegations and what the General Medical Council are going to be examining. The General Medical Council are not going to be litigating whether or not this amounted to negligent manslaughter because that matter has been determined elsewhere.

THE LEGAL ASSESSOR: The Panel today has to bear in mind that they are not adjudicating on facts and finding facts proved, but they obviously will bear in mind that there presumably will be expert evidence to the contrary at the trial of this matter, and they must not today form any conclusions about Professor Black's opinion.

MR BRASSINGTON: I quite agree and I was not seeking to do that; I was just simply seeking to draw the distinction between what are criminal charges and what are matters of professional regulation, and I think that that paragraph well illustrates it and that is why I draw your attention to it.

The opinion of Professor Black in relation to ES is set out at paragraph 5.2 and third amongst those points is the prescription on admission without explanation of strong opioid analgesia, when apparently the patient had only needed Paracetamol at the previous hospital. There is again failure to document the reason for starting the syringe failure; failure to explain in the notes the decision to start with 80 mgs of diamorphine; and the failure to explain the decision to increase the dose of Midazolam at the same time as the diamorphine was reduced on 12 April.

The next summary of conclusions to which I invite your attention is that for Patient GP, which begins on page 240 of your bundle, sir. Again, it is in very similar form; there is a table on pages 243 and 244. Page 245 at 4.8:

> "Despite this there is an important decision to be made on 26 August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the acute problems, whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital.
>
> Dr Barton makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view, however, that in view of his other problems it is within the bounds of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.
>
> Mr P deteriorates further in the evening and is prescribed a single dose of diamorphine as a result of a verbal request."

And reference is made to the drug chart and identification of the prescriptions therein.

There is again reference to the misleading and inaccurate death certificate.

Opinion at 5.2:

> "The failure of Dr Barton on 26 August to undertake investigation to exclude the first diagnosis made and the failure to review the investigation that was undertaken, the full blood count."

The failure, on page 248, to ask senior medical opinion at the time of a complex and serious medical decision on 26 August; the failure to document any reason for both starting regular opioid medication and possible high starting dose of Oramorphine on 27 August; the failure to document any reason to start the syringe driver on 30 August and whether that was a medical or nursing decision. There is then reference to deficiencies in relation to the drug chart, with which I need not trouble you.

Unless invited to by either my learned friend or by you I am not going to go, as I say, through the rest of the opinions; I am sure that you will read them carefully.

Those expert reports are before an Interim Orders Panel or Committee for the first time, and we say that it is new material which is significant, and to which you, in determining whether it is necessary to make an order today, should have particular regard, together with the fact that there are now no longer simply five patients being considered by the General Medical Council but 12, which you have read about in the notice of allegations provided.

This case has a long history. It was due to be heard before a Fitness to Practise Panel applying the PCC Rules in September of this year. However, matters were effectively taken out of the GMC's hands when on 28 April 2008 David Horsley, Her Majesty's Coroner for Portsmouth and South East Hampshire, wrote to Field Fisher Waterhouse, the external solicitors dealing with this case, to indicate that it was the intention of the coroner to hold an inquest into the deaths of ten people who died at the Gosport War Memorial Hospital. This is at page 261, sir. Eight of the patients that are being considered by the coroner overlap with the patients being considered by the GMC, and in those circumstances you may well think that it was appropriate, as happened, for the General Medical Council to postpone the hearing of the Fitness to Practise Panel for it was said that the likely timing of any inquest would be in autumn of this year and so potentially would have overlapped with the Fitness to Practise Panel hearing.

On 20 June 2008 the GMC wrote to Dr Barton's solicitors indicating postponement of the PCC hearing, which had been scheduled for 8 September. Dr Barton in subsequent correspondence accepted that this postponement was inevitable and necessary because of the overlap of issues. I should have said to you as well, sir, that the report from Professor Black in relation to the final patient that is the subject of allegations is at page 267 of your bundle.

So that is where matters rest currently. There is now no fixed date for a fitness to practise hearing to take place in relation to these allegations and the coroner's inquest is due to take place at some time this autumn.

The submission that I make on behalf of the General Medical Council is that in accordance with Section 41A of the Medical Act 1983, as amended, for protection of patients, in the public interest and in the doctor's own interests an interim order of conditions should be imposed upon the doctor's registration. You can be satisfied, we say, that there may be an impairment of the doctor's fitness to practise which poses a real risk to members of the public, which may adversely affect the public interest or indeed the interests of the doctor herself.

Any response to material such as this, if there is to be a response, must be a proportionate one and when considering whether the imposition of conditions would be a proportionate response I am bound to observe that Dr Barton appears, at some stage in 2002, to have entered into a voluntarily arrangement with her Primary Care Trust that she not prescribe opiates or benzodiazepines, and you will recall reference being made to that in the statement of the police officer Williams.

It appears that, having entered into such a voluntarily arrangement, the doctor was well able to continue practising her trade. It did not place such restriction upon her

that she was not able to continue in practice, and that is important, in my respectful submission.

I pose this question rhetorically to the Panel: in the circumstances of this case, given that there are 12 patients to be considered by a Fitness to Practise Panel about whom there are serious concerns as to the appropriateness of the prescribing of this doctor of opiates and sedatives; that there is a coroner's inquest scheduled to take place in relation to ten patients surrounding their care and the reasons for their death, I ask rhetorically what confidence can the public have in the medical profession or indeed in the body that is tasked to regulate it, that if knowing that those proceedings are ongoing she is permitted to continue prescribing such drugs? The answer, I respectfully suggest, would be none. Confidence and trust in the profession would be undermined and the credibility of the regulatory body would be in question, particularly when the public understand that this is a neutral act and that this neutral act would not prevent the doctor practising medicine, as the voluntarily undertakings previously did not. In truth there would be no hardship placed upon Dr Barton, but there would be protection of patients; there would be maintenance of confidence in the profession, and in those circumstances, sir, despite the passage of time, despite the failure of any criminal allegations to crystallise, these are serious matters and these grave allegations require action from the GMC to prevent an undermining of the justified faith and trust the public place in its profession and its regulator.

Unless I can assist you further, sir, those are the submissions that I make.

THE CHAIRMAN: Thank you, Mr Brassington. I now ask Panel members whether they have any questions for you for clarification. Mr John Walsh is a member of the Panel.

MR WALSH: It may be that we will be told this in due course but are you aware of the current status of those undertakings with the hospital?

MR BRASSINGTON: No.

MR LANGDALE: I will be able to assist.

THE CHAIRMAN: Dr Eve Miller is a medical member of the Panel.

DR MILLER: Just for clarification, were all the patients you have asked us to consider inpatients at this particular hospital?

MR BRASSINGTON: To the best of my understanding yes, but if I am wrong I welcome correction.

MR LANGDALE: They were.

DR MILLER: Does the GMC have any other complaints about the rest of Dr Barton's practice?

MR BRASSINGTON: As I understand it the matters that are to be heard by a Fitness to Practise Panel are those that have been reduced into the draft notice of hearing and its addenda.

THE CHAIRMAN: Mr Brassington, you suggest that the Panel needs to consider the issue of conditions. Do you have any instructions as to what those conditions should be? It is obviously for the Panel to decide but do you have any instructions?

MR BRASSINGTON: The instructions that I have in relation to this are that the conditions should mirror those which the doctor previously gave as undertakings. Of course there would be the necessity for other notification conditions in relation to her practice familiar to this Panel and drawn from the Conditions Bank, upon which I do not need to address you. Really the substance of it comes from the statement provided by the Chief Superintendant at page 78.

THE CHAIRMAN: We have no further questions for you, thank you. Mr Langdale, over to you.

MR LANGDALE: Sir, I do not mean to in any sense sound flippant, but Dr Barton could be forgiven for saying to herself, "Here we go again." It is remarkable – I hope I am not putting it too highly – that when exactly the same issues are brought before this Panel – as it now is, as opposed to the Committee – that no reason has been given as to why any change of circumstances should make the slightest difference to what the Interim Orders Committee found in 2004, in other words that there was no need to impose any kind of order with any kind of conditions.

All that is now being said is that there is a difference between the situation that pertained in October 2004 and the situation that pertains now in 2008, the difference being, in effect, there are now more allegations in the sense that there are now more patients, and that there is a further expert's report. My submission to the Panel is that when one looks at everything that has been presented in this case, and the history, that there is no reason supplied as to why that technical difference – an increase in the number of patients and a further expert's report – should have any bearing whatsoever on Dr Barton's fitness to practise in the interim period before the hearing. It is all very well to assert that the numbers are different, but it will not do to simply suggest that without giving any reason as to why that affects the position, bearing in mind that this Panel will not make a judgment about this case which is in any way different to the Interim Orders Committee, unless there is some real significant evidence of a change in circumstances which goes to the issue in this case as to whether any conditions should be imposed. In brief – although I shall say a little bit more, I hope at not too great length – in essence the reality is that the real change, compared to what the situation was in October 2004, is that there are no longer any criminal allegations hanging over Dr Barton's head. The police investigation, having been carried out over a long period of time, has found that there is no basis for bringing criminal allegations – that is something that is different and, if I may put it this way, in the doctor's favour compared to the situation in October 2004.

Secondly, another real and meaningful change from what the position was in 2004 is that Dr Barton has had a further four years of practice without blemish or criticism. That is a real change and a real difference and, in my respectful submission,

reinforces the fact that there is no proper basis for this Panel seeking to impose any conditions after four previous referral hearings and the distance of time, the lapse of time that has occurred since the last allegation or criticism that is made relates to 1999. It is now getting on for ten years since there has been any criticism of any of the conduct of Dr Barton.

That is why I say that this is an unusual referral.

In terms of the expert evidence there is absolutely no difference – leave aside wording and particular features which may be slightly different – with regard to the opinion of Professor Black to the opinions expressed one way or the other by five experts whose evidence was in existence and available to the Interim Orders Committee in October 2004. Professor Black is not saying anything different to what was the allegation against Dr Barton in terms of expert criticism in relation to the five patients who form the original – if I use the word "collection" I do not mean that disrespectfully – collection of patients considered by the Interim Orders Committee in October 2004. If any confirmation of that is needed this Panel need only refer to the transcript detail of the hearing in October 2004 when Mr Roger Henderson, appearing for the General Medical Council, set out in detail what the medical opinions were of various experts – it was not just one – with regard to those five patients. One can take it that my point is a proper one and it has some force because my learned friend, Mr Brassington, has not sought to suggest to you – quite properly – that Professor Black is saying anything essentially different by way of criticism about Dr Barton than what had already been said by way of criticism with regard to the initial five patients.

Furthermore, if one looks at the nature of the charges that were proposed to be brought in respect of the initial five patients, which are in your bundle at page 19, if you look at those it is immediately apparent that the essence of the nature of those charges is exactly – and when I say "exactly the same" not word for word but for material purposes – the same as the nature of the charges which are to be brought against Dr Barton in the forthcoming hearing. So there is not actually any difference, save for an increase in numbers and the fact that there is a different expert being called in to assist the General Medical Council at the hearing.

Again, if I can stress this – and I am sorry if I am repeating myself but it does seem to be rather important – not one word has been said as to why these differences, the extra number of patients and the fact that there is a different medical expert being used – make any difference to Dr Barton's position with regard to whether any conditions should be imposed upon her. There would have to be, I suppose, both in logic and in fairness some different reason applying after October 2004 for this referral to make any sense at all. As I say, we have not heard one thing advanced as to why it makes any difference and the Committee in October 2004 considered the matter in considerable detail, it is evident from the transcripts; and it is evident from all the background material that has been cited to you by my learned friend. They considered it in great detail – all the allegations were the same. When my learned friend Mr Henderson appeared for the Council he was saying that conditions should be imposed because a voluntarily arrangement was not going to be binding. Exactly the same arguments were applied as to why that should be required. He did not – and this is not a criticism really, but I cannot resist saying it – resort to rhetorical flourishes in terms of asking rhetorically what the public think if this, that and the

other was the case. The Committee in October 2004 made it very clear what they thought; they did not feel that public confidence would be damaged with regard to its view of the profession by the fact that there was no need to impose any kind of conditions.

The Panel will obviously be looking at the history – and I am not going to repeat it because it has been gone into in some detail and you have it all before you. I would like to stress this – because the situation has to be looked at very much in tandem with what was before the Committee in October 2004 – that the Committee in 2004 was well aware that there were question marks or concerns about a very large number of patients additional to the five who at that stage formed the basis for the charges. There were 88 cases that the police had been looking into.

It is also worthwhile pointing out that mention was made more than once by counsel appearing on behalf of the Council to the scope of matters relating to what had happened at the Gosport War Memorial Hospital. Just by way of illustration can I draw your attention to the bundle page 81? This is just to illustrate the point. If you look on page 81 at C – just between C and D Mr Henderson said – referring to the state of Detective Chief Superintendant Watts:

> "The statement shows the scale of the police concern on top of the reference which has already been made to the Preliminary Proceedings Committee to the Professional Conduct Committee of the Council for enquiry into certain matters ..."

So the Committee then were well aware that it might well not just be five cases that were involved in this case. The critical thing perhaps to bear in mind is that when the Committee was then considering should they impose any conditions or not they were well aware that it was not just five people about whom concerns were raised. It is now being suggested that this Panel should impose conditions because a further, comparatively speaking, handful of patients have now formed the subject of charges against Dr Barton – it is now 12 not five.

Similarly, if you look briefly at page 101 of the bundle at B:

> "An investigation surrounding the deaths of 88 patients occurring principally during the late 1990s at Gosport War Memorial Hospital. This investigation followed allegations that during the 1990s elderly pats at Gosport War Memorial received suboptimal or substandard care, in particular with regard to inappropriate drug regimes and as a result their deaths were hastened."

At page 105 of the same bundle Mr Henderson made reference, at C, to the piles of documents that concerned the cases. So all of that goes to show – and any other detail which this Panel may find relevant – is that the Committee in 2004 was not looking at the case as if the only concerns expressed by anybody related to five patients; yet it is now being suggested that a different view should be taken by this Panel because there are a further seven patients about whom allegations are made, as I repeat – but I do so to stress it – of no significantly different character in relation to the allegations and of no consequence or relevance with regard to what the position should be in the year 2008 with regard to Dr Barton.

It is worth bearing in mind that all of these allegations embrace a particular timeframe – 1996 to 1999; one patient in 1996 and three in 1999 – a limited timeframe. And this Panel will no doubt have very much in mind the points made to the Committee in October 2004 with regard to the particular working conditions which pertained when Dr Barton had these concerns raised about her professional conduct. It was in conditions far removed, radically different this Panel may think to the situation that pertains to her normal GP practice, which has been going on without blemish, without complaint ever since 1999. You will be aware, of course, that she resigned from the hospital in the year 2000 – her decision.

I do not think it is right to suggest that in some way the October 2004 hearing was just a rehearing of previous matters; it certainly was not the position adopted by counsel for the General Medical Council. Mr Henderson was not suggesting that that was simply a repeat of what had gone before; he was suggesting that there were differences. The Committee found that whatever those differences were they did not justify the imposition of conditions.

I think I shall probably be repeating myself if I go over any of the other material which I suggest thoroughly supports what I am submitting to this Panel. I have made the points; I think they can justifiably be kept pretty brief because it is our contention that looked at in the reality this is raising exactly the same issues – an increase in number and a different expert does not make any difference at all to what it is that this Panel has to consider as compared to what the Committee had to consider nearly four years ago.

May I just assist finally with regard to the position that Dr Barton is in with regard to the PCT and so on in Hampshire? There was a voluntarily arrangement entered into; it worked then perfectly well, it has worked since perfectly well. I think I need to make one thing clear. You will have observed from the transcript of the hearing in October 2004 that there seemed to be a sort of suggestion that maybe Dr Barton had not been adhering to the agreement. That suggestion was not pursued and indeed the Committee heard in quite some detail about prescribing, how the fact of the matter was that Dr Barton was, for example, not prescribing diamorphine and any prescriptions which might have been issued which might look as if they had been prescribed by her were not, and it was never suggested by counsel appearing on behalf of the General Medical Council that there had been any breach by her of the voluntarily undertaking.

It is not quite as closely defined as the original wording might seem to suggest. May I just pause for a moment? (Mr Langdale took instructions) Sir, I have been reminded – and if I can go back – about something which may be of significance. At the hearing in October 2004 counsel appearing on behalf of Dr Barton read out certain passages from an investigation report that had been carried out on behalf of the Commission for Health Improvement – I think it was known as the CHI report in the transcript – and I do not think that what he read out from that report appears in the transcript, so I had better just deal with it, if I may, briefly.

THE CHAIRMAN: Can you mention the report again for our purposes and also for the shorthand writer?

MR LANGDALE: Yes, it is the July 2002 CHI report relating to the Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital, and it is headed *Investigation*, as you can see from the document I am holding up. These paragraphs, as I say, were put before the Committee, and the point of this is simply to show how the difficulties of the conditions under which Dr Barton was working at the time in relation to which complaint is made – conditions and so on – and obviously to highlight the fact that she has not been since 1999 or early 2000 in any similar situation since. The paragraph that was read out was paragraph 6.8:

> "The CHI is not aware of any Trust systems in place to monitor or appraise the performance of clinical assistance in 1998."

Dr Barton, of course, was a clinical assistant:

> "This lack of monitoring is still common practice within the NHS. A consultant submitting 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. Staff interviewed commented on the long working hours of the clinical assistant in excess of the five contracted sessions."

Then paragraph 7.9, relating to what had been done subsequently:

> "Action was taken to develop and improve Trust policies around prescribing of pain management. In addition CHI learned that external clinical advice sought by the Portsmouth Health Care NHS Trust in September 1999 suggested that the prescribing of diamorphine with dose ranges from 20 to 200 mg a day was poor practice and could indeed lead to serious problems. This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20 to 40 mg per day."

Then reference to an agreed protocol.

> "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."

Then "Other Trust Lessons" paragraph 7.11:

> "Lessons around issues other than prescribing have been learned by the Trust."

A series of actions:

> "An increase in the frequency of consultant ward rounds on Daedalus from fortnightly to weekly; the appointment of a full time staff grade doctor in September 2000, which increased the medical cover, following the resignation of the clinical assistant."

That being of course Dr Barton:

"On additional consultant session began in the year 2000 following a district-wide initiative with local PCGs around intermediate care."

As I say, I mention those because they were before the Committee in October 2004 and they do not appear in the transcript, but they simply highlight the point as to the situation that Dr Barton was in in the latter part of the 1990s, in particular the problems and difficulties. I do not seek to repeat it because it is described already in the transcript of that hearing and the fact that action was taken to remedy defects which were not in any sense Dr Barton's fault.

Coming back, if I may, to the question of what the situation is with regard to what Dr Barton can or cannot prescribe in relation to the agreement she has with the PCT. As this Panel will be aware, in relation to opioid analgesics they technically include a large number of medications; for example, that term of itself would embrace codeine. It has never been part of the voluntarily arrangement that Dr Barton was not allowed to prescribe some opioid analgesics, but there is a clear line to be drawn between things such as codeine and there are other named drugs which are referred to in meetings between the PCT and Dr Barton in connection with the voluntarily arrangement. The understanding is and the practice is that Dr Barton does not describe what I think – and I may have the term wrong – may be called schedule 2 drugs, the drugs of the category such as morphine, to use the blanket expression, pethidine and so on. I want to make that clear to the Panel that it is not absolutely technically exactly what the words might be taken to mean on the face of them. Similarly, in terms of the benzodiazepines there has been some prescription of those in particular cases but as the Panel will be aware from the history of the matter the undertaking is and the voluntary arrangement or agreement is that she does not prescribe outside the guidelines. I can go into more detail if necessary but what I am going to do, if I may, is to provide the Panel with a letter written by the Community Pharmacy Development Manager at the PCT, which sets out that Dr Barton has been in full compliance with the voluntarily arrangement. As I say, I can go into detail more necessary but I do not think it is. I will make sure that my friend has a copy of it.

THE CHAIRMAN: Has he seen it?

MR LANGDALE: He will not have seen it yet. It is 9 July of this year. (Same distributed)

THE CHAIRMAN: That will be D1.

MR LANGDALE: Thank you. I will take you through it fairly quickly, if I may. I am going to the body of the letter.

"I have been closely monitoring Dr Barton's prescribing of benzodiazepines and opioid analgesics since 2002 following her voluntary agreement with the Fareham and Gosport Primary Care Trust to restrict her prescribing of diazepam and diamorphine. Any prescriptions for diazepam issued will be in line with BNF guidance with no prescribing of diamorphine. Prescribing data is available from April 2001 (prior to the voluntary agreement) through to

May 2008. The data is obtained from the NHS Business Services Agency, Prescription Pricing Division.

I have met with Dr Barton at regular intervals to discuss the data and when necessary have requested copies of prescriptions. The PPD data is recorded against the GP name printed in the bottom of the prescription not against the signature. The prescribing GP may be a partner in the practice other than the named GP for the prescription. Dr Barton has asked patients requiring long-term treatment with opiates or benzodiazepines to see other partners within the practice. Copies of all diamorphine prescriptions issued by the practice since May 2006 have been requested from the PPD. None of the prescriptions were signed by Dr Barton.

Dr Barton has maintained her compliance with the voluntary agreement which has been in place since October 2002."

That, I hope, deals with the matter clearly.

Sir, in conclusion it is respectfully submitted that this Panel should not, and indeed has no logical or proper basis for taking any different view to the view that the Committee took in October 2004. The only material changes from the situation that was presented to the Committee in October 2004 are two things, which support the submission I am making to the Panel. One is that there is now no police investigation; secondly, Dr Barton has had a further four years of practice without blemish, fully – no doubt one can say properly – supporting the confidence that the Committee had in October 2004 that there was no need to impose conditions.

That is all I seek to say; thank you.

THE CHAIRMAN: I will ask Panel members if they have any questions for you. Mr Walsh, lay member of the Panel.

MR WALSH: Coming to that undertaking on page 78, that is the only copy that we have, is it?

MR LANGDALE: It is the only copy that I have available to me. I will check if I may, with those instructing me, to see whether there is anything else that we have. I do have file notes of meetings which took place where various matters were being discussed, but they none of them suggest that there was any breach of the undertaking. (Instructions taken) I am told that is right.

MR WALSH: Looking at it as a lay person, it is not qualified in the way that you describe about, for example, the line on opiates that you described.

MR LANGDALE: This is not raised as a criticism by the General Medical Council and they are not suggesting that Dr Barton has not been abiding by the terms, but I thought it right to point out that it is not just as simple as it might appear from the original wording. One can see why the wording was employed but the understanding always was that it did not include every single conceivable opiate analgesic – for example, I am taking the very bottom of the range, codeine.

MR WALSH: There is no term to that undertaking – it is open-ended.

MR LANGDALE: It is open-ended and it is obviously currently still in force.

DR MILLER: Just to carry on the point made by my colleague, in the letter that you have provided of 9 July from the Community Pharmacy Development Manager, it has come down now to restricting prescribing diazepams, just one benzodiazepine, and diamorphine just one opioid analgesic, is that correct?

MR LANGDALE: May I just check that? (Instructions taken) I am told that is right, that it therefore embraces anything coming under that description – obviously morphine, pethidine and so on. I can provide the detail of the prescribing if necessary.

DR MILLER: The only other point I have is what is Dr Barton doing now?

MR LANGDALE: She remains in practice as a GP. I am not quite sure what further detail I can usefully provide.

DR MILLER: But with no other clinical assistant position?

DR LANGDALE: As I understand it, no; and she confirms.

DR MILLER: Thank you for that. Does she come under the appraisal process of the PCT?

MR LANGDALE: She does.

DR MILLER: When was her last appraisal?

DR BARTON: January this year.

THE CHAIRMAN: There are no further questions from Panel members for you, Mr Langdale and I think you have completed your submission. We have heard very clearly what you say. Mr Brassington, there is nothing else to add, is there?

MR BRASSINGTON: Only this: that my learned friend has suggested that not one word has been said as to why there is now a difference, and if I have not made that plain in my submissions that is my fault, and you might want to hear from me what I say about that. It has effectively been rehearsed by my learned friend already. There are now a greater number of patients about whom there has been expressed grave concerns as to the clinical care offered by this doctor. The timeframe has increased significantly from being 1998 to being now 1996 to 1998, over which this is said to have taken place, and that suggests a longer pattern of inappropriate prescribing.

I am also bound to make reference to the fact of the coroner's inquest, and although my learned friend teases me – rightly probably – for the rhetoric he suggests I flourish before you, I say that that is not done flippantly. You are here to protect the public

interest and so it is proper that you ask yourself that question, as to what the public perception would be.

From the letter that has just been put before me may I please make a comment – I not having seen this before – that has perhaps already been made by Dr Miller in her question of Mr Langdale, that there appears, does there not, to have been now a voluntary relaxation of the condition that was entered into by the doctor in 2002, over which the General Medical Council has no control and no say, which again perhaps illustrates the points that I have been making. If my learned friend wishes to come back then of course he may, but I have nothing further to add beyond that, thank you.

MR LANGDALE: Yes, may I very briefly?

THE CHAIRMAN: Of course.

MR LANGDALE: It is my fault. I am not suggesting that my learned friend has not said what is different – he made it clear, extra number of patients, a different expert's report, coroner's inquest. My point is – and I am sorry if this was not clear – that those changes, those differences do not raise any issue or question, or cast any doubt upon the fact that it was perfectly proper for Dr Barton to continue in practice without there being conditions. My point is that not a word has been said as to why those changes make a difference to the view that anybody should take about Dr Barton not requiring conditions to be imposed – why it is not in the public or in her interest to have conditions imposed. There has to be something to say, "Actually these changes make a difference as to why conditions should be imposed." That is my point.

With regard to the last point that my friend made, there is no difference to the arrangement that was in place, it is that the wording – as it was presented initially, in the way that has been touched upon by Mr Walsh – needed to be clarified. It is not as if there has been a change in what has been agreed between the PCT and Dr Barton since the voluntary arrangement was entered into. There is no difference; it is not as if she is now being allowed to prescribe things which before she was not allowed to prescribe under the terms of the arrangement.

THE CHAIRMAN: Thank you for that clarification, Mr Langdale. There are no further points from Panel members. Can I turn to the Legal Assessor?

THE LEGAL ASSESSOR: You are operating under Section 41A of the Medical Act as amended, and I stress that that is for an interim order – you are not determining these proceedings. You have heard that there is an expert's report now which was not available at previous interim proceedings, but you are not making any findings about that. You have also heard that the prosecution is no longer contemplated – in fact a decision has been taken that there should be no criminal proceedings. Again, you are not making any findings of fact.

The test for you is whether you are satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or in the interests of the doctor to make either an order for suspension, which you are not invited to do in this case, or an order for conditions. I should add that "otherwise in the public interest"

includes preserving public confidence in a profession and maintaining good standards of conduct and performance.

I also stress that Section 41A is not mandatory; you may make an order if you are satisfied of those things. But any order you make must be proportionate and therefore you do bear in mind what has happened at previous hearings and you will also bear in mind that whilst there are now more patients being contemplated the last Committee was aware that there were more than the five before it; also when considering proportionality you must bear in mind that the last patient about whom there is any question for prescribing died in November 1999.

THE CHAIRMAN: Thank you, Mr Seed. We will now go into private session.

PARTIES THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

PARTIES HAVING BEEN READMITTED

THE CHAIRMAN: I am sorry to have kept you waiting but we have had to make sure that we have our determination correct. Dr Barton, I am going to read out your determination and afterwards you will be given a copy and a copy will be given to Mr Langdale as well.

This is the Panel's determination in the case of Dr Jane Ann Barton.

DETERMINATION

THE CHAIRMAN: Dr Barton, the Panel has carefully considered all the information before it today, including the submissions made by Mr Brassington on behalf of the General Medical Council (GMC), those made on your behalf by Mr Langdale, and the documentation provided. The Panel has noted that your case was previously considered by the former Interim Orders Committee on four occasions and no order was made. However, the Panel has considered your case in the light of the submissions and information presented to it today.

In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders Panel has determined that it is necessary for the protection of members of the public, in the public interest and in your own interests to make an order imposing conditions on your registration for a period of 18 months as follows:

1. You must notify the GMC promptly of any professional appointment you accept for which registration with the GMC is required and provide the contact

details of your employer and the PCT on whose Medical Performers List you are included.

2. You must allow the GMC to exchange information with your employer or any organisation for which you provide medical services.

3. You must inform the GMC of any formal disciplinary proceedings taken against you, from the date of this determination.

4. You must inform the GMC if you apply for medical employment outside the UK.

5. You must not prescribe diamorphine and you must restrict your prescribing of diazepam in line with BNF guidance.

6. You must provide evidence of your compliance with condition number 5 to the GMC prior to any review hearing of this Panel.

7. You must inform the following parties that your registration is subject to the conditions, listed at (1) to (6), above:
   a. Any organisation or person employing or contracting with you to undertake medical work;
   b. Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application);
   c. Any prospective employer (at the time of application);
   d. The PCT in whose Medical Performers' List you are included, or seeking inclusion (at the time of application) ;
   e. Your Regional Director of Public Health.

In reaching its decision to place conditions on your registration, the Panel bore in mind that it is not its function to make findings of fact or to decide on the veracity of the allegations. The Panel has, however, given such weight as it considers appropriate to the allegations that you face.

In reaching this determination, the Panel has considered the information received initially from the Hampshire Constabulary concerning your alleged inappropriate prescribing for a number of patients at Gosport War Memorial Hospital and the investigations into their deaths. The Panel has noted from the overview of the police investigation contained in the statement of Detective Superintendent Williams dated 16 January 2007, that the Crown Prosecution Service has decided not to proceed with a criminal prosecution. However, the Panel has noted the criticisms in respect of your prescribing and record keeping contained in the report by Professor Black, an expert commissioned by the GMC.

The Panel has also taken account of the information that the GMC has referred your case for a hearing by the Fitness to Practise Panel into allegations that your prescribing in relation to 12 patients at Gosport War Memorial Hospital was inappropriate. The Panel has noted that the GMC has decided to postpone the Fitness to Practise hearing until the outcome of the Coroner's inquest into the deaths of ten patients at Gosport War Memorial Hospital, eight of which are the subject of the Fitness to Practise hearing. The Panel notes that the inquest is expected to take place in the autumn of 2008.

Mr Brassington submitted that in view of the serious concerns raised in relation to your prescribing, and the potential for risk to members of the public or the public interest it would be appropriate for the Panel to make an order imposing conditions on your registration. Mr Brassington submitted that the public interest includes the maintenance of public confidence in the profession.

The Panel also considered Mr Langdale's submission that there is no new information before the Panel today which justifies the imposition of an interim order.
Mr Langdale submitted that although the allegation formulated by the GMC now relates to 12 patients rather than the five patients who were the subject of the investigation when the Interim Orders Committee last considered your case in October 2004, the position has not altered.

Mr Langdale pointed out that you have continued to work as a general practitioner for the past four years and there have been no complaints about your practice.

The Panel had regard to the information that you entered voluntarily into an agreement with the Fareham and Gosport Healthcare Trust (the Trust) in which you gave an undertaking that you would not prescribe benzodiazepines or opiate analgesics with effect from 1 October 2002. The Panel has received a letter dated 9 July 2008 from Hazel Bagshaw, Community Pharmacy Development Manager at the Hampshire NHS Primary Care Trust (Hampshire PCT). Ms Bagshaw states that she has been closely monitoring your prescribing of benzodiazepines and opioid analgesics since your undertaking to restrict your prescribing of diazepam and diamorphine and confirms that you have maintained your compliance with the voluntary agreement which has been in place since October 2002.

While the Panel notes your compliance, it is concerned that the agreement is voluntary and that there are no formal arrangements in place to monitor your continued compliance. Given that this is not the first time that your prescribing has been queried and that there are to be inquests in respect of ten of the patients concerned, public confidence in the profession could be undermined if you were left in unrestricted practice in the meantime. The Panel considers that it is necessary for the maintenance of public confidence in the medical profession for the GMC to exercise control over your compliance with restrictions on your prescribing.

Taking all the information into account, the Panel is satisfied that there may be impairment of your fitness to practise which poses a real risk to members of the public and which may adversely affect the public interest and, after balancing your interests and the interests of the public, the Panel has determined to impose an interim order to guard against such a risk.

The Panel has taken account of the issue of proportionality and has balanced the need to protect members of the public, the public interest and your own interests against the consequences for you of the imposition of conditions on your registration. Whilst it notes that the above conditions restrict your ability to practise medicine, the Panel considers that the conditions are necessary to protect members of the public and the public interest whilst these matters are resolved. It is therefore satisfied that the

imposition of the above conditions on your registration is a proportionate response to the risks posed by your remaining in unrestricted practice.

In deciding on the period of 18 months, the Panel has taken into account the uncertainty of the time needed to resolve all the issues in this case.

The order will take effect today and will be reviewed within six months, or earlier if necessary.

Notification of this decision will be served upon you in accordance with the Medical Act 1983, as amended.

Dr Barton and Mr Langdale that concludes your case today. Thank you very much for coming to assist the Panel. Can I also thank your husband for coming here. I know it is not easy, it is not very good news but thank you for coming to support your wife today.

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GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF: BARTON, Jane Ann

PROCEEDINGS

THE CHAIRMAN: Good morning everyone. May I formally open the proceedings. We move on to the case of Dr Barton. Dr Barton is present and is represented by Mr Jenkins, counsel, instructed by Mr Ian Barker of the Medical Union. Ms Fiona Horlick, counsel, instructed by solicitors to the Council, represents the Council.

Dr Barton, may I say first of all, I am conscious that you are currently on sick leave, and that you have recently undergone surgery. I do appreciate your being here today. If at any stage you feel you want a break, or need to take a temporary break, then please do not hesitate to say so. I do appreciate the fact that you have come along.

(Introductions made)

If there are no further points, then I will ask Ms Horlick to open the proceedings this morning, please.

MS HORLICK: This case involves the inappropriate prescribing to five patients at the Gosport War Memorial Hospital between February 1998 and October 1998, five patients whose ages range between 75 and 91, and who all died at the hospital. Dr Barton at the material time was a general practitioner and also a clinical assistant in elderly medicine at the hospital.

To give the Committee some idea of the history of the case, the police began an investigation into the circumstances of the death of one of those patients, Gladys Richards. That investigation later extended to four other patients. The Interim Orders Committee has considered this matter, as you have already said, on two occasions before. Firstly, June 2001, when it was considering only the matter of Gladys Richards and on that occasion no order was made.

