File Reference	00078576
Home Location	IM Manchester
Owner Location	Fitness To Practise
Subject	Interim Orders Commitee (IOC)
Start Date	07/10/2004
Volume	
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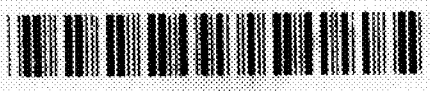


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Interim Orders Committee
CONFIDENTIAL

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Mr BARTON, Jane Ann 2000/2047

1. **Item**
2. **Addenda**
3. **Transcript**
4. **Documents**
5. **Miscellaneous**

Notes:

Tabs 1-3 relate to the Item, Addenda and Transcript from the last hearing to take place.

Tab 4 contains all other documentation in chronological order.

E:\Committee\IOC\Items\2004\October\Barton 07-10-04.doc

Confidential

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Interim Orders Committee

7 October 2004

New case of conduct

BARTON, Jane Ann

BM BCh 1972 Oxford

Code A

Specialty: GP

Current Employer: Fareham and Gosport PCT

Other interested parties: Hants Police, CMO and Department of Health

Legal representation: Mr Ian Barker, Medical Defence Union

Code A

FPD Reference and Name of caseworker: 2000/2047, Paul Hylton

Nature of case: Inappropriate prescribing/substandard clinical practice

Reason for referral to IOC : The Police have referred a number of cases to the GMC and the CPS are considering further cases.

Previous history: None

Case history: The Preliminary Proceedings Committee referred information in respect of Dr Barton for an inquiry by the Professional Conduct Committee on 29 August 2002. The PCC hearing has not yet taken place.

Index of papers

Item	Page No.
A summary of patient records and a brief expert review of patient records for the following patients: Harry Hadley Alan Hobday Eva Page Gwendoline Parr Code A Daphne Taylor Code A Dennis Amey Charles Batty Dennis Brickwood Charles Hall Catherine Lee Stanley Carby Code A	467 - 507

Copies of the patient records are not in the papers but will be available to the Committee at the hearing.

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Confidential

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Interim Orders Committee

19 September 2002

New case of conduct

BARTON, Jane Ann

BM BCh 1972 Oxford

Code A

Specialty: GP

Current Employer: Hampshire and Isle of Wight Practitioner and Patient Services Agency

Other interested parties: Police, CMO and Department of Health

Legal representation: Mr Ian Barker, Medical Defence Union

Code A

FPD Reference and Name of caseworker: 2000/2047, Michael Keegan/Venessa Carroll

Nature of case: Inappropriate prescribing/substandard clinical practice

Reason for referral to IOC : The CPS are now reconsidering the five cases and the case has been referred for an inquiry by the Professional Conduct Committee.

Previous history: None

Case history: The Preliminary Proceedings Committee referred this case for an inquiry by the Professional Conduct Committee on 29 August 2002.

Index of papers

In reply please quote 2000/2047

Please address your reply to the Fitness to Practise Directorate
Fax: Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

11 July 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

A member of the Council, who is appointed under Rule 4 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 to give initial consideration to cases, has asked me to notify you, under rule 6(3) of those Rules, that the Council has received from Hampshire Constabulary information which appears to raise a question whether, as a registered medical practitioner, you have committed serious professional misconduct within the meaning of section 36(1) of the Medical Act 1983. A copy of the relevant provisions of the Act is enclosed, together with copies of the Procedure Rules, the GMC's publication "Good Medical Practice" and of a paper about the GMC's fitness to practise processes.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Copies of information from Hampshire Constabulary may be found in the enclosed bundle of papers which is indexed at page 2.

The member has directed, in accordance with the Procedure Rules, that the information received from Hampshire Constabulary be referred to the Preliminary Proceedings Committee of the Council. That Committee will consider the information any written explanation provided by you, to determine whether the case should be referred to the Professional Conduct Committee of the Council for inquiry into a charge against you.

You are invited to submit at your earliest convenience a written explanation of the foregoing matter. The next meeting of the Preliminary Proceedings Committee will be held on 29 - 30 August 2002. It is in your interests that the Committee should have time to give careful consideration to any explanation you may wish to offer. You may therefore find it helpful to know that any explanation received by the Council before 21 August 2002 will be circulated to the Committee before the meeting. Any explanation received between 21 and 29 August 2002 will be placed before the Committee on the day of the meeting. Please address your explanation for the attention of Lorna Johnston, Conduct Case Presentation Team, fax number: Code A

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 10 days of receipt of this letter, of the name and address of all of your current employers including the Health Authority with which you have a service agreement, any locum agencies with whom you are registered, and the hospital or surgery at which you are currently working. If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation or hospital by which you are employed, or have any working arrangements. If you are approved under Section 12 of the Mental Health Act, you must also notify us of this fact.

I enclose a form for you to complete and return in the envelope provided. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Committee's consideration of the matter. **Failure to comply with this statutory requirement may result in further proceedings against you.**

The documents enclosed with this letter may contain confidential material. This material is sent to you solely to enable you to respond to the allegations in this letter: it must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference shown above.

Yours sincerely

Code A

Assistant Registrar

£100/2047

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Code A

27/07/00

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of **Code A**

Private and Confidential

Dear **Code A**

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998 The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON **Code A** who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Surgery, 148 Forton Road, Gosport, Hampshire. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Mr. Ian BARKER of HEMSONS (Solicitors) of London.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Code A

20/09/00

Ms W Bannister
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Ms Bannister,

Re: Dr Jane BARTON G.P.

My letter of the 18/9/00, and yours of the 19/9/00, appear to have crossed in the post.

The investigation is ongoing and a file will be submitted to the Crown Prosecution Service as soon as possible. I would estimate that the outcome is unlikely to be known for at least 3 - 4 months.

Dr BARTON has not been charged with any criminal offence.

Yours sincerely,

Code A

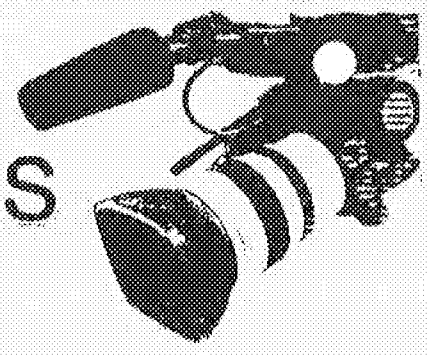
R J BURT
Detective Chief Inspector

Sink
Re discussed Sept 2001

HAMPSHIRE CONSTABULARY

MEDIA SERVICES

NEWS RELEASE



OPERATION ROCHESTER

Police have completed their investigation into the circumstances surrounding the death of a 91-year-old woman from Lee on Solent following a complaint by her family.

She died in August 1998 at the War Memorial Hospital in Gosport after being transferred there from Royal Hospital Haslar.

In line with patient confidentiality we cannot reveal the nature of her medical condition.

A file has have been sent to the Crown Prosecution Service and police are awaiting its decision.

We have the full co-operation of the Portsmouth HealthCare (NHS) Trust and the Royal Hospital Haslar for our investigation.

Ends 300301 Pauline Davey Code A

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB

Code A

www.hampshire.police.uk

CRIMESTOPPERS 0800 555 111

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fratton Police Station
Kingston Crescent
Portsmouth
North End
Portsmouth
PO2 8BU

Our Ref. : Op Rochester

Your Ref. : **Code A**

06 June 2001

Ms J Smith
General Medical Council
178 Great Portland Street
London
W1N 6JE

Dear Ms Smith

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I have been asked by DCI Ray BURT to provide you with the following documentation all previously disclosed to Dr BARTON.

1. Statement of Lesley LACK
2. Statement of Gillian MACKENZIE
3. Medical notes Gladys RICHARDS

Please accept my apologies for not supplying them earlier I have been on leave.

Yours Sincerely

Code A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref : MIC/Det.Supt/JJ/DM

Your Ref : 2000/2047 -mh

Code A

14 August 2001

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 7JJ

Dear Ms Smith

Re: Dr Jane BARTON

I am writing to notify you that on Friday 10th August 2001, I received written confirmation from the Crown Prosecution Service informing me of Senior Treasury Counsel's advice regarding the matters about which Dr BARTON was interviewed by the Police.

The advice is that, based on the papers submitted to the Crown Prosecution Service by Hampshire Constabulary, there is insufficient evidence to support a viable prosecution against Dr BARTON with regard to the death of Mrs Gladys RICHARDS.

As Senior Investigating Officer for the enquiry I have accepted this advice.

In the absence of any other significant evidence being forthcoming no further action will be taken against Dr BARTON in relation to the death of Mrs Gladys RICHARDS.

I must advise you that following publicity concerning the enquiry into Mrs RICHARDS death a number of members of the public have contacted the enquiry team expressing concerns about the circumstances attendant to the deaths of relatives who had died at the Gosport War Memorial Hospital. I must further advise you that we are conducting preliminary enquiries to determine whether or not these other matters should be the subject of a more intensive police investigation.

HAMPSHIRE Constabulary

I anticipate that these enquiries will be completed within the next six to eight weeks. I will advise you at the earliest opportunity of the outcome of our investigation.

Yours sincerely

Code A

J JAMES
Detective Superintendent

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. :

Code A

06 February 2002

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Ms Smith

Re: Dr Jane BARTON and Dr Anthea Everista Geredith LORD

I am writing following my letter to you of the 14th august 2001, concerning police investigations into patient deaths at Gosport War Memorial Hospital. You will note that this correspondence referred to preliminary police investigations to determine whether or not an intensive investigation of deaths at Gosport War Memorial Hospital was warranted.

In furtherance of those investigations expert reports were commissioned in respect of four other patient deaths and a further review of a particular death, Gladys RICHARDS in August 1998, which was previously subject of correspondence with the GMC. Receipt of the further reports was delayed for a number of reasons beyond our control.

However, they have now been reviewed and it has been determined that at this stage no further police investigations are appropriate. This decision is subject to review should further substantial evidence become available.