In February 2002, the Crown Prosecution Service decided not to proceed with the criminal proceedings. Then the Crown's papers were disclosed to the General Medical Council and thus the matter came before the Interim Orders Committee again on 21 March this year, and again no order was made.

The present position as I understand it is that the Crown Prosecution Service is reconsidering their original decision and there always remains a possibility that there may be proceedings in relation to one or more of these patients. There has also been a PPC hearing which took place at the end of August this year. The PPC referred the matter on to the PCC but they made no interim order with regard to registration at that time.

THE CHAIRMAN: Sorry? They referred to the PCC?

MS HORLICK: They have, yes. So, in other words, what has changed in a sense is the fact that the matter is now being referred on to the PCC and the possibility of criminal proceedings has raised its head again. Thus the matter has been referred to this Committee for its consideration today.

The information in relation to these matters is set out in pages 4, 5, 6, 7 and 8. I will come on to facts in relation to those five patients. You will also have within your

bundle, inter alia, a report from Professor Ford, and I am going to refer to some of his conclusions whilst dealing with each of the patients.

May I deal first with the patient Eva Page. She was admitted to the Dryad Ward which was one of the wards in which Dr Barton worked on 27 February 1998. She came under the care of Dr Barton. She was there for palliative care. She had a possible carcinoma of the bronchus. She died on 3 March 1998. She was 87 years old. She had originally been admitted to the Queen Alexandra Hospital on 6 February 1998, after her condition deteriorated over the preceding five days.

On 7 February 1998, she was noted to have a low mood, to be frightened and X-rays showed a potentially malignant mass superimposed on the right hilum. On 12 February 1998 a management plan was set up, which was to give palliative care in view of her advanced age. On 16 February 1998, there was a gradual deterioration in her condition. She had no pain but she was confused and she was continued on antidepressants. It was on 27 February, as I have said, that she was transferred to the ward and came under the care of Dr Barton. On the day that she was transferred, Dr Barton wrote in the medical notes that she was transferred to Dryad ward, continuing care. Diagnosis of carcinoma of bronchus, 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 confirm that she had been admitted for palliative care.

On 28 February 1998, she was noted to be not in pain. She was administered Thioridazine and Oramorph. She was distressed.

On 2 March 1998, she was noted to be very distressed and Dr Barton noted that adequate opioids to control should be administered. She had fear and pain. Therefore 5 mg of diamorphine was administered by a syringe driver.

On 3 March 1998, a rapid deterioration of her condition is noted. Diamorphine, Midazolam was commenced by syringe driver. It is this prescription which is the subject of criticism by Professor Ford. She died on that day, death being recorded at 21:30. His criticism is that there was no indication that Eva Page was in pain or distress, and with a frail, elderly and underweight patient that prescription was potentially very hazardous and poor practice, but he concluded that it was probably for palliative reasons that it had been prescribed by Dr Barton.

Dr Mundy is another doctor who has made a report in this case and in relation to this case, he concluded that Mrs Page had a clinical diagnosis of lung cancer.

THE CHAIRMAN: Is there a page number?

MS HORLICK: I am sorry, madam. It is page 57.

> "There was no documentation of any pain experienced. When she was transferred to Dryad ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding symptom control and she was started on opioid analgesia, in my view, inappropriately."

He comments:

> "The prescription for subcutaneous diamorphine infusion again showed a tenfold range from 20 mg to 200 mg."

In his conclusion is:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

That is the conclusion overall. Can I deal secondly with Alice Wilkie. She died on 21 August 1998. She was 81. She had been admitted on 6 August 1998 to the Daedalus ward where Dr Barton worked. She had been admitted to that ward for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection. In fact, she had been admitted to the Queen Alexandra Hospital on 31 July 1998. She was found to have a fever. She was given intravenous antibiotics. By 3 August the fever had settled and she was improving. She had severe dependency needs but on transfer to the Daedalus ward it was noted that her bed should be kept at her care home.

The nursing notes state that she was transferred to the Daedalus ward for a four to six week assessment and observation and then a decision would be taken about placement. In other words, it was intended that she would leave Daedalus ward to go back to some form of care home.

On 10 August it was noted that she was eating and drinking better and that she would be reviewed in one month, and if there was no specific special medical or nursing problem she would be discharged.

The next entry in the notes is by Dr Barton on 21 August.

THE CHAIRMAN: Can we have a page, please?

MS HORLICK: Page 79. There it is noted by Dr Barton:

> "Marked deterioration over last few days. Subcutaneous analgesic commenced yesterday. Family aware and happy."

A final entry on the same day is at half past six in the evening when death is confirmed but there had been no entry that Mrs Wilkie had been in pain on 20 August or in the preceding days, and no analgesic drugs had been administered to her before. It appears that Dr Barton had prescribed a regular daily prescription of diamorphine, 30 mg over 24 hours, and Midazolam, 20 mg over 24 hours. That had been started to be prescribed to Mrs Wilkie from 13:50 on 20 August, therefore the day before she

died. They were administered to her again on 21 August. There was no indication for the use of those drugs, no explanation as to why, and Professor Ford notes that it was poor practice, potentially very hazardous in a frail, elderly and underweight patient, and it could result in profound respiratory depression, and her death was possibly due, at least in part, to respiratory depression from the diamorphine, or that diamorphine led to the development of bronchopneumonia.

Dr Mundy comments on this patient at page 55 of the bundle. He said:

> "There was no clear indication for an opioid analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours."

Can I now turn to the matter of Gladys Richards, which was the matter originally investigated by the police. Madam, I am looking here at page 62.

She had been 91 years old when she was admitted as an emergency to the Haslar Hospital on 29 July 1998. She fractured the right neck of her femur. She had dementia. There had been a deterioration in the quality of her life over the previous six months. She had surgery for the fracture on 30 July 1998 and she was then referred to Dr Reid, who is a consultant physician in geriatrics on 3 August 1998. He concluded that despite dementia, she should be afforded the opportunity to remobilise her.

On 10 August 1998, just prior to her transfer to the Daedalus ward, it was noted:

> "[She] 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 a meantime she want the toilet. Occasionally incontinent at night, but usually wakes."

The following day, 11 August, she was transferred to the Daedalus ward. On that date, Dr Barton had written 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 nursing notes recall that she is now fully weight bearing and walking with the aid of two nurses and a Zimmer frame. However, on 12 August, the notes recorded that a little before midnight she had been very agitated, shaking and crying. Did not settle for more than a few moments. However, she did not seem to be in pain.

It seems the following day that she had been found on the floor at 13:30. No injury was apparent at the time but her right hip was internally rotated, and another doctor had been contacted for an X-ray.

On 14 August, Dr Barton had noted that sedation and pain relief had been a problem. Screaming was not controlled by haloperidol but very sensitive to Oramorph. Dr Barton had also proposed the rhetorical question, "Is this lady well enough for another surgical procedure?" It seems that she was, because she was readmitted to the Haslar Hospital. The hip was manipulated under sedation, and that was successful. She was discharged back again to the Daedalus ward on 17 August. Again it was noted that although she had been given a canvas knee-immobilizing splint which must stay in situ for four weeks, she could however mobilise full weight bearing. But the nursing notes on that day record that when she had been transferred back she had been very distressed and appeared to be in pain. Later that day, she had been given Oramorph 2.5 mg in 5 ml. A further X-ray was performed which demonstrated no fracture, so that was not the source of the pain. Pain demonstrated. Dr Barton had also noted that on 17 August, the day of transfer back, she had been under i/v sedation during the closed reduction. She remained unresponsive for some hours and –

> "... now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again."

On 18 August, it was noted she was still in great pain, nursing a problem.

> "I suggest subcutaneous diamorphine, haloperidol/Midazolam. I will see daughters today. Please make comfortable."

The nursing notes say that she had been reviewed by Dr Barton for pain control via syringe driver. It was further noted that she reacted to pain when being moved.

On 19 August, the nursing notes recorded that she was comfortable and she was apparently pain free. There appear to be no notes at all for 20 August, but the next entry is Dr Barton's on 21 August, where she records:

> "much more peaceful. Needs hyoscine for rattly chest."

She recorded as her overall condition deteriorated.

> "Medication keeping her comfortable."

The time of death is recorded as being 21:20 later that day. The cause of death was recorded as bronchopneumonia.

One can see set out on page 64 the dates and times of the various medication and opiates that were given to her during her time on the ward.

Dr Barton's treatment is criticised by Professor Ford. He says that even in a woman of Mrs Richard's age, there were good reasons to offer surgery for the fractured neck of the femur because without it, the patient remains immobile and nearly invariably develops serious and usually fatal conditions. He notes that Dr Reid believes that she had potential to benefit from rehabilitation, and that would have been implicit in her transfer to the Gosport War Memorial Hospital to receive rehabilitation there. It seems that Dr Barton did not appreciate that that was the reason for her rehabilitation and one knows from the papers that Dr Barton made a statement to the police. She

was asked about her entry on initial transfer to the Daedalus ward, the entry which said, "I am happy for nursing staff to confirm death," when Mrs Richards had been apparently transferred from rehabilitation. Dr Barton told the police that she appreciated there was a possibility that Mrs Richards might die sooner rather than later, and regarded the admission as a holding manoeuvre.

Professor Ford sets out reasons why Dr Barton's approach to Mrs Richards might well have been different to Dr Reid's. He concludes at the end of paragraph 2.18 that Dr Barton's experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

In paragraph 2.19, he sets out Dr Barton's explanation for the administration of drugs to Mrs Richards. He criticises some of her conclusions. He says that screaming is a well-described behavioural disturbance in dementia. It can be due to pain, but is often not. He concludes that there was not a proper clinical examination of the reason for the screaming because of course, he says, if the screaming had been worse on weight bearing or on movement, that would have provided supportive evidence that screaming was from pain, as opposed to dementia.

He notes that Mrs Richards had not been prescribed opiates before she was transferred to the Daedalus ward, he says:

> "This makes me consider it probable that Dr Barton prescribed ... Oramorph, diamorphine, hyoscine, and Midazolam when she first saw Mrs Richards and she was not in pain."

He said:

> "I do not consider it appropriate to administer intermittent doses of Oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. ... 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."

He also criticises the fact that there are no notes of fluid or food intake after Mrs Richards was readmitted to the Daedalus ward on 17 August, and between that and her death on the 21st. He says that although there were no clear descriptions of her conscience 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 seems that she was not offered fluids or foods, and intravenous or subcutaneous fluids were not considered as an alternative. He says the decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards on initial admission to the Daedalus ward was, in his opinion, inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression.

The prescription of oral paracetamol and my Lady opiates would have been appropriate and would have had 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. It goes on to explain why. He says:

> "The prescription by Dr Barton on 11 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 effect 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 is high risk of producing respiratory depression or coma"

He goes on in paragraph 2.27 to consider Dr Barton's statement in relation to the use of Midazolam which he said was inappropriate.

Dr Barton made a statement to the police in relation to this matter which is in your bundle. At the end of it, she says ---

THE CHAIRMAN: Page number, please? Is it page 153?

MS HORLICK: It is page 153 – thank you, madam. At the end of that, at page 162, paragraph 38, she says:

> "At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have an incidental effect of a hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose."

At paragraph 39, she says similarly:

> "Similarly it was not my intention to hasten Richards' death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly."

She did not believe that transfer to another hospital would have been in her best interests.

I now turn to Mr Cunningham. Mr Cunningham was 79 years old. He had had Parkinson's disease since the mid-80s. By July 1998, he had Parkinson's disease, dementia and depression. When he was seen on 21 September 1998 in the Dolphin Day Hospital by Dr Lord, she recorded that he was very frail, tablets had been found

in his mouth, he had a large necrotic sacral sore with thick black scar. His Parkinson's disease was no worse.

THE CHAIRMAN: Is this page 72?

MS HORLICK: It is, madam, yes. He decided to transfer him to do Dryad ward on that day. The entry by Dr Barton on 21 September says:

> "Make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death."

She decided to prescribe and administer diamorphine and Midazolam by subcutaneous infusion on the evening of 21 September, so the evening of the day that he was admitted. Professor Ford's opinion of that, at paragraph 3.10 was that he considered 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"

– apparently underlined –

> "doses of Oramorph earlier in the day. I consider the undated prescription by Dr Barton of subcutaneous diamorphine..."

and he gives the amounts –

> "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."

Apparently it had been prescribed and administered for pain relief and to allay anxiety but there was no clear recording that Mr Cunningham was in pain or, indeed, where the site of the pain was, if it existed.

On 23 September, it was noted that he had been chesty overnight and deteriorated. Professor Ford's conclusion is:

> "The symptoms could have been due to opiate and benzodiazepine induced respiratory depression. The family were told that Mr Cunningham was dying."

But on 24 September 1998, Dr Lord reviewed him and he was apparently in pain. On 25 September dosages were increased threefold. There was no record of Mr Cunningham receiving food or fluids since his admission to the Daedalus ward on

the 21st despite the fact that Dr Lord had prescribed a high protein diet for him when she transferred him to the Dryad ward. He died on 26 September, a little before midnight. The cause of death was recorded as bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer.

Professor Ford was also concerned about the initial note entered by Dr Barton on 21 September, that she was happy for nursing staff to confirm death, because – as he says – there was no indication by Dr Lord that Mr Cunningham was expected to die"

THE CHAIRMAN: I am sorry to interrupt. I am slightly confused because on page 72, it is suggested that Dr Lord had made that entry. I take it you are saying that that is wrong. It is paragraph 3.2.

MS HORLICK: I think there had been a further entry by Dr Lord on the 21st, saying that she was happy for nursing staff to confirm death. It was when Mr Cunningham was admitted to the Dryad ward on 21 September, having seen Dr Lord in the Dolphin Day Hospital. It was on that day that Dr Barton was recording, "Am happy for nursing staff to confirm death."

THE CHAIRMAN: I am sorry. I see they are both recorded.

MS HORLICK: Yes. I think Professor Ford's point was that there was no indication on the day that he was first admitted that there would be any indication of death ensuing in the near future. Professor Ford notes that it is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present, or from the combined effect of bronchopneumonia and drug induced respiratory depression as a result of the drugs which had been prescribed to him.

Dr Mundy comments upon Mr Cunningham's case at page 54. He says:

> "All the prescriptions for opioid analgesia are written in the same hand and I assume they are Dr Barton's prescriptions ... Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral morphine, the 24 hour dose requirement of diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience."

- just in parenthesis, one which is common to Dr Barton's prescriptions in all these cases.

> "The patient was reviewed by Dr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view, morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication."

Lastly, might I turn to Robert Wilson. I will be referring to notes on page 83. Mr Wilson was a 75 year old man. He had been admitted to the Queen Alexandra Hospital on 22 September 1998. He had a fracture of the left humerus. Morphine had been administered to him intravenously and then subcutaneously but he developed vomiting. Two days later, when he was given 5 mg of diamorphine he had lost sensation in the left hand. Five days later, it was noted that he had poor quality of life and poor prognosis, and he was not to be resuscitated.

However, by 7 October he had apparently stated that he did not want to go to a residential home and wanted to go home. Although he had previously been sleepy, withdrawn and in a low mood, when he was seen by Dr Lusznat, the consultant in old age psychiatry on 8 October, he was much better. He was eating and drinking well, and appeared brighter in mood. His Barthel score was 5/20. It was noted that he had been a heavy drinker over the previous five years and that he had possible early dementia, Alzheimer's disease or possible vascular dementia.

On 13 October it was noted that he required both nursing and medical care. He was at risk of falling and that what would be appropriate would be a short spell in long-term NHS care.

On 14 October he was transferred to the Dryad ward. An entry on the same date by Dr Barton reads:

> "Transfer to Dryad ward continuing care. HPC fracture humerus, needs help with ADL ... hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation."

I think here it is recorded as being 16 November, but that must be wrong because he had died by then. On 16 October, the notes record that he declined overnight, and gave details of that. He had a possible silent myocardial infarction and Dr Barton had written a prescription for subcutaneous diamorphine, hyoscine and Midazolam and that was administered to him on 16 October. Again, this is a course of action criticised by Professor Ford.

I am looking at paragraph 5.12. He says:

> "I am unable to establish when Dr Barton wrote the prescription .... 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."

He says it is an inadequate response to Mr Wilson's deterioration.

In the following 48 hours, the increase of diamorphine was from 40 mg/24 hours and then 60 mg/24 hours. At paragraph 5.13, Professor Ford says that that increase was 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 40 mg/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."

He notes that there were no justifications for those increases in those three drugs written in the medical records.

On 17 October, Mr Wilson was noted to have deterioration variously described in one place as rapid and another place as slow, but on 18 October there had been a further deterioration and his death was recorded at 23:40 that night.

Dr Mundy again comments on this case at page 56. He says:

> "Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given..."

and he notes that there was an entry earlier in the episode of care that Mr Wilson had refused paracetamol.

> "No other analgesia was tried prior to starting morphine."

He notes that once again, the diamorphine prescription had a tenfold dose range as prescribed. He also considered that the palliative care given was appropriate.

Professor Ford, on page 53, sets out sets out the appropriate use of opioid analgesics. He says:

> "Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain."

THE CHAIRMAN: I have not interrupted you before but...

MISS DOIG: It is surely Dr Mundy?

MS HORLICK: Dr Mundy, yes.

THE CHAIRMAN: I have let you go to some detail in the cases you have gone through, but I think you can assume that we have read the papers. I think if you could perhaps summarise rather than read the papers it would be helpful, and just pick out the points you think are particularly worth stressing.

MS HORLICK: Dr Mundy, as I am sure you have read, sets out the way that treatment should be given, and what should be tried before going on to a further treatment. His conclusion in relation to these cases can be found at page 57:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

They had not been given for long enough to ascertain the appropriate dose. Professor Ford also draws conclusions at the end of his report at page 59. He makes certain criticisms of Dr Barton's prescribing at the end of that report, and as detailed in the middle of it, as I have already set out.

THE CHAIRMAN: I think his conclusions are at page 93 and 94.

MS HORLICK: Yes, they are. Thank you, madam. Just to bring matters up to date, there is a letter from Dr Barton's solicitors which can be found at page 404, from the Medical Defence Union. That letter sets out in some detail Dr Barton's response to these allegations which I am sure the Committee has read. It is obvious that Dr Barton has ceased to provide medical care for the adult patients in the hospital, and she has voluntarily stopped prescribing opiates and benzodiazepines. As I said at the beginning, these matters have been considered before but the change in circumstances is the possible reconsideration of the matter by the Crown Prosecution Service, and the fact the matter has gone to the Professional Conduct Committee for their consideration.

THE CHAIRMAN: Do you have any recommendations?

MS HORLICK: No, madam.

THE CHAIRMAN: Can I just be quite clear about the sequence of events here? You referred to two previous IOC hearings?

MS HORLICK: Yes.

THE CHAIRMAN: Am I right, the first one, I think you said, was in June 2001, and only considered the case of Gladys Richards?

MS HORLICK: That is right, yes.

THE CHAIRMAN: The second one in March this year, did it consider all five cases?

MS HORLICK: Yes, it did.

THE CHAIRMAN: And the PPC hearing on 29 August, did they consider all five cases and the papers that we have today?

MS HORLICK: As far as I am aware, yes.

THE CHAIRMAN: And the referral back to the IOC now did not come from the PPC?

MS HORLICK: No, madam.

THE CHAIRMAN: It came from the President?

MS HORLICK: That is right.

THE CHAIRMAN: And you are saying it is because the CPS have now re-opened. I forget your wording.

MS HORLICK: They are reconsidering their original decision not to pursue the criminal ---

THE CHAIRMAN: But we have no papers to give us confirmation of that, or to give us any further... I am just trying to be clear how the situation has changed. So the only change has been that we have information, we know not how we got it, that the CPS are reconsidering.

MS HORLICK: That is right, although, as I am sure Mr Jenkins will tell you, the defence have been in contact with the officer in the case who is happy with the original decision that was taken by the Crown Prosecution Service not to proceed with the criminal proceedings. But, of course, it is not a decision which is taken by the police. It is a decision which is taken by the Crown Prosecution Service, whether to institute or discontinue proceedings.

THE CHAIRMAN: We do not know why the situation has changed?

MS HORLICK: My understanding is that the families of the patients involved were unhappy about the decision which was originally taken. You will notice in your bundle that they have written letters directly in the very recent past to the General Medical Council, to make complaints about the way that their parents were treated. I think, to be fair to Dr Barton, there has been a degree of pressure brought upon the Crown in this case to reconsider the matter.

THE CHAIRMAN: That is helpful. Did you want to say anything?

THE LEGAL ASSESSOR: Is there no additional material or evidence since the last hearing of the IOC?

MS HORLICK: As far as I understand it, there is no additional material.

THE CHAIRMAN: Most unusual circumstances. Does any other member wish to raise any points of clarification? (No reply) I just wonder whether the Committee ought to have a brief in camera session before we go further.

THE LEGAL ASSESSOR: I wonder whether Mr Jenkins has anything to say about this?

MR JENKINS: Can I help you. It may be, after I have made the few remarks that I have to say, that may assist a short in camera deliberation.

Mr Barker, who sits besides me, who is the author of the letter that you see at page 404, setting out observations on behalf of Dr Barton, two days ago spoke to Chief Superintendent Watts, who is the head of CID with the Hampshire constabulary. He is coordinating the police investigation into these five cases. He is an experienced police officer. He has been producing a guide for police generally, investigating cases of alleged medical manslaughter. He is not a police officer who has no experience of looking at this sort of investigation, this sort of case.

The police originally investigated the case of Mrs Richards and you will see a reference, I think on page 13 of the bundle, to a letter to the GMC in August 2001, that Senior Treasury Counsel – that is a senior criminal barrister – was asked to look at the case and the evidence in relation to Mrs Richards. The advice provided to the Crown Prosecution Service, which informed the police decision, was that there was case to be prosecuted.

Police subsequently looked into the other four cases and the view that they took was that those cases raised similar issues to that of Mrs Richards. In their analysis – this comes from the attendance note of a telephone conversation between Mr Barker and detective Chief Superintendent Watts. The police analysis of those other cases was that it was the same, or raised the same issues as those that were raised in the case of Mrs Richards, and upon that basis the police took the view that there was no case to be raised against Dr Barton. Subsequently there have been, as my learned friend has suggested, concerns raised on behalf of family members, relatives and the police have decided to send the case papers to the CPS. They have not yet gone. The understanding that Mr Barker got from the conversation was that this was a case of back-covering – I can use that expression – by the police. The police were perfectly satisfied. They had no concerns. Because of concerns raised by family members, they thought, "We will get the CPS to check," and that is the basis upon which papers have been sent to the CPS. There is no new evidence. There are no fresh allegations, there is nothing else that the police have sent on to the CPS, essentially other than the papers that you have seen. Those are the same papers that were seen by the earlier Committee this year. Nothing – nothing – in reality has changed.

There is a lot more I would like to say if the Committee were going on to consider whether to impose conditions or other matters, but you have suggested you might want to deliberate shortly in camera.

THE CHAIRMAN: First of all, can I comment and then ask the Legal Assessor. We certainly have precedents where the Committee considered at this stage whether they wish to continue to hear further evidence. It strikes me, in view of what we have heard, that this might be a case where I should deliberate with the Committee to see if they wish proceed with the remainder of the full hearing, if I can put it like that.

MR JENKINS: Indeed.

THE CHAIRMAN: Legal Assessor, do you wish to comment?

THE LEGAL ASSESSOR: All I was going to say is this. Do you have any comments on the propriety - not the power but the propriety - of this Committee to consider again a matter on which the Committee has already decided without any fresh evidence at all?

In normal circumstances, you would say, if you like, it is res judicata, and I doubt whether that doctrine strictly applies to this Committee, but it may be something which the Committee should take into account.

MR JENKINS: The normal circumstance in which a case might be reconsidered is if there is some fresh evidence or change of circumstances. It is advanced by my learned friend that there is a change of circumstances because this case has been referred by the Preliminary Proceedings Committee to the Conduct Committee and also the papers have now been sent to the CPS. I say those are somewhat manufactured as a change of circumstances. It is not a real change of circumstances. If there was further evidence or if there was another basis of concern about Dr Barton's practice, then that might alter matters. To the extent that the Committee may be concerned that they are invited to review an earlier decision, I agree entirely with the suggestion that they should decline to do so. I know at least one member of your Committee today was on the Committee that considered the case last time. That is Mr Winton. It seems a little strange that he should be invited to review the decision that the Committee he sat on then looked at.

I am prompted – the suggestion of back-covering is not an appropriate one. The police would not agree it, but that may be the effect of what is happening. The police were satisfied. They conducted their own inquiry. These are experienced police officers who are familiar with the concept of the gross negligence/manslaughter in a medical context. They did not see the need themselves to send the case to the CPS for further investigation. They have now done so because of concerns raised by the family, but there is no fresh evidence to place before the CPS.

I do not know that that answers the point. It is a response.

THE LEGAL ASSESSOR: I think it suggests that your thoughts are rather similar to my thoughts. I would really advise the Committee that without fresh material it would be only in extreme circumstances that the matter should be reconsidered again. I do not see evidence that there are such extreme circumstances. It could be that if the Preliminary Proceedings Committee had referred it here as part of their process of sending it to the Professional Conduct Committee that would be a factor which this Committee could take into account, but that is not the situation.

MR JENKINS: The generality of the position is the same as it was before. Dr Barton has, as you know, retired or resigned the job she held at the Gosport War Memorial Hospital back in 2000. You will have seen reference to correspondence in the transcript last time that she resigned because she felt she was under-resourced and could not do the job properly. That position clearly still holds. She is not in a position where she is dealing with those who are terminally ill or in the very last stages of their life. She continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates.

The condition to which she agreed with the Health Authority - that she would not prescribe opiates or benzodiazepines - lapsed at the end of March of this year because there was initially a time limit put on it, and the Health Authority did not see fit to invite her to renew that undertaking. So as far as circumstances changing since the last hearing before the IOC, 21 March 2002, I think that is the only change. I am sorry: the

condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.

THE CHAIRMAN: Ms Horlick, do you want to make any comment on the last few exchanges?

MS HORLICK: Madam, no.

THE CHAIRMAN: I think we should go into camera. As I see it, there are two issues here. One is whether there is new evidence since the last IOC hearing which justifies this Committee hearing the case afresh. The evidence is simply that we have heard that the CPS are reopening. The second, I think, is simply that the PPC have referred the case to the Professional Conduct Committee. That is the new evidence bit. If we decide that this is a full hearing and we are considering matters, then it is within our gift, and we certainly have precedent, that we can make a decision on the case if we feel minded to do so without hearing the full defence submission.

MR JENKINS: Thank you. I can tell you, if you were to ask for my submissions, they would be brief. I would be reminding you of what appears in the letter at page 404, and the transcript of the evidence that Dr Barton gave on the last occasion. I know you a familiar with them.

THE CHAIRMAN: Thank you, Mr Jenkins. We will go the to camera. If it looks like we are going to be taking a lunch break before we conclude, then we will let you know, but I am not saying that at the moment.

PARTIES, THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA.

PARTIES HAVING BEEN READMITTED

THE CHAIRMAN: Before I read the determination, I am going to ask the Legal Assessor to repeat the advice he gave us in camera.

THE LEGAL ASSESSOR: I advised the Committee that in light of the fact that there was no new evidence before them it would be unfair to the doctor for the Committee to consider the matter any further.

DETERMINATION

THE CHAIRMAN:

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A

of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and the Legal Assessor's advice.

That concludes the case for this morning. Thank you for coming. I hope it has not impeded your convalescence too much. I appreciate it is stressful for you.

4

A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

B

Thursday, 21 June, 2001

C

Chairman: Professor MacKay

D

Case of:

BARTON, Jane Ann

E

F

Dr. J.A. Barton was present and was represented by MR A. JENKINS of Counsel, instructed by Solicitors to the Medical Defence Union.

MISS L. GRIFFIN, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.

G

H

MISS GRIFFIN: Sir, this case comes before you under the Conduct procedures. The nature of the case is set out at the beginning of your bundle as, in summary, one of unlawful killing. A police investigation is continuing and has not come to a determination as yet, in relation to whether or not any charges will be brought against Dr Barton.

The papers before you relate to a patient by the name of Gladys Richards, who was treated at the Gosport War Memorial Hospital in August 1998, where she died. Mrs Richards was born on Code A There is a short summary of her medical condition at page 57 from the Royal Hospital Haslar, Gosport, Hants, dated 10 August 1998, written by Sergeant Staff Nurse Curran.

The Committee can see that Mrs Richards had sustained a right fractured neck of her femur on 30 July 1998 whilst in the Glenheathers Nursing Home. She was admitted to the ward and had a right cemented hemi-artheroplasty, and was now fully weight-bearing, walking with the aid of two nurses and a Zimmerframe.

Her past medical history is set out in summary. She was deaf in both ears. She had had cataract operations to both eyes. She had a recent history of falls and was suffering from Alzheimer's, which condition had deteriorated over the previous six months. She had had a hysterectomy in 1955. Her allergies were set out and the drugs that she was currently taking.

The Committee can then see certain details set out as to her day-to-day living.

Straddling that document is a letter from Dr Reid at pages 56 and 58, dated 5 August 1998. Again, in summary it gives the Committee some information as to Mrs Richards' standard of health shortly before her death in 1998.

Sir, the complaint about Dr Barton is brought on the basis of the two statements at the beginning of your bundle. The first is from Mrs Leslie Lack, and the second is from Mrs Gillian MacKenzie, the daughters of the late Mrs Richards. I ask the Committee to pay attention to those careful, considered and detailed statements in coming to their conclusions today. Those ladies were extremely concerned about the standard of care and attention that was being paid to their mother while she was under the care of the hospital, and in particular Dr Barton. They speak about concerns as to the standards of the care assistants and their attitude towards their mother, and also the standard of care afforded tot heir mother by the nurses at the hospital and their level of communication. They also complained of the level of nourishment and hydration provided to their mother, particularly in the last days of her life.

It was the wish in particular of Mrs Lack that her mother be transferred back to the Haslar Hospital, from where she had been transferred to the Gosport War Memorial Hospital. It transpires that that hospital was willing to accept her, but that Dr Barton was reluctant to send her back. What was explained to the ladies shortly before their mother's death was that she had developed a haematoma after the successful manipulation of her hip after it had become dislocated. The suggestion was made at that stage that as she was in so much pain and had been receiving significant pain relief, that she should have some Diamorphine. The reaction of her relative was to

say that that was tantamount to a suggestion of euthanasia, and that was denied by the doctors.

The daughters repeated their request that their mother should be transferred. Dr Barton said that that would not be appropriate because their mother had suffered too much trauma for one day already, and that the hospital would seek to keep her pain-free that night.

The next morning, on return to the hospital, Mrs Richards' daughter was told that in effect nothing more could be done for their mother. They were told that the appropriate action would be a syringe driver with morphine to ensure that she had a pain-free death.

Their first information to that effect did not come from Dr Barton. However, they did speak to Dr Barton about it. Her attitude was that it was going to be "the kindest way" and that they were to expect as the next thing a chest infection. Certainly Mrs Lack and Mrs MacKenzie found that that latter comment was extremely insensitive.

It is suggested within the papers and within the medical notes that the daughters accepted the course of action of a syringe driver with the morphine. However, they maintain that it was something in effect that they submitted to and there was no question of their accepting that course in the knowledge that it would lead to their mother's death. What they wished was for her pain to be relieved. They believed her to be strong and to be fighting to recover.

It would appear that subsequently the syringe driver was put in place, that their mother received no nourishment in her final days, or indeed hydration. They did not see a doctor in the days immediately preceding their mother's death, and certainly at the point of her death there was no doctor present.

I understand that the death certificate refers only to bronchopneumonia and does not refer to the haematoma of which they had been told a couple of days previously.

It was Mrs MacKenzie's opinion that their mother had not been given a proper chance to make a recovery.

The medical notes begin at page 56. There are nursing notes that are copied on a number of occasions, but it is most convenient to turn to page 239 which shows a nursing care plan for 13 August 1998 through to 19 August 1998. That contains entries in relation to the drugs administered to Mrs Richards.

On page 240 there is a contact record, which begins with 18 August 1998. It sets out contact with the family. At one stage Mrs Richards' daughter is noted as being "quite upset and angry". On the morning of 19 August the Committee will see that the daughters were seen. The note reads: "Unhappy with various aspects of care. Complaint to be handled officially." On 21 August there is a note: "Patient's overall condition deteriorating. Medication keeping her comfortable. Daughters visited during morning." At the top of page 241: "Condition poor. Pronounced dead at 21.20 hours." The earlier part of that contact record is at pages 242-243.

Sir, in relation to pain relief there is a note on page 243 that on 18 August 1998 the patient was reviewed by Dr Barton for pain control by a syringe driver, and her treatment was discussed with both daughters. "They agreed to use of syringe driver to control pain and allow nursing care to be given."

Dr Barton's notes are copied at pages 222-223. The Committee may find some of them difficult to read. We have the benefit of a police statement by Dr Barton, however, in which she sets out the substance of some of those notes in typewritten form. The Committee will note in particular the note in the form of a rhetorical question: "Is this lady well enough for another surgical procedure?" That was made on 14 August 1998. Turning the page, the Committee will see on 18 August the first note, "still in great pain" continuing, "I will see daughters today; please make comfortable". On 21 August: "Much more peaceful" or "restful" and there is a reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

The doctor's statement provided by the Hampshire police is at the back of the document. The Committee will have regard to that in coming to their conclusions. In essence, Dr Barton refutes any allegation of wrongdoing in her care of Mrs Richards in the days leading up to her death.

Sir, it may be suggested that there has been significant delay in this matter coming before you. The statements of Mrs Flack and Mrs MacKenzie that were provided to us by the police were not forthcoming until 6 June 2001, as can be seen from page 6. This matter comes before the Committee at the first possible opportunity subsequent to the information being provided to the General Medical Council.

It is my submission that in this case it would not be appropriate to consider conditions on the doctor's registration; that in essence the facts in the papers raise such a significant concern about this doctor that this Committee ought to consider suspending her registration on an interim basis.

THE LEGAL ASSESSOR: The events took place in August 1998. Do we have any information about when the inquiry commenced?

MISS GRIFFIN: I understand that there was an initial investigation by the police which was concluded, and no action was taken at that time, on the advice of the Crown Prosecution Service. I know not the basis for that advice. Subsequently a complaint was made about the conduct of that investigation by Mrs Richards' daughters, and the matter has subsequently been re-investigated.

THE LEGAL ASSESSOR: Is it the second investigation that is being referred to in the letters at pages 4 and 5?

MISS GRIFFIN: Yes.

THE LEGAL ASSESSOR: The statements were taken in January and March 2000 by the police. The letter of 27 July on page 4 indicates that the investigation is ongoing and no charge is preferred. The letter at page 5, dated 20 September, says

that the investigation is ongoing and that a file will be submitted to the Crown Prosecution Service as soon as possible. The outcome was estimated to be unknown for three or four months. We are now a considerable distance ahead of that period. Are you aware whether a file has been submitted to the Crown Prosecution Service?

MISS GRIFFIN: I understand that it is within their remit, but no decision has been taken.

THE LEGAL ASSESSOR: Do you know whether or not, in the course of their investigation, the police have sought and obtained independent medical evidence to determine whether their case can be substantiated?

MISS GRIFFIN: Sir, we have provided the Committee with the evidence that was before the screener, and that is the only evidence that I have had sight of.

MR JENKINS: Can I deal with those queries now, because I have some information. You have been told that the daughters complained. They did complain; they complained about almost everybody. I put the facts baldly and try not to put any gloss upon it. You will see that they complained about the nursing home where their mother was, long before she came under Dr Barton's care. They complained about the first hospital. I do not think all the members of staff were complained about, but some of them were. They complained about this hospital where Dr Barton had charge of this patient.

The allegation appears to be a conspiracy to murder. It appears that everyone has put their heads together in looking after this elderly lady and agreed not to feed her and to give her a grossly excessive course of treatment. The sisters complained to the police and the police conducted an investigation, and that resulted in no action being taken. They then complained about the police who had conducted an investigation, and a second investigation has commenced. We do not have a result of that investigation. Those instructing me act for Dr Barton in the criminal investigation, and we therefore know that within the next few weeks there is to be a meeting between the police and the prosecution service and Treasury counsel instructed to advise the CPS, at which time we are told a decision will be taken. We know that expert opinion has been sought by those who investigate this matter. We have not seen a copy of the expert opinion, nor do we know what that opinion contains. We are certainly concerned at a very considerable delay. That is the background.

The first point I make on Dr Barton's behalf is that, plainly, there is no conceivable basis here for suggesting that the drugs that were prescribed and administered to this lady were inappropriate. There is no basis at all for saying that the level of drug prescribed was excessive for this patient. There was no basis for arguing that the Diamorphine that was prescribed and administered caused the death. Similarly, in relation to the hydration and the other aspects of care provided to this patient, there is no basis for saying that what was provided was inappropriate. There is no medical opinion, and there is no argument either that any failure to hydrate this lady caused her death. The sisters suggest that it was their understanding that the haematoma could have caused death.

Isle of Wight, Portsmouth and South East Hampshire Health Authority

NHS

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Direct Line
Direct Fax Code A

Our Ref: Code A

13 February 2002

Private & Confidential
Dr Jane Barton

Code A

Dear Dr Barton

Following our meeting last night I wish to set out the basis of our agreement. I have shared this letter with Dr Ian Reid since it relates, in part, to the Gosport War Memorial Hospital.

- We agreed that you would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital.
- We agreed that you would voluntarily stop prescribing opiates and benzodiazepines with immediate effect.
- We were unable to put a timescale on these restrictions but agreed to review the situation monthly.

In view of the anticipated press interest, the Health Authority and Portsmouth HealthCare NHS Trust have prepared a draft statement which we have attached for your perusal.

Many thanks for your co-operation.

Yours sincerely

Code A

p.p. Dr Peter Old
Acting Chief Executive
Email Address: Code C

Attachment

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Switchboard: 023 9283 8340
Direct Dial: 023 9283 5000

From Fax Number: 023 9283 5197

STRICTLY PRIVATE & CONFIDENTIAL FAX TRANSMISSION

TO:	Code A	
TO FAX NUMBER:	Code A	**DATE:** 15 March 2002
FROM:	Dr Peter Old	**PAGE 1 OF** 3

If you do not receive all pages of this fax, please phone 023 9283 5000 immediately
Thank you

MESSAGE:

As per our telephone conversation please find attached letters to Dr Jane Barton.

Regards

Peter Old

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

Case of
BARTON, Jane Ann [*Conduct Case*]

T. A. REED & CO

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

PROFESSOR NORMAN MACKAY in the Chair

Case of
BARTON, Jane Ann

DR BARTON was present and was represented by MR A JENKINS of counsel, instructed by the Medical Defence Union.

MR J LLOYD of counsel, instructed by Field Fisher Waterhouse, the Council's Solicitors, appeared in order to present the facts to the Committee.

[The Chairman introduced those present to Dr Barton and her legal representatives.]

MR LLOYD: Dr Barton was previously before this Committee in June of last year, when she was subject to police investigation into the death of an elderly lady by the name of Gladys Richards at Gosport War Memorial Hospital in 1998. The only evidence before the Committee in June of last year were statements taken by police from her two daughters, the medical notes of Mrs Richards and exculpatory statements by Dr Barton herself, and by Dr Lord, the consultant geriatrician of the ward to which Mrs Richards was admitted. Those documents appear at pages 7 to 278 of the Committee's bundle. There was at that time no independent medical expert opinion indicating any fault on the part of Dr Barton and, in those circumstances, the Committee found no grounds on which to make an order concerning her registration. The transcript of the proceedings is at pages 280 to 289 of the bundle.

As I say, at the time of that hearing the police investigation was still continuing, not only into the death of Mrs Richards but into the deaths of four other patients as well. The police subsequently received three experts' reports on these five cases: the report of Professor Livesley, which is at pages 294 to 327 of the bundle, into the case of Mrs Richards only; the report of Dr Mundy, which is at pages 328 to 334 of the bundle, which relates to the other four patients; and the report of Professor Ford, at pages 335 to 373 of the bundle, which deals with all five cases.

Having received advice from counsel, the police decided not to prefer criminal charges against the doctor, but the reports were forwarded to the Fitness to Practise Directorate in the light of very serious concerns raised about the standard of care given by Dr Barton and, in the light of those matters, it has been referred back to this Committee.

At the relevant time Dr Barton was working as a clinical assistant in elderly medicine at Gosport War Memorial Hospital. Can I deal with the reports, first of all insofar as they relate to Gladys Richards? Mrs Richards was a 91-year-old patient who was operated on for a fractured femur on 28 July 1998 and transferred to Daedalus ward at the hospital on 11 August 1998. She was further operated on on 14 August 1998 and returned to the ward on 17 August.

Professor Livesley's opinion is at pages 307 to 311 of the Committee's bundle. Perhaps I can summarise the opinions which I appear in those pages, I hope accurately. It says first of all that, despite recording that Mrs Richards was not in pain on 11 August 1998, she was prescribed wide dosage ranges of opiate and sedative drugs to which Mrs Richards was known to be sensitive. Secondly, when she returned to the ward on 17 August 1998 in pain, but not suffering any life-threatening condition, she was not given oral pain relief but continuous subcutaneous administration of diamorphine, haloperidol and midazolam from 19 August until her death on the 21st. During that time at no time did Dr Barton appropriately review Mrs Richards' condition. Also, thirdly, during this period there is no record of Mrs Richards being given fluids as food in an appropriate manner.

A So far as Dr Ford's report is concerned, he deals with this case at pages 341 to 347 of the Committee's bundle. I would ask the Committee to refer to the paragraphs at 345-6, "Evaluation of drugs prescribed and the administration regimens". I shall not read out passages from those paragraphs but I shall, if I may, refer to the summary conclusions at page 347, in which the doctor says,

B > "During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death".

C Perhaps I can move on to the second patient, Arthur Cunningham. He was aged 79 when he was admitted to the hospital on 21 September 1998, to attempt to heal and control pain from a sacral ulcer. His case is dealt with by Doctors Mundy and Ford. Dr Mundy's comments are at pages 330 to 331 of the bundle. Perhaps I can summarise his criticisms. He said, "Morphine was started without any attempts to control the pain with less potent drugs"; the use of a syringe driver was started without clear reason, and the dose of diamorphine increased without clear indication.

D So far as Dr Ford is concerned, his report into the case of Mr Cunningham is at pages 348 to 354 of the bundle. Again, may I refer the Committee, without reading it, to the passage which is headed "Evaluation of drugs prescribed" at pages 350, and the summary at page 354, which I will read if I may.

E > "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."

F Moving on to the case of Alice Wilkie, she was an 81-year-old lady who was admitted to Gosport on 6 August 1998 with urinary tract infection, complaining of pain, and she was prescribed diamorphine. Dr Mundy deals with this patient at page 331 of the Committee's bundle and his comments are these:

G > "There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given, and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed...initially was excessive and there is no evidence that the dose was reviewed prior to her death".

H Dr Ford deals with this at pages 355 to 358. His conclusion at 358 is this:

A

"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".

The case of Robert Wilson, aged 75. He was admitted to Gosport on 14 October 1998, having suffered a fractured arm. He was also known to suffer with alcohol abuse, gastritis, hyperthyroidism and heart failure.

B

Dr Mundy deals with that at pages 331 to 332. He has no significant criticism of Dr Barton.

Dr Ford is more critical at pages 359 to 363. Again I would refer the Committee to the "Evaluation of drugs prescribed and the administration regimens", and perhaps I can read some extracts from those paragraphs.

C

"The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate."

At paragraph 5.12,

D

"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".

Paragraph 5.13,

E

"The increase in diamorphine dose...is not appropriate...and potentially very hazardous. Similarly the addition of midazolam...was...highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive".

Finally, the case of Eva Page. She was an 87-year-old lady who was admitted to Gosport on 27 February 1998 for palliative care, having been diagnosed with possible lung cancer. Dr Mundy deals with her case at pages 332 to 333 of the bundle. He says that, in the absence of any symptoms relevant to the cancer and of any pain, she was inappropriately started on opioid analgesia.

F

Dr Ford deals with the matter at pages 364 to 368 of the Committee's bundle. Again, I ask the Committee to refer to his evaluation and to the summary at page 368. He says,

G

"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 3 March. In my view this was an inappropriate, potentially hazardous prescription".

H

That deals with the reports of those three experts.

The most recent developments in relation to the doctor's practice insofar as they relate to her hospital practice are revealed in letters from the NHS Trust, which are at pages 378 to 380 of the bundle. I would ask the Committee to have regard to those. They are both dated 13 February 2002.

It is clear that Dr Barton has entered an arrangement with the Trust, and we can see at page 380 that it has been agreed that she "would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital" and that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect". It would appear from page 378 that the arrangements that have been come to with her would be reviewed subsequent to this hearing.

So far as any conditions upon this doctor's registration are concerned, clearly the Committee will have regard to the issues of protection of the public and public confidence in the profession. It is our submission that it would not be appropriate that this doctor's registration should remain unrestricted, and that the voluntary arrangement into which she has entered should be formalised by conditions, perhaps along the lines of those imposed by the NHS Trust.

I know not whether the doctor has any private practice outside of her NHS practice, but it may be that the Committee would wish to consider imposing a condition which restricts her to NHS practice, for the purpose of her ongoing supervision. Those are my submissions on behalf of the Council.

THE CHAIRMAN: There may be questions from members of the panel.

MR WARDELL: Is your last point that you certainly are not seeking for the Committee to consider suspending this doctor? I wanted to clarify that.

MR LLOYD: It is a matter of course for the Committee, but I have taken instructions on it this morning to clarify the position. The position is as I have set it out.

MR WARDELL: There is another matter, and it may be that Mr Jenkins wants to develop this. I have no idea what is in his mind, but I wanted to seek clarification as to whether the Committee is entitled to know what is Dr Lord's role in this matter, as is set out in the Hampshire Constabulary letter which is in front of us at page 292. There is implicit criticism there of the consultant in charge. Are we entitled to know whether that particular consultant has been referred to the Council, or whether the police are continuing their investigations into him, or whatever? It may be that could be relevant to the part that this doctor has played relative to the consultant.

MR LLOYD: I can certainly say that, so far as any police investigations are concerned, they are concluded, and there are no police investigations ongoing into Dr Lord. I wonder if I may take instructions on the other matter? [*Having taken instructions*] I have no instructions on any other action taken against Dr Lord.

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, I want briefly to go through your *curriculum vitae*. The Committee will see from the front page of their blue papers that you qualified with the degree MB BCh 1970 in Oxford and that your home address is in Gosport. If we turn to page 266 of the bundle, we can see a statement produced by you to the police at a stage some months ago. I want to go through it with you, if we may.

You say in the second paragraph there that you joined your present GP practice, initially as an assistant, then as a partner and, in 1988, you took up the additional post of clinical assistant in elderly medicine on a part-time session basis. You say the post originally covered three sites but, in due course, was centred at Gosport War Memorial Hospital. You retired from that position this year. I think you retired in the spring 2000, is that right?
A Yes, that is right.

Q How many sessions were you doing at the War Memorial Hospital? I think we have the answer at paragraph 4, but I will just ask you about it. Tell us how many sessions you were doing.
A The health care trust allocated me five clinical assistant sessions, of which one and a half were given to my partners in the practice to cover the out-of-hours aspect of the job; so that I remained with three and a half clinical assistant sessions in order to look after 48 long-stay geriatric beds. I would visit each of the wards at 7.30 each morning, getting to my surgery at nine. Towards the end of the time doing the job, I was back very nearly every lunchtime to admit patients or to write up charts or to see relatives. Quite often, especially if I was duty doctor and finished my surgery at about seven in the evening, I would go back to the hospital in order particularly to see relatives who were not available during the day because they were working. That became a very important time commitment in the job.

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord was trying to cover both wards as well as her commitments on the acute side and the other hospital in the group, and found it very difficult to be there very often.

Q I will break it up and take it in stages, if I may. You would be there from 7.30 to nine o'clock each weekday morning, is that right?
A Yes.

Q You have mentioned two wards. One was Daedalus; the other was Dryad ward.
A Yes.

Q Were you in charge of both of the wards?
A Yes.

Q How many beds were there?
A Forty-eight in total.

Q Over the period with which this Committee is concerned, what was the level of occupancy typically of those 48 beds?
A We were running at about 80 per cent occupancy, but of course that was not enough for the health care trust towards the end of my time there. They attempted to increase it up to 90 per cent, which is running a unit very hot, when you have one part-time jobbing general practitioner and no increase in resources of nursing staff, support staff, OT and physio, and no support from social services.

Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

Q So yours was the medical input?
A Mine was the medical input.

Q Between half-past seven in the morning and nine o'clock each weekday morning.
A Time to see each patient, to actually look at each patient, but not time to write anything very substantial about very many of them.

Q If you wanted to see relatives, were you able to see relatives at those early hours in the morning?
A No, except for that one particular case where they spent the night in her single room with her, with their notebooks. Generally, relatives preferred to see me either at lunchtime or in the evening. I would see them in the morning if it was that urgent, but it was generally not appropriate.

Q When you first started this job in 1988, what was the level of dependency typically of patients who were under your care?
A This was continuing care. This was people who – now, because their Bartell or dependency score is less than four, are a problem – went to long-stay beds and stayed there for the rest of their natural lives. So I had people that I looked after for five years, for 10 years, in these beds. The sort of people that I was given to look after in these beds generally were low dependency; they did not have major medical needs, but were just nearing the end of their lives. The analogy now, I suppose, would be a nursing home.

Q Did that position change as time went on?
A That position changed.

Q Tell us how.
A Continuing care as a concept disappeared. The National Health Service was no longer going to look after people who were as dependent as that. It was going to go into the private sector. I cannot give you an exact year, but it happened in the 1990s. At the same time, social services found that, with their budget constraints, they had difficulty placing people with a Bartell of less than four. So there was constant conflict between what we were supposed to be looking after and doing with the patients and what the private sector was going to take from us.

Q Just explain to us, what does a Bartell of less than four mean? What is the range of the Bartell scores?
A You or I have hopefully a Bartell of 20. That means we are able to take care of ourselves; do all the activities of daily living; cut up your food and eat it; go to the loo; change your clothes; walk about. Most of these people in the places mentioned have a Bartell of zero; I think one chap had one of four. So these were very dependent people.

Q That is an indication of the requirements made of nursing staff?
A Nursing requirements. They could not do anything for themselves, basically.

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on maternity leave, they made the decision not to employ a regular locum, so that I did not even have full consultant cover on that ward and so that Althea was left to attempt to help me with both, although she was not officially in charge.

Q Althea is...?
A Dr Lord, the other consultant.

Q Did she have other clinical commitments outside the two wards with which we are concerned?
A She had her acute wards up on the Queen Alexandra site; she had a day hospital and outpatients to run down at the St Mary's site in Portsmouth – so she was a very busy lady.

Q How often was she able to undertake a ward round on the two wards with which you were concerned?
A She did not ward rounds on Dryad ward. She came to Daedalus on the Monday to do a continuing care round. Towards the end of my job she designated six of her beds as slow stream stroke rehab' beds, and she did a Thursday ward round – which I could not always make because it was my antenatal day. She was in the hospital and doing outpatients on Thursday as well, so she was in my hospital twice a week – but available on the end of a phone if I had a problem.

Q You have told us that over a 10-month period there was no consultant cover at all.
A Yes.

Q That is 10 months during 1998, which is the period essentially within which the cases that this Committee have been asked to consider fall?
A Yes.

Q Were your partners in your GP practice able to help at all?
A My partners provided the out-of-hours cover – those who were not using Healthcall. They would admit patients who arrived from the district general hospital and see that they had arrived safely. They were in general unwilling to write up pro-active opiate prescribing or any prescribing for patients because they felt that I was the expert and it should be left to me to do it. I think they felt it was not part of their remit, providing cover for me, to prescribe for the patients.

Q So if anyone was to prescribe opiates or other forms of strong analgesic to patients, would it always be you?
A It was generally me.

Q We know that your time at the War Memorial Hospital was limited to the mornings, lunch times and evenings, when you told us you would see relatives. If you were not in a position to prescribe for the patient and the patient was experiencing pain, what provision was there for another doctor to write up a prescription?
A They would have to either ask the duty doctor to come in or they would have to ask the duty Healthcall doctor to come in. That is why, in one of the cases, you see somebody has written up "For major tranquillisers" on one occasion, because that duty doctor obviously either felt it inappropriate or was unwilling to use an opiate and he wrote up major tranquillisers instead.

The other alternative was, of course, that they would ring me at home. If I was at home – and I am only at the end of the road in the village – I would go in and write something up for them, outside the contracted hours.

Q You have said that your partners regarded you as the knowledgeable one about opiates and palliative care.
A Yes.

Q Tell us what your experience may be in those areas.
A In 1998 I was asked to contribute to a document called the *Wessex Palliative Care Guide*, which was an enormous document that covered the management of all major types of cancer and also went into management of palliative care and grief and bereavement. Each month, another chapter would arrive through the post for you to make comments on, contribute your experience to and send it back. This document was published in 1998 as the *Wessex Palliative Care Guide* and we all carry the *Wessex Palliative Care Handbook* around with us, which contains a sort of----

Q Is that it?
A Which you carry in your coat pocket. [*indicates document*]

Q You contributed towards that?
A I contributed to the writing of that and I am acknowledged in the thanks in the major document. I attended postgraduate education sessions at the Countess Mountbatten and also at the other hospice locally, The Rowans.

Q Just remind us, where is the Countess Mountbatten?
A The Countess Mountbatten is part of Southampton University Hospitals and it is in Hedge End, which is about 10 miles from Gosport. The Rowans is a similar distance in the other direction. I am still in very close contact professionally with both the director and the deputy director of Countess Mountbatten. I still go to their postgraduate sessions and I still talk to them about palliative care problems. They are always very available and helpful, and of course they provide district nursing, home care nursing input into our community, which is enormously helpful in general practice.

Q Are you – perhaps I can use the expression – up to date in developments locally in primary care and matters of that nature?
A I was also, at the time of these allegations, chairman of the local primary care group which, on 1 April this year, becomes a primary care trust, so that I was very involved in the political development of our district. I knew only too well that the health care trust could not afford to put any more medical input than I was giving them, on the cheap as a clinical assistant, into our cottage hospital at that time. I knew what the stresses and strains were on the economy and I knew where the money needed to go.

I could have said to them, "I can't do this job any more. It's too difficult; it's becoming dangerous", but I felt that I was letting them down. I felt that I was letting down the nursing staff that I had worked with for 12 years, and I felt that I was letting patients down, a lot of whom were in my practice and part of my own community. So I hung onto the job until 2000. In the thank-you letter I got for my resignation letter they said that I "would consider, wouldn't I, the three quarters of a million they were looking for, to beef up community rehabilitation services in the district" – which included replacing my job with a full-time staff grade, nine-to-five, every weekday in Gosport.

Q We will come to some correspondence shortly. After you resigned, your job was taken over by another doctor?
A Yes, a single, full-time staff grade. I hear on the grapevine that the bid has gone in for two full-time staff grades to do that job now.

Q Is this to do the job that you were doing within three and a half clinical assistant sessions?
A In three and a half clinical assistant sessions. It is just a measure of the difference in the complexity and the workload that is being put into a cottage hospital.

Q Can I ask about your note-keeping? You had a significant number of patients; it was at 90 per cent occupancy. Clearly that is----
A Between 40 and 42 patients, yes.

Q What time would you have during your clinical session to make notes for each of the patients?
A You could either sit at the desk and write notes for each patient, or you could see the patients. You had that choice. I chose to see the patients, so my note-keeping was sparse.

Q You accept, I think, as a criticism that note-keeping should be full and detailed?
A I accept that, in an ideal world, it would be wonderful to write full and clear notes on every visit you pay to every patient every weekday morning.

Q But the constraints upon you were such, I think, that you were not able to do so?
A Yes.

Q Were the health authority aware of your concerns as to staffing levels and medical input?
A Yes.

Q Were they aware of your concerns over the increasing level of dependency that patients had who were transferred to your unit?
A Yes. In the dreadful winter of 1998, when the acute hospital admissions – admissions for acute surgery and even booked surgery – ground to a halt because all their beds were full of overflow medical and geriatric patients, my unit received a letter asking us to improve the throughput of patients that we had in the War Memorial Hospital, accompanied by a protocol for the sort of patients we should be looking after: how they should be medically stable and everything like that. I wrote back to the then acting clinical director and said, "I can't do any more. I can't really even look after the ones that I have got, because of their dependency and medical needs. Please don't give me any more". I got a bland reply, saying that we were all going to try to help out with this crisis in the acute sector.

Q We will look at the correspondence. Can I come to nursing staff, your relations with them, and the experience of the nursing staff? Clearly you started 12 years before you retired. Did the number of nurses increase over the period of time that we are talking about?
A Marginally.

Q What about the level of experience of the nursing staff? The impression that we have is, towards the end of the period, you are dealing with patients who had very high dependency. Was the experience of the nursing staff raised in order to meet that increase in need?
A By an large they were the same people and they learned in the same way that I did: by having to deal with these more difficult needs. I do not think I can

A comment on how much input the Trust put into improving their skills. I think that would be inappropriate for me to do.

Q Perhaps I can ask this. Was it apparent that the Trust were seeking to raise the level of experience and qualification of the nursing staff in the War Memorial Hospital? And the answer should go on the transcript.
A Does it?

B

Q Was it apparent?
A It was not apparent that they were making any great attempts to improve the cover, the experience and the training of some of the nurses.

Q Were the health authority aware of your concerns, both as regards nursing
C levels and levels of medical staff?
A Yes. I did not put anything in writing until 1998 – or was it 2000?

Q I think it was 2000.
A 2000 -- but I was in constant contact with the lower echelons of management. Any remarks you made about the difficulties you were having, the worries you had and the risk of the patients you were covering, would definitely fall
D on stony ground.

Q You chose to prescribe opiates. It is something which is criticised by the experts whose reports are before the Committee. You chose to prescribe over a range, and quite a wide range, for certain of the opiates that we have seen.
A A professor of geriatrics in a teaching hospital, or even a big district
E general hospital, will have a plethora of junior staff. There will be never any need for any opiate dose to be written up for more than 24 hours, because somebody will either be on the end of the bleep or be back on the ward. That was not the case in Gosport War Memorial. If there was a weekend, if I was on a course, if I was on sick leave, if I was on holiday, I have already explained that there was not the cover for someone else to write drugs for me, and therefore I wrote a range of
F doses. I implicitly trusted my nursing staff never to use any of those doses inappropriately or recklessly. You will see from each of the documents that there is no question that any of these people received enormous amounts of opiate or benzodiazepine.

Q If the nurses wished to move from one level of administration of opiate up tot he next stage, but within the range that you had already prescribed----
G A They would speak to me.

Q How would that happen?
A Because I was in, if it was a weekday morning. I was on the end of the phone in surgery or, if I was at home and it was a weekend and they were worried, they would ring me at home. I did not have any objection to that.

H

Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
T A Reed & Co A I trusted them implicitly. I had to.

Q What we see again and again in the comments of Professor Ford and others is that the expert can see no justification for raising the level of prescribing. The expert in each case will have looked at the notes. Was there always recorded a justification for increasing the level of prescribing or the level of administration?

A Not always in my notes. I would hope that the nursing notes would be copious enough. In particular, interestingly, the night staff tend to make more of a full record of what the patient has been like through the night. It was quite often their feeling, night sister's feeling, that the patient was less comfortable or was beginning to bubble, or something like that, that would suggest to me that we needed to move up a step or in a step with the drugs we were using.

Q I will ask you to turn to page 370, which is the final couple of paragraphs of Professor Ford's report. Paragraph 7.5, two-thirds of the way down that paragraph, he says,

> "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".

What do you say about levels of nursing staff on the ward during the period with which we are concerned?

A He is absolutely right. These experienced, caring nurses had the choice between tending to patients, keeping them clean, feeding them and attending to their medical needs, or writing copious notes. They were in the same bind that I was in, only even more so. As you can see from the medical records you have had, the health care trust produces enormous numbers of forms, protocols and guidelines, and sister could spend her whole morning filling those out for each patient or she could nurse a patient.

Q He goes on,

> "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".

Do you have a comment on that?

A I agree entirely. There was inadequate senior medical input.

Q During 10 months of 1998 was there any senior medical staff input?

A No.

Q It is not apparent that Professor Ford was aware that you were doing three and a half sessions----

A In a cottage hospital.

Q ...in the cottage hospital.

A No.

A Q It may be that Professor Ford believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Dr Lord's medical notes – is absolutely correct. She was caring and thoughtful and considerate, and with a considerable workload – probably more than she should have been carrying. Therefore it is difficult to criticise. She did what she could, within the constraints that she had available to her.

B Q I am not going to go through the individual cases. This is not a trial; this Committee is not here to find facts proved or not proved. But I think it fair to you to invite you to comment on Professor Ford's next paragraph. He says,

> "...the level of skills of nursing and non-consultant medical staff" – it was only you – "and particularly Dr Barton",

C – the word "particularly" suggests he may have believed there were other medical staff –

> "were not adequate at the time these patients were admitted".

How do you respond to that?
D A I find it very upsetting. I was only a clinical assistant. The definition of a clinical assistant is in fact that it is a training post, and the only training that I received was that I went to get for myself as a part of my postgraduate learning, and I did my best at that time. In my opinion they were probably adequate.

Q Can we turn to the last page of the bundle, page 380? This is a letter
E dated 13 February 2002 and sets out matters that were agreed between you and the acting chief executive, Dr Old. Yes?
A Yes.

Q Attention has already been drawn to this document, but is it right that you agreed to cease to provide medical care, both in and out of hours for adult patients at the Gosport War Memorial Hospital?
F A Yes.

Q And you agreed voluntarily to stop prescribing opiates and benzodiazepines.
A I did.

G Q Had you not agreed those, were you threatened with any action?
A Dr Old told me that, under the change in Government legislation on 14 December last year, he was entitled to suspend me from general practice; but he did not wish to do that and, provided we came to this voluntary agreement, he would wait to see what the GMC had to say on the matter.

Q This is the same health authority who had been putting through a
H significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?

A This is the employers of the health care trust who had been putting through significant.... The health authority in fact purchase work from the health care trust and, theoretically, employ general practitioners. So this was my employer telling me that he could suspend me from the day job as well. So I agreed to the voluntary restrictions on my practice. At that time I had four patients in general practice on opiates and approximately 15 on any form of benzodiazepine.
B I handed the four patients over to my partners and said I felt no longer able to treat them. I no longer sign any prescriptions for sleeping tablets in general practice; the other partners do that for me.

Q You have given us the figures. Do you describe yourself as a high prescriber of benzodiazepines?
A I was quite surprised at how few of my patients got benzodiazepines from
C me.

Q And of those prescribed opiates----
A One was for terminal care. She went into hospital a couple of days after I was suspended and died there. The other three are maintained by the partners for longstanding chronic pain.

D Q Just to remind the Committee, in your statement at page 266 you say in paragraph 3,

> "As a general practitioner, I have a full-time position; I have approximately 1,500 patients on my list".

E A Yes.

Q The Committee can see, of the 1,500 patients, precisely how many are prescribed benzodiazepines and/or opiates.
A Yes.

Q [*To the Committee*] Sir, we have a small bundle of correspondence. I am
F sorry that you have not been given it in advance.

THE CHAIRMAN: We will refer to it as D1. [*Same handed*]

MR JENKINS: Sir, we are giving you a number of letters. I am happy if they are collected in D1, or we can number them sequentially.

G

THE CHAIRMAN: I assume they have been circulated. Shall we put them in chronological order?

MR JENKINS: I would be happy with that. The first letter you should have is one dated 16 February. It is from the consultant physician, Dr Jarrett. He talks of a "bed crisis at Queen Alexandra Hospital continues unabated". "It has fallen on
H us", he says,

A "to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some under-utilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post-acute patients. A policy offering guidance is enclosed".

You should see a document, enclosure 2, "Emergency use of community hospital beds". You will see it reads,

B

"Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals".

C Can I break off and remind the Committee, this relates to the year 2000. The situation with which you are concerned for the five patients whose records you have were treated in 1998. So this is after, but we hand these documents to you to give you the continuing picture. You will see,

"Therefore patients referred to these beds for post-acute care should be:

D

1. Waiting for placement...
2. Medically stable with no need for regular medical monitoring...",

and the other matters that you see listed.

The next document is a letter from Dr Barton dated 22 February to Dr Jarrett. The letter reads,

E

"I was very disappointed and also quite concerned to be shown a letter from yourself dated 16 February on the subject of the bed crisis at Queen Alexandra and addressed to the various ward managers and sisters.

F Less than a month after I wrote a letter to the clinical director expressing my concerns about the situation in our continuing care unit, I find that we are being asked to take on an even higher risk category of patient.

These post-acute patients have a right to expect a certain standard of medical care, appropriate levels of therapy and supervision, and appropriate out-of-hours cover during this period of time in hospital.

G

I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards, and the other consultant cannot be expected to provide anything other than firefighting support during this time.

H As a result, I am unable to do the clinical assistant job to a safe and acceptable standard, which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my

staff are subjected to ever-increasing pressures from patients and relatives, causing stress and sickness levels to rise.

I would also question the term 'under-utilisation' in a unit which is handling approximately 40 per cent of the continuing care done by Elderly Services at this time".

The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

The next document is the one with the fax strips down the centre of it. It is a letter from Dr Barton dated 28 April 2000, tendering her resignation. It is addressed to Peter King, personnel director, and it reads as follows:

"Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example, on one of the wards I will only be having locum consultant cover until September. In addition, an increasing number of higher risk 'step down' patients continue to be transferred to the wards, where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation".

You will see a reference to the original contract of employment in 1993.

The last letter, dated 19 May from Fiona Cameron, is one responding to the letter we have just read. The second paragraph reads as follows:

"I am writing to offer my thanks for your commitment and support to Gosport War Memorial Hospital over the last seven years. There is little doubt that over this period both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure".

Sir, that is the evidence I seek to place before you. I have called Dr Barton and, if there are questions for her, the Committee or Mr Lloyd may wish to ask those questions now before I go on to sum up, if I can put it that way.

THE CHAIRMAN: Mr Lloyd, do you wish to ask questions?

THE LEGAL ASSESSOR: I have no questions, sir.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who Code A who commenced her annual leave on 27 April 1998 and followed on with Code A leave from 1 June until 8 February 1999. So basically she was Code A and then she was gone for the rest of the year.

Q And no replacement or locum cover?
A No.

Q So you were in fact on your own in a training grade post?
A Yes.

MR WARDELL: I would like to ask some questions in order to have a feel for the 48 beds you were looking after with regard to patients. You mentioned the Bartell Score, that I am not familiar with at all but I am pleased that I am at 20.
A On a good day!

Q Absolutely! You said that the bed occupancy rate was about 80 per cent when you were there. Perhaps you were looking after about 38, up to 40 patients?
A Yes.

Q With regard to your looking after those patients, could you give us a feel of what you did? You said you were there for an hour and a half in the morning. Can you run through fairly quickly the typical kind of week you would have at the hospital?
A I would arrive as they opened the front door of the hospital at 7.30 and I would go straight to Dryad ward first. I would walk round the ward with the nurse who had just taken the night report, so it was the most senior nurse on. We did not, fortunately, have these named nurses at that point. I would stop by every bed and I would ask, "Are they in pain? Have they had their bowels open? Do I need to see the family? Is there anything I should know?". So I got a report at the foot of each bed. That was Dryad.

Daedalus liked to do it slightly differently, in that I did the report with the person who had taken the hand-over in the office, and then was invited to look at any patients they had concerns about. They preferred to do it in front of their paperwork. But the concept was the same: you went through all the patients in your care each morning, and that took until just before nine.

Q How many days a week did you do that?
A That was five. That was each weekday morning.

Q Was that your total involvement with the hospital?

A That is when it started. Generally, with the rate at which we were running admissions in 1998, I think an average week would contain five admissions. I had to try to get them to bring them down to my hospital before four o'clock in the afternoon. Lunchtime was better, because (a) they get very cold and stressed if you carry them round the countryside and bring them in after dark and (b) it gave me time to clerk them and to check whether any further investigations, bloods or anything needed doing, and to get them settled into the ward. So I would go back most lunch times, unless I had a PCG or purchasing meeting or something like that. In those days I was only on duty once a fortnight, but I would quite often go back in the evening if I felt there was somebody I was particularly worried about – to talk tot he relative or to support the nursing staff.