In reviewing the reports (which are enclosed) it is clear that the commentary and conclusions of the authors raise very serious concerns about the standard of clinical and nursing care delivered to the named patients at Gosport War Memorial Hospital. Specifically the care delivered by Dr BARTON is subject to particular criticism and raises concerns about her professional conduct. To a lesser extent there are implicit concerns about the professional conduct of Dr LORD as the consultant physician who had overall responsibility for patients on Daedulus and Dryad wards at Gosport War Memorial Hospital.

HAMPSHIRE Constabulary

It is my conclusion that the reports should be disclosed to you as the regulatory body for the named individuals for your action as appropriate. I should further advise that disclosure to you is for the purpose as described on the advice of our Force solicitor and disclosure to any third party should be referred back to us in the first instance.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Code A

J JAMES
Detective Superintendent

c.c. Julie MILLER
Investigations Manager
Commission for Health Improvement

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. : 2000/2047

Code A

14 February 2002

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Mr Hudspith

Re: Dr Jane BARTON

I am writing following your letter of the 7th February and our conversation of the 13th concerning the above named.

As I outlined to you the enquiry at Gosport War Memorial Hospital has generated a significant amount of documentation.

In the first instance, as agreed, I will arrange for you to be copied:

* Any statements/reports referred to in the LIVESLEY, FORD, MUNDY reports.
* Patient notes for any person referred to in the above reports.
* Any other obvious supporting documentation.

I will arrange for Detective Sergeant Code A to collate the papers. If you have any queries he can be contacted on Code A

Should you, after receiving the first tranche of documents, identify further material you would like disclosed please contact David direct.

If I can be of any other assistance please advise.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Medical Report:
concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of ... providing an independent view about treatment given to Mrs Gladys RICHARDS and the factor(s) associated with her death.

Synopsis

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. A registered medical practitioner prescribed the drugs diamorphine, haloperidol, midazolam, and hyoscine for Mrs Gladys RICHARDS.

1.2. These drugs were to be administrated subcutaneously by a syringe driver over an undetermined number of days.

1.3. They were given continuously until Mrs RICHARDS became unconscious and died.

1.4. During this period there is no evidence that Mrs RICHARDS was given life sustaining fluids or food.

1.5. It is my opinion that as a result of being given these drugs, Mrs RICHARDS's death occurred earlier than it would have done from natural causes.

CONTENTS

page no.

The writer's declaration

1. This report consisting of thirty-four pages is true to the best of my knowledge and belief and I make it knowing that if tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

Introduction

2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.

2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).

2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.

2.3. I have included in Appendix D references to published material.

2.4. Appendix E contains details of my qualifications and experience.

2.5. This report has been presented on the basis of the information available to me—should additional information become available my opinions and conclusions may be subject to review and modification.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable RICHARDS (nee Beech) was born on Code A and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.

3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.

3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. Dr J BASSETT is a general practitioner who visits.

3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.

3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.

3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.

3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.

3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.

3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Relevant aspects of Mrs RICHARDS's medical history

4. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.

4.1. It is noted that she also had a past medical history of bilateral deafness for which she required hearing aids.

4.1.1. Unfortunately both of her hearing aids were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital).

4.1.2. It is noted that on 8th July 1998 her general practitioner, Dr J BASSETT wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an '**URGENT** [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her

confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

4.2. It is also noted that Mrs RICHARDS had had operations for the removal of cataracts and required glasses.

4.2.1. Unfortunately her spectacles were also lost at the Glen Heathers Nursing Home and had not been replaced by August 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital

4.2.2. As Dr BASSETT had noted Mrs RICHARDS poor hearing probably contributed to her confusional state. The absence of her spectacles would also make it difficult for Mrs RICHARDS to be aware of what was going on around her, further aggravate her confusional state due to lack of sensory stimulation, and increase her dependency on others for her normal daily activities.

4.2.3. The absence of both her hearing aids and her spectacles would make the assessment of and communication with Mrs RICHARDS extremely difficult

4.2.3.1. It is noted that such sensory deprivation can produce and aggravate confusional and disorientated states.

4.3. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.

4.4. On 29th July 1998, at the Glen Heathers Nursing Home, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

4.4.1. In the Accident & Emergency department she was given 2.5mg of **morphine** and 50 mg of **cyclizine** at 2300 hours to relieve her pain and distress. She was known to be taking **haloperidol** 1mg twice daily and **Tradazone** 100mg at night.

4.5. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].

4.5.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st –7th she was weaned over to two tablets of **co-codamol,** requiring these on average twice daily for pain relief.

4.5.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

4.6. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'

4.6.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'

4.7. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-

4.7.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame.**' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'

4.8. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital. She was not in pain and had been fully weight bearing at the Royal Hospital Haslar walking with the aid of two nurses and a Zimmer frame.

4.8.1. At the Gosport War Memorial Hospital there was an unsigned 'Summary' record which is apparently a Nursing record and this states:-

4.8.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition...'

4.8.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" – keeps teeth in at night.'

4.8.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single **microgram** doses] B.D. [twice daily]'

4.9. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with **ADL [activities of daily living]**.... I am happy for nursing staff to confirm death.'

4.10. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & **analgesia** during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'

4.11. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to **oramorph**. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'

4.12. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] SPALDING Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'

4.12.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.

4.13. The Nursing Contact Record at Daedalus ward continues:-

4.13.1. '14/8/98 am [morning] R[ight] Hip Xrayed – Dislocated [paragraph] Daughter seen by Dr BARTON & informed of situation. For transfer to Haslar A&E [accident and emergency department] for reduction under sedation [initialled signature]'

4.13.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'

4.14. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam

allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation e [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

4.15. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.

4.15.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'

4.16. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'

4.17. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. The Daedalus ward nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'

4.17.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist & no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

4.17.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'

4.18. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

4.19. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'

4.20. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-

4.20.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of **syringe driver** to control pain [It is noted that Mrs LACK has disagreed with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'

4.20.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'

4.20.2.1. It is noted that a 'disturbance reaction' occurs in patients when they are moved that is easily mistaken for pain requiring specific treatment. It is noted here that Mrs RICHARDS was described as being 'pain free' at this time apart from when she was being moved.

4.20.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature, dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone – either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Code A Nursing co-ordinator [initialled signature]'

4.20.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

4.20.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours] Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'

4.21 Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'

4.21.1. It is noted that Mrs RICHARDS was already being given hyoscine at this time and had been doing so continuously since 19th August 1998.

4.21.2. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.

4.22. The Nursing Care Plan records state:-

4.22.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'

4.22.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

4.22.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

4.22.4. 'Re-admitted 17/8/98'

4.22.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'

4.22.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine – comfortable. Daughters stayed. [initialled signature]'

4.22.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'

4.22.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

4.22.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.

4.22.9.1. There is no record that Mrs RICHARDS was offered any fluids.

4.22.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

4.22.11. The Nursing Care Plan for 'Personal Hygiene' states:-

4.22.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

4.22.11.2. '18.8.98 Night: oral care given frequently'

4.22.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

4.22.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

4.22.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

4.23. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

5. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.

5.1. On 11th August 1998:-

5.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given—

5.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]);

5.1.1.2. once on 12th August (10mg at 0615);

5.1.1.3. once on 13th August (10mg at 2050);

5.1.1.4. once on 14th August (5ml [10mg] at 1150);

5.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030); and,

5.1.1.6. twice on 18th August 1998 5ml [10mg] at 01230[sic and ? meaning 0030 hours] and 5ml [10mg] at [?]0415).

5.1.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

5.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

5.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

5.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.

5.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.

5.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.

5.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

5.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of **Lactulose** [a purgative].

5.2. On 12th August 1998:-

5.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

5.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.2.2. Oramorph 10mgs in 5mls to be given orally once at night.

5.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.3. 18th August 1998 -

5.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours

5.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours

5.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and continuously subcutaneously diamorphine 40mgs, and haloperidol 5mgs, and midazolam 20mgs during each 24 hours.

5.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively.

5.4.1.1. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.

5.4.1.2. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

5.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been

prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].

5.4.3. It is also noted that all the drugs for subcutaneous administration were not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.

5.4.3.1. It is not known who selected the dosages to be given.

Death certification and cremation

6. The circumstances of Mrs RICHARDS death have been recorded as follows:

6.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]

6.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to -

6.2.1. '1(a) Bronchopneumonia'.

6.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.

6.2.3. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.

6.3. The body was cremated.

Conclusions

7. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.

7.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.

7.2. Mrs RICHARDS's had a confused state that after December 1997 had been aggravated by the loss at the Glen Heathers Nursing Home of her spectacles and both of her hearing aids.

7.3. On 29th July 1998, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport.

7.4. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.

7.5. On 11th August 1998, and having been seen by a consultant geriatrician, Mrs RICHARDS was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.

7.6. At that time Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] to be administered orally four hourly.

7.6.1. At that time also Dr BARTON prescribed for Mrs RICHARDS diamorphine, hyoscine, and midazolam. These drugs were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

7.6.2. Also on 11th August 1998, at the end of a short case note, Dr BARTON wrote 'I am happy for nursing staff to confirm death'.

7.6.3. It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs (diamorphine, hyoscine, and midazolam) were not administered at that time.

7.7. On 13th August 1998, Mrs RICHARDS's artificial hip joint became dislocated.

7.8. The following day, 14th August 1998, although Dr BARTON had recorded 'Is this lady well enough for another surgical procedure?' she arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.

7.8.1. It is noted that at the age of 91 years, and despite Dr Barton's comment about Mrs RICHARDS, and her confused mental state, Mrs RICHARDS was considered well enough by the staff at the Royal Hospital Haslar to have two operations on her right hip within about two weeks.

7.9. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

7.10. There is no evidence that Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

7.11. Despite this, and on 18th August 1998, Dr BARTON, while knowing of Mrs RICHARDS's sensitivity to oral morphine and midazolam, prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given (from wide dosages ranges) continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

7.11.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.

7.11.2. It is noted, however, that in clinical practice these drugs are administered subcutaneously in the management of distressing symptoms during end-of-life care for cancer.

7.11.3. It is also noted that Mrs RICHARDS was not receiving treatment for cancer.

7.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

7.13. During this period when a syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs RICHARDS was given fluids or food in any appropriate manner.

7.14. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.

7.15. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.