Q Mr Jenkins put in front of us a number of documents, including the second one, which is "Emergency use of community hospital beds". In point 7 there, the second sentence reads, "...this placement does not entitle patient to NHS continuing care".
A There was no such thing in 2000. If your condition became medically stable and you could persuade social services to either fund you or agree to have you at all, then you would be moved on – even though your dependency score might be very low.

Q In that period, say 1998 to 2000, were you experiencing dilemmas whereby – and I use the word "conspiracy" advisedly, because I have the evidence from a report that I chaired during that period when I was in another post in the House of Commons – in evidence we had it said that there was a conspiracy between social services, doctors and management with regard to trying to push people who were entitled to have NHS care out of hospitals into nursing homes, where they would have to pay out of their own resources? Were you in that horrible dilemma?
A If you knew anything about Gosport, you would realise that (a) there is not much potential for private practice and (b) there were not vast numbers of patients who were self-funding. Self-funders were not the problem then. If they were stable and social services would agree that they could go to a nursing home at all, that was not the problem. I would never conspire with anyone in social services.

Q I was not levelling that at you. I was just thinking about the dilemma, that if you had patients in beds, such as the patients you were dealing with, then they would be covered in terms of the NHS system----
A They were not.

Q They were not?
A They were not. They were not entitled to stay in any of those beds. In order to keep them in those beds, you had to write in the notes, "Requires ongoing medical care". Despite a Bartell of zero, if they required no further medical input and their medical condition was stable, you then had to find them a nursing home. But the sort of people we are talking about here were not going to become stable.

MR WINTER: You refer to raising concerns in 1998 verbally with lower levels of management about your working situation. Would you be prepared to say a little

more about what you actually did and whether you considered putting your concerns in writing at that point?
A I should have put my concerns in writing, because I was sitting on these strategic bodies. We were talking about how the health community was going to move forward, how we were going to improve step-down care, and how we were going to make available more beds for acute surgery so that the Trust achieved its waiting list targets and therefore its money from region. But I did not put anything in writing. I became increasingly concerned. I spoke to lower management, who probably did not even relay those concerns further up. I spoke to my clinical colleagues.

Dr Lord tried at that time to get more funding and was unsuccessful. The first time we got any extra funding was in 2000 when I resigned and we got an extra three-quarters of a million for St Christopher's and Gosport War Memorial to do more post-acute rehabilitation work. So they knew we were in trouble, but I did not go to print at that stage.

Q Could you say approximately how many times you raised these matters with people in lower management?
A Once every couple of months.

THE CHAIRMAN: I wonder if I might be allowed to ask a few questions, just so that I understand the situation? Am I correct in assuming that Gosport War Memorial Hospital is a stand-alone community hospital?
A It has no theatre facilities; it now has no A&E or minor injuries facility; it has a little X-ray department with basic, standard equipment in a Portacabin. It has a little outpatient department to which consultants come down from the centre to do peripheral clinics, and it has approximately 100 beds.

Q These are including the 48 long-term care beds?
A We have long-stay elderly medical patients; we have babies; we have a maternity unit and we have a small GP ward.

Q Can you tell me roughly what the average length of stay was in, say, 1989, about 10 years ago, and then in the later part of the 1990s? How had the average length of stay changed?
A I had patients I had had for five years. I had some very ill patients transferred from the Royal Hospital, Haslar, after orthopaedic surgery or transferred from the main unit because they lived in Gosport and their relatives lived in Gosport. But those were the minority. The majority of patients were long stay.

Q Was there a calculation of the average length of stay in the early 1990s?
A It would be difficult to do, because we also did shared care and respite care in those days. I was looking at the figures the other day. You would find it very difficult to get a feel for the average length of stay, but it was generally reckoned to be a good long time. Then in the late 1990s – I could not find any research on this subject, but there are two major risk times for these elderly transferred from a nursing home to an acute unit and then down to a long-stay

unit. They may well die in the first two, three days – something to do with the shock of being moved really makes them quite poorly. If they survive that----

Q While you do not have a specific figure for average length of stay, you are quite convinced that the dependency level increased over the decade?
A Massively, yes.

Q We are aware of how the Gladys Richards case came to the surface. It is not clear to me from the papers how the other cases were identified. Can you help me with that? [*Dr Barton conferred with counsel*]

MR JENKINS: Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Gladys Richards complained. What I said to an earlier Committee was that they complained about everybody, including the police officers who conducted the inquiry. They generated some publicity locally about their concerns, as a result of which relatives of other patients – and I think the four with which you are concerned – expressed concerns. I think that is how the police became involved in those other cases.

DR BARTON: The health care trust also decided to invoke CHI, the Commission for Health Improvement, and CHI produced a lot of local publicity saying, "If you have any concerns about your hospital, this is the phone number, these are the people to get in touch with". And of course I have no input as to how much and where they got their information from; but they must have received an enormous amount of positive and negative feedback from the people of Gosport.

THE CHAIRMAN: Technically, as a clinical assistant you did not carry ultimate responsibility for the clinical care of patients?
A No. You will see in a couple of the reports that we were using the Fentanyl skin patch for opiate pain relief. I was not allowed to sign for that. That had to be countersigned by a consultant. I was working for a consultant.

Q And the consultants under whom you worked reviewed the prescribing practices that you indulged in, did they?
A I do not know. Not with me.

Q So you did not do the ward rounds with the consultant?
A Yes.

Q You did?
A Yes, but no comments were made at any time at this point about reckless prescribing or inappropriate prescribing.

Q They did not raise any questions about the prescribing that was being done for these patients?
A They did not raise any concerns, no.

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.

Q Turning to page 380, I would also like some clarification. It implies in the first bullet point there that there is still some relationship to the Gosport War Memorial Hospital. What was the continuing relationship you had?
A In Gosport there is something called the Gosport Medical Committee, which is made up of all the practising doctors on the peninsula, which I think at the moment is about 36. We are employed by the health care trust to look after 20 GP beds upstairs from my erstwhile geriatric beds. We have admitting rights to those beds and we are allowed to look after our own patients. We are also invited to look after step-down patients from the acute unit. Although, as a GP you can be much more hard-nosed about refusing to accept somebody who you feel is beyond the capability of the hospital to look after than I could as a clinical assistant downstairs in the wards. That is why you will see something about, "a retrospective audit of your prescribing on the Sultan ward". That is, what I was doing – whether I was prescribing inappropriate opiates upstairs on the GP ward.

Q That has been helpful clarification. Was I correct in assuming – this is the second bullet point – that you told us this was in relation to your primary care duties?
A The voluntary stopping prescribing opiates?

Q Yes.
A Yes, I am not prescribing any opiates or benzodiazepines at the moment.

THE CHAIRMAN: I think these are the points I wanted to raise. Are there any further points from members of the panel? In the absence of further points, Mr Jenkins?

MR JENKINS: There is one, sir, and it was raised by Mr Lloyd. Do you have any private patients?
A No.

MR JENKINS: Sir, may I sum up very briefly? You may think that this is plainly an excellent and dedicated doctor. It may appear to you, and I would encourage this view on your behalf, that it may have been problems with the allocation of resources at the Gosport War Memorial Hospital which has led to a situation where best practice was not followed.

You will have to consider the reports of the various experts placed before you. You will have to consider as well whether they are considering Dr Barton's position as it was. I may have missed it, but it is not apparent from my reading of the reports that there is shown to be an understanding by Professor Ford and the other doctors that they were well aware that Dr Barton was working three and a half sessions; that she was effectively, during the period with which we are concerned, the only medical input into the care of these patients; that she had a significant number of patients to see and to evaluate and to continue to care for, in a very restricted period of time.

A You have to consider whether it is necessary for the protection of members of the public to impose conditions. I do not deal with the question of suspension because I say that it is plainly not appropriate in this case.

Is it necessary for the protection of members of the public to impose conditions? Dr Barton is no longer undertaking the job that she started in 1988. You know the reasons why. I say she poses absolutely no threat to members of the public, B either in her general practice or in any form of hospital medicine. She does not undertake any of the latter.

Is it necessary in her own interests to impose conditions? I say not. The last issue is whether it is otherwise in the public interest. You will know that there has been a police investigation, in fact two, arising out of the complaints in this case. C You will know the results of the police investigation: that a decision has been taken not to charge.

I repeat what I have said. It is slightly troubling that it is not apparent that the experts instructed by the police have been presented with the full picture of Dr Barton's clinical involvement with these patients before being invited to express a view. D But I say that it is not in the public interest either for this body to impose conditions upon this doctor in the circumstances in which you know she practises. She does not pose a risk to patients. It is not necessary in her interests, and it is not otherwise in the public interest.

If, however, you feel that because of police investigation, because of the possibility of press coverage, that it is necessary to demonstrate that this body is able to E make decisions, I would invite you to do no more than reimpose what Dr Barton has voluntarily agreed with the health authority.

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

F THE LEGAL ASSESSOR: The advice I give the Committee is as follows. They may make an order restricting this doctor's registration only if they are satisfied it is necessary to do so for the protection of members of the public, otherwise in the public interest, or in the interests of the doctor. In addition they must be satisfied that the consequences of any restriction that they might impose of her registration will not be disproportionate to the risks posed by the doctor remaining in G unrestricted practice.

Mr Jenkins, Mr Lloyd, unless there is anything else on which you would like me to advise the Committee, that is the advice I give.

MR JENKINS: Sir, I have mentioned the little green book with which Dr Barton has helped. I leave it with you.

H

THE CHAIRMAN: Thank you.

The parties withdrew by direction from the Chair and the Committee deliberated in camera.

The parties having been readmitted:

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the evidence before it, including the submissions made on your behalf.

The Committee has determined, on the basis of the information available to it today, that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 21 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-NINE)

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

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

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

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THE CHAIRMAN: Good morning everybody. Welcome back. Mr Kark, before we begin, can I for the record indicate that our Panel Secretary, Christine Challis, will be away for a couple of weeks and in that time we are going to be looked after by Lola Babatunde? Thank you.

JANE ANN BARTON, Re-called
Cross-examined by MR KARK, Continued

MR KARK: Dr Barton, I was going to turn to the issue of note making and I was going to be quite short about it because you have already made admissions in relation to those charges. May I ask you this? When did you first recognise that your note making was a problem? When did you first realise that you had insufficient time to make proper notes?
A I imagine that it started to become apparent to me after the first complaint made by the family in 1998, which resulted in a police inquiry in the year 2000.

Q Up until then you had not been aware that you had been making inadequate notes, is that right?
A I had not given it thought, otherwise obviously I would have attempted to address the problems sooner.

Q And you would have been well aware, in broad terms at least, that good medical practice required you to keep – I am going to read it out. It is at the back of our folder, Bundle 1 and you perhaps do not need to turn it up unless you want to. It provides,

> "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".

You accept, I think, that there were significant failings in your note making. Is that right?
A Entirely.

Q In some cases we have heard the patients arrived at your hospital without the previous hospital notes. Can I suggest to you that more often than not you did have the relevant notes for the patient and it was a small minority of patients where you did not have the previous hospital notes?
A Obviously at this remove of time I am unable to give you a percentage, but I would say that probably 75 per cent, everything arrived in order and with the correct x-rays and notes, and possibly 25 per cent meant that the transmitting hospital had to be contacted and they had to be asked for any relevant notes, drug charts and x-rays.

Q Where you did not have the previous hospital notes, it would make it even more important, would it not, to perform a proper and accurate assessment and make a note of it?
A Yes.

Q It would be important to record the patient's current condition, symptoms and signs, previous diagnosis and a plan of treatment.
A Yes.

Q So far as assessment of these patients is concerned, the initial assessment would not usually be done as part of your normal ward round, would it?

A The patients tended to arrive at lunch time, or unfortunately sometimes later on in the day, so that too much time would have elapsed to wait to clerk those patients in until the following morning, even if I had had time in that hour and a half to do a full clerking.

Q So you would return, as you told us, at lunch to do that.
A And sometimes later in the day to do that.

B Q When you talk about a "clerking in", would that also mean an assessment of the patient's condition?
A Yes.

Q When you were assessing a patient's condition, are you telling this Panel now that you would have done a full examination in each case?
A I am.

C Q So in every case we have looked at, you would have performed a full and proper examination?
A Except for two of them, one of whom I had watched Dr Lord examine him in the day hospital, and there was one gentleman who had been clerked in by Dr Ravi.

Q Absolutely right.
D A So there are two that I did not actually perform the initial assessment on.

Q But in relation to the other 10, when you clerked them in you would have performed a proper examination.
A Yes.

E MR LANGDALE: Just while we are on the figures, may I remind my friend that there is one other of course that Dr X clerked in. Just so we know.

MR KARK: My learned friend is quite right. I am grateful for the correction. Can you just help us, please, with what your practice was in making a full examination of a patient and assessing their condition? What would you actually go through?
F A The same formula that you had done since being a medical student, since being a house officer: examine the patient at the side of the bed; look at their general condition and then go through a system examination, albeit brief in some areas.

Q If you were aware that a patient had, for example, had a hip operation, would you have examined the wound site?
A If it was uncovered. Obviously I would not have asked the nurses to take the dressing down at that point in time, but I would have made myself available to look at it at another time if it was appropriate.

G Q You would also expect blood pressure to be checked?
A Yes.

Q Heart rate to be checked?
A Yes.

H

Q And you would have performed an examination of the chest and the lungs?
A Yes. I would have a nurse with me to help me sit the patient up or roll them over in order to examine the back of the chest, having listened to the front of the chest.

Q Again, we will look at our individual patients as we go through them and the notes that you made, but do you accept that you failed to make a note on those patients where you did clerk them in, of that examination?
A Yes.

Q If you were assessing a patient on a course of palliative care, would that minimise the necessity to make a full note?
A No.

Q If you were assessing a patient on a course of palliative care, it would be all the more necessary, would it not, to make a note of that decision and why it was made?
A I agree.

Q Can you turn to the 1991 issues raised by some of the nurses, please? These events back in 1991 – and we will look at the notes in a moment – must have caused you considerable concern.
A Yes.

Q You appreciate, I expect, that the matters raised first in July 1991 almost mirror the issues which have arisen in the cases that this Panel is examining? Do you want to have a look at them before you answer that question? Let us go to File 1, Tab 6, page 2.
A I think the issues were quite different in 1991. The issues were difficulties between existing night staff and a new day sister, and attitudes towards care of patients at the end of their lives.

Q Let us have a look at the concerns that were being expressed and see whether or not they are relevant to the issues that this Panel are now considering? Do you have page 2?
A I do.

Q The following concerns were expressed and discussed:

"1. Not all patients given diamorphine have pain".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used".
A I disagree.

Q Let me ask you the question. The issue of the sliding scale not being properly used is certainly an issue in this case, is it not?
A I agree.

Q "The drug regime is used indiscriminately, each patient's individual needs are not considered".

Do you accept that that is an issue that has been raised in this case?
A I do not agree.

Q Why not?
A Because my drug regime was not used indiscriminately. It was used perfectly appropriately in these 12 cases that we are looking at.

Q I understand that that is your case. But you understand that the suggestion is being made to you that in some cases people were being put on opiates quite unnecessarily. You understand that that is part of the case against you?
A Yes.

Q "4. That patients' deaths are sometimes hastened unnecessarily".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients' needs".

It has not been expressed in exactly those terms in this case, but there is the suggestion that once a patient was on a syringe driver, of the 12 that we have looked at, it was never reduced or adjusted down.
A Except in one case.

Q We will look at that.

"6. That too high a degree of unresponsiveness from the patients was sought at times".

You appreciate in this case that the allegation is that some patients were so over-dosed that they become wholly unresponsive, unconscious; yes?
A I do not agree with the fact that they became unconscious and unresponsive purely because of the dosage of the drugs.

Q Those issues were raised, and others, back in 1991, and you presumably were alerted to those quite quickly. Yes?
A I was aware that there was concern raised by the night staff.

Q Did you become aware that what the nurses' representatives wanted was a written policy?
A Not at that time. I thought that the issue had been resolved by Mrs Evans and the management team. It was only when one of the night staff was attending a course at Portsmouth University and came in contact with the Clinical Tutor, Code A that it became apparent that their concerns had not been fully addressed and the issue raised its head again.

Q These concerns bubbled on into December 1991, did they not?

A A Yes.

Q We can see if we go to page 18 of this section of the file that here is somebody called Code A Branch Convenor for the Royal College of Nursing, writing to Beverley Turnbull saying,

> "I think I have made it quite clear that unless you receive confirmation at your meeting that a policy will be drawn up which addresses all of the concerns that you first brought to Mrs Evans' attention back in July then a grievance will be lodged".

I have to confess that I am not quite clear what the significance of a grievance being lodged is.
A I was not at that time aware of that letter or what he was intending to do or not to do. That letter was not copied to me.

Q Were you aware that some of the nurses at least, and those representing them, wanted a written policy?
A No.

Q If we go to page 23, we can see that on 17 December 1991 you were present at a meeting with Mrs Evans, Dr Logan and a number of the nurses. Yes?
A Yes.

Q And none of the nurses in fact spoke out, did they?
A No.

Q If we go on to page 25, we can see just a summary of the comments raised during the discussion. All staff had great respect for you; did not question your professional judgment. The night staff present did not feel that their opinions of patients' conditions were considered before prescribing of diamorphine. The patients were not always comfortable during the day even if they had slept during the night. There appeared to be a lack of communication causing some of the problems. Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying, regardless of their symptoms. All staff agreed that if they had concerns in future relating to prescribing of drugs, they would approach Dr Barton or Sister Hamblin in the first instance".
A Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt that this was appropriate.

Q So far as you were concerned, did that resolve the issues that had been raised?
A I felt that the majority of the night staff were much more comfortable about how decisions about end of life care were being made on the unit and how they were to be involved in those, if at all possible.

Q When we heard from some of the nurses who described how their understanding and perception changed, but the practice did not appear to, would you agree with that?
A Because the practice was appropriate and they now understood what the practice was and what it was aiming to achieve.

Q The practice did not change one jot, did it?
A No.

Q As a result of these concerns raised in 1991.
A No. If opiates were appropriate at the end of life, they were given to patients.

Q The answer is, I think, that you agree that the practice did not change one jot.
A Yes.

Q Mrs Hallman, in 1999, had a meeting with you, when she came to speak with you because she had been told by Sister Hamblin that she had upset you in some way, and she reported that you said to her, "You do not understand what we do". First of all, I expect you remember that piece of evidence.
A I have a vague recollection of the incident and I have the evidence here in front of me. What I meant by "You do not understand what we do here", was that I felt that Shirley was quite inexperienced in palliative and terminal care. She freely admitted that, that the unit she had worked in previously did not do palliative and terminal care in the same way that we did. I felt that a move back to Queen Alexandra would allow her to receive some training in how to become more proficient in this. It was not an attempt to get rid of her, or belittle her or reduce her grade so that she earned less money. It was a genuine attempt to help her increase her experience in the job that she was doing, and I think that she chose to misunderstand what I said.

Q First of all, I just want to establish with you that those were the words that you used, "You do not understand what we do here".
A I have no recollection at this distance of time what the actual words were, but the sense of the words sounds correct.

Q What you were saying to her in effect was that she did not understand appropriate palliative care?
A She was inexperienced in appropriate palliative care, yes.

Q Before we turn to the individual patients, can I just also put this to you. Do you accept that some people are prepared to live with a degree of discomfort or pain provided they are allowed to stay alive?
A I beg your pardon!

Q Do you accept that some people would prefer to live with a degree of pain or discomfort provided they are allowed to remain alive?
A What an extraordinary question.

Q Could you answer it.
A Are you suggesting that in any of these twelve cases I was instrumental in ending these people's lives?

Q Well, we will come ---
A All these people were dying from the various conditions from which they suffered, and the management that I gave them was palliative and then terminal care for the conditions which killed them. In no way did I contribute to their deaths.

Q Do you agree that some people are prepared to live with a degree of pain?

A A I am just completely flawed by that question.

Q It is not a complicated one, Dr Barton. We know that in one case at least, one of the relatives wanted you to reduce the dose, to discover whether his step-father in fact wanted to remain conscious as opposed to dying in effectively the state of a coma, and I want to ask you: do you accept that some people are prepared ---
A That was not Mr Cunningham's choice. That was Mr Farthing, his step-son's, choice, B who was not his next of kin and who I did not feel that it was appropriate to even ask that question of a dying relative.

Q I understand that is your evidence. Do you accept – I will ask for a final time – that some people are prepared to live with a degree of pain?
A Yes.

C Q You were interviewed in 2005, I think it was, and in fact earlier in 2000, by the police. Yes?
A Yes.

Q You were interviewed over many, many, many hours and days. Yes?
A Yes.

D Q And you chose to answer none of their questions?
A Not on the first occasion. I prepared statements for the police and I felt, under legal advice, that that was the most appropriate way to answer the allegations, by carefully thought-out, prepared written statements.

Q Those statements which you described as being carefully thought out, and I am not going to disagree with you for a moment about that, were they made – and I do not want to E know what advice you actually received – but were they created with the assistance of a solicitor?
A They were created by me.

Q Yes. Were they put to your solicitor before they were handed over to the police?
A They were seen by my solicitor before they were handed over to the police, yes.

F Q Can we take it that you put into those statements everything that you could then remember after having had access to the notes?
A You can. I did.

Q And you did not, and would not have, deliberately left anything out?
A Not at all.

G Q And can we take it that your recollection when you made those statements would, if anything, be slightly better than your recollection now?
A Possibly. It was still a couple of years later. It was still quite difficult to remember, particularly confrontations with relatives.

Q But so far as a patient's condition is concerned, can we take it that you put everything into your police statements that you possibly could remember?
H A I did.

Q Can we turn then, please, to Patient A, Mr Pittock. You will need the chronology. You can have his notes as well if you want to, of course. Just to remind you in relation to this patient, you told the police that you had now no real recollection of him?
A Yes.

Q And your comments thereafter in your statement – and I am looking at your paragraph 15 – were all based on comments such as "I believe that I would have"?
A Yes.

Q "I would have", "I anticipate that"?
A Yes.

Q All of which reflect that you could not – and I am not criticising you for this – but all of that reflects that you could not actually remember the patient. Yes?
A Yes.

Q Can we just have a quick look at this patient's admission. I am going to avoid as much as I can going right back through all of the notes, but could we start, please, on the chronology at page 9. This is the day before his admission. He was reviewed by Dr Lord, who made a note that he was suffering from:

> "Chronic resistant depression. Very withdrawn. Completely dependent – Barthel 0. Superficial ulceration of left buttock and hip. Hypoproteinaemia. Suggests high-protein drinks and bladder wash-out of hours. Happy to take him to GWMH. RH [rest home] place can be given up as unlikely to return there.
>
> All nursing care given."

Can we just pause for a moment. Dr Lord was suggesting that he needed bladder wash-outs. Yes?
A Because he had an indwelling catheter by this time.

Q Was that something that could be performed at the GWMH?
A Certainly.

Q And high-protein drinks. Those could be given?
A They could be ordered from the kitchen, yes. Those were both nursing duties to organise for the patient when he arrived on the ward.

Q Yes. If we look below in the correspondence, we see that there is, I think, a transfer letter:

> "Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall prognosis poor. Happy to arrange transfer to Dryad Ward."

Dr Lord told us that she would not have transferred any of her patients unless they were sufficiently stable for her to do so.
A Yes.

A

Q Can we look at what happened to him on admission. You made a brief summary of his conditions. Can I just ask you this. You recorded no plan and no mention of the high protein diet?
A That was a nursing procedure which the nurses taken from the transfer letter and organised. It was not necessary for me to set that up.

B

Q Then, if we can read on, he is given Arthrotec. Then if we go to the bottom of page 12, please, of the chronology, he is reviewed there by Dr Tandy, who records that he is depressed, catheterised, he had superficial ulcers and a Barthel of zero. Professor Ford described this gentleman as nearing the end of his life.

"Will eat and drink. For TLC [tender loving care]."

C

A Yes.

Q Over the page, we can see that he was seen by you and Dr Tandy.

"To commence Oramorph 4 hourly this evening."

Can we also look at the next prescription that you wrote after the Oramorph: diamorphine, 40-80 mg. Yes?
D
A Yes.

Q I am sorry. And midazolam, of course, 20-40 mg. Up until that day this patient, I do not think, had taken any form of morphine at all, had he?
A No.

E

Q He was not, in fact, at this time, recorded as complaining of pain other than, as we see at the top of page 12, saying that he has generalised pain. Yes?
A Yes.

Q And Professor Ford described the use of Oramorph as appropriate, but I want to look at the level of diamorphine that you prescribed.
A Yes.
F

Q This is the first one of these prescriptions, so we are going to have to look at it in a little more detail that we will, perhaps, later on. The purpose of these prescriptions was, as we understand it, to allow the nurses to initiate, if it was necessary, diamorphine and midazolam at the lowest level. Yes?
A Yes.

G

Q Once you have written a prescription like this out, it allows the nurses to initiate it at any stage that they feel right?
A Yes.

Q It allows them to initiate the dose either at the minimum dose, or at any dose along the range?
A Yes.
H

Q The minimum dose in this case would have been – was – 40 mg of diamorphine?
A Yes.

Q Which would have been the equivalent of 120 mg orally?
A By your calculations, using a third, yes.

Q It is not my calculations, no. It is the BNF's calculations.
A Right.

Q And the Wessex Handbook's calculations. It is not my calculations. The equivalent on the BNF calculation would be 120 mg orally, would it not?
A Yes.

Q What would you expect would happen to this patient if the nurses started him on that day with 40 mg diamorphine?
A If he had been in quite an appreciable amount of distress and psychological pain and some physical pain, I hope that it would have relieved his symptoms.

Q Would you have expected it to have a profoundly depressing effect on his vital systems?
A It was possible, but it is in individual judgment looking at a particular patient how they are going to respond to the opiates and anxiolytics and what dose to try for them. At this point in his life, he had left the palliative care pathway, for which you are given guidelines by the BNF and Wessex Handbook. He had entered the terminal care pathway. He needed sufficient analgesia to keep him comfortable, and the estimation of the amount of drug you are going to use would be made by looking at the patient, standing at the bedside, nursing him, tending to him, seeing him, not from a handbook or a BNF.

Q Did you take into account when you wrote out this prescription the Oramorph prescription that you were writing at the same time? In other words, were you presuming that the patient would have started on Oramorph before he started on the syringe driver?
A I was assuming that he would use the oral route if it was appropriate, and he could manage it.

Q You see, if that had happened, let us just look at what you were prescribing on that day, but looking at the Oramorph first of all. Five milligrams five times daily obviously would be 25 mg. Yes?
A Yes.

Q Your prescription for diamorphine, was it predicated on the basis that he might require the whole of that Oramorph dose?
A Yes.

Q And he would require it because of the degree of pain that he would be in?
A Yes.

Q Presumably it would also be predicated on the basis that he was in such pain that he required subcutaneous drugs to relieve it, or he was unable to swallow?
A Yes.

Q And that by the time the syringe driver would be used, he would require a substantial increase from 25 mg orally?
A Yes.

Q And that such an increase would be at a minimum level of at least four times what he had been receiving?
A Yes. And that was on clinical assessment of the patient.

Q Yes.
A And the severity of the bed sores, and the degree of rigidity and immobility of the patient, and the mental anguish of his ongoing depression and withdrawal.

Q Where, please, have you ever red that it is acceptable to start a patient on a subcutaneous dose which is four times the previous dose that they had received?
A It is not written in guidelines, but you do it on the assessment of the patient, not what you read in the text book.

Q Let us not worry about the guidelines for a moment. Have you read any report, any proper piece of research anywhere, that would justify that approach?
A I think it would be very difficult to perform research on patients at the end of their life, as this man was. I think it would be very difficult to do double-blind trials and cross-over trials. This man was dying.

Q At the time that you wrote this prescription you had never read anything that could conceivably support it, had you?
A No.

Q And if in fact the nurses had gone up to 80 mg, that would have been an eightfold increase, would it not?
A Certainly.

Q Why to that did you feel the necessity to add midazolam?
A Because of its anxiolytic properties, because of its preventing terminal restlessness, because he was on antipsychotic drugs before he went on to the syringe driver and I wanted those symptoms controlled by the midazolam.

Q You would appreciate, would you not, as you have already told us, I think, that to add midazolam to diamorphine would substantially increase the level of sedation?
A I would.

Q Can we look at what actually happened to this patient? He was given Oramorph on the day that you prescribed it, on 10 January, and he was given, I think, 5 mg at night. Yes?
A Yes.

Q Let us go over the page to page 14. During the day, from 6 o'clock in the morning of 11 January, he was given first of all a dose of 5 mg, and then three further doses of 5 mg – that is 20 mg – and then 10 mg administered at 20.00 hours. Yes?
A Yes.

A Q So he is getting 30 mg a day?
A Yes. The equivalent of eight co-proxamol tablets on the second layer of the ladder.

Q On that second day, before he had even started his first syringe driver of a minimum dose of 40 to 80, you doubled the minimum dose.
A Yes.

B Q In evidence you told the Panel that you did so, as I understand it, because of the intensity and depth of his pain, his rigidity and discomfort.
A And mental distress.

Q Do you now remember that?
A I have told you that I do not actually remember the case, but that is what I would have done faced with that situation with that man dying.

C Q What you actually said in your police statement at paragraph 23 was this:

"I would have been concerned, although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly".

D A Yes.

Q "And that appropriate medication should be available to relieve this if necessary". Yes?
A Yes.

E Q There is no indication there that his pain, anxiety and distress had in fact increased; it was simply a feeling by you that it might.
A It was.

Q That is not the same as saying that you did that because of the intensity and depth of his pain, his rigidity and discomfort is it?
A It is anticipating these symptoms.

F Q So you were anticipating the depth of his pain, his rigidity and discomfort?
A Yes.

Q You thought those things might happen, but actually they had not?
A They had not at that moment in time, no.

G Q What had changed between 10 January and 11 January which caused you to double the minimum dose?
A I had made a further medical assessment of him.

Q Had you?
A On the Friday morning.

H Q Why do you say that?

A Because I went in every morning and I would be looking at him and how his condition had changed since my previous examination of him.

Q If, in fact, he was not displaying pain rigidity and discomfort, why would you feel the need to double the dose? Nothing had happened.
A Yet.

B Q You felt it appropriate to give him a minimum starting point of 80 mg of diamorphine and let us not forget midazolam which you also doubled.
A Yes.

Q This is a man who was then on 30 mg of Oramorph.
A Yes, and I relied on the nursing staff reporting to me that at that moment in time he did not need any more than that 30mg of Oramorph.

C Q An exact equivalent dose subcutaneously would have been 10mg, a slight increase would have been 50 mg of diamorphine.
A Yes.

Q This now before he started the syringe driver at all is an eight-fold increase is it not?
A Yes.

D Q Have you read anywhere that that sort of increase is in fact appropriate and justified?
A No.

Q You said that with a sense of astonishment.
A No, I say it with a sense of perfect honesty. I have never seen it written down how somebody not standing at the patient's bedside can make an assessment of what level of
E analgesia and anxiolytic treatment they are going to need as they approach death. Guidelines are fine.

Q You have relied on this, Dr Barton, on a number of occasions.
A I have.

Q As have your representatives, that it is crucial to stand by the bedside. Yes?
F A It is.

Q Do you think that the editors of the BNF and those who wrote the Wessex Guidelines had never stood at a patient's bedside?
A I sometimes wondered.

G Q The guidelines would have been based on the treatment of patients suffering pain would they not?
A Yes.

Q Doctors standing by the bedside watching patients in pain and prescribing to them.
A Yes.

Q To deal with pain.
H A Yes.

A

Q No doctor wants to see his patient in pain.
A No.

Q You must have known that the Wessex Guidelines - because you apparently wrote something, I cannot now remember what you did for the Wessex Guidelines - you knew that the Wessex Guidelines ---
B A Very appropriate in palliative care, not always appropriate when dealing with an individual patient requiring terminal care, dying.

Q Help us with that, palliation ---
A [Palliation] is the relief of symptoms that you know are possibly not going to be curative but are going to make the patient comfortable. This is at the far end of the process. This is all systems shutting down, the patient in front of you dying.
C

Q Doctor, at this stage this patient was not, unless you failed to note it, displaying great symptoms of pain was he?
A I was minded that it quite possibly would be necessary and not very long in the future judging by his condition.

Q Can we take it that if you had the palliative care hand book in your pocket at the time
D that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

E Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you were not looking at those were you?
F A Not on this particular occasion, no.

Q Let us look at what happened to the patient. On page 15, we are now on 15 January, his catheter had been bypassing and the patient is described as being in distress. A catheter bypassing can be very unpleasant, I expect, for a patient.
A I imagine that the distress she was referring to was not just caused by the fact that his catheter was leaking. He was in general distress and I actually saw him that morning.
G

Q On 15 January, you instituted a syringe driver.
A I did.

Q Up until this point, he had been on 30mg orally a day.
A He had.

H

Q From 11 January?
A And he had not been assessed over the weekend.

Q When you say he had not been assessed over the weekend?
A The 15 January was a Monday morning, so I would have come back from the weekend and been appalled at the condition that he was in.

Q You then instituted a syringe driver.
A Yes.

Q You now had the opportunity not just of following your own prescription but you could have written out a completely new prescription, could you not, to deal with a patient's symptoms then?
A I could.

Q We know that you did not do so because there is no further prescription; we are still relying on the prescription that you wrote out on 11 January. Yes?
A Yes.

Q Let us imagine for a moment that we are going to use the guidelines. The patient is on 15mg equivalent, but you want to increase it because the patient is in pain and distress. Yes?
A Yes.

Q If you want to increase it, because a measure of flexibility is allowed within the palliative care guidelines and the BNF, instead of reducing it by a third, you could reduce the oral dose by half when converting it. Yes?
A Yes.

Q That would give you 15mg with an increase in pain relief.
A Yes.

Q Can you just tell us your thinking when you decided to give this patient five times more than that?
A Because that was the dose that he needed.

Q How did you assess that?
A By assessing his clinical state that morning.

Q It is extremely unfortunate, I expect you would agree, that you made no note whatever about it.
A Yes.

Q If the patient had deteriorated to that extent, that is something, undoubtedly, you should have made a note about is it not?
A Yes.

Q Did you use the concept of titration at all for this patient?
A No.

Q The nursing staff, who you have roundly praised and told us that you relied on, had in their patient notes a prescription from you over that weekend for a syringe driver to instituted.
A Yes.

Q There was absolutely no reason why, either on the Saturday or the Sunday, if the patient's distress was such that it was felt to be needed, they could not institute that syringe driver was there?
A None at all.

Q Do you know why they did not?
A I have no idea.

Q It rather makes your anticipatory prescribing slightly pointless in this case does it not? The patient is apparently reduced to great pain and distress, such that by the Monday morning you have to give him what I am going to describe, frankly, as a huge dose of diamorphine and midazolam and the nurses have not done anything about it.
A I cannot comment on what happened over the weekend. I can only tell you what I saw at 7.30 that Monday morning.

Q The dose was started at 8.25 in the morning and by the afternoon/evening he was unresponsive. Yes?
A Yes. You would expect that as the initial level began to build up that there would be a period possibly of reduced consciousness. By the next day some agitation noticed when being attended to.

Q What does that actually mean.
A He did not like being turned, nursed or washed or his dressings changed on his sacral ulcers, although if he was left alone he was probably reasonably comfortable on that level of analgesia.

Q When he was being moved, you say he exhibited some distress, presumably through pain?
A Yes.

Q Why did you choose haloperidol to add to the mixture?
A Because it is an antipsychotic and I thought that the agitation that he was showing might have been part of his depression and dementia and that that would be a better approach to controlling his symptoms than increasing the diamorphine at that point in time.

Q If patient is unconscious ---
A Well he was not.

Q Why do you say that?
A Some agitation was noticed when being attended to; he was not unconscious.

Q Are you saying that some agitation means that he was responsive in speaking?
A He was responsive. I do not say he was speaking.

Q I do not think we have put haloperidol into the section in our file from the BNF. May I pass a copy of it please to you and also to the Panel. (Same handed) There are two pages that need to go in and I will ask your Panel assistant to pass them out.

THE CHAIRMAN: These are to go into Panel volume 1 behind tab 3. Would you like to indicate a page positioning for them, Mr Kark?

MR KARK: We might as well put them at the back after co-codamol. I have not paginated these. It would be 52 and 53. We added co-codamol a couple of weeks ago and that is page 51.

THE CHAIRMAN: We did add a co-dydramol reference and we put that in at page 51. We will mark these pages 52 and 53.

MR KARK: Do you have that, Dr Barton?
A I do.

Q I am putting it because I think it is appropriate that we have this available to us. We can see that it is for schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement and violent/or dangerously impulsive ---
A These are all indications by mouth; I was not using it orally. You do not have the subcutaneous indication in there. It will be in the palliative care hand book.

Q I have copied the wrong bit. You can put that aside. I will find the right bit and we will come back to it. Let us go back to the chronology. At page 16, Mr Pittock is now on a syringe driver with 80mg of diamorphine, 60mg of midazolam and 5mg of haloperidol. Would you expect his level of consciousness to be much reduced?
A No.

Q Why not?
A Not with haloperidol. It was not very sedating.

Q Diamorphine and midazolam at those levels would reduce his conscious level considerably, would it not?
A It would.

Q Can we go to the following day, the 17th first of all, the diamorphine has now been increased by 50 per cent. Yes?
A Yes

Q The midazolam has been increased by slightly less than 50 per cent. The haloperidol has been quadrupled.
A Yes.

Q Can we take it that you cannot now remember your thinking behind that prescription?
A I was aiming for a balance of the different drugs I was using to keep him as comfortable as possible.

Q If we go on through page 20, I think that remains as it was before, and page 21 we can see that on 20 January he was on 120 mg of diamorphine, 80 mg of midazolam. The

haloperidol was discontinued, but he was now on Nozinan. The Nozinan you had added, I think, on the 18th.
A Yes, on the Friday.

Q The Nozinan was to do what?
A That is a much more sedating, anxyolitic anti-psychotic.

Q That would have what?
A Stopped the restlessness and agitation.

Q It would have considerably increased his level of sedation, would it not?
A It would.

Q When Dr Briggs reviewed this patient, he would have been reviewing an unconscious, but apparently agitated patient.
A Yes.

Q You would not have expected him to review this patient's treatment overall, would you? You would not have expected him to go right back to the beginning of your prescriptions and review the entire programme, as it were.
A No, but I would have expected, if he felt there was anything inappropriate about any of the prescriptions, he was at liberty to change them.

Q Of course, all of the prescriptions that you wrote out and administered, you say were based upon your observation of the patient or on the nurse's observation of the patient.
A During that week, yes.

Q Can we just have a look at the charges together, please? Do you have those available to you?
A Yes.

Q Head of charge 2 is dealing with this patient. We can see what you have admitted and all of the administration of the drugs, of course, is admitted. Can we go down to (b)(i)? The suggestion is that,

> "the lowest doses prescribed of Diamorphine and Midazolam [on 11 and 15 January] were too high".

You do not accept that.
A Too high for what?

Q For the patient's condition at the time.
A The patient's condition required those levels of both those drugs as you can see from the fact that he continued to need increased dosages for several days afterwards.

Q Do you nevertheless accept that they were dramatically over any form of guideline that you could have been relying on?
A I do, but I still say that they are appropriate for that man in that condition on that day.

Q On reflection, just thinking about the dose ranges, do you accept that an eight-fold increase, which would have been the top of your range, must have been too high?
A No.

Q You do admit that the prescription created a situation whereby drugs could be administered to Patient A which were excessive to his needs.
A Yes.

Q On what basis do you admit that?
A That if one of my nurses had decided to institute the syringe driver at the dose of 200 mg of Diamorphine, that could have been excessive to his needs.

Q I think they could not, on these prescriptions, have started at 200, could they? But they could have started at 180 or 120 with Midazolam.
A That is not considered to be appropriate for nurses to be able to prescribe that level of medication, although it was appropriate for me to prescribe that level, because I thought it was appropriate.

Q I just want to pause on the thinking behind that. You accept that prescriptions created a situation whereby drugs could be administered by the nurses which were excessive to his needs. Yes?
A Yes.

Q Does that not mean that the dose range was too wide?
A Yes.

Q Can we look at (b)(ii) again? In relation to 2(a)(ii) and 2(a)(iii), it is alleged that the dose range was too wide. Do you now admit that that is so?
A Yes.

Q Right. You do not accept that the doses of diamorphine administered to the patient on 15 and 17 were excessive to his needs.
A No.

Q Do you accept that your prescription described at paragraph 2(a)(vi), which was the addition of the Nozinan which you have just described, I think, as a strong sedative, effectively, in combination with the other drugs already prescribed, were excessive to the patient's needs?
A No. It did not work, but it was not excessive to his needs.

Q Then (e) charges you as follows,

"Your actions in prescribing the drugs as described n paragraphs 2(a)(ii), (iii), (iv) and (v)" –

Just to remind ourselves, that is Oramorph and diamorphine 40 to 80 on 5 to 10 January, and then the prescription on 11 January, the diamorphine and midazolam, and then the prescription on 15 January, then on 17th and then on 18th, were inappropriate. That is the charge. That is the allegation. You accept that in relation to 2(a)(iii) at least, it was potentially hazardous. Yes?

A A Yes.

Q Again I just want to understand your thinking. If a prescription by you is potentially hazardous, and now you have admitted too wide, how can it be appropriate?
A It is not the same question. The starting dose that I gave him from the range I had written out, I felt was appropriate to that patient at that time.

B MR KARK: The stem of the charge reads,

> "Your actions in prescribing the drugs as described".

MR LANGDALE: Sir, I feel I must interrupt because the question is being put on a basis which may possibly be confusing and may indeed run contrary to the evidence that has been heard by the Panel.

C

Going back to Charge 2(b)(ii), the dose range was too wide, that is something about which Professor Ford gave evidence. He said in relation to the dose range,
"If the starting dose was correct" -- in relation to Mr Pittock, we are not talking about the 20 to 200 case – he said,

D

> "If the starting dose was correct, then the dose range was not too wide".

In other words, if one goes, by way of illustration, to the prescription shown on the history at page 13, the dose range on that prescription, 40 to 80, was not too wide; in other words, if you prescribed a dose range at a level and the highest was simply double that level, that was not in itself too wide. Questions are being put to Dr Barton on the basis that the dose range was too wide in those circumstances, which Dr Barton's indication at the start of the case was that that was not correct. Similarly, when one looked at the diamorphine on 11th, the range

E was 80 to 120. If 80 was the correct starting dose, then 120 was not too wide a range, because it allowed for an increase.

So the evidence adduced by my learned friend from his own witness is not that the dose range was too wide. The criticism made by Professor Ford was that the starting point is too high.

F So I think, sir, that these questions are running the risk of actually creating a confusion and possibly resulting in unclear answers, because it is very important – I say this by way of illustration in relation to 2(b)(iii),

> "the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs".

G That is the case if, for example, a nurse, given a range, wrongly started at the top of the range, when the patient's needs did not require it. That is the whole point about the "could be", in relation to these charges. We are running into the same problem in regard to the question of "potentially hazardous". I would like my friend to frame his questions, if he would, very carefully in terms of the evidence that we have heard and what the charge items actually say.

MR KARK: I am grateful for that reminder of Professor Ford's evidence, but this is now Dr

H Barton's evidence, and she may well admit charges, and she is entitled to admit charges if, on

reflection, in her view, her doses – we have heard she was standing by the patient at times – were in fact too wide. She is perfectly entitled to admit that.

MR LANGDALE: What I am objecting to is my learned friend putting forward as part of his case something that his expert witness does not state. It is not Professor Ford's evidence, and therefore unless my learned friend is seeking to say that we ignore Professor Ford's evidence for these purposes, my learned friend should not be putting a case different to the one he has called through his own witness.

MR KARK: I am sorry, but Professor Ford's whole premise on this was that the starting dose was wrong in the first place. Dr Barton should not have been writing these prescriptions at all. If Dr Barton is going to give the evidence that her starting point is acceptable, she is still entitled to be asked, or I am still entitled to ask her, well, even on that premise, that the starting point is alright, if that is your evidence, Dr Barton, "Do you accept the range is too wide?" I will pursue that unless stopped. I think it is a perfectly legitimate point to put to her, but I will move on on a ruling.

THE CHAIRMAN: Before I turn to the Legal Assessor and ask for his view, I think what Mr Langdale was saying was that the evidence that Professor Ford had given was that "if", and he did not accept it, that starting dose had been correct, then it would follow from the doubling up principle that the range in this case would not necessarily have been too wide. He was concerned that the witness might inadvertently have been confused by these two different elements.

MR KARK: I do understand that. This is rather circular. I keep coming back to Professor Ford's starting point which is that we should not be starting from here anyway. Dr Barton is saying we should be starting from here and I want to ask her whether her view is that, if she is starting at that range, nevertheless in her view the dose is too wide. She has accepted that it was. Maybe a correction is now going to be forthcoming, but I do not think it is inadmissible to ask her, because the whole premise of Professor Ford's evidence was that this was wrong in the first place.

MR LANGDALE: May I make a suggestion to avoid what sometimes is quite properly put, but sometimes a little cumbersome when the Panel has to take advice from the Legal Assessor? This is not cloud cuckoo land. The witness has been sitting there and has heard what has been said. If my learned friend wants to put his questions in the circumstances, I think he can, but I made it clear that he must make it clear on what basis he is suggesting the range is too wide if it is contrary to his own main witness on the subject. I think we are going to be wasting time unless, my friend having considered what has been said, he rephrases his questions or proceeds in a way that he thinks is appropriate.

THE CHAIRMAN: I am grateful for that. I think the real point, Mr Kark, is that we need to avoid confusion at all costs. Even if the witness is not confused, the Panel may well be.

MR KARK: Certainly sir. Dr Barton, having heard that short interchange, do you want to go back to 2(b)(ii)?

A I was very confused about what you were trying to ask me. I do not agree that the lowest dose that I prescribed was too high, and I do not agree that the dose range that I prescribed on that chart was too wide.

Q But you do accept that the prescription did create a situation whereby drugs could be administered which were in fact excessive to the patient's needs.
A Yes.

Q So far as that is concerned, you still stick by your guns, do you, that you say that these prescriptions were, nevertheless, in Patient A's – Mr Pittock's – best interests?
A They were.

MR KARK: That is all I seek to ask you about Patient A. You have been giving evidence for an hour and a quarter and I expect a break would be good for both of us.

THE CHAIRMAN: Perhaps the business of the incorrect photocopying could be dealt with before we move on to the next patient.

MR KARK: I will certainly try, sir.

THE CHAIRMAN: We will break now and return at five minutes past 11.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Yes, Mr Kark?

MR KARK: We have been looking at haloperidol. Perhaps we could just flag this up in the Palliative Care Handbook which you referred to. Perhaps we should go to Tab 4 to see what it says about it. We can turn to page 15 of the file numbering and page 26 of the internal documents. The heading is, "Drugs used in the syringe driver". About half-way down the left hand column we see haloperidol. So this is obviously to be used by subcutaneous injection;

"2.5 – 10 mg over 24 hours. Antidopaminergic".

A "Antidopaminergic antiemetic".

Q Which is what?
A Antiemetic is anti-sickness.

Q That bit I understand.
A It is anti-the sorts of things you get in Parkinson's Disease, rigidity and stiffness.

Q "Higher doses occasionally used for sedation".
A Yes.

Q "Extrapyramidal side effects occur with high doses".

What does that mean?
A Dystonic, odd movements. That is what the nurse at that weekend was concerned about with Mr Pittock, hence calling Dr Bates in.

Q Then if we go to page 21, under the general heading of "Confusion", on the right hand side, under "Management", we see "6. Drug Therapy",

A

"If paranoid, deluded, agitated or hallucinating, haloperidol 1.5 – 3mg up to three times a day orally".

A Yes.

Q Then we see underneath that,

B "Review early as symptoms may be exacerbated by sedative effects".

A "Watch for extrapyramidal side effects", which is what they thought he had that weekend, and the next two drugs are much more appropriate for the condition that we were in, in the next paragraph, the midazolam, between 10 – 100 mg over 24 hours or the Nozinan 25 – 100 mg over 24 hours.

C Q And,

"Review early as symptoms may be exacerbated by earlier sedative effects."

That means what? That it can ---?

A We were not particularly concerned about the sedative effects in this patient, in the terminal care of his condition. They are talking here about using it orally for schizophrenic and psychotic patients.

D

Q Right.

A Which was not really relevant for using it in a syringe driver.

Q All right. Finally we have part of the BNF, which we need to punch. This is from the 1998 BNF. We have a heading "Prescribing in Palliative Care". I am going to see if we may already have this, in fact. We do. We do not need that, because we can go back. I am afraid I just had not seen it earlier – I beg your pardon. Let us go back to tab 3. We did not look at this earlier, Dr Barton, and you may want to do so. At page 3 of tab 3 – page 13 of the BNF but page 3 of our file – "Restlessness and Confusion":

E

"Restlessness and confusion may require treatment with haloperidol…"

F

and that is dealing with 1 – 3 mg by mouth every eight hours. Then, on the right hand side of page 4, under the same heading "Restlessness and Confusion" under "Syringe Drivers":

"Haloperidol has little sedative effect; it is given in a *subcutaneous infusion dose* of 5-30 mg/24 hours."

A Yes.

G

Q That deals, I think, with that. You can put it away. Can you turn, please, to Elsie Lavender and Patient B. You may want to get the chronology out for Patient B. This lady, we know, in February had a fall and she was X-rayed apparently at the Royal Haslar. She was treated over a fairly lengthy period of time and then came to you on 22 February, as we see form page 7 of the chronology. I think you agree with Professor Ford in essence when he said it was too early to say that this patient's chances of recovery were small. Do you accept that she had a reasonable chance of recovery?

H

A I accept that she had a chance of recovery, but that she had a number of comorbidities and she had only just been managing at home before she came into hospital, so that her outlook was probably residential or nursing home, certainly not home.

Q Right. You said, I think, in evidence to Mr Langdale, "I felt that she deserved the opportunity to try to remobilise".
A Yes.

B

Q This patient, up until her transfer to Daedalus Ward had been on co-proxamol and dihydrocodeine, I think.
A Yes.

Q If we need to, we can go back in the chronology. Would you go to page 2. At the bottom you will see:

C

"Prescribing co-proxamol and dihydrocodeine. Administered until transfer to GWMH."

A Yes.

Q So she does not appear to have been on anything stronger than that?
D A Which, in the palliative care guidelines, is an equivalent of 30 mg of oral morphine.

Q Quite. You told the Panel that the problem with her wrists may have been pre-existing. Is that right?
A There was mention somewhere in her notes of her having had a carpal tunnel syndrome problem previously, and she also may have had a neuropathy, a nerve damage, in the arms due to her diabetes.

E

Q Did that not require an evaluation by you?
A It would have been assessed in the general examination of the patient on arrival, but not recorded.

Q Was not recorded. On 23 February she is reviewed by you. On 24 February she is reviewed by you again. On 24 February there is a note by Nurse Joines that her pain was not controlled properly by DF118 – that is dihydrocodeine?
F A Yes.

Q Did you consider at this stage, as Professor Ford said you should have done, that there should be an evaluation because the pain should not have been worse at that stage?
A I did not feel at that stage that transfer back to the unit that had discharged her to us would have been productive in any way for this lady. Had she been put through the MRI
G scanner and had a fracture of the cervical spine being found, there was no specific treatment for it. Her treatment was not palliation of her symptoms.

Q Does that mean in effect that she would have been on a terminal pathway?
A Yes.

Q So your view was, from 24 February when this patient is continuing to complain of
H pain, that she is on a terminal pathway?

A A Yes.

Q Did you consider asking to see the X-ray or the X-ray report which had been done on 5 February?
A No.

B Q Before you decided to institute opiate medication to deal with her pain, did you not consider that an assessment of the cause of her pain would be a good idea?
A Any assessment of the cause of her pain would not have been germane to her management. It would not have altered our management in any way.

Q You started this patient, as we see, on 24 February on 20 mg a day of MST. Yes?
A Yes. Which was in effect a step-down from the equivalent dosage of step two analgesia that she had been having previously, but it was a good starting dose for MST.

C Q At the bottom of page 9, we see that when moved she was screaming "My back", but she was uncomplaining when left alone?
A Yes.

Q On 26 February, if we look at the top of page 11, I just want to examine with you by this stage what she had actually been on. Up until this point, this patient had been on 20 mg
D MST a day?
A Yes.

Q Yes?
A Yes.

Q You then wrote out a prescription for diamorphine of between 80 and 160 mg per
E day?
A Yes.

Q Together with 40 to 80 mg of midazolam. Yes?
A Yes.

Q From what she had been on to that point, that would as a starting point, have been an
F eightfold increase, if administered immediately. Yes?
A Yes.

Q You agree with that?
A Yes.

Q And she had never had midazolam before?
G A No.

MR LANGDALE: I am sorry. It may save me re-examining and taking more time. Is this on the basis that she is receiving MST 30 mg per day, because I think the right figure is 40. I may have misunderstood what was being put. If you look on page 10, you can see it is 20 twice a day.

H

MR KARK: I am sorry. What I was putting to the witness – and I do not mind the interruption at all – was that up until that day she had been, I think, 20 mg per day. If you go back to page 9 of the chronology, you can see 25 February, do you see 10 mg twice daily administered? Take your time because it is important.

A That is the weekend again. That is a Sunday, so that when I came in on the Monday morning and reviewed her, I increased the MST and wrote up the anticipatory prescription for the syringe driver.

Q I understand that, but up until the Monday she had been on 20 mg a day?

A Yes.

Q Right. At the point that you wrote out that application for diamorphine and midazolam. If administered immediately that would have been an eightfold increase?

A Yes.

Q Let us go back to what happened about the MST. You then increased her MST to 20 mg twice daily. Yes?

A Yes.

Q And that was started at 10 o'clock that evening. Yes?

A Yes.

Q So on that day she receives 30 mg and on the following day the prescription takes effect and she receives 40 mg a day?

A Yes.

Q Again, on the basis of a prescription that you wrote out, the nurses could at any stage have instituted those prescriptions which you had directed subcutaneously?

A Yes.

Q And they could have done so either by reference to you or they could have done that of their own volition and normally, but not always, they would have let you know afterwards?

A Yes.

Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?

A Yes.

Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?

A Yes.

Q That prescription of yours continued to the 4 March, if we go to page 12, where we can see that the MST dose – I think this is a Monday again – was increased again and she was put up to 30 mg twice daily, 60 mg a day?

A Yes.

A Q We look at what happened on 5 March, page 13 of the chronology. You describe in your notes how this patient has deteriorated over the last few days?
A Yes.

Q You know that Professor Ford criticises you for a lack of evaluation, or re-evaluation of the patient?
A Yes.

B

Q But you accept, I expect, that there is no note of any proper evaluation here?
A No.

Q And there should be?
A Yes.

C Q If one took place.
A Yes.

Q Are you saying that you would nevertheless have re-assessed the patient and performed a proper examination of her?
A I would.

D Q But made no note ---
A Made no note of it.

Q --- of it. Nor indeed has any nurse made any note of any such examination. Yes?
A Yes – or no. Yes.

E Q On 5 March there is a note in the nursing care plan, at the bottom of page 13:

"Pain uncontrolled - patient distressed. Syringe driver commenced...."

Apparently the patient had had a very poor night?
A Yes.

F Q This patient had previously been on 60 mg of morphine. The equivalent would be 20 mg. If you wanted to give her an increase in the dose and stay within the BNF guidelines, you would have halved it and given her 30 of diamorphine. Yes?
A Yes. On the palliative care guidelines, yes.

Q On any guidelines you care to mention. Yes?
A Yes.

G Q What you in fact decided to administer to this patient was 100 mg, which is three times the dose recommended, which would have included an increase?
A Yes.

Q In fact, just more than three times, is it not?
A Yes.

H Q To that you have added midazolam?

A A Yes.

Q Again, this is the last question: nowhere in any literature are we going to find any sort of teaching or guidance that justifies such a dose, are we?
A No. But I was the patient's carer. I was standing at the bedside. I was assessing the level of pain and discomfort and terminal distress she was suffering, and I considered that was an appropriate dose to give her in the syringe driver.

B

Q You told the Panel that when you wrote out this prescription, you had over-sedation in mind. Yes?
A Yes.

Q And so you were well aware, were you, that this patient could become over-sedated?
A Yes.

C

Q With potentially fatal consequences?
A Yes.

Q In fact the syringe driver, I think, was commenced on 5 March by Margaret Couchman, and what she told the Panel was that the pain was uncontrolled, the patient distressed, the syringe driver commenced. She said, "I think I remember from my interview
D that I was told by the night staff how distressed she was, so the note was based on what I was told by someone else."
A At the handover at eight o'clock that morning she would have been told that the patient had had a terrible night, which is an example now of the same night staff working on that ward, communicating with the day staff and agreeing that terminal care should not be given.

E

Q Yes. She said, "If I had spoken to the patient and she had complained herself about pain, I probably would have noted it." Yes?
A When?

Q So she is relying before she starts this patient on what is effectively her terminal pathway, as we have chosen to describe it, she is relying on a report by the night staff?
A Yes.

F

Q Yes?
A Yes.

Q Not upon anything she has seen?
A Because she is still having the handover in the office at eight o'clock in the morning, or quarter to eight.

G

Q And not upon anything that you have seen?
A Not until I went in then to see the patient when I arrived on the ward.

Q She said, "Dr Barton would have come in, and I would have told her how distressed the patient was and how much pain she was in."

H

A A Yes. And instead of relying on a snapshot view taken by myself that morning, those are the observations of the night staff who had been caring for and turning her and seeing to her throughout the night, which were entirely valid.

Q And it was on that basis that you started this patient on, would you accept, a massively increased dose of diamorphine together with midazolam?
A I accept that it was an appropriate dose of opiate and anxiolytic to give her that B morning.

Q Do you accept it is a very large increase indeed?
A It was a large increase over what she had been receiving orally, yes.

Q You cannot now claim that you performed any re-assessment can you?
A I am sorry? C

Q Do you claim that you performed any re-assessment?
A I went in to see her that morning.

Q And made no note about it.
A And made no note about it.

D Q It can have been no surprise to you that this patient died the following evening can it?
A No --

Q She died at 9.28 pm. Alan Lavender's evidence was this:

> "I attended daily, I met with Dr Barton after two to three days. She said to me, 'You can get rid of the cat. You do know that your mother has come here to die'".

E

Do you accept that that was the sort of conversation, if you were being blunt and brusque about it, that you may have had with him?
A I certainly would have suggested that if we were considering a rest home or a nursing home that an alternative home would have to be found for the cat, but I deny that I would have used as quite as blunt language as that when talking to the son of the patient.

F Q He said,

> "It was as if her death had been pre-determined soon after she was on a syringe driver. I assumed it was for pain. She deteriorated quite quickly. She appeared unconscious and smelling terrible and leaking faeces".

Can I ask you this, and we will come to this with another patient, is the loss of control of G bowels and bladder sometimes a consequence of sedation with diamorphine?
A It is sometimes a consequence of being on the pathway to dying.

Q Is it also sometimes a consequence?
A If you are giving people large doses of opiates you are much more likely to make them totally constipated than make them loose control of their bowels and, again, you have the problem of retention of urine if you are giving high dose of opiates. A lot of these people H were catheterised so that that situation did not arise. Mrs Lavender put herself on the

terminal care pathway when she fell top to bottom of her flight of stairs at home before she ever came into hospital. I did not put her on the terminal care pathway.

Q You say she put herself on the terminal care pathway; what you are saying is by the time she reached your hospital she was on the terminal care pathway. Is that right?
A Yes.

Q Her son described her as,

"Appeared to be making a full recovery, she was alert, lucid and other than a little pain in her shoulder not complaining of pain. It was obvious that it was a little tender and she did not like people touching it".

A I suggest that is a tribute to the dose of MST that she was having prior to the last day of her life, it was giving her that degree of pain relief without any sedation.

Q From the time that she arrived at your hospital, did you consider or suggest any alternative treatment other than palliative care?
A No.

Q Can we turn to the heads of charge briefly, please. We take it looking at 3(b)(i) that you do not accept that the lowest commencing dose prescribed on 26 February - which was 80mg of diamorphine and 40mg of midazolam, and on 5 March, which was 100mg and 40 mg respectively - that those were too high?
A No.

Q Over the page you do not accept, presumably, that although the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her needs, that it was inappropriate to prescribe those drugs?
A No.

Q Or that it was not in her best interests?
A No.

Q In relation to your management of Patient B it is alleged you did not perform an appropriate examination and assessment of Patient B on admission.
A I do not agree.

Q You did not conduct an adequate assessment as Patient B's condition deteriorated.
A I do not agree.

Q Let us just pause here for a moment; you did not provide a plan of treatment.
A There was no plan of treatment. She was being given palliative care and end of life care.

Q So the plan of treatment was palliation?
A Yes, make comfortable.

Q When we look at your notes and we consider your answers about performing assessments but not noting them, how is that meant to work with the partners in your GP

practice on a day when you are not working, on a course, or you are chairing a discussion somewhere and one of your GP partners is called to come in to assist a patient, what are they meant to be basing their care upon?
A They are basing their care on the expert guidance they are given by the nursing staff in charge of that patient. It is exactly the same situation if you are asked to do a house call on a patient in their own home or a patient in a nursing home or rest home, you do not have in front of you a full set of comprehensive case notes, but you rely on the person looking after that patient to give you the information you need.

Q But you accept, do you not, that their task would have been made very much easier if you had been making proper notes?
A In none of these cases would comprehensive notes have made any difference to the care of the patients given by Dr X, Dr Briggs or Dr Brook.

Q Do you not accept that by failing to make a proper note of your assessments which you say you were conducting, you were leaving any doctor who came after you in a worse position in order to deal with that patient than they should otherwise have been?
A Yes.

Q Can we move on please to Patient C. Patient C was quite ill when she arrived at Queen Alexandra Hospital - his is Eva Page.
A Yes.

Q In the clinical notes of 12 February when she was still at the Queen Alexandra Hospital there is a note that the aim in the management of this patient should be palliative care.
A Yes.

Q She was recorded as not for CPR.
A Yes.

Q So one has to be realistic about the prospect of this patient.
Can we turn to the chronology at page 4. She was reviewed by Dr Lord On 25 February. Perhaps we ought to look brief at the entry of 19 February, the page before. Plainly at that stage she is described as being tired and thirsty. There is a plan that oral fluids should be encouraged, but she was still eating relatively solid food. Yes?
A Yes.

Q She was given a little midazolam, 2.5mg to help her to go to sleep. Can we go to page 4, please.

> "Reviewed by Dr Lord. Confused and some agitation says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try Thioridazine. Transfer to GWMH" –

and in fact it should reveal for continuing care. That is what she was coming to you for. Yes?
A Palliative care, continuing care.

A Q On 27 February she was transferred to you. You did make a note and Professor Ford is not critical of this particular note of yours that we see at the bottom of page 4. She was able, as we see from the top of page 5, to hold a beaker and pick up small amounts of food, but she needed a lot of encouragement. Your prescription when she arrived was a relatively small dose of Oramorph given the patient's condition.
A Yes.

B Q Which Professor Ford I think described as being reasonable.
On 28 February we can see that she was very distressed and calling for help and she was given Thioridazine with no relief. She remained distressed and Oramorph was given and then Dr Laing apparently prescribed regular Thioridazine and heminevrin.
A Yes.

Q What would heminevrin do?
C A It is a sedative.

Q Then we see (page 6)

"Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Independent turning in bed. Two members of staff for bath/shower. Encourage fluid intake".

D

It then goes on to say that she should be encouraged to do for herself what she can in terms of personal hygiene.

We can see through the notes that she is then regularly receiving though Thioridazine and heminevrin. Can we then go to what happened on 2 March. This is a Monday. Your note reads,

E

"No improvement on major tranquilliser".

The major tranquilliser would have been Thioridazine would it?
A Yes.

F Q Then,

"I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today". She was then reviewed by Dr Lord and said to be,

"Spitting out Thioridazine, quieter on prm, SC diamorphine. Fentanyl patch started today. Agitated and calling out ..."

G That review by Dr Lord appears to have been after she was started on the Fentanyl patch. Do you agree?
A After she had the first dose of subcutaneous diamorphine and the Fentanyl patch had been put on. She then had a subsequent dose during the ward round.

Q If we go over the page, we will have to come back to page 8, we can see what happened about the patch. You prescribed it. It was a 25mcg patch and it was administered
H at 8 o'clock in the morning. Yes?

A Yes.

Q A Fentanyl patch is rather slower to kick in is it not than an immediate injection?
A Yes, it takes approximately 24 hours to reach its steady state level.

Q You also knew that it would remain in the system for longer and the effects of it would build up over time.
A To the 24 hours and then remain at steady state until it was taken off on the third day.

Q You also told us that if a syringe driver was started you would see to it that the patch was removed immediately.
A I would not remove the patch myself by hand, but I would ensure that the nursing staff knew to remove the patch.

Q Why would that be so important?
A Because otherwise the Fentanyl level would remain at that steady state while you were adding in the diamorphine in the syringe driver.

Q Which could lead to?
A It would give a higher dose than you in fact wanted from the syringe drive.

Q And could lead to an overdose and over sedation; yes?
A It could do, yes.

Q Even when you remove the Fentanyl patch, you know that that does not remove the Fentanyl from the system.
A The Fentanyl level slowly degrades back down again over the subsequent 24 hours.

Q It takes that long to get rid of it does it not?
A Yes.

Q You also agree that you would not want to run both together; you would never want to run a syringe driver and a Fentanyl patch at the same time would you?
A No.

Q That is in fact precisely what happened here is it not?
A We do not know what happened because none of the nurses have actually signed for taking off the patch, but I would assume that having our normal protocol was that when a syringe driver was started, the patch was removed.

Q We have seen in a later case that it is specifically recorded.
A Sister Hamblin recorded that she had taken the patch off. I can only assume that whoever took this one off did not record it on the drug chart.

Q That is a significant failing is it not if that happened?
A It is.

Q A Fentanyl patch may be put on the body where you would not normally see it. If the patient is lying in bed where would you expect the Fentanyl patch to have been put? It can be put on any hairless part of the body can it not?

A She did not have a very hairy body.

Q Can you remember where it was?
A I have no idea where they put it.

Q If the Fentanyl patch was administered, as it appears to have been at 8 o'clock on 2 March, we can take it that there would be no reason to remove that until the syringe driver started.
A Yes.

Q So on 3 March when the syringe driver did start, it would be pretty much at its peak would it not?
A Yes.

Q By that I mean at its most potent.
A Yes.

Q We see that following the administration of the syringe driver at the bottom of page 9, it is recorded that there is a rapid condition this morning - I may be putting this wrong, so just pause for a moment before answering - the syringe driver was started at 10.50 in the morning and in fact this note must post date that because it is a note by Nurse Hamblin:

> "Rapid deterioration in condition this morning. Neck and left side of body rigid - right side flaccid. Syringe drive"

it should be commenced "at 10.50".
A Yes.

Q The time at which that note had been made it would appear that the syringe driver had already been commenced. Yes?
A Yes, but it does not tell you at what time that morning the rapid deterioration in condition occurred. It was certainly before she recommenced at 10.50.

Q On 2March when that Fentanyl patch was started, and the day before the syringe driver was started, this patient was effectively opiate naive.
A Yes.

Q What do you say is the purpose of the Fentanyl?
A I am sorry, she was not opiate naive; she had Oramorph. The purpose of the Fentanyl was to give her palliation of her symptoms of pain and distress and in a terminal cancer patient it appears that it was quite appropriate to use that kind of opiate administration in this lady.

Q Can we just go back to the issue of whether or not she was opiate naïve? She transferred to your hospital on 27 February.
A Yes.

Q Up until then she had received no opiates at all, right?
A Yes.

A Q On 28 February she receives one dose of Oramorph 5mg at 4.20.
A So she is quite opiate naïve, not totally.

Q Just a moment, let us finish this. She gets no opiates on 1 March, yes?
A Yes.

B Q By 2 March you would not expect the Oramorph to be having any effect whatever, would you?
A No, it would be out of the system.

Q That is why I put to you that she was effectively opiate naïve.
A Yes.