7.16. Dr Barton recorded that death was due to bronchopneumonia.

7.16.1. It is noted that the continuous subcutaneous administration of diamorphine, haloperidol, midazolam, and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.

My opinion

8. When Mrs RICHARDS was first admitted to Daedalus ward at Gosport War Memorial hospital on 11th August 1998 she was not in pain and had been fully weight bearing walking with the aid of two nurses and a Zimmer frame.

8.1. Despite recording that Mrs RICHARDS was not in pain, on 11th August 1998 Dr BARTON prescribed wide dosage ranges of opiate and sedative drugs to which Mrs RICHARDS was known to be sensitive.

8.1.1. Dr Barton also recorded that 'I am happy for nursing staff to confirm death.' when Mrs RICHARDS had been admitted for rehabilitation and her death was not obviously imminent.

8.2. When, at the age of 91 years, Mrs RICHARDS dislocated her operated hip and despite her confused mental state, she was considered well enough to have a second operation on her right hip within about two weeks of the first operation.

8.3. There is no evidence to show that after her second operation Mrs RICHARDS, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

8.4. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.

8.5. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.

8.6. Despite this, and from 18th August 1998 for an undetermined and unlimited number of days, Dr BARTON prescription led over 24-hours periods to the continuous subcutaneous administration to Mrs RICHARDS of diamorphine 40mgs, haloperidol 5mgs, and midazolam 20mgs to which was added hyoscine 400mcg from 19th August 1998.

8.7 The administration of these drugs continued on a 24-hours regime without their dosages being modified according to Mrs RICHARDS's response to them and until Mrs RICHARDS died on 21st August 1998.

8.8. There is no record that Mrs RICHARDS was given any food or fluids to sustain her from the 18th August 1998 until she died on 21st August 1998.

8.9. As a result of the continuous subcutaneous administration of the prescribed drugs diamorphine, haloperidol, midazolam, and hyoscine Mrs RICHARDS became unconsciousness and died on 21st August 1998.

8.10. No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

8.11. It is my opinion that Mrs Gladys RICHARDS's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam, and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.

APPENDIX A

14. I have received and read the following documents:-

14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.

14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows.-

14.2.1. 1) Draft (unsigned) statement (MG11) of Lesley HUMPHREY.
14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
14.2.5. 5) Draft (unsigned) statement of Lesley LACK.

14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-

14.3.1. A Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
14.3.2. B Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
14.3.3. C Typed copy of Notes prepared by Mrs LACK and given to Social Services
14.3.4. D Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)

14.3.5.	E	Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JK	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to S/Cdr SCOTT
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O (1)	Typed copy of signed statement of Anne FUNNELL (RHH)
14.3.14.	O (2)	Typed copy of signed statement of Lesley HUMPHREY (Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK
14.3.16	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to Lesley HUMPHREY (Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Dr Peter BREGGEN published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-

14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,

14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.

14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:

14.5.1.	E 25	Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
14.5.2.	E 22	Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS
14.5.3.	E23	Copy of Glen Care Homes file Re: Gladys RICHARDS supplied Nursing Homes Inspectorate
14.5.4.	E 24	Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
14.5.5.	D 63	Police letter 090300 to Code A Haslar Hospital with further questions
14.5.6.	D 65	Letter 100400 from Code A at Haslar including Patient transfer order and further medical records
14.5.7.	D 104	Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
14.5.8.	D 108	Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
14.5.9.	D 110	Copy typed Gladys RICHARDS Death Certificate dated 240898

14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-

14.6.1. JOICE Christine
14.6.2. GIFFIN Sylvia Roberta
14.6.3. PULFORD Monica Catherine
14.6.4. WALKER Fiona Lorraine
14.6.5. MARJORAM Catherine
14.6.6. Code A
14.6.7. PERKINS Margaret Joan
14.6.8. TUBBRITT Anita
14.6.9. COUCHMAN Margaret
14.6.10. WALLINGTON Kathleen Mary
14.6.11 FLETCHER Anne
14.6.12. COOK Joanne
14.6.13. Code A
14.6.14 Code A

14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:

14.7.1. Doctor Jane Ann BARTON
14.7.2. Phillip James BEED

14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-

14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Code A R to Mrs Gillian MACKENZIE to which had been added a petition form.

14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Ms Lesley HUMPHREY, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.

14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-

14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER – Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).

14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED – Clinical Manager Daedalus Ward (Reference D143).

14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE – Staff Nurse Daedalus Ward (Reference D144).

14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD – Enrolled Nurse Daedalus Ward (Reference D145).

14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN – Staff Nurse Daedalus Ward (Reference D146).

14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.

14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-

14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.

14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.

14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).

14.12.2.3. Memorandum from Mrs. L HUMPHREY of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital. 21st August, 1998.'

14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.

14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 – 8.2.99.

Appendix B

Facts of the environment - obtained from the statements of Mrs RICHARDS's daughters

15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.

15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.

15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Dr BASSETT. Mrs MACKENZIE had formed the opinion that the drugs Dr BASSETT was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.

15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'

15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.

15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'

15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review... However, there was no evidence of malpractice by the Home.'

15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs

LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'

15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'

15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'

15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'

15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the

consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'

15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'

15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.

15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'

15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.

15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."'

15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma

was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.

15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." .... [In her witness statement Mrs Mackenzie has stated that ' DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until

her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'

15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that "On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."

15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.

15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998], it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at

any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'

15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'

15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

Glossary

Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.

ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.

Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.

Bronchopneumonia is inflammation of the lung usually caused by bacterial infection. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients. It can contribute to the cause of death in moribund patients.

Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.

Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.

Dementia is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.

Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see **licensed** below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.

Lactulose is a preparation taken by mouth to relieve constipation.

A **microgram** is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see **licensed** above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A **syringe driver** is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

Texts used for reference have included:

1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.

   1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.

2. *ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry*. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.

3. Breggin P R. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives*. 1993. HarperCollins Publishers. London. pp. 578.

4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. *British National Formulary*. Number 32 (September 1996). The Pharmaceutical Press. Oxford.

5. *Cecil Textbook of Medicine*. eds. J.C. Bennett & F. Plum. W.B. Saunders Co. 20th Edition. 1996.

6. Letter from Clive Ward-Able (Medical and Healthcare Director) and Lee Neubauer BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.

6.1. A copy of this letter has already been supplied to the Police and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.

7. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.

8. Letter from Dr R J Donnelly, Medical Director of Janssen-Cilag Ltd.

8.1. A copy of this letter has already been supplied to the Police and reports that Haldol™ decanoate (haloperidol) is not licensed for subcutaneous use.

9. Letter from Miss Jo Medlock, Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

9.1. A copy of this letter has already been supplied to the Police and reports that Serenace™ (haloperidol) ampoules are not licensed for subcutaneous administration.

10. MeReC. Pain control in palliative care. *MeReC Bulletin National Prescribing Centre*. 1996; 7 (7): 25-28.

10.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.

11. Sims Graseby Limited. *MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual*. Sims Graseby Limited. 1998.

Appendix E

The writer's qualifications and experience including the management of dying patients

Code A

Code A

Code A

References as numbered above:

1 Livesley B, Ellington S. Report on the independent comprehensive review of the care of elderly people at St. Christopher's Nursing Home, Hatfield. East and North Hertfordshire Health Authority, 1996 (by invitation)

2. Livesley B. Memorandum of recommendations and evidence submitted to the Health Committee on long-term care provision and funding. Volume II; pp. 114-22. London: HMSO, 1996. (by invitation)

signed Code A date 10th July 2001

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KIM/gnf/gosport

18 October 2001

CONFIDENTIAL

Detective Superintendent J James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
PORTSMOUTH
PO2 8BU

Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

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 guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and assume they are Dr Barton's prescriptions although the signature is not decipherable. 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. 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.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod 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.

3 ROBERT WILSON

Code A

hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Dr Luznat, Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

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 (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. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous Diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in Diamorphine. Once again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson's condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration ..... right side flaccid". The patient died at 2130 that evening.

Comments

Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. 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 her symptom control and she was started on opioid analgesia, in my view, inappropriately. Following her spitting out of medication she was given a topical form of an opioid analgesic (Fentanyl). A decision was taken to start a syringe driver because of her distress. This included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous Diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It was clear that her physical condition deteriorated rapidly and I suspect she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS

I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient's dose requirements. The reason for switching to parenteral Diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range (20 mg to 200 mg) of

Diamorphine on the "as required" section of the drug chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by medical staff in conjunction with the nursing team. There was little indication why the dose of Diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of Diamorphine as described in these four cases suggest that the prescriber did not comply with standard practise. There was no involvement, as far as I could tell, from a palliative care team or specialist nurse advising on pain control. I believe these two issues require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:
Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

Contents

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord Code A , M Berry, JM Brewer, J Cook, E Dalton, W Edgar, Code A and A Funnell.

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments *"quality of life has ↓↓ markedly last 6/12"*. She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states *'After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.'* Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented *'I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was *'noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'*. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes *'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *in the medical notes "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death"*. The summary admitting nursing notes record *"now fully weight bearing and walking with the aid of two nurses and a Zimmer frame"*. On 12th August the nursing notes record *"Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

minutes at a time. Did not seem to be in pain". On 13th August nursing notes record *"found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote *'sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?"* A further entry the same day states *"Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks".*

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states *"fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night."* A transfer letter to the nurse in charge at Daedalus ward states *"Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing".*

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h *"in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml"*. A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August *"still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable".* Nursing notes record *"reviewed by Dr Barton for pain control via syringe driver".* At 2000h *"patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs".* On 19th August the nursing notes record *"Mrs Richards comfortable"* and in a separate entry *"apparently pain free".* There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton *"much more peaceful. Needs hyoscine for rattly chest".* The nursing notes record *"patient's overall condition deteriorating. Medication keeping her comfortable".* A staff

nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
17 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement "*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Sackman and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting; "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Curran that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton's statement that diamorphine and oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam. 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "*... it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and midazolam was commenced. It also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effects on conscious level and respiration to

frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole, looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death.'* On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr
midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr
midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following"*. On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record "*agitated at 2300h, syringe driver boosted with effect*".