C Q Thank you. Can we look at the charges in relation to Patient C, please? You have admitted that the prescription that you wrote out on 3 March was too wide, yes?
A Yes.

Q You have admitted that the prescription created a situation whereby drugs could be administered to the patient which were excessive to the patient's needs.
A Yes.

D Q What is alleged against you is that,

"Your actions in prescribing the drugs as described in paragraph 4(a)(ii)" –

that is the diamorphine and the midazolam in that wide range, "were inappropriate". Can I just ask you to think about this? How can that prescription be appropriate?
A You are talking about the subcutaneous prescription in a patient already receiving and about not to be receiving a fentanyl patch. Because I wished to deal with the terminal distress. We thought that she had probably had a stroke, a cerebral metastases. I was concerned that she might well suffer from terminal restlessness and agitation and I wished to add midazolam so in order to use midazolam, I wanted to use the diamorphine with it and cease using the fentanyl patch.

E Q I just want to make sure that we all follow this. Even though you accept that the dose range was too wide; even though you accept that you created a situation whereby drugs could be administered to this patient which were excessive to the patient's needs, nevertheless you stand by your case that such prescription was appropriate.
A It was appropriate.

F MR KARK: Thank you. We can move on to Patient D. I am not sure how long we have been going.

G THE CHAIRMAN: We have been going over an hour already so we will break for 15 minutes.

(Adjourned for a short time)

H THE CHAIRMAN: Welcome back everyone. Yes, Mr Kark?

MR KARK: Dr Barton, we were just about to deal with the case of Patient D, Alice Wilkie. She had been admitted to the Queen Alexandra Hospital at the end of July 1998. She is described as having dementia. She had then an unresolved urinary tract infection. She was 81 years old. She had been prescribed and administered a small amount of haloperidol whilst she was at that hospital on 1 August, and then she comes to you on 6 August. This was the clerking in that you spoke about earlier, although I think we heard from the doctor that he did not regard this as an assessment. He regarded it simply as notifying that the patient was arriving at the hospital. In any event, certainly up to the point of her arrival at your hospital, we should regard this patient, should we not, as being opiate naïve?

A Yes.

Q She was transferred to your hospital, I think my record is, for four to six weeks' observation and then to decide on placement.

A Yes.

Q There is a note on 10 August by Dr Lord that her place at Addenbrooke's was to be given up. What is RV?

A Review in one month.

Q If no specialist medical or nursing problems, patient to a nursing home. Then on 17 August there is a record of deterioration. The 17 August was a Monday.

A Yes.

Q Up until this point, I do not think we have any note from you at all, do we?

A No.

Q How often would you have seen this patient?

A During that preceding week I would have been on the ward, but as I explained in my evidence-in-chief, the ward was in a certain amount of chaos.

Q Because of Mrs Richards.

A Because of Mrs Richards, and I neglected to make any note of any change in Mrs Wilkie's condition during that preceding week, or she may have remained quite stable during that week.

Q But also with other patients when Mrs Richards was not on the ward, I think you have accepted that there was a singular failure to make notes of any of your assessments, was there not?

A Yes.

Q Then on 17 August there is a contact record. That would be made by a nurse, would it?

A Yes, that was made by Philip Beed.

Q Her condition generally deteriorated. There is no mention of pain, is there?

A No.

Q In fact the last mention of any pain was back on 6 August. I will just find it for you. It is on transfer when there is a note, "Does have pain at times but unable to ascertain where".

A There is another one on page 6,

"Does have pain occasionally but cannot advise us where".

Q That is right, but that is on the same date, is it not?
A Yes.

Q Then can we look at your prescription? On this occasion I am going to ask that we actually look at the copy of the original. That is in Bundle D and it is page 145. I am trying to avoid doing this too often, but it may be appropriate in this case.
Our chronology reveals, or has put this prescription on to 17 August. I just want to ask for your assistance. If we look at page 145, is this a prescription written up by you?
A Yes.

Q How much of this is written out by you?
A All the left hand side, the drug doses were written up by myself, and the right hand side, the administration was written by Philip Beed.

Q Would this be your normal practice, to write a daily review prescription in this way without putting a date on it?
A My assumption would be that with this lady I wrote that on the morning of 20 August, the day it was started, and that I would have expected Philip Beed to write in the date it was administered at the top of that column on the 20th, which is why I did not date it, because he was going to date it that day.

Q That is why I am asking about the date and where we have it on the chronology. Looking at this now you cannot say, can you, when you wrote it?
A No.

Q We have not looked at this aspect and I have not got the relevant statute in front of me, but when you are writing out a prescription for a controlled drug, is it not a requirement that it is dated?
A I do not know.

Q In any event, whenever you wrote it, whether it was on 17th or later, you have made no record in any note of why you wrote it out.
A No.

Q Apparently you thought it was appropriate to start this patient at 20 mg of diamorphine. We have become rather inured, perhaps, to seeing these prescriptions, but 20 mg of diamorphine to an opiate naïve patient is not a small amount, is it?
A No. It is the equivalent of, by your calculations, 60 mg of morphine orally during the 24 hours. By my calculations in those days it was 40, which is 5 mg of Oramorph five times a day and a double dose at night, so it is a reasonable starting dose even for an opiate naïve patient if you are considering that they are at the point of terminal care.

Q Can I just pick you up on that? Whether or not a patient is at the point of terminal care does not justify you putting them on a syringe drug with opiates in it, does it?
A Yes. This lady, at that point in time, on the morning of 20 August, the Monday morning, required terminal care and she required subcutaneous analgesia, so I wrote the chart up that morning and it was administered by Philip Beed.

Q Just pause for a moment, Dr Barton, and think about that answer. Because a patient is on a route to terminal care, that is cause enough, is it, to prescribe opiates by way of syringe driver.
A Because the daughter had reported to Philip that her mother was in pain and distress and because we had noted over the previous few days that her general condition had deteriorated. I wrote down, "Marked deterioration over the last few days". Not an excuse to write up every person reaching the point of terminal care for a syringe driver with opiates, but appropriate for this lady that Monday morning.

Q That is precisely why I asked you to clarify that.
A I am sorry, I did not mean to give you a carte blanche to give everybody – I do apologise.

Q What you are saying is that for this patient it was appropriate.
A That Monday morning it was appropriate.

Q If it was written up on the Monday morning.
A Yes.

Q Let us look at what happened on the Monday morning, and that is 20 August. Marilyn Jackson gave evidence about this. She said this:

> "I went in one lunch time and mum was really very sleepy. She was flinching in her face. I asked her if she had a pain. She said yes. I told a nurse. Beed eventually came and said, 'We did not know your mother was in any pain and we will give her something to relieve her. You may find when you come in this evening that your mum is sleepy'".

Let us just pause there for a moment before I read on in that lady's evidence. A relative reports that her mother is in pain. Would that of itself have justified you writing up a syringe driver prescription of between 20 and 200 mg of diamorphine?
A Not under normal circumstances, if the ward was being run with its normal level of efficiency, but I think at that particular time I think the situation, the circumstances were not normal. I think Philip paid great heed to what the very sensible daughter, who had been spending quite a lot of time with her mother, said, in the absence of having been able to have the time to make the observations himself.

Q I want to come back to your prescription. When do you say you wrote this?
A I started the syringe driver at 13.50 on 20 August.

Q Sorry, when do you say you wrote up this prescription?
A I anticipate that I wrote it that morning. I have no recollection at this distance of time of when I wrote the prescription.

Q We see this word of yours, "anticipate", all the way through the police statements. What it means is that you are guessing on the basis of the notes.
A It is an educated guess, but I am guessing, yes.

Q Yes, on the basis of the notes. So you anticipate that you wrote that up when?

A A On the Monday.

Q When on the Monday?
A There are two alternatives.

Q That would be the 17 then, not the 20th.
A Yes, all right.

B

Q It is your words.
A "Condition generally deteriorated over the weekend", but I did not write anything up until,

"Marked deterioration over the last few days".

C I made an entry on 21st, "subcutaneous analgesia commenced yesterday".

Q That is not, with respect, what I am asking you about. Can you help us as to when you wrote up this prescription?
A The answer is I cannot.

D Q If Marilyn Jackson saw her mother at lunch time and went to find Philip Beed, you certainly normally would not have been there at lunch time to write up any prescription, would you?
A Unless I was either clerking in a patient or about to attend a ward round.

Q If you had been there on that day and decided that that is what the patient needed that day.
A After examining her.

E

Q Of course after examining her, would you not have written in the date, 20 August?
A You will notice that I wrote it up on a daily review prescription page, which is the back page of the chart. There is not a space for me to write the date that I prescribed the prescription.

Q There is a date.
F A There is the date when it was administered.

Q There is a date when you are saying, not when it is administered, but when you are saying it should start. Is that not what a regular prescription is all about?
A No. On a daily review prescription, there is not a start date box for me to fill in. The box is filled in by the prescriber prescribing the drugs.

G Q If you had been there on 20 August would you, do you think, have written up when that syringe driver commenced?
A Sorry?

Q If you had been there on 20 August, you had become aware of this conversation between Philip Beed and Marilyn Jackson, would you have put in the date?
H A Not on that page of the drug chart because there was not a space for me to put it.

Q Philip Beed then apparently reacted to that comment by Marilyn Jackson?
A Yes.

Q And he instituted this patient on 30 mg of diamorphine?
A Yes.

Q The equivalent of a 90 mg by my or the BNF's or the Palliative Care Handbook's calculation?
A Yes.

Q Of oral morphine. Yes?
A Yes.

Q Would you agree that would be a very high dose in these circumstances?
A It was a dose that he felt at that time was appropriate.

Q Do you agree it is a very high dose to start a patient on the equivalent of 90 mg oral morphine? That is a large dose, is it not?
A It is a large dose.

Q And higher than the minimum that you had prescribed?
A Yes.

Q Marilyn Jackson said this: "I went back at about eight o'clock and she was unconscious. I tried to rouse her but she never regained consciousness. She died the following evening. Why did they use a high dose of diamorphine in a syringe driver? The syringe driver was never mentioned to me." First of all, in relation to communication with Marilyn Jackson, do you agree that if that is right, that is an extremely unsatisfactory state of affairs?
A Had it occurred like that, it would have been extremely unsatisfactory.

Q And you would not be surprised, would you, with this patient who was opiate naïve if she was started, as we know she was, on a dose of 30 mg of diamorphine and 20 mg of diamorphine, if she quickly became unconscious? That would not surprise you?
A She became comfortable and pain free, is the entry.

Q Your description is "comfortable and pain free"?
A Yes.

Q She is unconscious, is she not?
A I have no idea whether she was unconscious or not. She was certainly comfortable and pain free, which is what ---

Q The evidence of her daughter ---
A --- Philip was aiming to achieve with the dosage in the syringe driver.

Q I will not go back to it, but that should not necessarily be the aim of palliative care, should it?
A This is terminal care, we are talking here. This lady was dying.

Q Are you say that doses can therefore be higher, and that a state of unconsciousness is the goal?
A I am saying the doses may well have to be higher. A state of unconsciousness is not the goal but relief of symptoms is the goal.

Q The goal, surely, is the relief of symptoms but if possible keeping the patient alert and conscious?
A But it is a constant balance between the two, and it is very difficult with the severity of the symptoms always to maintain alertness and consciousness at the cost of pain relief.

Q If this patient was complaining of pain to her daughter – she was flinching in her face – is there any reason why she could not be given a 5 mg or 10 mg dose of oral morphine that you can think of?
A If she was not by then able to swallow, or she was unwilling to take fluids, I have no idea.

Q Presuming for a moment that she was conscious enough to speak to her daughter, if she was able to eat and drink – at least to drink – there would be no reason, would there, not to give her oral morphine?
A Unless you were minded to give the midazolam in order to deal with any restlessness.

Q If she could not eat or drink and she needed immediate relief from pain a syringe driver, as you told us yesterday, was not the appropriate method, was it?
A Go through that statement again.

Q If she could not eat or drink, but she needed immediate relief from pain, then the institution of a syringe driver was not the appropriate method to give her ---
A It depends whether the pain was an acute situation or whether the pain was a chronic situation which had been building up, in which case the subcutaneous route would have been absolutely ideal for her.

Q But not necessarily of this high dose?
A Quite necessarily in his opinion at this high dose.

Q What Philip Beed told us was that he could not remember the patient at all.
A No.

Q "30 mg would have been based on the level of pain the patient was experiencing. I had no other reason for giving diamorphine," and then he spoke about hydration.
A Yes.

Q Here is a nurse, albeit a senior one, on the basis of your prescription setting a higher than minimum level of diamorphine.
A Yes.

Q Adding midazolam to it?
A Yes. And had he consulted me either before or after putting up that syringe driver, I would have agreed with his clinical judgment.

Q How do you know? How do you agree with ---

A Because I had worked with Philip Beed for five years. I knew that he was a very competent senior nurse and his assessment would have been accurate at the bedside of that patient on that day.

Q His comment to Marilyn Jackson apparently was that he had not realised that the mother was in pain.
A But this is what he did once he realised that she was in pain, as was a perfectly B appropriate line of treatment to take once he realised that she was in pain.

Q He also, however, appears to have made no note of that?
A No.

Q That is an extremely satisfactory position, is it not?
A The whole situation at that time was extremely unsatisfactory. C

Q And the first note that you have made about this patient was on 21 August?
A Yes.

Q At the top of page 9:

"Marked deterioration over last few days. SC [subcutaneous] analgesia commenced D yesterday."
A Yes.

Q Sorry, I should finish that.

"Family aware and happy."

E A Yes.

Q And she died that day, that evening at 6.30?
A Yes.

Q Do you accept that with this patient the opiates that she was given are very likely to be a prime cause of her death?
F A No.

Q I was going to refer to the charges which are the charges on page 6. Perhaps I should do so in any event. I expect your answer is going to be the same. You have admitted that the dose range was too wide. You have admitted that they created a situation whereby drugs could be administered and which were excessive. You have admitted that the prescriptions were potentially hazardous but you say, do you, that such a prescription was appropriate?
G A I do.

Q And in the patient's best interest?
A I do.

Q I would like to move on please, to Patient E. I am sorry; there is something else I ought to ask you, and it is this. There are two matters, actually. We do not need the notes H

for that. You told us that it was to your regret that your attention was focused on Gladys Richards. Yes?
A Yes.

Q Are you saying that as a result of that, your care of this patient, Alice Wilkie, suffered?
A I think in retrospect had both Philip and I been aware a few days earlier of the deterioration in Alice Wilkie, that we would have instituted the more normal pathway of giving her a small dose of Oramorph and then moving on to the syringe driver when her pain and distress merited it, rather than going straight for subcutaneous analgesia on that 20 August.

Q Does it follow that because it was left to the relative to point out to Philip Beed that her mother was in pain, that if you were going to institute opiate analgesia there is an even higher level of responsibility to review whether that level of analgesia was correct?
A Yes.

Q Because there is a great danger here if people's minds are elsewhere, that the patient could in fact be over-sedated?
A Yes. But she was not.

Q Let me turn to Patient E, please, about whom we have just been speaking. We have spent quite a lot of time in this case, of course, looking at the case of Gladys Richards and we know that she was taken to the Royal Hospital Haslar. She had fallen at her nursing home. She had fractured the right neck of her femur on 29 July. She underwent an operation. She had some morphine, I think, on the day of her operation and also two days later, on 2 August. There is a note on 3 August that she had a little discomfort on passive movement, but she was sitting out in a chair and she should be given the opportunity to try to remobilise. She is going to be transferred to you. On the 8th there is a note that she was a bit distressed but had some haloperidol and had a bit of breakfast and ate a good lunch. Then, on 10 August, we have this referral, that she is now fully weight bearing, walking with the aid of two nurses, which I think you doubt.
A It was not what I saw when I admitted her to the ward on 11 August.

Q Why did you not reveal in your note any concern at this significant change in the patient's state of health?
A Because I was making an assessment on admission of the patient, and our plan for the future was going to be based on my assessment and that of my nurses. What was found – allegedly found – at the previous hospital was not relevant to that assessment. We would give her our own assessment and it was perfectly possible that the act of transferring her had in fact set her back and her mobility quite a lot. She might then improve.

Q We heard from, I think, more than one witness that although patients can deteriorate on transfer, it is quite often a temporary situation?
A Certainly.

Q And so can you just help us? Why do you say that the earlier assessment was effectively irrelevant to your considerations?
A Because I had now a baseline assessment with a Barthel of 2 and usually continent and needing help with ADL on which my nursing staff were then going to work. It was not

relevant whether Haslar said or did not say that she could walk with two people and a zimmer.

Q What about the fact that when she became fidgety and agitated, it meant she wanted the toilet?
A I am sure that my nursing staff were very experienced and adept at recognising non-verbal clues in demented patients when they wanted to use the toilet.

Q Apart from the morphine that she had received at the time of her operation and very shortly after it, this is a patient whom we should regard as opiate naive?
A Yes.

Q A patient who needed to mobilise if she was to recover. Yes?
A If possible, yes.

Q Can we just have a look, please, at what you prescribed. You prescribed 5 to 10 mg of Oramorph.
A Yes.

Q This was presumably on admission?
A Yes.

Q At the time that you assessed her?
A Yes.

Q So the first prescription that you wrote out for this lady who, up until this point was opiate naïve, was 5 to 10 mg Oramorph is required. I presume that in fact should be four times daily?
A Yes. Four hourly, I would think it was.

Q Four hourly. All right, yes. Then you also wrote out your usual – if I may all it – very wide dose of diamorphine?
A Yes.

Q And midazolam?
A Yes.

Q And haloperidol?
A Yes. And hyoscine.

Q And hyoscine. Did you regard this patient as being on a terminal pathway?
A No.

Q Did you regard this patient as being in your hospital purely for palliative care?
A No.

Q Can you explain, please, why you thought it appropriate to give the nurses the power immediately to institute a syringe driver with this patient?
A Because I anticipated with the severity of the dementia in this patient and the insult to her that the fractured neck of femur had caused she could, at some stage in the future, become

palliative and then terminal. I was not anticipating it happening that day or that week even, or even that month, but I wanted the drugs written up in anticipation so that they could be used. Had I done that for Alice Wilkie, Alice Wilkie would have had a more comfortable few days taking Oramorph before she needed subcutaneous analgesia.

Q So you wrote this prescription up not on the basis of anything that was actually happening?
A No.

Q But because, as you put it, you anticipated ---
A I did.

Q --- that they might one day need palliative care?
A I did.

Q And might one day become terminal?
A I did.

Q I suppose it could be said of anybody in this room.
A No. Not today.

Q Let us see what happened to her. She was given Oramorph pretty much immediately?
A The nurses felt that after that journey, and probably my assessment of her, that she was quite uncomfortable, so she was given a dose that afternoon and late that night to settle.

Q And the following day, 12 August, she is given Oramorph again. yes?
A At 6.15 in the morning.

Q And haloperidol was given?
A Yes. Just before midnight.

Q And the reason why the Oramorph was not given again that evening is because the patient was drowsy. Can I just ask you to turn up a particular note. It is bundle E, of course, page 64. I am afraid it is a very poor quality copy. It may be that we can do better.
A Page 64 is "Exceptions to Prescribed Orders".

Q Yes.
A Is that what you want?

Q That is right.
A All right.

THE CHAIRMAN: It may be that this is a replacement copy, but it is usually fine.

MR KARK: Oh yes – I have stupidly left the old one in as well. (To the witness) Page 64, 12 August, 18.00 hours. "All medications – Patient drowsy".
A Yes.

Q Is that an indication that she was not given any medications because she was drowsy?
A Yes.

Q So on the evening of the day after her admission ---
A Yes.

Q --- when she had been prescribed Oramorph and given Oramorph, and also haloperidol, she was so drowsy that the nurses did not think it appropriate to give her any more?
A Yes.

Q Is that a fair way of describing that?
A Yes. She had had a dose of haloperidol that morning and she had had her lactulose that morning, and that evening she was too drowsy to take the lactulose or the haloperidol, and they quite appropriately did not give any Oramorph because it did not seem to be indicated. She was not in pain and she was not uncomfortable.

Q And she was drowsy?
A I do not think you can blame the Oramorph for the drowsiness that evening.

Q Would the haloperidol cause her to be drowsy at all?
A Possibly.

Q On 13 August as we know, this patient was found on the floor by Philip Bead. Apparently he checked her and put her into a chair and Dr Brigg contacted and advised an X-ray and analgesia. She was given Oramorph and haloperidol. It is plain from what follows that she would have been actually in some considerable pain because she dislocated her hip.
A Certainly.

Q Is that something which normal would be fairly visible?
A I never saw the X-ray; I do not know which way the hip dislocated.

Q On 14 August, she was reviewed by you.
A Yes.

Q She was screaming. It was not controlled by haloperidol, but she is said to be very sensitive to Oramorph.

"Right hip shortened. X-ray query is this lady well enough for another surgical procedure".

She was in fact taken back to hospital and operated upon.
A Yes, she had a closed reduction of the right hip, not an open operation, no cutting.

Q It was manipulated?
A It was pulled and manipulated under intravenous sedation.

Q Lesley O'Brien told us this:

"It turned out she had a fall. She dislocated her new hip. It took them 24 hours to transfer her back to the Haslar. She was admitted there and operated on successfully. She recovered consciousness the next day, took fluids and she was eaten and drinking.

A She only had minor discomfort. Within 24 hours she was up standing and weight bearing again, back to how she was before".

Is that evidence with which you are prepared to accept?
A I cannot accept or deny it. I was not there. I did not see her at the Haslar Hospital. I did not know what state she was in after being 24 hours unrousable after the midazolam.

B Q This was the lady who was previously a nurse.
A Yes.

Q The patient comes back to you on Daedalus ward and you knew on her transfer that this patient had been affected more than most by the midazolam that she had received.
A I knew that.

C Q So you knew that she was sensitive to morphine and you knew that see was sensitive to midazolam.
A No, I did not know that she was sensitive to midazolam. This was midazolam being used in a entirely different way. It was being given as a bolus intravenously to cause anaesthesia.

D Q As a pre-med?
A She was very slow to recover from that which I felt was the significant point to make a note of, in that she had been very slow to recover from another anaesthetic insult.

Q Perhaps it is misunderstanding, but if you say that somebody is sensitive to a drug does it not mean that they are going to react more than the normal person to it?
A Her brain reacted more than the normal way to a bolus of intravenous midazolam, not the midazolam itself but the way that her brain reacted to it.

E Q Do you still have your notes available to you? Could you turn up page 31 to look at the readmission. You describe her in this note as, "Now appears peaceful".
A At that moment in time when I examined her she appeared peaceful.

Q What time do you say this was?
F A I am sorry, I have no idea. I would imagine that it was lunch time, but I did not put a time on the admission note.

Q Because she is coming back from the main hospital, is she not, so she is not going to be arriving at 8.30 in the morning; the normal time of arrival would be lunch time.
A Yes.

G Q Can we keep a finger there please and go to page 47. Do you see at the top "17 August 1998 13:05"?
A Yes.

Q This is a nurse note by Miss Couchman.
A Yes.

H Q "In pain and distress. Agreed with daughter to give her mother Oramorph 2.5mgs. Daughter reports surgeon to say she must ---

A "Mother must not be left in pain".

Q "Mother must not be left in pain if dislocation occurs again".
A Yes.

Q "Dr Barton contacted and has ordered an X-ray".
A I imagine that at 13:0 5 I had been and gone and that when I saw her and readmitted her, she was comfortable, but she became subsequently uncomfortable at 13:05.

Q If she had been transferred in the way that has been described ---
A I have no explanation as to why when at the moment in time that I saw her she seemed comfortable, but that is the note I made.

Q I understand that. You are telling us that you believe that that was prior to the note made by Margaret Couchman. Is that right?
A Yes.

Q A further X-ray was to be taken.
A Yes.

Q Did you order it by telephone?
A And viewed by one of the partners.

Q When you came in on the 18th, had that X-ray been taken?
A Apparently it had and it had been viewed by one of the partners and Philip Bead's report that there was no dislocation seen. I understand that it showed a large haematoma at the site of where the dislocation had occurred.

Q Would you have asked to see that X-ray?
A No.

Q Why not?
A Because I am not an orthopaedic surgeon. I would accept what my partner and the radiologist said about the X-ray.

Q What about the radiologist's report?
A That would come back to me in due course.

Q Let us look at what happens to this patient hereafter. You make a note,

"Still in great pain, nursing a problem. I suggest subcutaneous diamorphine, haloperidol and midazolam. Will sees daughter today. Please make comfortable".

If we turn over the page, we can see your prescription at the top of page 13, Oramorph, diamorphine to start at 40mg and midazolam. As you know, Professor Ford has said about your prescription for diamorphine that that was high but not unreasonably so.
A Yes.

Q In relation to the midazolam, his view is that that was simply unjustified. What do you say was the purpose of giving this patient midazolam?

A A It was to provide her with relief of any restlessness and mental distress and to act in conjunction with the haloperidol which I swapped over because she had been having it orally and therefore continued to give it. Midazolam would also provide some sedation for her.

Q The diamorphine should take away her pain should it not?
A It should take away her pain.

B Q Which is what she was immediately complaining of.
A Yes.

Q You knew that so far as the midazolam was concerned when she had it in a different setting that she had taken rather longer than normal to recover from it.
A It was still an appropriate drug to use under those circumstances in that patient.

C Q Can we take it that you would have appreciated reading the hospital note, as apparently you had, that with this particular patient it was likely to have an extra sedatory effect?
A Possibly.

Q There was no need at all, I suggest, to add midazolam to this mix.
A In my clinical judgment there at the patient's bedside, it was an appropriate drug to D add to the diamorphine and the haloperidol.

Q Lesley O'Brien told us,

"On 18 August Dr Barton came in the doorway and folded her arms, lent on the wall and said, 'The next thing will be a chest infection'".

E So far as this patient is concerned, that is in fact exactly what happened is it not; she did get a chest infection?
A She did.

Q Do you accept that is something you may have said to Lesley O'Brien?
A I cannot imagine that I actually couched it in those terms, but I certainly would have been minded to tell the daughters that in view of the prolonged immobility and her general F state that she was going to develop a chest infection.

Q This lady's problem was a haematoma.
A It was a huge haematoma around the site of the operation, the prosthesis.

Q What active steps could be taken to relieve a haematoma?
A Nothing. G

Q Does it depend on the type of haematoma?
A Nothing could have been done for that haematoma.

Q Why do you say that?
A Had she survived, the body would eventually have resolved it and it would have hopefully drained away, but there was nothing surgical or acute or immediate that you could H do to relieve it. You certainly would not stick a needle into it or something like that.

Q Dr Barton, you had not seen it.
A I knew it was on the X-ray.

Q But you had not seen the X-ray.
A I knew what the X-ray showed and I was not minded to stick a large bore needle into the thigh of a lady who had recently had surgery to that hip to remove a collection of blood which in itself was not doing the patient any harm.

Q Why are you describing this as a massive haematoma?
A Because I think that is what was said on the X-ray report.

Q You are saying that there were no active steps that you could have taken?
A Nothing.

Q What can happen with a haematoma, as you have said, is that it can resolve itself.
A Yes.

Q But that takes time.
A Yes.

Q Did you think that provided you palliated her symptoms of pain carefully that this haematoma might resolve?
A Yes.

Q Would it be important to avoid bronchopneumonia to keep the patient in at least semi-conscious state, so that they could clear their own secretions. Would that help?
A Yes, but she had to have adequate analgesia and she had to have haloperidol for her terminal dementia and she had to have midazolam for her restlessness otherwise she would make the haematoma worse I imagine.

Q Lesley O'Brien said this:

"The amount they gave her caused her never to wake up again. She was not conscious; she was not screaming or moving or doing anything".

A She was not in pain and she was peaceful and she was comfortable which was the aim of the prescriptions, nothing else.

Q For peaceful we should read unconscious and unrousable.
A For peaceful you should read comfortable and free of pain.

Q Do you agree with Dr Lord when she says that sometimes what one has predicted does not happen?
A Are we talking about this?

Q No, she made a general comment.
A Yes.

Q One of the dangers of putting a patient on a terminal pathway, ignoring this patient for the moment, is that you might get it wrong. Do you agree?
A Yes.

Q Was this patient on a terminal pathway?
A When she came back having been unrousable for 24 hours approximately after her intravenous midazolam, she was on a terminal pathway.

MR KARK: Sir, perhaps that is a convenient moment.

THE CHAIRMAN: We will rise and return at 2 o'clock.

(Luncheon adjournment)

THE CHAIRMAN: Mr Kark?

MR KARK: Can we turn to the case of Mrs Ruby Lake, Patient F. This lady had been living alone. She is described on page 2 of our chronology as mobile, independent and self caring. and then she had the misfortune to fall and fracture the left neck of her femur. Post-operatively she suffered a degree of left ventricular failure.
A Yes.

Q She remained fairly unwell and she had bouts of breathlessness. On 12 August, if we go to page 8, we can see at the entry one above the bottom, that being 11 August, that she had a wash, her a bottom and sacral area were very red and breaking down. She was incontinent of faeces. She complained of stomach pain and remained very sleepy. Then on 12 August she is described as "Much improved. Has sat up today. Developing sacral bed sore". Would you agree that the picture of this lady is somewhat up and down; she has her good days and she has her bad days?
A Yes, and very slow to recuperate from the surgery.

Q Then on 13 August, page 9 of hour chronology, she was assessed by Dr Lord for her future management.

> "Post-op recovery was said to be slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work in her mobilisation".

The physio has visited her for the past six weeks. That was a referral to Dr Lord and then the review by Dr Lord takes place over the page at the top at page 10. She is said to be catheterised.

> "Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease, LVF [left ventricular failure] have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement".

The lady was obviously fairly poorly.

A A Yes.

Q In the following entry on 14 August she is described by the physio as, "Brighter today. Sitting out. Walked short distances with a frame + 1 - managed very well" and then the plan is to gradually increase her distance of walking as her energy increases. Again, it is the same picture, up and down days; she can be brighter and better and moving with a frame. Do you agree?

B A Yes.

Q On 15 August, page 12, she is given codeine phosphate, no doubt that would be for pain would it not?

A Yes.

Q "L [left] sided chest pain in ribs through to back - since being manhandled". I do not

C want to be critical of anybody outside this room, but the day before she had been reviewed by a physio who had plainly walked her for a distance with a frame.

A Yes.

Q I suppose it is not inconceivable that that manhandling by the physio might in fact the next day have been causing her problems. Yes?

D A It is possible, yes.

Q If that is right, if it is the manhandling that had caused her some pain, it is the sort of pain, hopefully, that would resolve itself.

A Yes.

Q It is not a chronic sort of pain; it is the pain as a result of the exertions of the day before.

E A Yes.

Q I should go on, she is also said to have pain in her left shoulder from arthritis, but she has paracetamol to good effect, which would mean that the paracetamol appears to have controlled the pain.

A Yes.

F Q Go to page 13, over the page, please. On 17 August she is described as being "well. Mobilising slowly. Awaiting transfer to GWMH". She is described by the physio as,

> "bright. Sitting out in a chair. Independent to sit and stand. Mobile with Zimmer frame and supervision. Managed well".

G So again I am not going to try and make out that this woman is going to be dancing down the steps the next day, but again it is a picture of this lady being capable of movement and having her good days.

A Slow improvement.

Q Then we can see at the end of that day's entries that at 20.15 she seemed confused in the afternoon. She had had a spike in temperature, 38.8. That is not a very high temperature, is it?

H A No.

Q She had been given some paracetamol. The next day,

"Reviewed by SHO at the Royal Hospital, Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3",

So that is relatively normal, is it?
A Yes.

Q "Mobilising well. To go to GWMH today".

There is then an entry at 02.00,

"Increased shortness of breath. Recommenced on oxygen therapy".

I suppose that must have taken place before the entry I have just read. They are the wrong way round.
A I cannot tell you whether it happened the morning she was transferred or the morning before the day she was transferred.

Q I am presuming this note is made on 18 August at 2 o'clock in the morning.
A In which case it is the day before.

Q Why cannot it have happened on 18 August when she is transferred?
A I do not know. It could be either. It is not clear from the chronology.

Q If we need to we can have a look at the note, which is page 614. That would appear to be a note made at the Royal Haslar, would it not?
A Yes.

Q It is 2 o'clock in the morning, as we can see, on 18 August.
A So it is the day she was transferred and she had an episode of shortness of breath in the night.

Q Did you have the ability to give oxygen therapy at Gosport?
A Yes.

Q So these entries are, I think, the wrong way round. The next entry is,

"Reviewed by SHO at Royal Hospital Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3. Mobilising well, go to GWMH today".

She is then transferred to your hospital, Dryad Ward.
A Yes.

Q We see there is a fairly lengthy transfer letter:

"Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved, it appears. Presently she is slowly mobile with Zimmer frame and supervision. Able to wash top half

independently but requires help to wash back and bottom. Bilateral leg ulcers redressed every 4-5 days. Has broken area on left buttock and in cleft of buttocks – improving. Has small appetite, oral fluids need encouraging. Urinary catheter in situ. Diarrhoea resolved. Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing".

That is not a particularly gloomy outlook, is it?
A No.

Q Then she is reviewed by you on the same day as the entries we have just looked at.

"Transfer to Dryad Ward continuing care".

Then you set out her history. Past medical history angina, CCF. I cannot again remember what that is.
A Congestive cardiac failure.

Q I am grateful.

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death".

What you told us about this lady, as I understood it, is that this is a lady who is at the end of her life and is likely to be on a terminal care route before too long. You said your comment about gentle rehabilitation was slightly tongue in cheek. Can you help us with that?
A No. She was entitled to come to the ward. She was entitled to be considered for gentle rehabilitation, but with her co-morbidities and risk factors, I was not enthusiastic as to whether rehabilitation would work for her. It follows on from Dr Lord's note that she had cardiac problems and might not make a full recovery.

Q I understand that, but did you regard her, I think you said – I should have checked the transcript – as a lady who was at the end of her life?
A She was certainly towards the end of her life, but whether it was days, weeks or months I was unable to say on that first assessment of her on the ward.

Q Likely to be on a terminal care route before too long. Why?
A With her past history of angina and congestive cardiac failure, with her dependence. Her Barthel 6 does not really give a good assessment of medical co-morbidities. It only refers to the activities of daily life. This was a potentially very ill elderly lady.