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine*'. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration"* and that she was seen by Dr Peters. The nursing assessment sheet notes *"does have pain at times unable to ascertain where"*. The nutrition care plan states on 6th August 1998 "*Due to dementia patient has a poor dietary intake*". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "*Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain*". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate, and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However Mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states "*ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis*".

5.2 On 7th October the notes record he was "*not keen on residential home and wished to return to his own home*". Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter "*On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged*". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads "*Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (*activities of Daily Living*), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation*". On 16th November the notes record; '*Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI. ? decreased __ function. ↑ frusemide to 2 x 40mg om* '. On 17th October the notes record '*comfortable but rapid deterioration*'. On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October "*History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles*". On 15th October "*Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor*". An earlier note states "*settled and slept well*". On 16th October "*seen by Dr Knapman an as deteriorated over night. Increase*

*frusemide to 80mgdaily. For A.N.C (*active nursing care)". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:

14 Sep 1445h oramorph 10mg
2345h oramorph 10mg

16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion

17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr
midazolam 20mg/24hr

18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr
midazolam 40mg/24hr

Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time. This was poor practice and potentially very hazardous. Similarly the addition of midazolam and subsequent increase in dose to 40mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate *"mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) *'In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'*. On 13th February the notes record *'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'*. The notes record *'son agrees not suitable for invasive Tx* (treatment). *Matron from RH visiting today will check on ability to cope.'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February *'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'*. On 19th February the notes summarise her problems *'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'*. On 18th February the medical notes state *"No change. Awaiting Charles Ward bed"*.

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on CXR on admission. Generally unwell off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking, needs hoisting, Barthel 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death".* The nursing notes state she was admitted for *'palliative care'*, that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states *'encourage adequate fluid intake'.* On 28th February an entry in the medical notes by Dr Laing (duty GP) record *'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records *'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states *' spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.'* A further entry by Dr Lord that day records *'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states *"S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded".* On 3rd March a rapid deterioration in Mrs Page's condition is recorded *'Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs.

7.4 In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used only when the patient is unable to take medicines by mouth, has malignant bowel obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of "involuntary euthanasia" existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff's understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Dr Lord's medical notes and her statement leads me to conclude she is a competent, thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments *'it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 Diamorphine

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, *"sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. *"midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine*'

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

Code A

28th May 2002

Mr M. Hudspith
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Mr Hudspith,

Mrs Gladys Richards

As progress is being made with your enquires regarding the conduct of medical staff at the Gosport War Memorial Hospital I wish the following concerns to be put on record.

When I approached the Gosport C.I.D. on 2 October 1998 I alleged a case of gross negligence manslaughter relating to the death of my mother, Mrs Gladys Richards. I quoted the points of law to be proved following Lord MacKay's ruling in 1995 concerning the case of Adomako. At that time I had not seen the medical files.

As you are aware the second investigation commencing in October 1999 revealed the contents of the files to me. I subsequently alleged a more serious situation as it appeared to me there was written indication of 'intent'. I am still of that opinion. The total disregard of Dr. Ian Reid's letter dated 5 August 1998 and the discharge letter from Haslar dated 10 August 1998 constitutes more than negligence. In addition the discharge note from Haslar dated 17 August 1998 indicates my mother was once more mobile. The medical files are now in your possession and you are aware of the grave issues raised. The P.C.A. upheld all my complaints relating to 'investigative failures' in the first investigation by Gosport C.I.D. I understand a similar situation has arisen relating to cases brought to the attention of police in 2001 and formal complaints have been lodged with the Chief Constable.

I am aware of the boundaries set for the G.M.C. and cases are not referred to the criminal court. However the patterns set in my mother's case and apparently followed in approximately nine other cases (to date) are such that I feel very strongly they should be dealt with in a Court of Law. A recent remark in a conversation with a police officer "Juries do not like to convict Doctors" says something of the intelligence of the average jury and the explanation of the law by an unbiased judge – let alone the Obiter Dicta by a Judge (Mars – Jones/Carr) (1986)

I hope your legal panel will bear this in mind and make recommendations accordingly before deciding on a hearing only before the G.M.C. I understand that a hearing would be open to the public with press coverage and this could bar a case being heard in the criminal court.

Yours sincerely

Code A

Gillian. M. MacKenzie

Copies:
RT Hon David Blunkett MP
Paul Kernaghan Chief Constable
Nigel Waterson MP Eastbourne
Peter Viggers MP Gosport
Duncan Geer PCA
Paul Close CPS London
David Parry Treasury Counsel

Tel. 01329-284661

Code A

28 June 2002

Mr M HUDSPITH
British Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr HUDSPITH,

WAR MEMORIAL HOSPITAL, GOSPORT

It has been brought to my attention that you are involved in an investigation into various members of the medical staff at the above hospital in late 1998, and feel you should be aware of the untimely death of my step-father in September of that year whilst under its care, if you do not know already.

My step-father was Arthur Denis Brian CUNNINGHAM, who was admitted into this hospital on 21 September with serious bed-sores, as outlined in various papers sent by me to the Hampshire Constabulary some considerable time ago. He died on 26 September, apparently from Bronchopneumonia.

For my own peace of mind, I would like you to take account of Mr CUNNINGHAM's case along with the others, and I will be pleased to assist your enquiries in any way possible. To this end, I would be readily available for a personal interview in your office during most of July and August, as I will be residing in London during that period.

I look forward to hearing from you.

Yours faithfully,

Code A

C R S FARTHING

Code A

11 April 2002

General Medical Council
178 Great Portland Street
London
W1W 5JE

Mr Michael Hudspith

FORMAL COMPLAINT

I am writing further to our recent telephone conversation with yourself regarding my mother Alice Wilkie's treatment at the Gosport War Memorial Hospital in August 1998.

I am completely dissatisfied with the sub-standard care that my mother received and her subsequent death on 21 August 1998. To summarise briefly the events which took place, my mother was taken from Addenbrooke Nursing Home on 31 July 1998 to Queen Alexandra hospital as a result of a Urinary Tract Infection. My mother stayed at Queen Alexandra for five days and appeared to be making good progress. Subsequently, she was sent to the Gosport War Memorial Hospital for assessment and rehabilitation.

At the Gosport War Memorial my mother appeared increasingly sleepy, weak and unwell, she couldn't stand or walk unaided. When I queried this with the ward sister I was simply told "yes, she was deteriorating". I was given no explanation as to why or what actions were being taken to help her. Just a few days later, I was called into Phillip Beed's office and was advised that my mother was dying and there was nothing that the hospital could do to help her. I thought this was strange at the time and was at not point given any explanation as to why this deterioration had taken place and why nothing could be done. I told Phillip Beed that I did not wish for my mother to suffer but that was the depth of our conversation at this time. There was no explanation of what actions would be taken with my mother and her care.

Whilst visiting on August 20th I noticed that my mother appeared to be in pain. When I mentioned this to the nursing staff they were dismissive and said that they could see no evidence of this. I had to ask twice and waited for over an hour before Phillip Beed came to see me. He did not examine my mother at this stage and did nothing to ascertain the level of pain she was in, but he did say he would arrange for some pain relief that would make her sleepy. I left the hospital at 13.55 and at this point nothing had been done to alleviate my mothers discomfort despite the fact that her notes state that she was placed on a syringe driver at 13:50. I had not left the hospital at this time so where has this discrepancy come from? I telephoned my daughter as I was very concerned about my mother and asked her to go to the Gosport War Memorial to find

out what was happening. When my daughter arrived, the nurse said to her in a very rude manner "your mother seems to think that your grandmother is in pain". By the time I returned to the hospital at eight o'clock that evening, my mother had been placed on a syringe driver administering Diamorphine drugs into her system. She was totally unconscious and never regained it. She died the next evening.

I have many questions that have never been answered regarding this. Why was my mother placed on Diamorphine via a syringe driver, when only that afternoon, the nursing staff appeared unaware and unconcerned that she was in any pain? Why were other drugs not tried first to relieve her discomfort and why was the Diamorphine administered in 30mg quantities? I believe that 5 to 10 mg's would be a normal dosage. I cannot understand why Diamorphine was used when no other drugs had been tried first. Why was no investigation done to find out where my mothers pain was and the cause of it. I suggest that it could have been a simple problem that could have been resolved with less severe pain relief.

Also, early on the morning of the 21st August a Lady came to my mothers bedside and merely stated "anytime now" before walking away. I recognised the lady as Dr Barton. She was very uncaring, rude and abrupt and did not bother to explain to myself or my daughters either who she was or what the current situation was regarding my mother. This is unacceptable and unprofessional on the part of Dr Barton.

I was persuaded to go home for some food and a change of clothes late in the afternoon of the 21st. I expressed my concern about leaving her to Phillip Beed as I did not wish for her to be alone. I was assured by Beed that should any change take place he would contact us immediately. However, when I returned a short while later Phillip Beed entered my mothers room in front of us and told us that she had just died. However, I do not believe that she died upon our return, but I believe that she died alone and had not been monitored in our absence. Phillip Beed told us that my mother had waited until she heard our voices before passing away, however, it was quite obvious that she had died much earlier than this. My mothers records state that her daughter and granddaughter were present at time of death, this is disputed by us and we know this was not the case.

I have now received my mother's medical file and am most distressed by it. The file itself appears to be incomplete and the details contained within it are sadly lacking to say the least. One of my main concerns is that in this file, there is a note from Phillip Beed stating that I had agreed for my mother to be placed on a syringe driver. I can categorically tell you that this 'alleged' conversation never took place. Also, there appears to be a mix up on the records of my mother and another patient Mrs Gladys Richards. A note stating that my mother was given Oramorph was crossed out with a note saying that this was written in error on the wrong notes. Also, the time of death on my mothers files says 18:30 and 21:20. How can she die twice? After speaking with Gladys Richards daughter she has confirmed that 21:20 is the time her mother passed away. This is gross incompetence on the part of the hospital and I wonder whether my mother was given these drugs in error or whether it was only written on her notes in error. The notes themselves are incomplete and there are whole days when nothing is written on them and there is no record of what, if anything, she was given to eat or drink. I would expect that if she had a UTI, was catheterised and

dehydrated then there should be a note of both her intake and her urinary output. This was done at Queen Alexandra but does not appear to be done at the Gosport War Memorial.

I would also like to know why my mothers notes state DNR on them without this being discussed with myself and also why her place at Addenbrooke was given up without my knowledge. After all the note from Queen Alexandra said that she was merely entering the War Memorial for rehab and assessment, she did not go there to die!!!

I am not prepared to let this matter lie. I believe that my mother died as a direct result of negligence on the part of the hospital and the administering of Diamorphine drugs which were not necessary. The death certificate states she died of Pneumonia but she showed no symptoms of this before dying and we were at no point advised of this condition. I am not happy that this case is being left and am pursuing the matter with the Police further as I believe that criminal acts have taken place. I will not rest until appropriate action has been taken against Dr Barton and Phillip Beed.

I look forward to hearing from you soon.

Yours sincerely

Mrs M Jackson

Code A

CC: Chief Constable Kernaghan – Hampshire Constabulary
Peter Viggers MP
David Blunkett MP
Iain Duncan Smith MP

Iain Wilson

Code A

COPY LETTER

18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and [redacted], who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Code A

Iain Wilson.

Code A

Friday 17th May 2002

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

I wish to make a formal complaint against two doctors working at The Gosport War Memorial in Gosport, Hampshire, during the time that my mother was in their care. The doctors concerned are [redacted] and Jane A BARTON (GP Code No. Code A

My mother was admitted from Queen Alexandra's Hospital, Portsmouth on 27th Feb 1998 and died the evening of the 3rd of March 1998.

The events leading up and including her death were investigated in a serious crimes investigation carried out by The Major Incident Complex, Portsmouth. Her case was serious enough to be sent to medical experts for opinion, I believe this report substantiates concern in her treatment. I also believe you have a copy and am aware of this case.

It is important to note that I was first made aware that there was concern in the treatment of elderly patients during 1998, when Mrs Gillian MacKenzies's case made local press news. At that time I wrote a letter to the police stating that I had concern relating to my mother, this was on the 9th April 2001. I was told that my mother's case would be investigated. I heard nothing until the 13 February 2002. At that time I was invited with other concerned relatives to a meeting with the head of the enquiry team who explained the events of the investigation and the reasons as to why no further action would be taken. At this meeting I first learnt that my mother's case was one of four cases investigated and expert opinions sought. I was also told at this meeting that these reports would be available to me. This promise was rescinded, and I was told later that Court Orders would be required, and this may well be refused.

I subsequently obtained my mothers notes and after perusal with a professional opinion, I found several grave areas of concern. I now understand from Mrs Ann Reeves (another unhappy relative) that these police reports were sent to you and you have/are investigating further.

I am annoyed that throughout this time I have been kept in the dark by the police as to any investigation made, and the investigating officers decision to take no further action, and his subsequent withdraw of the offer to release the medical opinions. I am presently making a formal complaint to The Chief Constable, Hampshire Police.

I trust you are able to assist me in this very serious matter.

Yours truly

Code A

Bernard Page

53

MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Statement of : **Lesley Frances LACK**

Age if under 18 : **Over 18yrs** (if over 18 insert 'over 18')

Occupation : **Retired**

This statement (consisting of 20 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : **Code A** Dated the 31 January 2002

I am the natural daughter of Gladys Mable RICHARDS (Nee BEECH) who was born on the Code A Code A

My mother died on the 21st August 1998 whilst she was an admitted patient at the Gosport War Memorial Hospital.

I am a retired Registered General Nurse (RGN). I retired during 1996 after 41 years, continuously, in the nursing profession. For 25 years, prior to my retirement, I was involved in the care of elderly people. For 20 years, prior to my retirement, I held supervisory and managerial positions in this particular field of nursing.

My mother was a resident in two nursing homes from 1991 or thereabouts. The first was located in the Basingstoke area and the most recent was the 'Glen Heathers' Nursing and Residential Home, Milvil Road, Lee on Solent, Hampshire. My mother spent approximately four years at the 'Glen Heathers' Home. On admission to Glen Heathers my mother was ambulant - able to go up and down stairs and walk well.

She was generally well, physically, but had the onset of dementia and became increasingly forgetful. At the beginning of 1998 my mother's dementia was becoming more marked and she had become less able physically. She was inclined to wander and following a change in her medication began to have falls.

However, despite this my mother was able to stand, walk and attend the toilet. I used to take her out for trips in my car. Her last visit to my home occurred during Christmas 1997.

My mother left the 'Glen Heathers' Home on the 29th July 1998 and was admitted to the Haslar Hospital, Gosport.

Code A **Code A**

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

My mother had suffered a fall, at the Home, at approximately 1450 hours during the afternoon of that day. She was eventually taken to Haslar Hospital, by ambulance, at approximately 2100 hours that evening where she was diagnosed as having broken a neck of femur on her right side.

Whilst it may not have a direct bearing on my main concerns surrounding my mother's death, which I will describe later in this statement, I would like to point out that I did have serious reservations as regards the standard of care which my mother was receiving whilst residing at the 'Glen Heathers' Home.

In fact, following my mother's admission to the Haslar Hospital on the 29th July 1998, I had decided that, if and when my mother recovered, she would not be returning to the 'Glen Heathers' Home.

I was asked by the Social Services Department why I had made this decision and, in response, I prepared and provided a hand-written account describing what I considered to be a catalogue of unacceptable events which had led me to conclude that the level of care which my mother was receiving at the 'Glen Heathers' Home was no longer acceptable to me.

The hand-written account was prepared, by me, during August 1998 and I consider that it represented a truthful statement which dealt with various events and circumstances which I had observed or had become aware of during the months which preceded my mother's admission to the Haslar Hospital.

I will not, for the purposes of this statement, refer in detail to the matters described in that account but I will, by way of introducing the events which followed, make some brief references, drawing on my personal recollections and my notes, to my involvement in the events leading to my mother's admission to the Haslar Hospital on Wednesday the 29th July 1998.

I was a frequent and regular visitor to the 'Glen Heathers' Home whilst my mother was residing there and I played an active role in helping her in her daily routines. My visits were generally daily in the last 8 months of her life.

I recall that I was unable to get to the 'Glen Heathers' Home at lunchtime on Wednesday the 29th July 1998. I telephoned the Home to inform them that I would be going there later in the afternoon.

When I arrived, at approximately 1550 hours, I saw that my mother was lying in an armchair. She appeared to have an anxious expression on her face. I asked a care assistant to help me to move my mother into a more comfortable sitting position which, together, we tried to do but, as a result, my mother screamed out in pain.

Code A

Code A

Signed : L. F. LAC[redacted]gnature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I saw John PERKINS, an RGN and the Home's Matron/Manager, and I asked him if there was anything wrong with my mother which might account for her pain. He told me that she was fine.

I clearly knew that this could not be the case but I was not in a position to do anything more at that time. I had to leave the Home at 1615 hours in order to meet a flight at Southampton Airport. I said that I would return later.

I arrived home, from the Airport, at approximately 1810 hours. I found a message on my telephone answer machine, timed at 1528 hours, from a woman I knew as Margaret who was an RGN who worked at the Home. Margaret stated that my mother had experienced a fall earlier and, whilst she was alright, she was a bit noisy and upset. Margaret asked if I could attend the Home, before teatime, and sit with her, to calm her down.

I immediately telephoned the Home, at approximately 1815 hours, and spoke to John PERKINS. I told him about the message from Margaret and pointed out that I had seen him, at the Home, after the message had been left on my answer machine.

John PERKINS agreed that this was the case but stated that when he had spoken to me he was not aware of my mother's fall. He stated that he had learned about it during the 1800 hours 'hand over' process when Margaret had gone off duty.

I asked John about my mother's current condition and he said that she was OK. I told John that I would call again later. I had to go out in the meantime.

I returned home at approximately 2030 hours. I found three messages from the Home on my telephone answer machine:

1) 2008 hours - from John PERKINS - stating that my mother was quite agitated and noisy and inviting me to attend and sit with her.

2) 2029 hours - stating that my mother was calling as if she may be in pain. She had been put to bed and consideration was being given to calling a doctor.

3) 2030 hours (approximately) - from a woman named Sue, a member of the night staff - stating that she was sorry but she was sure that my mother had a fractured femur. She went on to state that when she had started work she had been told, by John, to see my mother who had been shouting for ages. Sue stated that when she did so the injury appeared obvious and, as a result, she had called an ambulance.

Code A 8

Signed L. F. LACK Code A ature witnessed by R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I telephoned the Home and advised the staff that I would meet the ambulance at the Haslar Hospital.

On admission to the Haslar Hospital my mother was 'x' rayed and the diagnosis was confirmed. Furthermore, it was observed that the injury was consistent with my mother having been 'walked' after the fall had occurred. There was a shortening of the limb and an external rotation of the right foot. My mother was extremely upset and was crying and wailing in fear.
I subsequently sought a full explanation from the 'Glen Heathers' Home about the events which occurred on the 29th July 1998. As a result I saw a woman named Pauline, an RGN and consultant/advisor to the Home.

Pauline read to me from several statements which had been obtained from members of staff at the Home. I was not given copies.

During this process I was advised that my mother had fallen at 1450 hours in the dining room.

The statements read to me, by Pauline, indicated that my mother had been walked to the lounge, at some time after the fall had occurred, and, at some time thereafter, walked to the bedroom from the lounge.

The statements confirmed the following key points:

1) The fall had occurred at 1450 hours.

2) The serious injury which had apparently been sustained during this fall was not identified or even suspected by the staff despite my mother clearly showing signs of being in considerable and sustained pain.

3) My mother was walked on two occasions after apparently sustaining the injury which appears to have seriously aggravated her condition.

4) A doctor was not called to the Home.

5) My mother's condition was not effectively identified until a member of the night staff correctly diagnosed the likely cause of her severe discomfort and pain at or about 2030 hours when an ambulance was called to the Home and she was taken to the Haslar Hospital.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I can produce a copy of the hand-written notes which I prepared. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/1.

Following her admission to the Haslar Hospital, at approximately 2100 hours on Wednesday the 29th July 1998, my mother underwent a surgical operation. This was carried out during the following day, Thursday the 30th July 1998, following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.