Q Potentially very ill.
A Yes. I saw them week in, week out, year in, year out. I looked after hundreds and hundreds of these ladies. The fact that you fall and fracture your neck of femur is often a very strong pointer to the fact that you are nearing the end of your life.

Q It can be, can it not?
A It can be.

Q It is certainly an unfortunate event for any elderly person.
A It is a very major life event for some of these people with major health problems.

Q Many recover, do they not?
A Many recover.

Q This lady again, as with many others that we have looked at, up until this stage, her pain had, I think, been controlled by paracetamol.
A It had.

Q Apart from the early days, no doubt when she had to have her operation, totally opiate naïve, yes?
A Yes.

Q Can we look at your prescription, please, page 16 of the chronology? You prescribed Oramorph, 5 – 10 mg as required. Temazepam, 10-20 mg as required. Was that to help her sleep?
A Yes.

Q Diamorphine by syringe driver, 20 – 200 mg. Hyoscine and midazolam, 20 – 80 mg. Yes?
A Yes.

Q This was one of your anticipatory prescriptions, was it?
A It was.

Q It allowed the nurses at any stage thereafter to initiate effectively what would have been the end of this patient's life, the beginning of the syringe driver.
A Yes.

Q You thought that was appropriate, did you?
A I did.

Q Her Barthel was 6, rather better than many that we have seen.
A But as I said, the Barthel only refers to a measurement of the activities of daily living. It does not give you a score as to frailty of the cardiovascular system, or severe dementia, which she did not have. It is only a measure of one of the strengths of the patient. It does not measure all of them.

Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the BNF of course.
A Of course.

Q On the day of her admission – let us look at what happened if we go back to page 15 – it looks like she was given 5 mg of Oramorph as soon as she arrived. Is that right?

A A At 14.15, fairly shortly after she arrived, I imagine.

Q She had not been given any Oramorph at the previous hospital, had she?
A She had not, but she had undergone the trauma of a transfer across, being unloaded into a bed, being assessed by myself and the nurses. She probably deserved a small dose of adequate analgesia at that point.

B Q This is a comment that you have made previously, "She deserved Oramorph". Can you just explain to the Panel what you mean by that?
A My patients did not have to suffer pain unnecessarily.

Q There is no suggestion that this patient was in pain, is there?
A The nurses would not have given that dose of Oramorph if they had not felt that she required it for pain.

C MR LANGDALE: You say no sign of pain. Perhaps you should look at page 15, Barrett.

MR KARK: Thank you.
A She had leg ulcers. She had a sacral pressure sore. She had undergone a journey and she had had a fractured neck of femur repaired. It is quite possible she was in quite a lot of pain.

D Q You concluded that she, as you put it, deserved Oramorph.
A Yes.

Q Let us look at what happens to her in the evening.

E "Settled and slept well 22.00 until midnight. Woke very distressed and anxious, says she needs someone with her. Oramorph 10 mg given 00.15 with little effect. Very anxious during the night. Confused at times".

Yes?
A Yes.

F Q If a patient is confused, Oramorph is not something that is likely to assist them, is it?
A No, but if she is beginning to go into a little bit of congestive cardiac failure, lying flat in the bed at night, it is a very appropriate drug for the night staff to give at that time.

Q How would you diagnose congestive heart failure?
A It is something the nurses would assess when they saw her. They knew her history from the notes. They knew that it was possible that it was going to happen to her and they would act appropriately.

G Q How do you diagnose it?
A You have got to listen to the chest and see if they have got any creps at the basis of the lungs. Night staff do not normally carry stethoscopes. They would be making a clinical judgment that this lady needed Oramorph.

H Q Would they be looking at this patient without a stethoscope and saying to themselves, "I reckon this lady has got congestive heart failure"?

A Yes. They knew she had congestive heart failure. They knew that she had been breathless the night before her transfer.

Q That is something the night staff would be doing, is it, diagnosing congestive heart failure?
A It is quite appropriate for them to deal with it in that way at that time of night.

B Q What she actually wanted, this lady, was for someone to sit with her.
A That is what she said, yes.

Q Yes. That is what she said. Of course we do not know what the staffing levels were like on that particular night, but it would not be an appropriate response to this patient if somebody could just sit with her, to give her morphine, would it?
A If that is what she said, is what she meant and was the only problem she had that night, it would have been very nice if there was someone available to sit with her. But she remained confused and very anxious. I would think it was the confusion that made her say she wanted someone with her. I was not there. I cannot tell you what the situation was clinically, but I feel it was appropriate that the night nurses gave her a dose of Oramorph at that time of night to settle her and make her more comfortable.

Q But which might, do you agree, have increased her confusion?
A Not a dose of 10 mg orally, no.

Q You do not think so?
A No.

Q An elderly frail patient just moved to new surroundings.
A I do not think so. She had no problems with the first dose after her arrival in the afternoon.

Q How do we know that?
A Because they would have mentioned it in the nursing report had they had any major problems.

Q Do elderly patients sometimes hallucinate with small amounts of morphine?
A Occasionally.

Q Page 16 again please. Just looking at your syringe driver prescription, I mean if the nurses had given that prescription, administered that prescription, even half-way up the scale, at 100 mg diamorphine and 40 mg of midazolam, might that have killed the patient?
A Certainly.

G Q Shall we go over to see what happened to the page, over to page 17? Nurse Hallman has made an entry at 11.50,

"Complaining of chest pain, not radiating down arm – no worse on exertion".

Is that an indication that it may not be a heart problem?
A She felt that it might not be a heart problem.

H

Q "Grey around mouth" would indicate what?
A That it might be a heart problem. It was more serious than a musculoskeletal strain that she had suffered before her transfer to us.

Q What should be the normal immediate reaction if this lady is suffering a degree of heart failure?
A Give her a dose of morphine.

Q How would you do that?
A She had Oramorph written up on the drug chart, so she very properly gave it.

Q I think you said, so far as the syringe driver is concerned, that you may have been in hospital and you would have sanctioned this.
A I would.

Q This lady, at 4 o'clock in the afternoon, the day after she arrived at your hospital, has a needle inserted into her and a syringe driver started.
A Yes.

Q That, so far as this lady is concerned, as you put it, she is now in her terminal stage.
A Yes.

Q You think you were chairing a meeting at the time.
A Yes.

Q But you would have agreed to the syringe driver being started once it had happened.
A They did not put the syringe driver up until 1600 so it is quite possible I would have seen her and assessed her before they put the driver up, after they had given the Oramorph.

Q And the dosage that she was given – I think previously – the day before, she had had 10 mg, had she not?
A Yes.

Q And then on that day she had had 20 mg. I am sorry – no. The day before she had had 5 mg. Then she gets 10 mg at quarter past twelve, so we are now into 19 August, and a further 10 mg at 11.15. Yes?
A Yes.

Q So the day before she was on 5 mg. At this stage she has 20?
A Yes.

Q And she started at a dose of 20 mg. The equivalent dose would be 60 mg of Oramorph. Yes?
A Yes.

Q To which you added midazolam?
A Yes.

Q What note is there to reflect that this lady is now in the terminal stage of her life?
A There is no note to record that.

A

Q Either by a nurse or by you?
A No.

Q No note at all?
A No note at all.

B Q Do you think that is acceptable?
A No.

Q Was there a culture on this ward of just not bothering to make a note about these sort of significant events?
A No.

C Q You were not making notes, were you?
A I was not good at making notes, but my nurses were certainly usually considerably more conscientious about making notes than that particular day.

Q And you did not pick up that your nurses had not made a note?
A I did not, no.

D Q Some 17 hours later, if we go over the page... We should, perhaps, with the bottom of page 17.

"Condition appears to have deteriorated overnight. Driver recharged 10.10."

A Yes.

E Q

"Family informed...

Night: General condition continues to deteriorate. Very bubbly."

That would be an almost inevitably consequence of the syringe driver causing this patient to lose consciousness, would it not?
F A That would be the inevitable consequence of her congestive cardiac failure causing her to retain secretions both in the lungs and in the upper respiratory tract.

Q

"Ruby rousable and distressed when moved. Syringe driver recharged at 07.35 (on 21st)."

G A So she was not unconscious and she was not over-sedated.

Q She is rousable when moved?
A Yes.

Q The following day, at the top of page 18 – in fact it is 20 August – the diamorphine is doubled?
H A Yes.

Q The midazolam is doubled?
A At 16.50.

Q At 16.50.
A Yes. The initial doses are discarded and the hyoscine is also increased at 16.50 because she was increasingly bubbly.

Q Some 15 hours later, I think it is, the diamorphine is put up again. The midazolam is put up again. Yes?
A Yes.

Q And all of this is occurring, we need to remind ourselves perhaps, within three days of her being described as well, comfortable and happy?
A Yes.

Q She is now at the very end of her life, is she not?
A Yes is.

Q Let me remind you of what Diane Mussell had said about this patient. She was moved to the GWMH on 17 August. I think she is a day out in her dates, is she not? Yes. "She seemed clean and well cared for. She was able to talk until late on 19 August when she was quite agitated and depressed. I felt there was a good chance she would be coming home. By the 20th there was a notable deterioration. She was unable to respond, either through hand gestures or oral communication. I think she was on a syringe driver by that time." She went on to say, "There was nothing that struck us out of the ordinary regarding her care." Anita Tubbritt gave evidence about this patient on Day 14. She said the decision to increase the dose – and this is on 21 August – from 40 to 60 would have been "a joint decision between me and Nurse Turnbull. I cannot remember the basis for it. On 19 August, the patient was deteriorating. That would mean the patient's breathing. Perhaps there was discomfort or distress, physical pain, pain, agitation, probably all those things." But again, with a lack of notes, she was not able to say?
A Yes.

Q You recorded her cause of death as broncho-pneumonia. You would accept, would you not, that the sort of drugs that this patient was being given could in fact effectively initiate broncho-pneumonia?
A I think that the condition she was suffering from could well end up as broncho-pneumonia. Broncho-pneumonia is a common terminal event in congestive cardiac failure.

Q Did you at any stage, if a patient had become unrousable, as I suggest this patient had according to the evidence of Diane Mussell on the 20th; she was unable to respond either through hand gestures or oral communication – did you consider reducing the dose?
A I did not.

Q How often, can you help us, did you ever reduce the dose of a syringe driver?
A I would be unable to tell you at this remove of time.

Q It is not something that happened very frequently, is it?
A I would think probably not.

A

Q You also said about Professor Ford's evidence that the criticisms by Professor Ford "do not give me cause to question my judgment"?
A I did.

Q You said that on other occasions as well?
A I did.

B

Q Do you mean that? That they do not even give you pause for thought about your judgment?
A I do.

Q The effect of that answer is to demonstrate, is it not, that if allowed to do so, you would behave in exactly the same way again?
C A I have not been practising palliative care in any form since 2002.

Q I understand that,
A And the whole ethos of palliative care and possibly, I suspect, terminal care, has change din the intervening ten years since I last did it. I think that staffing levels and protocols nowadays would mean that you would not practise anticipatory prescribing and syringe drivers would not be put up in the same way that we had to do them all those years
D ago.

Q But, Dr Barton, having listened to the evidence, apart from your failure to keep notes?
A Yes.

Q You simply to not accept the criticisms of Professor Ford, do you?
A I do not.

E

Q I do not think there is any purpose, in light of those answers, in taking you to the charges. You do not accept your prescriptions were either inappropriate or not in the best interests of Patient F?
A No.

Q That is in spite of you agreeing that they were potentially hazardous. Yes?
F A Yes.

Q Let us move on, please, to Patient G. Arthur Cunningham we know had been looked after for a while by Dr Lord at the Dolphin Day Hospital. He had been a fairly frequent visitor to the Dolphin Day Hospital and then, on 21 September, if we go to page 8 of the chronology, which is where I am going to start, he was again reviewed by Dr Lord at the Dolphin Day Hospital in relation to his sacral ulcer. He was admitted to your hospital. The
G purpose of his admission to your hospital was for aggressive treatment of his sacral ulcer. Do you agree?
A It was.

Q Obviously you were, or should have been, better equipped to deal with his sacral ulcer than either a nursing home would have been or the Dolphin Day Hospital would have been?
A Yes.

H

Q If we go over the page, to the top of page 9, this was the patient who had not been swallowing his tablets and we can see the plan set out by Dr Lord. His laxatives and antibiotics were stopped.

"(2) Dryad today, Aserbine for sacral ulcer, nurse on ---"

Is it "site" or "side"?
A Side.

Q

"... on side, high protein diet, Oramorph ... if pain
(3) N/Home [Nursing home] to keep bed open for next 3/52 [3 weeks] at least
(4) Patient informed of admission – agrees
(5) Inform N/Home, Dr Banks + social worker. Prognosis poor."

Yes?
A Yes.

Q We can see that the plan was to admit him to Dryad Ward for treatment of his pressure sores and then you reviewed him, as we see at the top of page 10 of the Dolphin Day Hospital. Yes?
A Yes. It says reviewed by Dr Barton on Mulberry Ward. That is not correct.

Q I have crossed that through on mine.
A I saw him with her at the day hospital and then was invited to look at the sore on Dryad Ward.

Q You agreed for him to be admitted. Yes?
A I did.

Q Your note, would you agree, is rather more pessimistic than those that had preceded yours?
A Yes.

Q "Make comfortable" – and that is code, is it not, for palliative care?
A Yes.

Q

"Give adequate analgesia. Happy for nursing staff to confirm death."

Yes.
A Yes.

Q All of that note reveals, does it not, that this patient was in fact so far as you were concerned on a terminal pathway?
A Yes.

Q Did you tell him that?
A No.

A Q Did you tell him that the likelihood was that as soon as he got to your hospital, he would be on a syringe driver?
A No.

Q Did you have any intention, in fact, of trying to cure his sacral sore?
A I was happy to follow the plan given to me by Dr Lord with the nursing procedure, to try and get to the black eschar of the surface of his sacral wound and to try and improve his B nutrition, which had obviously been very poor for several weeks in the nursing home, and to make him comfortable. I was entirely following what Dr Lord had laid down for me but it was the second worst sacral sore I have ever seen in my medical career, and I did not feel when I saw it that afternoon that we had a snowflake's chance of healing it. It was right down to the bone.

C Q And your view was that it was not going to be practical to try and give him a high protein diet?
A I was happy to get the nursing staff to order the high protein diet from the kitchens, but I was much more preoccupied about making him comfortable than worrying about what the nurses were going to give him to eat.

Q Day 11, page 78 in the coroner's inquest, you said this:

D "I agreed with Dr Lord that his prognosis was poor. It was not going to be practical to try and give him high protein diet."

A This is a nursing procedure, not a medical procedure. The nurses order from the kitchens what they consider to be a high protein diet and, had it been appropriate, of course we would have given it to him.

E Q Why was it inappropriate?
A Sorry?

Q Why was it not appropriate to give him a high protein diet?
A Because he became seriously ill that evening and it was not appropriate then to try and give him a high protein diet.

F Q What did you expect the nurses to follow?
A The guidance that they had been given by Dr Lord. It was not at variance with anything I said or did. It just became impractical to give a man a high protein diet when he needs a syringe driver.

Q So when you, their resident doctor, assessed him and simply revealed than in your view he was to be made comfortable ---
G A Yes.

Q --- and had to be given adequate analgesia?
A Yes.

Q You nevertheless expected the nurses, did you, to follow a route which you considered to be impractical?
H

A I probably did not even discuss whether it was impractical or not. They had the instructions from Dr Lord, and they would have set in motion the Aserbine and the high protein diet.

Q But, Dr Barton, these things do not happen in a vacuum, do they? You were not simply making a note, and then leaving the hospital. You would have been speaking to the nurses, would you not?

B A I would. And I would have said that in my opinion he was to be made comfortable.

Q Yes. You would have reflected quite clearly to the nurses your pessimistic outlook, would you not?

A Yes. I would. I do not think it was pessimistic. I think it was a realistic outlook, faced with the sight and smell of the sore.

C Q And the reality of this patient was that before he had ever even got into Dryad Ward so far as you were concerned he was on a terminal pathway?

A Yes.

Q Let us have a look at the prescription, please, that you wrote out at page 12. You wrote him up for Oramorph. You wrote him up for diamorphine. I am not going to go through each of these any more, and you will appreciate why, and you wrote him up for

D midazolam?

A Yes.

Q In the evening of his admission, he was given Oramorph. In fact he was given Oramorph in the afternoon and then again in the evening?

A Yes.

E Q We have to look, I think, at the note on page 13 before we come back to see what happened to him that night. Page 13, at the top of the chronology, is a note made by Nurse Hallman on 22 September. It talks about an episode the evening before. Yes?

A Yes.

Q When this patient, on any view, if the note is right, had behaved very badly indeed.

F A For a very good reason – probably that he was in a lot of pain and distress at that time, to cause him to behave like that.

Q He was certainly very confused, was he not?

A He was.

Q Whether it was pain causing his confusion or anything else, there is no reason for this man to have behaved in that way unless there was something wrong?

G A Unless he was toxic and in a lot of pain and confused.

Q You said "toxic and in a lot of pain and confused". Undoubtedly he must have been very confused, must he not. Yes?

A Remember, I had seen the sore that afternoon. I knew how toxic he was likely to be, having just stopped the antibiotics at the day hospital because they had been ineffective. He was likely to be toxic as well.

H

Q When you talk about a patient being toxic, do you mean that they have toxins in the blood?
A Yes.

Q Is that something that is relatively easy to check?
A To ---?

Q Check.
A If you had the facilities to do blood cultures you could check for toxins in the blood. We did not have facilities at the hospital to do blood cultures very often.

Q You could take bloods though, could you not?
A Not at that time of night, no. We had a blood lady who came on week-day mornings and took blood, and then it was taken to the main hospital at lunch times.

Q If this was an urgent - you are a doctor you could take blood could you not?
A I would not be taking blood under these circumstances.

Q Let us see what happened. He remained agitated until approximately 8.30 in the evening. We know that he had been given Oramorph 10 minutes or so before becoming calmer. If we look at page 11, it is quite complex. You see right at the end of the entry on page 11, "Oramorph 10mg at 20:20". Yes?
A Yes.

Q That seems to have been effective because he remains agitated until 20:30, no doubt when the Oramorph kicks in?
A I think that is very quick. Yes, I suppose it was beginning to kick in and then at the same time they put up the syringe driver.

Q The syringe driver was not started until 11.
A I beg your pardon, I am looking at the following night. That night it was 23:10.

Q The syringe driver was put up shortly after 11 o'clock at night.
A Yes.

Q As requested. Have you been able to glean from listening to the evidence or reading the notes who requested it?
A No.

Q The syringe driver being set up at that time of night would be done without your verbal authority would it not?
A I would not be in the hospital. It is quite possible that they rang me earlier in the evening and I suggested the Oramorph to proceed to the syringe driver if they felt that they were not going to be to control his symptoms overnight, or they may have gone ahead on their own say so knowing that I would be the following morning.

Q The scenario is this: either they telephone you at the time, but you certainly do not re-examine the patient?
A No.

A Q Or they set it up of their own volition, and obviously you certainly do not re-examine the patient.
A No.

Q The time that you would have next seen the patient at best guess would be the following morning.
A Yes.

B Q Unless the patient was in significant pain, setting up a syringe driver would have been quite unjustified would it not?
A No.

Q Can you tell us why not?
C A I have suggested that he was in pain; I have suggested that he was very confused, agitated, restless, frightened, all of the reasons for which I would want to put up a syringe driver to give him both diamorphine and midazolam to control his symptoms.

Q You would be content, would you, that this patient who was transferred to your hospital on that day for treatment of his sacral ulcer is started on an end of life progress by way of syringe driver?
A I would if it was appropriate and he needed it.
D Q You would not say to your nursing staff "Hold on, that is going to mean the end of this patients life. Let us just wait until the morning, give him Oramorph."
A If they felt that that was the appropriate course of treatment to take that night, I would have agreed to it. I had seen him that afternoon. I knew what clinical state he was in that afternoon.

On the 21, that day, he had told Mr Farthing that his behind was a bit sore and asked for some
E chocolate. Yes?
A I can make no command about that conversation, I was not there.

Q It certainly appears that he was able at times to eat and certainly drink because he had two glasses of milk that night.
A Yes.

F Q There was absolutely no reason not to give him Oramorph until the morning was there?
A Certainly, except the clinical impression of the night staff was that he needed subcutaneous analgesia and they put it up.

Q Let us have a look at page 13. The syringe driver has been started and the driver is said to be running as per chart. Over the page, we can see the syringe driver was continued at
G 20:20 in the evening. On 23 September, he is described as becoming in the evening a little agitated, "syringe driver boosted with effect". Can you help us, this was your hospital and your nurses, what would you take that reference to be?
A I was aware that there was a button on the side of the Graseby syringe driver that it says on it "start, boost" but I was not aware that you got a very large dose of anything that was in the driver if you pressed the button. I always felt that it was probably more satisfactory for the nursing staff to feel they had done something to help relieve the pain than
H that he had got an increased dose of opiate or midazolam, otherwise the driver would have

run out much more quickly if you had been able to increase the rate. It would have run through more quickly which, as far as I know, it did not do.

Q Can we look later at what happened later on the 23rd, if you go to page 15. This is the morning, diamorphine continued at the same rate but midazolam tripled. Yes?
A Yes. You have missed out a day; you have missed out the point at which because he was toxic he became chesty overnight and I added hyoscine into the driver to control his chestiness. That is the 23rd.

Q I beg your pardon. I am going to come back to page 14 in any event, but I am just looking at the prescription and what was administered to him. I want you to deal with the tripling of the midazolam. In normal circumstances - we have looked a lot at diamorphine - midazolam would also have a very sedatory effect would it not?
A It would be very effective for terminal restlessness and agitation.

Q Professor Ford described this as a very high dose for this patient which would produce very marked sedation. Would you agree with that?
A It was an appropriate dose in the minds of the nursing staff and myself to give him at this point in his terminal illness.

Q Let me try it again. Do you agree with Professor Ford that this was a very high dose which would produce very marked sedation?
A It would produce different individual effects in individual patients and in this particular patient it did not produce an excessive amount of sedation, either at the dose of 20 or at 60mg.

Q On the 24th, we can see first of all at what happened to him and then we will look through the notes, at the bottom of page 16, diamorphine is doubled at 10.55 and then it is increased to 69, so in one day in fact it has tripled has it not?
A Yes.

Q The midazolam goes up to 80mg.
A Yes.

Q Let us have a look at the notes going back to page 15. You note that he remains unwell

> "Son has visited again today and is aware of how unwell he is. Sc analgesia is controlling pain just. Happy for nursing staff to confirm death".

That I think is actually the first explicit reference to pain except from his old back injury.
A And his knees.

Q Did you at any stage re-examine this patient to see what was happening with his sacral sore?
A The sore? No.

Q Did you re-examine this patient?
A I re-examined the patient, but I did not turn him over and look at his sacral sore.

Q At the top of page 16, this is a note from Nurse Hamblin

"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 40mg, midazolam 80mg and hyoscine 800mcgm. Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. ... Nursed on alternate sides during night, is aware of being moved".

Then he is said to have a peaceful nights sleep.
He was already on an increased dose of diamorphine of 60mg and 80mg. Can we look just in the middle box at page 17. "Peaceful night, position changed". Yes?
A Yes.

Q Over the page to page 18,

"Condition appears to be deteriorating slowly. All care given ... mouth care given".

The driver is now recharged with another increase. Yes?
A Yes.

Q On the basis of the notes, can you see any justification for that?
A Whoever was responsible for changing the syringe driver must have decided in consultation with me or whoever was on duty that day that the increase was appropriate to control his condition.

Q On the basis of the notes, can you see any justification for that increase?
A There was nothing in the notes in justification or otherwise.

Q When we looked at the nursing notes earlier, we saw a similar failure did we not? This is not just a one off failure is it?
A No.

Q I am going to suggest to you again there was a culture here of simply not bothering to make notes. Do you accept that now or not?
A I do not. There was a culture of both myself and my nursing staff doing our very best to give the most appropriate treatment and care to our patients and neglecting the paperwork.

Q Giving this patient on 26 September 1998 diamorphine at a rate of 80mg and the midazolam at 100mg of which Professor Ford was very critical and described it as a very high dose indeed, those doses ran a clear risk that the drugs would bring about the end of his life.
A He was dying. He was reviewed on that day, 26 September, by my partner, Dr Brooke, who also obviously felt that the medication was appropriate for his condition at that time.

Q Let me remind you of the words of Mr Farthing. He spoke about telephoning the ward and was told that his stepfather had become aggressive to the staff and they had given something to calm him down. "I said I would be in the next day to have strong words with him". This now is 23 September.

"I went to the ward. He was unconscious, unrousable, he was totally different. He had gone from a normal person to someone who was totally comatose".

If that reflects this patients position, that is not acceptable is it?
A What you are seeing from the clinical notes that we did make, that was not the position. This was a man who was obviously toxic when he arrived at the day hospital on the Monday afternoon. He became increasingly confused and toxic during the evening and on the following morning he required an appropriate dose of sedative and analgesics which would have made him much more comfortable. He was not unconscious or unrousable.

Q By the 24th, if we go back to page 16, he was on 40mg which was increased to 60mg of diamorphine and midazolam at 80mg. Yes?
A Yes.

Q Mr Farthing said this:

"Dr Barton not come in until the next day of the 24th at around 5 pm. He had not become conscious all day. Dr Barton told me bluntly that he was dying from the poison emanating from his bed sores".

Yes?
A Yes.

Q That is your evidence now.

"She refused to remove the syringe driver due to the pain he would experience".

Let me pause there for a moment. You have referred to him in your notes as his son. Yes?
A In the statement I wrote for the police I referred ---

Q In your clinical notes, page 15 of the chronology,

"Remains unwell, son has visited him again today".

Yes?
A Yes.

Q Did you know whether he was a stepson or a son?
A I cannot remember.

Q He was clearly a very caring and loving relative was he not?
A Clearly.

Q Why could you not reduce the dose so that he could speak to his father?
A Because his father/stepfather was in the terminal phrase of his life. My duty was totally to his father and it would have been inhumane to stop the infusion of the opiates and the anxiolytic.

Q Inhumane to this man who two days earlier said that his butt was a bit sore and he was requesting some chocolate.

A A Inhumane to that man in the condition that he was in on the ward that day.

Q You told the Panel, "If I had felt he was over sedated, there would be no problem in reducing his opiates". Is that still your evidence?
A Quite right.

B Q Whether Mr Farthing was a next of kin or a loving relative, would you have taken account of his sentiments?
A No.

Q No?
A No, my duty lay to Mr Cunningham.

C Q So it does not matter if he is the next of kin or anybody else does it?
A No.

Q Going back to the initiation of the syringe driver, can I just remind you of what Ingrid Lloyd said to us on day 14 and then I am going to ask you to comment on it. She talks about 21 September. Let us go back in the chronology and remind ourselves where we are. This is on the day of his admission. She says that Nurse Hallmans entry is a retrospective one and that was in relation to the events of the night before.
D A Yes.

Q In that the events she described had already been happened.

> "They were mentioned in handover. It was with this knowledge that she and I agreed that a syringe driver should commence. This was done so that Mr Cunningham remained in a pain free and peaceful state. Although I have stated in the notes Mr Cunningham was peaceful at 2030 hours, it was not certain he would remain in this state. The syringe driver was not commenced until 2310 hours as it required two nurses and Fiona Walker wasn't available until this time as she had other duties to attend to as the night nurse in charge".

E I will continue so that you have the full picture.

> "The purpose of the syringe driver was to enable a pain free and peaceful state for Mr Cunningham. With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Shirley and Fiona. The drugs were being prescribed to be given at our discretion".

F Let me just take you back.

> "Although I have stated in the notes that Mr Cunningham was peaceful at 20.30, it was not certain that he would remain in this state, and it was started at 10 past 11 because it required two nurses".

G If a syringe driver was being administered in an anticipatory manner, on the basis of your anticipatory prescribing, that would not be a very satisfactory state of affairs, would it?
A I think in this particular circumstance it was perfectly appropriate for them to use that method of administering the opiate and the anxiolytic to a patient who had previously shown,

H

through the latter part of the day, that his behaviour became very disturbed and difficult both for himself and other patients, as well as the staff, if he was not given adequate analgesia and sedation.

Q That rather reflects the comment I think you made yesterday. "I take this stand by what I did".
A I do.

Q If this patient had become conscious at Mr Farthing's request; you had reduced the dose and he had become conscious and had the ability to ask you to remove the syringe driver, would you have done so?
A It is a hypothetical question. I cannot answer it.

Q Mr Farthing was asking you to reduce the dose so that he could speak to his father. If his father had then said, "I am sorry, I do not want to die in this way".
A I could not have been put in that position of being asked to do that, because I would not have agreed to reducing the amount of analgesia he was being given for very good clinical reason.

Q Let me put it another way. If a patient says to you, "I don't want that thing in me. I would rather die as conscious as possible", you would not be able to put a syringe driver into that patient, would you?
A That is the situation that Dr Lord was talking about, not initiating analgesia at the request, in her case, of the next of kin or, in your hypothetical case, the patient themselves. The patient has a perfect right to say, "I do not want any analgesia. I wish to die in agony".

Q The patient has the perfect right to say, "Take that thing out of me".
A Certainly.

MR KARK: Would that be a convenient, moment, sir.

THE CHAIRMAN: Yes, I think it would. We will return at half past three.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everybody. Mr Kark, before you begin, I just want to say, Dr Barton, I have been reminded that this is not an endurance competition and this Panel well understand the stresses that extended cross-examination places on any witness. You have heard me say this before and Mr Kark invited you at the beginning of his cross-examination, if at any time during the course of the day you feel you have reached that point when you have had enough, then please say so and we will not subject you to further questions at that point. If you are happy to go on now we shall proceed.

MR KARK: Dr Barton, I was proposing to try and deal with two more patients this afternoon and then stop, but again, if you do not feel awake enough or capable, then just indicate and we will stop. I did mean, however, to ask you just one more question about the last patient, Arthur Cunningham.

You are charged with not obtaining the advice of a colleague when his condition deteriorated, and you have admitted that you did not. I just want to have your evidence. Do you accept

that you either could or should have sought advice, either as his condition deteriorated or when Mr Farthing asked you to stop the medication, as it were?
A I have been considering your question during the break. I have never, in 35 years of practising medicine, been asked by anybody to withdraw, or withhold analgesia so that they could die in pain. I have never been asked by a relative to withhold or withdraw analgesia. I was just completely knocked sideways by the question you asked me. I felt perfectly competent to deal with Mr Cunningham's problems and his terminal illness. It was just that your idea of withholding analgesia from somebody who was dying was just abhorrent to me.

Q Right. Did you think about obtaining the advice of one of your consultants when you had the son or stepson there saying, "Please, do not necessarily stop but perhaps reduce the dose so I can speak to him"? Did you think it would be appropriate to take the advice of a consultant?
A No.

Q This is a situation which you have just told the Panel was totally novel to you.
A Abhorrent. I did not say it was novel. I said I just could not consider anybody wanting to put a loved relative through that sort of pain that would have ensued had the analgesia been reduced.

Q Dr Barton, with respect, that is your take on it. Mr Farthing did not want his father to be in pain. He wanted to be able to speak to him. You understand that, do you not?
A Yes.

Q He was not doing it so that his father could relive any pain. That was not the purpose of his request, or did you think it was?
A No, I did not think that for one moment, but that would have been the effect.

Q The reason I said it was novel was because you have just said that in 35 years it had never happened to you, so it was, with respect, for you a novel experience.
A A first, yes.

Q Let us move on. Patient H, please. This is Mr Robert Wilson. This is the gentleman who was or had been an alcoholic, effectively.
A Yes.

Q He had alcoholic liver disease.
A Yes.

Q He had fractured his left humerus in a fall on 21 September and it seems that he did not want it to be repaired. He did not want to undergo an operation.
A Yes.

Q His wife did not return from her holiday. His sons only found out what had happened to him about a week after the event. You, I think we can safely say, have no independent recollection of him.
A No.

Q In relation to this patient, you have accepted, I think, that you knew that this man had been or was an alcoholic and had alcoholic liver disease.

A A Yes.

Q He had, during the course of his stay at the Queen Alexandra, on a number of occasions, had paracetamol. He had also had, I think, codeine. On 3 October he had had 2.5 mg of morphine because his arm was hurting him.
A Yes.

B Q That was by way of injection.
A Yes.

Q Again this is a patient who, when he got to you, we should properly regard as opiate naïve.
A Yes.

C Q Codeine is not going to affect his future resistance to morphine realistically, is it?
A No.

Q You knew, and I understand what you say about it, that those with liver problems such as this, needed to be treated particularly carefully.
A I knew that and I also knew that opiates were not contra-indicated if they were necessary for the patient.

D Q I have understated the morphine position so let me correct it. I think he was given 2.5 mg on 3, 4 and 5 October, which were described as being, "of good effect" for his painful arm. Then if we go to page 17 of the chronology,

> "No problems. Eating well. Elbow and cuff in situ arm remaining swollen".

E He is described as "chatty and funny".

> "Hand remains very red and oedematous. Sacral cleft quite red with penile discharge. Ankles very oedematous and tender. Appetite variable. Paracetamol given as prescribed.
> PM Sat out for most of afternoon, but was very tired and needed to rest in bed by the end of the afternoon. Communicating quite well although varies according to mood. Asked doctor to consider stronger analgesia, now prescribed codeine phosphate".

F So the doctors were not ignoring any requests for analgesia, and they were prepared to prescribe him codeine and paracetamol, even though he had liver problems.
A Yes.

G Q If we can go, please, to page 22 of the chronology, 13 October. He is reviewed y the medical team. He has oedematous limbs at high risk of breakdown. His right foot already about to break down. This is due to oedema secondary to cardiac failure and low protein. His weight is up to 114.4 kg. For those who like old-fashioned language I think that is about 17.5 stone. He is described as being in a good mood this morning, "no complaints of any pain". He was passing urine independently using a bottle. Peaceful night. Slept well again. No complaints of pain. Then we have the referral letter, again revealing to you that he had alcohol problems. He was being transferred for continuing nursing care needs.
H A Yes.

Q His Barthel was 7, which again in your terms at your hospital would be relatively high. Somebody needing a lot of help but very much better than many of your patients.
A But not giving you a measure of the co-morbidities present in this patient.

Q I entirely understand that. It is simply the assistance that he needed with his activities of daily living.
A Yes.