My mother received a replacement hip, on her right side, and remained in the Haslar Hospital for a further eleven days until Tuesday the 11th August 1998.

I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.

Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.

She was, with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.

Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.

Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.

I will now deal with the matters which arose during the following ten days culminating in my mother's death on Friday the 21st August 1998.

In doing so I will draw upon my personal recollections and also refer to a further set of hand-written notes which I prepared, whilst sitting at my mothers bedside, while she was still alive with my sister Gillian MACKENZIE, as I was unhappy with the events that had befallen my mother.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I telephoned the Complaints Department at Portsmouth Health Care Trust on Wednesday 19th August from Daedulus ward and spoke to Lesley HUMPHREY in depth. Having listened, she advised me that everything must be in writing. I continued adding to my notes - hence the use of different pens. I prepared these notes on the advice of Lesley HUMPHREY, the Quality Manager for the Portsmouth Health Care Trust, to whom I expressed my serious concerns about the care and treatment given to my mother by staff at the Gosport War Memorial Hospital.

The hand-written notes, a copy of which I passed to Lesley HUMPHREY, are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS on 20.8.98.

I produce the original hand-written notes which I prepared comprising of 5 numbered pages. These notes have attached to them a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/2.

I am in possession of a further page of notes, in my hand-writing, which I prepared at the time. I cannot now recall whether this additional page was copied to Mrs HUMPHREY with the other pages. This single page has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LFL/2A which I have signed.

Many of the events and occasions I refer to in this statement took place in the presence of my sister Gillian Mackenzie. The addition to the notes were made when my sister and I read them prior to passing them to Lesley HUMPHREY as requested. Gillian remained at the hospital with me from 18th to 21st August 1998 inclusive, either of us leaving for very short periods only.

I visited my mother the day of her admission and discussed her present condition with the staff and on the following day after her admission to the Gosport War Memorial Hospital, namely Wednesday the 12th August 1998, I was rather surprised to discover that I could not rouse her. As she was unrousable she could not take nourishment or be kept hydrated.

I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days.

I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar Hospital during the period after the surgical operation to replace her hip.

Code A

Code A

Signed L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate a possible cause. I consider it likely that she was in need of the toilet.

I became concerned that perhaps the staff at the Gosport War Memorial Hospital may have misinterpreted my mother's anxious and occasionally noisy behaviour. She had been showing signs of dementia for some time, prior to her admission to the Haslar Hospital, and she was prone to becoming very anxious at times particularly when she wanted to use the toilet.

One of the consequences of being rendered unrousable, by the effects of 'Oramorph, was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.

I would like to clarify an important concern I felt at this stage.

I believed that it was possible, having regard to the level of recovery which my mother had achieved upon being discharged from the Haslar Hospital the day before, that her reported behaviour could have been wrongly attributed to the presence of pain as opposed to other possible causes, such as anxiety, which could have been addressed naturally or by the use of alternative and milder forms of medication. I believe that the possible misinterpretation of my mother's behaviour is a particularly significant factor in this case.

In the circumstances which I have just described I consider that it is possible that my mother's signs of anxiety could have been misinterpreted for pain whereas, subsequently, it appears likely that the fact that my mother, after having fallen, and was clearly showing signs of being in pain, these signs were either ignored or dismissed as being the result of her dementia.

During the following day, Thursday the 13th August 1998, I received a telephone call at approximately 1400 hours, from my daughter, Karen READ, who is a qualified nurse. As a result I went to the Gosport War Memorial Hospital to see my mother.

I arrived at the Gosport War Memorial Hospital at approximately 1545 - 1600 hours. I immediately saw that my mother appeared to be uncomfortable and in pain. She had an anxious expression, was weeping and was calling out. She was sitting in a chair and appeared grossly uncomfortable.

I spoke to several trained and untrained members of staff expressing my concern over my mother's condition. I was told that there was nothing wrong and that her behaviour was the result of her dementia. I was not satisfied with this explanation and I was convinced that my mother was in pain.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R.J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

Later, at approximately 1630 - 1700 hours, a care assistant came into my mother's room. She told me that my mother had fallen from a chair earlier that day.

I immediately enquired if my mother had been examined by a doctor but the care assistant did not know. I also asked if my mother could be x-rayed but I do not recall receiving a response to this request. I was able to give my mother a fruit drink which I had brought with me and she drank it readily. The whole glass.

A little later I saw an RGN who was doing the medicine round at approximately 1730 - 1800 hours. I was, at this time, feeding my mother by tea spooning her with some soup. My mother was quiet then.

The RGN asked me, " Do you think your mother is in pain?" In reply I expressed the view, "Not at the moment while I'm feeding her." I was rather taken aback by the RGN's rather curt reply, "Well you said she was in pain". I replied, "Yes, she has been very uncomfortable since I got here. Do you think she has done some damage?" The RGN replied, "No, she only fell on her bottom from her chair". I was shocked by this seemingly casual and insensitive remark - when this accident could very easily have caused damage and had not been checked.

I remained with my mother until approximately 1945 hours that evening (Thursday the 13th August 1998). After I had fed her she once again became distressed and showed signs of being in considerable pain. She remained in this condition, throughout, until my departure. I left very distressed as my mother was crying out and I could do nothing for her.

After I arrived home I received a telephone call from Daedalus Ward at the Gosport War Memorial Hospital. The caller stated that, "When we put your mother to bed she was in great pain and she may have 'done something'. The doctor feels it's too late to send her to Haslar and our x-ray unit is closed. We will give her 'Oramorph' for the night to keep her pain free and x-ray her in the morning".

I was becoming extremely concerned about what was happening to my mother.

It appeared, to me, at that time, that my mother had suffered a potentially serious fall at some time prior to my daughter's telephone call, to me, at approximately 1400 hours. I have, earlier in this account, referred to conversations which I had, during the afternoon and early evening, with two members of staff who both knew about, and referred to, the fall.

Despite the fact that my elderly mother was known to have suffered a fall, so soon after a hip operation, and then so clearly showed signs of anxiety, discomfort and pain, the reason was not properly explored and diagnosed.

3

Signed : L. F. LACK Code A

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410 Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

This, in fact, resulted in what I believe was an avoidable delay of eight hours, in the first instance, before it was acknowledged, at approximately 2130 hours, that my mother, "may have done something".

I reiterate that I was, at that time, advised that the proper facilities (x-ray unit) for diagnosing my mother's condition, at the Gosport War Memorial Hospital, "were closed" and that the doctor, "feels it is too late to send her to Haslar".

Instead, my mother was given 'Oramorph' for pain relief and remained, effectively untreated, at the Gosport War Memorial Hospital overnight.

I strongly believe that the failure, on the part of the staff at the Gosport War Memorial Hospital, to properly and promptly take steps to accurately diagnose my mother's condition, on Thursday the 13th August 1998, and immediately initiate action to effectively deal with the cause by seeking a transfer to the Haslar Hospital where treatment was available, represented an example of a pattern of omission and failure which, ultimately, contributed in her death.

The following morning, Friday the 14th August 1998, I went to the Gosport War Memorial Hospital. I arrived as my mother was being taken, on a trolley, to the x-ray department. She was still deeply under the effects of the 'Oramorph' drug. I accompanied my mother whilst she underwent the x-ray process the associated movements of which caused her great pain.

When the x-ray process was completed we returned to my mother's ward and I was called into an office by Philip, the Ward Manager, where I also saw Dr BARTON. I was told, "Your worst fears of last night appear to be true, we have rung Haslar and they have accepted her back".

My mother was admitted to the Haslar Hospital, for the second time, during the late morning of Friday the 14th August 1998. I accompanied my mother and she was expected. The Consultant was called and he saw my mother in the Casualty Department immediately.

The Consultant showed me the x-rays and the position of my mother's limb, something else which I had observed, the day before, at the Gosport War Memorial Hospital.

My mother's right hip, which had been the subject of a surgical 'replacement' operation 14 days previously, had become dislocated from its socket. Within one hour of being admitted my mother underwent a successful surgical operation to manipulate the hip back into the socket.

This did, indeed, confirm my fears about the care my mother had received. She had fallen, whilst at the Gosport War Memorial Hospital, and it had taken almost 24 hours to secure effective treatment.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I remained at the hospital until approximately 10pm.

My mother did not regain consciousness until approximately 0100 hours on Saturday the 15th August 1998 due to the amount of analgesia required for the procedure. I telephoned the ward at this time as I was anxious. The night staff told me she had just regained consciousness. She was the catheterised so that there was no need to use a slipper pan. She had a drip as she had been given nil by mouth since before the x-ray procedure carried out on Friday the 14th August 1998.

She remained pain free, in a full length leg splint. The Consultant showed me that both legs were level and straight. No analgesia was required and she was able to use a commode for the toilet with weight bare for transfer. My mother began to eat and drink and the drip was removed. Her fluid balance was acceptable. I visited daily.

Such was my mother's progress that during the following day, Sunday the 16th August 1998, she became easily manageable.

The issue I wish to highlight, at this point, is that when my mother's condition was correctly diagnosed and treated her pain and discomfort were removed and she recovered well.

My mother was examined early on Monday the 17th August 1998 when a transfer back to the Gosport War Memorial Hospital was recommended. I contacted the Haslar Hospital by telephone at approximately 0830 hours as requested and was told that my mother would be transferred that morning.

I offered to attend the Haslar Hospital so that I could pack my mother's things and accompany her but I was told that there was, "No need, she is fine".

I arrived at the Gosport War Memorial Hospital at approximately 1045 hours with Gillian MACKENZIE and we were told that the ambulance, carrying my mother, was due at midday or thereabouts.

We returned to the Gosport War Memorial Hospital at approximately 1215 hours.

On entering through the swing doors to the ward I heard my mother screaming. When I arrived at my mother's room a care assistant said, "You try feeding her. I can't do it. She is screaming all the time".

My mother had a staring anxious expression. She was griping her right thigh, at the sight of the surgical operation, tightly.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

She uttered the words, "Do something, do something. The pain, the pain. Don't just stand there. I don't understand it. The pain, the pain, the pain. Sharp, sharp. This is some adventure". Gillian MACKENZIE was present.

An SRN came into the room because of the noise my mother was making. I removed the sheet covering my mother as she lay on her bed and pointed out the awful position she was in. She was lying awkwardly towards the left side and the hips were uneven.

My mother was crying in pain and I said to the RGN, "Can we please move her." We moved her together with our arms together under her lower back and our other arms under her thighs. We placed her squarely on her buttocks and within minutes she had stopped screaming.

I was concerned that my mother's position had not, apparently, been checked when she had been transferred from the ambulance. I was also concerned about the fact that, once again, the source of the pain had not, immediately, been sought.

I left my sister, at the Gosport War Memorial Hospital, at around this time and I went to the Haslar Hospital. This would have been about lunchtime.

I was so appalled at my mother's condition, discomfort and severe pain that I went to the ward in which she had been treated, E3, and enquired about her condition upon discharge earlier that morning.

When I had, earlier that day, telephoned E3 ward and I had been further advised that my mother was eating, drinking, using a commode and able to stand if aided. The Consultant responsible for my mother was, I was told, happy that she could be sent back to the Gosport War Memorial Hospital.

It is, perhaps, worthwhile re-emphasising that this was the level of recovery my mother had achieved on the morning of Monday the 17th August 1998 prior to being discharged from the Haslar Hospital. Whilst she was an elderly and frail lady she was not suffering with a fatal illness. Her discharge notes from Haslar refer to her care for the next 4 weeks, to ensure her progress was maintained.

Upon leaving Haslar Hospital's E3 ward, after confirming the information I had earlier been given, I met the Doctor who had been present in the Casualty Theatre at the time of my mother's second operation which took place on Friday the 14th August 1998. This Doctor had been with the Consultant when all the procedures were explained to me, upon my mother's admission, that day. The Doctor asked, "How's your mother?"

1 1 6

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said, "We've had no referral. Get them to refer her back. We'll see her."

I then returned to the Gosport War Memorial Hospital where I noted that the Charge Nurse Manager frequently checked my mother. He acknowledged my concern and the fact that my mother was obviously in pain.
I asked for my mother to be x-rayed and enquired what had happened between my mother having left the Haslar Hospital and her arrival at the Gosport War Memorial Hospital.

It was acknowledged that "something" had happened. The Charge Nurse was concerned for my mother's pain and analgesia was given three times between her admission and 1800 hours.

Philip, the Ward Manager, agreed that my mother needed an x-ray to establish if further damage had been done to the hip.

The x-ray department refused to act upon forms of authority prepared and signed on behalf of the doctor who was unavailable.

An appointment for x-ray was made for 1545 hours as the Doctor who had been called was expected at approximately 1515 hours.

The Charge Nurse did all he could to expedite this, keeping me informed and constantly checking my mother's obvious severe pain. He administered pain relief in readiness for the x-ray procedure. He was courteous and attentive at all times.

Dr BARTON arrived and I left the room as requested whilst she examined my mother. She stated that whilst she did not think that there was further dislocation the x-ray could go ahead. A review would be conducted later when the result of the x-ray was known.

I accompanied my mother to the x-ray department. My mother remained in pain despite the pain relief which had been administered to her. I was not allowed to accompany her as I had been the previous week . Whilst I waited outside I could hear my mother wailing, while the x-ray was taken.

In due course I returned to the ward and I was told that there was no dislocation but obviously 'something' had happened. I was not given sight of the x-ray.

Code A **Code A**

Signed : L. F. LACK Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I was told, by either the Ward Manager or Doctor BARTON, that my mother would be given 'Oramorph' for the pain, four hourly, through the night and she would be reviewed in the morning. I told them that Haslar would accept her back but Dr BARTON felt that was inappropriate.

I told Dr BARTON and the Ward Manager that I had been to the Haslar Hospital that morning, explained what was happening, and told them that Haslar would be prepared to re-admit my mother. I considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.

Dr BARTON said that, "It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery."

The following day, Tuesday the 18th August 1998, I returned to the Gosport War Memorial Hospital with my sister in the morning. Upon arrival we were told by, the Ward Manager Mr Philip BEED, that whilst my mother had undergone a peaceful night she had, however, developed a massive heamatoma in the vicinity of the operation site which was causing her severe pain.

The plan of management, as explained to us by the Ward Manager, was to use a syringe driver to ensure my mother was pain free at all times so that she would not suffer when washed, moved or changed in the event she should she become incontinent.

The outcome of the use of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I knew that the continuous use of morphine, as a means of relieving her pain, could result in her death. She was, at that time, unconscious from the effects of previous doses of 'Oramorph' and therefore unable to take nourishment by mouth. It was my understanding that it would not have been possible for nourishment to have been given to my mother, by way of a drip, whilst she remained at the Gosport War Memorial Hospital.

As a result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, " Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free".

The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998.

A little later Dr BARTON appeared and confirmed that a haemetomía was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection."

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : **R. J. BURT Detective Chief Inspector 7410**

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I considered that this was a totally insensitive remark to make to someone, such as myself, who was experiencing some of the feelings associated with the first stages of bereavement.

I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'.

I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death.

I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON more strongly on this issue.

In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and from where an offer had already been made to do so.

I accept that my mother was unwell and that her physical reserves had been depleted. However she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly it was to care for her.

My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on the 19th August and no further urine was passed. The same catheter bag remained in place until her death.

Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.

I passed, as I have previously mentioned, a copy of the notes I had prepared (LFL/2) to Mrs HUMPHREY.

In reply I received a letter from Max MILLETT, the Chief Executive of the Portsmouth Health Care NHS Trust, dated the 22nd September 1998.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I can produce a copy of this letter which has, attached to it, a Hampshire Constabulary exhibit label which I have signed and which bears the reference LFL/3.

Whilst there are a number of issues which cause me concern I would like to make some particular comments on the contents of this letter.

In order to do this I have been provided, by DCI BURT, with a typed copy of the letter (LFL/3). This copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/3A and signed by me, was constructed to enable me to add hand-written comments which I have done. I feel, however, that I should point out that where I have chosen not to record such a comment this does not imply that I necessarily agree with, or accept, what has been stated.

I have been shown, by DCI BURT, a copy of an Enquiry Report which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/4 which I have signed.

I have been provided, by DCI BURT, with a typed copy of this Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference LFL/4 and signed by me, was constructed to enable me to add hand-written comments which I have done. I, once again, point out that where I have chosen not to comment on a particular reply or issue this does not imply that I necessarily agree with, or accept, what has been stated.

I have had sight of a Report, prepared by Dr LORD and dated the 22nd December 1998, which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/6 and signed by me.

If this Report is supposed to represent an independent assessment of the treatment which my mother received at the Gosport War Memorial Hospital then I find this difficult to accept.

Dr LORD was the Consultant for Daedalus Ward at the Gosport War Memorial Hospital but, in her own words, "....did not attend to Mrs RICHARDS at all....".

Dr LORD's Report appears to have been prepared by reference, some time after the event, to information, notes and documents supplied by colleagues with whom she worked on a regular basis.

I have been shown, by DCI BURT, a Portsmouth Health Care NHS Trust Risk Event Record. Attached to this document is a Hampshire Constabulary Exhibit Label bearing the reference LH/2 which I have signed.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I have examined this document, which comprises of 3 sides of paper, and I would like to make the following observations.

On page 1, at 12 (a) after the words 'Seen by?' there is a hand-written entry, "Dr BRIGG".

I believe that this contradicts information contained in the letter from the Portsmouth Healthcare Trust (LFL/3) dated 22nd September 1998 where, at point (4), it states that Dr BARTON was present on the ward just after my mother's fall.

Furthermore, at 12 (a), there is a further hand-written entry which states, "Advised by telephone - analgesia & RV mane". This may be cross referred to an entry in my mother's Health Care Record (LH/1/C/21) which is dated 13.8.98 and timed at 1300.

At 12 (b) it states, in reply to the question, "Has next of kin been informed? The corresponding "Yes" has been positively ticked and dated 13/8/98. Furthermore it states that I had been informed by telephone.

I was <u>not</u> informed and I was not telephoned. My statement shows I was on the ward and had great difficulty in finding anyone to confirm my mother was injured.

It is my opinion that the Risk Event Record is incorrect. My mother was not seen by Dr BRIGG.

Part 'E' of the Risk Event Record shows that a particular question, which appears among a series of 'tick box' questions and states, " Slipped, tripped or fell on the same level", has been positively answered. In my view this is incorrect. The normal height of the seat would be between 17 and 25 inches so my mother's fall to the ground would have involved a considerable drop.

I have been shown, by DCI Burt, a copy of a Portsmouth Health Care Trust Health Record. Attached to this Health Record is a Hampshire Constabulary Exhibit Label bearing the reference LH/1/C.

This Health Record relates to my mother and I would like to make the following comments in respect of this document.
On the page marked LH/1/C/6, which is a copy of a Discharge Letter from the Royal Hospital Haslar, I note the comment, "She can, however, mobilise fully weight bearing." I wish to highlight the fact that this relates to my mother's condition on the 17th August 1998.

On the page marked LH/1/C/8 there is a copy of a hand-written note, apparently signed by Philip BEED, which is addressed to Haslar A & E and is dated 14th August 1998. In these notes it states, "No change in treatment since transfer to us 11/8/98, except addition of Oramorph etc.

Code A

121

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I would comment that no analgesia was required until the staff at the Gosport War Memorial Hospital first used Oramorph when my mother was agitated and probably in need of the toilet on the 11th August 1998 which was the day of her admission from the Royal Hospital Haslar.

I saw that my mother was deeply unconscious when I visited her on the 12th August 1998. In my view this medication probably affected the opportunity to offer nourishment as early as the 11th August 1998.

On page LH/1/C11 I note, with some concern, an entry under the date of the 11th August 1998, in what I believe is Dr BARTON's hand-writing, the comment, "I am happy for nursing staff to confirm death."

My mother was well and enjoying a good convalescence following a major operation. She was able to eat and drink. She was able to stand whilst requiring help with all daily living events.

Perhaps this comment may be considered, by some, as being 'normal' procedure for aged admissions but not in my experience. Such a question may, perhaps, be considered if the patient was suffering from a terminal illness and death is likely or imminent. The evidence does not suggest that my mother was in this condition.