Q He is still in a lot of pain with his arm and difficulty on moving. On a high protein diet, legs very oedematous and at high risk of breakdown secondary to cardiac failure and low protein. He needs 24 hour nursing care. Medication paracetamol four times a day. Over the page, refused to mobilise. Remains oedematous. Transfer summary,

"Ensure left arm supported. Sit to stand practise with two. Transfer practise with 2...Plan: Continue with active movements mobility and transfer practice".

Would you agree that just as with the patients who have had to have these hip operations, getting a patient like this moving, is pretty critical to their rehabilitation.
A And, by the same token without adequate analgesia it would be impossible to get him mobilising, hence the entry, "refused to mobilise", because it hurt.

Q I understand that. But shall we deal with one issue at a time. Do you agree that with a patient like this, and those who have had those hip operations, if they are going to have any chance of recovery, you have got to try to get them moving.
A Yes.

Q He is given codeine, paracetamol that day, and then he is transferred to you, and you make a note yourself of his past medical history, his alcohol problems, recurring oedema, congestive cardiac failure. You note that his Barthel is 7, "Plan: gentle mobilisation". On the same day we can see there is a nursing entry, if we go to page 24, he is described as, "fully comprehending".
A Yes.

Q "Restless at times. Used urinal with assistance as he wanted to stand".

So it is a reflection that he is able, at least, to stand and move about, albeit with assistance.
A Yes.

Q The last time that this patient had had morphine, I think, had been about nine days before on 5 October after he had knocked his arm.
A Yes.

Q Let us see what you prescribed for him, please. If we go over the page to page 25, Oramorph, up to 10 mg four-hourly.
A Yes.

Q That was actually given to him on the day of his arrival on the ward, and you prescribed diamorphine – again I will not go through it – and midazolam and the lowest dose

equivalent to diamorphine would be 60 mg orally. The most he had had until that time was 5 mg.
A Yes.

Q After he knocked his arm.
A Yes.

Q A massive increase, would you agree?
A Yes.

Q Do you accept that your prescription appears, at least on the face of it, to be flying in the face of his management by other doctors up to that date?
A I think that my management reflected my feeling that although he had come to me for gentle rehabilitation, that his overall prognosis was poor. He was in incipient cardiac failure when he arrived with me and that his condition could well deteriorate at any time.

Q Yes. I will put the question again. Do you accept that the prescriptions that you wrote out on the day of his admission appeared, on the face of it, to be flying in the face of his management by other doctors at that stage?
A They appeared to be flying in the face because they are more realistic than the previous prescriptions that were written.

Q So none of the other doctors, in your view, who had been dealing with this patient up until this stage at the Alexandra Hospital had been realistic.
A About the long-term future for this man, no.

Q In your view, was this patient for terminal care?
A No. He was for palliative care because none of the conditions from which he suffered were curable. He had irreversible liver disease. He had congestive cardiac failure. He probably had a degree of renal impairment. None of these were curable, so any treatment that we gave him was palliative.

Q Are you saying that your view that he was never going to leave your hospital?
A I thought that it was unlikely that he would ever leave the hospital.

Q But he came to you for rehabilitation, did he not?
A Yes.

Q And rehabilitation was not an impossibility?
A No.

Q Or was it?
A No.

Q No. When you wrote out what I hope you will forgive me describing as your usual prescription of diamorphine 20 to 200 and midazolam 20 to 80, what account, if any, did you take of his alcohol liver-related disease?
A I did not reduce the doses because I knew that he had previous acute alcoholism and had liver damage. I kept the doses exactly the same.

A Q You took no account of it, did you?
A No.

Q It would have been important, would it not, for the nurses to be aware that he had had alcoholic liver disease and the effect that that would have on the administration of any opiates?
A Yes.

B

Q Why did you not reduce your usually wide range to take account of that fact?
A Because I still felt that, should the need arise, that it was appropriate that he had an effective amount of diamorphine and midazolam should he need it.

Q The potency of the drugs that the nurses would administer would be made more potent by reason or stronger by reason of his liver disease, would they not?
C A Yes.

Q Did you give the nurses any special warnings about that?
A The nurses were well aware of the special conditions, as evinced by Shirley Hallmann's long history of heavy drinking. The nursing staff would have been aware that he had a chronic alcohol problem.

D Q Yes. Shall we look at what happened to him from the day of his admission when he was able to use a urinal with assistance because he wanted to stand. He was given, on the day of his admission, I think it is, 20 mg of oral morphine. Yes?
A The ---

Q I am looking at page 25 – 10 mg administered at 14.45 and 23.45?
A Yes.

E

Q Did you consider whether codeine might do it – whether codeine might control his pain?
A I knew that codeine had not controlled his pain because he had been prescribed it on the acute ward in addition to paracetamol.

Q But did you consider an intramuscular dose into his arm? If his arm was particularly
F painful, it might help control his pain?
A Intramuscular injection of what?

Q Of morphine?
A No. It was very swollen and oedematous. It would have been quite inappropriate to inject morphine into the arm.

G Q On the following day, 15 October, the day after his admission, he was commenced on Oramorph four times daily, 10 mg, and a double dose at night.
A Yes.

Q And so if we look at the bottom entry on page 26 we can see that Oramorph was administered, 10 mg at 10 o'clock, 2 o'clock and 6 o'clock in the evening, and then the 20 mg dose was given on that one occasion, giving him 50 mg on his second day at your hospital?
H A Yes.

Q Yes?
A Yes.

Q Did you consider at any stage that this man's deterioration appears to have broadly followed the potency of the opiate medication you were giving him?
A No. I felt that his deterioration mirrored the increase in chestiness and emergence of his cardiac failure, following the move to my hospital and the first night.

Q You see, if we look at the entry in the middle of page 26 when he has been started on these doses of Oramorph, he is given 20 mg at midnight with good effect, then 10 mg at 6 o'clock in the morning.

"Condition deteriorated overnight. Very chesty +. "

I think that means very, very chesty.

"difficulty swallowing medication. Incontinent urine ++"

Now the day before he had been able to stand at a urinal?
A I think that the "very chesty ++" and the "difficulty swallowing medication" and the incontinence mirrored the appearance of his cardiac failure, which would have been ameliorated, if anything, by doses of Oramorph during the night, not made worse.

Q Page 27, please. He is reviewed by Dr Knapman. There is a note that he had declined overnight with shortness of breath.

"... bubbling. Weak pulse. Unresponsive to spoken orders."

Did you consider that what happened to this man, who three days earlier had been described as being in a good mood with no complaints of any pain, may have been the result of your opiate medication that was causing that man to be like that?
A Dr Knapman obviously did not consider that it was a result of the opiate administration. He felt that he was in cardiac failure and he gave an increased dose of diuretic to try and reverse the increasing cardiac failure that he was demonstrating.

Q When you gave evidence, you seemed to suggest – and I just want to have this clear from you – that it was Dr Knapman who had instituted or directed the institution of the syringe driver. Is that your evidence?
A It is difficult to say because obviously I did not make a note, but I was not in the hospital that Friday morning, 16 October. It is quite possible that I was not available at the hospital for the rest of the day, in which case Dr Knapman, as the duty doctor, would have been asked to agree to the syringe driver.

Q Except that he would not need to, would he?
A They would have asked him if it had been appropriate, but no, it was written up anticipatorily for them to use should it become necessary.

Q I am going to ask you, I am afraid, to look at some nursing notes. Could you take up the file for Patient H, could you go to page 266B. That is 16 October 1998. That is the day we are looking at, is it not?

"Seen by Dr Knapman am as deteriorated over night. Increased Frusemide to 80 mgs daily. For A.N.C"

A All Nursing Care.

Q

"Wife informed will visit this morning."

And that note is signed off – I am not sure who that is, I am afraid.
A No, I am not sure who that is.

Q The next entry is p.m., is it not?
A Yes.

Q 16 October 1998, p.m.

"Patient very bubbly chest this pm. Syringe driver commenced 20 mg diamorphine 40-0 mcgs Hyoscine. Explained to family reason for driver. Wife informed of patients continued deterioration. Has been to visit."

And that is signed by Nurse Hallmann.
A Yes.

Q There is no indication from that that Dr Knapman authorised that syringe driver, is there?
A And there is no information as to whether I authorised the syringe driver either there.

Q I understand that.
A No.

Q On any basis, the syringe driver was available to be authorised because you had written it up?
A Yes.

Q If we go to page 28, we can see at the top that Oramorph had been given to this patient that day, 30 mg, and then diamorphine was started through the syringe driver at 20 mg at ten past four in the afternoon. I am not going to go back again through the conversion rates but, again, do you accept that that is a fairly significant increase?
A Yes.

Q It is from 30 mg up to the equivalent of 60 mg orally, is it not?
A Yes.

MR LANGDALE: I am sorry – I would just like to clear this point up. I think in fact in the previous 24 hours, he had been on a total of 50 mg of Oramorph. If I have got that wrong,

A I apologise, but I think in the previous 24 hours, the administration of diamorphine has been 50.

MR KARK: I think Mr Langdale is right. If we go back to page 26 – I am grateful. I have certainly made a note – 50 mg for 24 hour period. Then, on the 16th... Yes, Mr Langdale is right. He is given Oramorph in the morning, and then he is started on the syringe driver. It is still an increase but it is certainly not such a significant increase. Yes?
B A Yes.

Q All right. Then at page 28 we can see that he was reviewed. Professor Ford described this patient. "By this stage he has deteriorated and is very ill." It is described as a rapid deterioration. Professor Ford said this, and I want to ask you to comment on it: "No one appears to have considered the effects of the opiates and the response" – and this is looking at the entry at the bottom of page 28 – "is to add another sedative in. There was a failure to
C monitor carefully the effects of the opiates." First of all, are you saying that you were considering the effects of these opiates?
A Yes, and if he was suffering from congestive cardiac failure the opiates were entirely appropriate to manage his symptoms.

Q When he came to your hospital ---
A He had already put on 11 kg in weight, which was made up of fluid. His arms, his
D legs were oedematous. He was already on the point of developing congestive cardiac failure. It would have been that journey in the minibus and the transfer that would have tipped him into congestive cardiac failure.

Q That is your view?
A Yes.

E Q And I understand. You appreciate that on the day after his arrival on 15 October he was given, as Mr Langdale has just properly pointed out, 50 mg of morphine orally, which is more morphine than he had received in his entire stay in the Queen Alexandra Hospital.
A And it was entirely appropriate to give him that for the condition that he was in.

Q You spoke about his transfer. Let us look at what Gillian Kimbley said about it, because she actually travelled with him. She told us: "I travelled with him on his transfer to
F the Gosport War Memorial Hospital. He was not too bad. He was in a wheelchair. It took about an hour and a half. I could hold a conversation with him. He was exhausted. We spoke to Dr Barton and she said to him, 'Get straight into bed and I will give you something to calm you down'." You appeared to be rather appalled at that. I have to say, of all the criticisms in the case, that is not one that I would level at you. You were simply telling, on her account, the patient to get into bed because he had had a long journey.
A Yes.
G

Q All right.
A That is normally a nursing procedure, however, not for the medical staff to undertake.

Q But if he had had a long journey, there would be no problem about saying to a patient, "Hop into bed", would there?
H A He was probably not capable of hopping by that time. He would have been helped into bed, yes.

Q She said this: "He had his sedation. He seemed okay. He had his lunch. He was fine. I visited him the next day. In less than 24 hours there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense. He was semi-conscious. I spoke to a sister and she said, 'Your husband is dying. He will be dead within a week.' I could not believe it. By 16 October he could not even speak. I had no further conversation with him from that time." From the drugs that he was given you would have no reason to disagree with that report of his condition, would you?
A I would ---

Q That is quite likely to be the effect of the drugs.
A From the condition that he was suffering from, I could understand that she had noticed a very marked deterioration in his overall ability to hold a conversation and hold his food in his mouth. I would be blaming it on the effect on his brain function, caused by the congestive cardiac failure rather than the opiates necessarily.

Q Again in relation to the transfer, she said, "He was buffeted a little bit on transfer, but it was not too bad. He was a bit tired afterwards. It did not take four hours. The plan was for him gently to get mobilised. The sister discussed with me his cardiac failure and the fluid on his body. From the 16th he was unconscious." Now, this is a patient who undoubtedly had a long journey, but it was a long journey from which he might have recovered. Do you agree with that?
A He might have recovered, but the treatment that he was given was perfectly appropriate on his arrival at the ward and the next day when his congestive cardiac failure became apparent.

Q Mr Code A gave evidence about this patient as well. I just remind you. He said: "I saw him the evening before his transfer to GWMH. He had eaten. He had been drinking. Sat up alongside his bed. Someone had the *Daily Sport* and there was a jovial atmosphere. On the 15th" – so this is the day after his admission and the day after he has been started not on the syringe driver but on his Oramorph – "he was in a comatose state. He did not appear able to move himself. I leant over. He spoke his last words, 'Help me, son, they are killing me,' and I thought he was dying. He was comatose." Does your answer apply to that as well, that it would have been his illness that was causing him to be in that state?
A Yes.

Q Mr Code A went on: "I could not rouse him," and he never saw you. You have no recollection of this patient, have you?
A I have not.

Q So far as this patient is concerned, going to the heads of charge if you would please, in particular to head of charge 9(b), which I think you find on page 9 if you have the green copy.

> "b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. ..."

- which we have looked at already. The prescription was 14 October –

> "... 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."

Do you agree that in light of his alcoholism and liver disease your prescriptions should have been lower?
A No.

Q I will not take up time going through the rest of those charges, and I was going to turn to Patient I. Dr Barton, are you alert enough to deal with another patient, or would you like to break now?
A Could I have a brief break, please.

MR KARK: I am sure you can.

THE CHAIRMAN: I do not think it was the doctor's alertness that we were concerned about, but merely the fact that it is a very gruelling experience. You can certainly have that break, Doctor.

THE WITNESS: Thank you. Shall I just go and come back?

THE CHAIRMAN: Please do, and anybody else who would like a short break, now is the time.

(After a short pause)

Q Dr Barton, Patient I, was the 92-year old patient who on 19 March 1999 was pulled over by her dog causing her to break her right hip. She was operated on on 20 March and you may or may not remember that morphine caused her to have hallucinations.
A Yes.

Q Nevertheless, she did in fact continue to receive some opiates during her stay at the hospital. Unfortunately, she continued to have pain in her hip for quite a while after her operation. If we go to 24 March, the day before, at the bottom of page 6, there is reference to her skin being very thin and fragile lower legs. "Has proved difficult to get mobilised and her post-op rehabilitation may prove some what difficult". Her main problem is described by Dr Reid as,

"Pain in her right hip and swelling of her right thigh. Even a limited range of passive movement in right hip still very painful".

Yes?
A Yes.

Q At the top of page 8,

"Still in a lot of pain which is the main barrier to mobilisation at present - could her analgesia be reviewed?" She is still been given paracetamol. At the bottom of page 8 we see that the swelling on her right leg has increased; that her skin is paper thin and very fragile. Haematoma is said to have developed and broken down. "Dress with gelonet. Elevate. Ready for GWMH when bed available. Needs great care of skin + warn GWMH of skin state".

At the bottom of page 9, we can see that she transfers to Dryad ward. That is on 26 March. Her last dose of morphine, by my reckoning, had been some five days earlier, 5mg on 21 March. Again this is a patient who we must regard as opiate naive.

A Yes.

Q On the first day of her arrival at your hospital upon your prescription, she was given I think 25 mg of Oramorph if you go to page 11. Yes?

A Yes.

Q Again, can we take it that the palliative care hand book has figuratively gone out of the window, as has the BNF? You are starting this lady on 25mg of opiates.

A She had had major surgery. She had a very early transfer to us. She had a journey. She had a lot of pain in that hip. This is not the palliative care pathway I am throwing out of the window. This is a lady in need of realistic levels of analgesia while we get to know her and assess her rehab potential. "Plan, sort out analgesia". It would not have been appropriate to continue giving her paracetamol and that level of dosage of Oramorph was equivalent in strength to one daily and considerably more pleasant for most patients to take than the codeine-based analgesics.

Q She had not been on eight dihydrocodeine had she?

A No, and that would have been the alternative. I was going to move up from the first rung of the analgesic ladder. I was not going to continue to give her paracetamol. I went to the bottom of level three rather than the top end of level two.

Q Let us examine that for a moment. She had on 23 March, if you go back to page 6, a gram of paracetamol.

A Yes.

Q That is not the maximum is it?

A Yes.

Q It is the maximum?

A No, 1 gram four times a day would have been the maximum. We would accept that her analgesia was not adequate during her time at Haslar.

Q I understand that. Let us look at what she had been on. Page 6, on 23 March 1 gram of paracetamol. The next day another gram, page 8.

A Yes.

Q The next day another gram of paracetamol. Did you think about increasing her paracetamol?

A No, I did not think that that would be appropriate analgesia.

Q Did you think about going to level two on the analgesic scale?
A Yes, and I have explained that the equivalent to a reasonable dose of level two analgesia would have been a small dose of Oramorph which is what I gave her.

Q Why could you not start on the next level up from paracetamol?
B A I could have.

Q You could have done?
A I could have done.

Q If we go on to page 11, this patient, as we see at the top, is said to be experiencing a lot of pain on movement. Yes?
C A Yes.

Q We heard from both Professor Ford and Mr Redfern about this patient. Yes?
A Yes.

Q Mr Redfern considered it very unusual to continue requiring morphine so late on.
A Yes.
D

Q Professor Ford said you would not have expected such pain so long after the operation. Yes?
A Yes.

Q Did you ask yourself "What on earth is going on with this hip?"
A Yes, but I did accept that there are enormous variations in the rate at which people get
E over major surgery. I was also aware that she had had a haematoma develop and break down before she was transferred over to us and that might have indicated that the prosthesis was still very uncomfortable.

Q What was your continuing plan, therefore, for this patient?
A To sort out her analgesia to make her comfortable?

F Q Did that plan change at any stage?
A No.

Q I suggest you never went back to the root course of this patient's pain did you?
A No.

Q Mr Redfern told us that in orthopaedics they had a very low threshold for re-
G operating. You smile, so we had better record it. Why are you smiling about that?
A Because orthopaedic surgeons are well known to have a very threshold for re-operating. If it moves, operate on it. This lady had barely survived her first major surgery. She would certainly not have survived another operation.

Q That is your view apparently of Mr Redfern.
A Yes.
H

Q Let me just remind you of some of his evidence. This is Day 16/21.

"Q What would have happened if this lady had been sent back to the Haslar Hospital? Would it have required a re-exploration of her hip?
A On the assumption that there was a failure of fixation, then there would have been an evaluation of her general fitness to [under]go revision surgery".

A Yes.

"A And had she passed that assessment, which is usually done by the anaesthetist who is scheduled to do the surgery, then she would have undergone revision surgery.

Q That evaluation is very important?
A Yes.

Q Because decisions have to be made about what is in the patient's best interest?
A That is correct".

Q Then he was asked this:

"Q If a patient is elderly, in poor physical shape, it may well be thought this is not in the patient's best interests to undertake surgery under general anaesthetic?
A Yes. There would have to be considerable co-morbidity though. We have a very low threshold for operating on people with fractured neck of femur, because they commonly carry considerable co-morbidity. The bar is set fairly low".

A Yes.

Q Is that your understanding as well?
A Yes.

Q Then,

"Q And one would want to evaluate whether it is generally in the patient's interests and that they will survive the insult that general anaesthetic involves?
A Death under anaesthesia is extraordinarily uncommon, even in very frail patients".

Is Mr Redfern one of those surgeons who you would ---
A I think that is a very balanced account of the risks, but the risks of re-operating on an elderly frail lady at her age, even without a large number of co-morbidities, are exponentially higher. She has been through it once and you are asking her to go back to theatre and have it re-explored. I did not feel at that time it would be appropriate for her.

Q What is the realistic alternative for this patient?
A Sort out her analgesia.

Q And then?
A Keep her comfortable.

Q Does that mean this patient is on a terminal pathway again?
A She is on a palliative care pathway because it is perfectly possible that without having further surgery, particularly if there had been an infection there which we were beginning to suspect, that she would regain a certain amount of function, an adequate amount of function.

Q Would you have discussed the possibility of surgery or going back to the hospital with the patient?
A Not at that stage. It was too soon at that stage.

Q On 28 March she was given two doses of Oramorph which apparently she vomits up, if we can go to page 13. You advised to stop Oramorph. Yes?
A Yes, go back down to level two.

Q She is now on to co-dydramol.
A Yes.

Q On Monday 29 March, she is given two tablets four times days list. Is that the maximum?
A Yes.

Q There is no mention of any pain in the nursing notes is there?
A There is not.

Q Over the page at page 14, on 30 March, again the same dose of co-dydramol, "Both wounds redressed with paranet". What is that?
A A dressing.

Q Then,

"Steri-strips from surgery removed. One small area near top oozing slightly - mepore dressing in situ. Check in a couple days. Sat out in chair for assisted wash/dressed. Zinc and castor oil applied to bottom, liquid paraffin ...applied to legs".

A On that day it appeared as if her condition was possibly beginning to improve apart from this slightly worrying thing about the oozing on the top of her dressing beginning.

Q On the Wednesday, we come back to Oramorph. Yes?
A Yes.

Q Which Professor Ford described as being appropriate if the co-dydramol had not worked.
A Yes.

Q If we go to the top of page 15, she is described as walking with a physiotherapist this morning but in a lot of pain.
A Yes.

Q This is now five days after admission.
A So it is two weeks after surgery.

A Q By this stage, surely you must have been beginning to worry about what was causing this patient's pain.
A I was beginning to wonder why she was still in a lot of pain. The physio I feel would have noted had the prosthesis been dislocated or had collapsed at that point because it would have been apparent when she walked.

Q The physio might have done.
B A No, would have done.

Q But this was your patient.
A Yes, but they are very expert professionals when assessing post-operative hip surgery patients.

Q Dr Barton, this is your patient; she is several weeks after surgery; you would have
C been seeing her according to your evidence daily would you?
A During the weekdays, yes.

Q Would it not have concerned you, whatever the physiotherapist was doing, because he might be making it worse, would it not have concerned you to re-examine the leg and the hip?
A What by X-raying it you mean?
D

Q No, first of all re-examine it.
A There was nothing to see. It had a dressing on it which was just oozing.

Q It was oozing; why could you not swab that?
A We then did swab it.

E Q I know you did then swab it.
A When there was enough to swab, when it became apparent that it was likely to be an infection, then we took a swab and instituted antibiotics.

Q Can we just pause, please, page 15, 1 April, Thursday so you would have been on duty.
A Yes.
F

Q The wound is described in the following way:

"Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound".

Does that give fairly obvious indicators of a possible infection?
G A It is a possible infection. It is also possible that that haematoma that she had at the time shortly after the surgery was now resolving and discharging through the suture line. That would give you serous fluid and a bit of blood. It was not necessarily infected at that point.

Q Would you not want to swab it to find out?
A I was going to swab it the following week.
H

A Q I am not sure where you have gone; I am still on Thursday 1 April when this patient's wound is oozing a lot of serous fluid and blood. Would you not have wanted to swab it?
A It would have been possible to swab it, yes.

Q Would you not have wanted to find out what was going on?
A Yes.

B Q Over the weekend, she is then on the Thursday to deal with her pain started on slow release morphine. Yes?
A Yes.

Q On the Sunday, her wound is still losing serous fluid and blood.
A Yes.

C Q So that is not getting any better?
A No.

Q We see that you actually get to her, at least you are noted as seeing her on Tuesday 6 April.
A Yes.

D Q "Seen by Dr Barton. MST increased to 20mg. Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter".

Then a swab is taken, and that was at your direction, was it?
A Yes.

E Q So it took from Thursday to Tuesday to take a swab from this oozing wound.
A Yes.

Q Can you explain why?
A No. I cannot explain why we waited from Thursday to Tuesday to do the swab. I have no intelligent explanation of it.

F Q In terms of a wound infection, that is actually quite a significant period of time potentially, is it not?
A Yes.

Q You want to get antibiotics started if you need to, as quickly as possible.
A Yes.

G Q Can we go please to page 18? You apparently see the patient in the morning and it looks as if, at that time, the fracture site is described as, "red and inflamed". That would be the wound site, would it?
A Yes.

Q "Seen by Dr Barton", and you start her off on antibiotics.
H A Yes.

Q Those are general antibiotics. You do not know what is going on in there, but you understandably --
A I am awaiting the results of the swab but I am going blind to suitable broad spectrum antibiotics to treat infection.

Q This patient is then seen by Dr Reid, and he obviously performs a full examination, does he not?
A Yes.

Q "Still in a lot of pain and very apprehensive. MST up to 40 mg a day. Try adding flupenthixol".
A An anxiolytic.

Q "For x-ray right hip as movement still quite painful – also, about 2" shortening right leg".

Can you explain why that is something that you had not noticed?
A Because it had not been apparent until that day. I had not seen any shortening the last time I had examined the hip, which would have been the previous Thursday when I did not take the swab.

Q Did you review her on that day with Dr Reid?
A I do not think I was there.

Q You see your note that we have just looked at, "Seen by Dr Barton", would have been made in the morning, would it not?
A But I would have looked at the patient in the bed and looked at the wound – they would have shown me the wound oozing, but I would not have attempted to walk her or examine the hip.

Q No, but you plainly did not undertake the same sort of examination that Dr Reid conducted.
A No, I did not, not that morning.

Q Because we can take it, I think, that the leg probably did not shorten itself two inches --
A During the morning.

Q During the morning.
A No.

Q And Dr Reid on the Wednesday has asked for an x-ray.
A Yes.

Q This presumably is something that would have been relayed to you, "Dr Reid examined one of your patients and found that one leg was two inches shorter than the other leg and asked for an x-ray".
A Yes.

Q That would be relayed to you, or you would see it in the notes.
A Yes.

Q The following day, you would want to know what had happened about that x-ray or what was happening about the x-ray, would you not?
A I knew that it had been booked. I did not pursue the x-ray any further than that. I knew that Dr Reid was going to review it when he saw her on the next ward round.

Q Which would be when?
A The following Monday, by which time she would have finished her course of antibiotics.

Q But her antibiotics, of course, are not going to deal with her shortened leg.
A It is going to deal with her wound infection.

Q If she has got a shortened leg, certainly as a lay person it is very much like the repair has collapsed in some way, is it not?
A Something has happened to the repair, but that is not as urgent a problem as dealing with the wound infection.

Q So your comment, that I have recorded, is that nothing about the x-ray would have altered your management.
A That is correct.

Q You also said, "I would not have looked at the x-ray".
A No.

Q Why not?
A Because looking at the x-ray would not have altered my management of her patent wound infection, leaving aside whether the prosthesis had or had not collapsed, or the head had dislocated. That would not alter my management of the wound infection and you could not transfer her back to the orthopaedic unit with a raging wound infection.

Q Did you think of consulting the orthopaedic department to see what they would do?
A No.

Q Can we go over please to page 21 of the chronology? Sorry, I have missed something important. Can we go back to page 20? On the Saturday there is a nursing note that she had a very poor night and the patient appeared to be leaning to the left.

"Does not appear to be as well and experiencing difficulty in swallowing".

A Yes.

Q You say, I think, "I would take this to be a stroke".
A Yes, or a transient ischemic episode.

Q Did you have any other possible diagnosis for that?
A No.

A Q Bearing in mind that her right hip is painful and inflamed, apparently, that something has gone wrong with her operation. Did you think it could be connected to that?
A If she had a wound infection and she had become septicaemic, I suppose a bolus of infection to the brain. That is a possibility.

Q Come Sunday, page 21, she is described as,

B "Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way",

and there is pain on movement.
A Yes.

Q If we look at the review by yourself, and you think this is on the next day I think, 12 April.
C A I do.

Q "Enid's condition has deteriorated during this afternoon. She is very drowsy, unrousable at times. Refusing food and drink. She denies pain when left alone but complaining when moved at all".

"Unrousable at times", would you need to reflect upon that when you administer any
D morphine to her?
A No. I would be aware that she was unrousable at times because she had entered the terminal phase of her life on the Saturday.

Q So at this stage all hope is lost for this patient. Is that right?
A Yes.

E Q No point in looking at any x-ray.
A This is Saturday we are talking about?

Q No, Monday 12 April. Just pause for a moment.
A Yes, they come in on Monday morning. I am not expecting to look at the x-ray one way or the other. I come in to find that Enid has deteriorated markedly over the weekend and
F has entered the terminal phase of her life.

Q That is your view.
A That is my view.

Q At the bottom of page 21 we can see that on the Sunday she is given Oramorph at 7.15 in the morning, 5 mg and then 20 mg of MST.
G A Twice.

Q So a total of 45 mg.
A Yes.

Q Which would be, MST is oral, so 45 mg, an equivalent dose would be around 20mg.
A Yes.

H

A Q Of diamorphine. Over the page please to page 22 and 23. You wrote out your usual prescription for diamorphine and midazolam, did you not?
A Yes.

Q You decided that this patient should start on 80 mg of diamorphine.
A Yes.

B Q Which would be the equivalent oral dose of 240 mg orally.
A Yes.

Q Now reflecting upon that, do you accept that that was far too high?
A I prescribed what I considered to be an appropriate dose to control her pain and her symptoms on that Monday morning when I saw her on the ward. I did not consult with the Palliative Care Guidelines. I gave Enid what I thought was appropriate for her condition.

C

Q She was, the day before, described as "very drowsy and unrousable".
A Yes.

Q You then give her a dose which was four times as high as the one she had been on.
A Yes.

D Q Even now you do not think there was anything wrong with that, do you?
A I gave her what I felt on that morning, seeing her, was the appropriate dose.

Q So the answer, Dr Burton, with respect, is no.
A No.

Q You do not think there was anything wrong with that.
E A No.

Q You must have been surprised when Dr Reid reduced it by a half.
A If he felt it was appropriate to reduce it, that is absolutely fine.

Q It is absolutely fine, all things might have been fine, but did you not say to Dr Reid, "What are you doing with this patient?"?
F A I was not there.

Q No, but did you become aware that that is what had happened, that he had reduced the dose that you thought was necessary by a half?
A Yes.

Q Did you take it up with him?
G A No.

Q Why not?
A Because I did not think it was necessary to take it up. I had had my opinion of how she should be treated that morning. He had a different opinion that afternoon. He had changed the dose of the analgesia. That was absolutely fine.

H Q But did you say to yourself, "Well, one of us must be wrong"?

A No, neither of us were wrong. It was a clinical judgment on both occasions as to what dose you give that patient in front of you.

Q What then happens is that, having reduced the dose, it appears that a nurse, either by mistake or deliberately, doubled the dose of midazolam.
A Yes, that is apparent.

B Q Dr Reid himself described that as "astonishing". This was a doubling up – I was going to say it was Nurse Hamblin but I am not sure that that is right. Do you find it surprising that a nurse would think it appropriate, if that is what happened?
A I can only think that that was the instruction that she thought she had gotten from him. I was not there. I cannot make any further judgment other than that, but she may have understood him to say, "Put them both to 40", or something like that. I can honestly give you no more intelligent answer than that.

C Q The ability to increase that dose by doubling it was allowed for by our prescription, was it not?
A Yes, it was.

Q Professor Ford described your starter dose as definitely excessive. You do not accept that, do you?
D A I do not accept that.

Q And he also commented that even reducing it by as much as a half, with the midazolam, you could not now assess how the patient was. You agree with that, presumably, because she would be unrousable.
A I did not assess her. I did not see her that night.

E Q And the patient died at 1.15 the following morning.
A Yes.

Q Do you accept that it seems very likely that this patient died as a result of the sedation that she was on?
A No.

F Q You put down her cause of death as CVA.
A Yes.

Q What was that based on?
A The evidence of my nurses when they saw her on that Saturday morning, and the evidence of what I saw when I saw her on the Monday morning. Again, I did not record anything.

G Q If you had recorded her cause of death as being a direct result of over-sedation, would that have initiated an inquiry?
A I have no idea.

Q Did you consider that she might have been over-sedated?
H A Not at all.

Q Even after you knew that Dr Reid had reduced the dose by a half?
A Not at all. I felt that on that Monday she was dying, and the initial dose that I gave her was appropriate for her condition.

MR KARK: That is all I ask you about Mrs Spurgin. Sir, I wonder if in the circumstances that would be a convenient moment.

THE CHAIRMAN: I think it would be a very convenient time, thank you. Mr Langdale?

MR LANGDALE: May I just mention a matter which may arise in connection with all witnesses. I know from what my learned friend has indicated to me, he anticipates his cross-examination will go some way into tomorrow morning but will conclude before lunch time. I would have thought such re-examination as I have for Dr Barton will not take any great length of time.

There is a witness whom the defence are anxious to call. It is a nurse. She is in real difficulties in terms of holiday arrangements, as I understand it, if she is not called tomorrow afternoon. The Panel are not sitting on Thursday. I understand it would or might be just about possible for her to give evidence on Friday, but that would be causing her some difficulties. I just wonder whether the Panel would be kind enough to consider whether it would be appropriate for her to be called tomorrow afternoon. I do not think she is going to take anything like all afternoon. Those besides me think not.

THE CHAIRMAN: If there would be no objection to the Panel delaying their questions, then I think we could accommodate you. I think in any event, the Panel at this time are feeling very much again that we have been moving very fast, and they would wish to have an opportunity to look at transcripts beforehand, so it may be in fact that that would work well and I could say now, yes, by all means arrange the witness for such time after Mr Kark has finished, and hopefully after you have completed your re-examination. Do you have any sense of how long that witness is likely to need?

MR LANGDALE: Mr Jenkins says maybe up to an hour. He will be taking the witness. She is not dealing with lots of patients. There is only one patient she deals with. I doubt if Mr Kark's questions will be particularly lengthy with her. Something of that order.

THE CHAIRMAN: I think we have no difficulty in doing that and I have to say now that we would rise then at the end of that period, whenever it was. Given that the following day is a non-sitting day, it will not be possible for the Panel to be using that day for its review, so we would probably be trespassing into Friday. I think what I will say is, when we rise tomorrow – at whatever time it is – we will then give an indication of a "not before" time for the Friday morning. We would do our independent study, and you would not need to be here waiting on us, in effect.

MR LANGDALE: Thank you very much

THE CHAIRMAN: Very well. Thank you very much, ladies and gentlemen. Tomorrow morning please at 9.30.

(The Panel adjourned until Wednesday 22 July 2009 at 9.30 a.m.)