On the same page (LH/1/C/11) there is an entry under the date of the 14th August 1998 which is once again, I believe, in Dr BARTON's hand-writing. It states, "Fell out of chair last night."

Further reference to the Risk Event Record (LH/2) shows, at point (9), that the accident occurred on the 13th August 1998 at 1330 hours and it will be recalled that the Portsmouth Health Care Trust Letter (LFL/3) states that Dr BARTON was on the ward following accident.

I query whether, in fact, my mother was seen at all.

A further comment, in the same entry, states, "Daughter aware and not happy." I re-iterate that I was "not happy" because I could get nothing done for my mother who was simply given pain relief without any apparent attempt to discover the cause of her discomfort.

Finally, in the same entry, the question is raised by, I believe Dr BARTON, "Is this lady well enough for another surgical procedure?" This question was not, however, raised with me.

On the reverse side of page LH/1/C/11, under an entry dated the 17th August 1998, there are references to my mother's condition following the operation on 14.8.98 as per the nurse's notes of Haslar, not to her condition on 17.8.98.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

There is a comment, I believe in Dr BARTON's hand-writing, "....now appears peaceful." I know that my mother screamed and cried in the period following her re-admission.

My mother was only 'peaceful' being given Oramorph on 3 occasions which rendered her quiet and unconscious. In fact this treatment had rendered my mother incapable of taking any nourishment from this point and she did not regain consciousness again.

I would like to draw attention to the fact that there are no Doctor's notes from the 18th - 21st August 1998.

On the same page, under the date of the 21st August 1998, there is an entry which, I believe, is also in Dr BARTON's hand-writing which I feel I must challenge. Contrary to what Dr BARTON has written I strongly believe that my mother did not have a rattly chest nor any other symptoms of Brocho-pnuemonia.

On page LH/1/C/21, and on the following 3 pages, also so marked and headed 'Contact Record', I note that no entries appear to have been made over the period of the 11th / 12th August 1998.

On page LH/1/C/21, under an entry dated the 13th August 1998, there are comments which clearly indicate that my mother was not seen by a Doctor or examined by way of X-ray following her fall at 1.30pm that day.

It was not until 7.30pm or 8.30pm that it was appreciated that my mother's hip was the cause of my mother's pain. Telephone contact, only, was made and advice sought and given by a doctor who did not know my mother.

I was present on the ward and repeatedly sought help for my mother. I was casually informed, by a Health Care Assistant, that my mother had indeed had a fall.

In my opinion there was a serious lack of action for a post operative patient in view of her obvious gross "discomfort" which was brought to the attention of all grades of staff by myself. The comment included in the entry, "Daughter informed", may refer to the phone call received after I returned home at approximately about 9pm -10pm that evening.

On the same page, under an entry dated the 17th August 1998, there appears to be a reference to my mother being in pain and distress but no action was taken.

There is an 'added' comment which refers to the fact that when my mother was transferred there was, "No canvas under patient...." In my view this represented a serious breach of work procedures and should be questioned.

Code A

Code A

Signed : L. F. LACK Signature witnessed by : [redacted] Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

I consider that the circumstances of my mother's transfer from the Royal Hospital Haslar, to the Gosport War Memorial Hospital, should be the subject of investigation. How was she brought from Haslar? How was she lifted? How was she transferred to her bed? Was the bed moved from the wall? How was she deposited in her bed? And By whom? Who was present?

This was a woman, 2 days post operative, who was transferred on a sheet. How could this have happened? And Why?

Who was informed, and when, as regards her degree of pain which was very obvious when I arrived 30 minutes after this entry was apparently made.

On the following page there is a further entry which is also dated the 17th August 1998 and timed at 1305 hours. This entry does not refer to my mother's awful position, which I observed upon my arrival, or the fact that I asked the RGN to look at the way in which she was lying and to adjust her to be equally on both hips.

It was at this point that I told the staff that the Royal Hospital Haslar would be prepared to re-admit my mother. The Surgeon had said that she should not be in pain.

I once again point to the fact that my mother was pain free and mobilising prior to her transfer.

It should be noted there is no entry, on the 17th or 18th August 1998, regarding the fact that my sister and I were told that our mother had a massive haematoma. I can find no written evidence of this fact.

I see that no contact notes were made on the 20th August 1998.

In an entry dated the 21st August 1998 there is a reference to the fact that, "Daughters visited during morning." I would state that, in fact, we were constantly at the Gosport War Memorial Hospital, day and night, from the 17th August 1998 until the time when my mother died.

I would like to comment, in respect of the Nursing Care Plan, on the 2 pages marked LH/1/C/22, lacks information regarding the events that occurred.

With reference to the pages marked LH/1/C/22/4, headed 'Personal Hygiene' and 'Care Plan', there is, in my opinion, a gross lack of attention to the needs of daily living. Not even face and hands were washed and there are no entries at all on the 17th, 19th or 20th August 1998.

Finally, by reference to the page marked LH/1/C/22/1 and headed 'Nutrition' I comment that, in my opinion, this form is sadly lacking in information.

Code A

Code A

Signed : L. F. LACK

Signature witnessed by : R. J. BURT Detective Chief Inspector 7410

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Lesley Frances LACK**

There are only 3 entries in total and no entries at all in respect of the 12th, 17th, 18th, 19th or 20th August 1998.

Furthermore there is no acknowledgement of the fact that my mother was having NIL BY MOUTH due to her induced unconscious state by the giving of pain relief only for 5 days prior to her death and during previous days of the 11th, 12th and 13th August 1998.

I have been shown, by DCI BURT, a copy of a Royal Hospital Haslar Medical Record. Attached to this document is a Hampshire Constabulary Exhibit Label bearing the reference AF/1/C which I have signed.

I would like to comment that in my opinion, when comparing it as a residual account of events with the Portsmouth Health Care Trust's Health Record (LH/1/C), it supersedes the latter in terms of quality and content.

Having examined the Medical Record (AF/1/C) I consider it to be totally accurate as regards the condition and treatment/care afforded to my mother Mrs Gladys RICHARDS. There is attention to detail and all information contained therein is as I remember.

I would particularly like to highlight a particular issue and refer to a page in the Medical Record marked (AF/1/C/11).

It should be noted that after my mother's initial admission to the Royal Hospital Haslar, when it was uncertain if she would survive, the Doctor, to his credit, has written, "She is to be kept pain free, hydrated and nourished."
To me this indicated that there was a will, and an intention, to afford to my mother total care whilst she was alive.

I wish to draw attention to the excellent standard of treatment which my mother received while at the Royal Hospital Haslar. She was nursed with care and consideration with, significantly, attention being paid to hydration and nourishment. There was an expectation, for the immediate future, on her transfer to the Gosport War Memorial Hospital.

In my view this is in direct contrast, in all aspects, to the standard of care and attention which my mother received at the Gosport War Memorial Hospital during the last 6 days of her life the most notable feature being the refusal to refer her back, once again, to the Royal Hospital Haslar when an offer had been received to accept her.

Code A

Code A

Signed L. F. LACK Signature witnessed by : R.J. BURT Detective Chief Inspector 7410

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MG11(T)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Statement of : Mrs Gillian MACKENZIE

Age if under 18 : Over 18 (if over 18 insert 'over 18')

Occupation : Housewife (previously Personnel Manager) Retired

This statement (consisting of pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature : Code A Dated the March 6 2000

I am the elder daughter of the late Mrs Gladys RICHARDS and sister of Lesley LACK who currently lives at Gosport, Hampshire.

My mother died at the Gosport War Memorial Hospital on Friday 21st August 1998.

Following my father's death, in 1974, my mother either lived in close proximity to my sister or in nursing homes managed by my sister. My sister retired recently after a long career as a trained nurse. She has many years of nursing experience especially in the care of elderly people.

Immediately prior to her death my mother resided in a nursing home located at Lee-on-Solent, near Gosport, Hampshire. It was called the 'Glen Heathers' Nursing Home. My sister, having retired to live in the Gosport area, was not concerned in any way with the management of these premises.

During the time my mother was a resident at the 'Glen Heathers' Nursing Home I occasionally visited her there.

During the last six months of her life I became unhappy with the standard of care which my mother was receiving at the 'Glen Heathers' Nursing Home and I made various complaints.

I particularly recall one visit to my mother which occurred during the last six months of her life.

Code A

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Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I noticed that my mother was suffering with a very bad cough. I asked the nursing staff why she wasn't being given antibiotics. I was told that it was because she was on other drugs. I was told, furthermore, that my mother was being given tranquillisers. I had not, previously, been aware of this fact.

I was very concerned and I decided to see Dr BASSETT who was my mother's GP. I asked him about the choice of drugs which were being prescribed for my mother.

He was aggressive and defensive and did nothing to alleviate my queries. As I had previously done some research, relating to another matter, I had formed the opinion that the drugs which were being administered to my mother could contribute to her confused mental state and deterioration of her physical health. One drug was Trazodone, a Tricylic, and the other was Haloperidol, a Neuroleptic drug.

Following the meeting with my mother's GP I sent him a copy of a book called 'Toxic Psychiatry'. I did so in order to draw his attention to the possible side effects of the drugs in question. I had formed the personal view that the drugs which were being administered to my mother were capable of adding, significantly, to the symptoms of her so called dementia, falls etc.

Early in the morning, on Thursday 30th of July 1998, I received a telephone call from Mrs Karen REED who is my niece. She informed me that my mother had been admitted to the Haslar Hospital, in Gosport, and was about to undergo surgery.

Mrs REED told me that my mother had suffered a fall at the 'Glen Heathers' Nursing Home and that she was going to have an operation to address a broken hip.

I immediately travelled from my home, in Eastbourne, to the Haslar Hospital. I arrived there shortly before my mother was brought, from the operating theatre, back onto the ward.

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

During my mother's stay at the Haslar Hospital I remained with her, throughout, apart from two brief visits back to my home. I was with my mother until shortly before she was transferred to the Gosport War Memorial Hospital.

Together with my sister, Mrs Lack, I had visited the Gosport War Memorial Hospital in order to examine the facilities before my mother was transferred. My sister and I were in agreement that she should be transferred there.

I would like to clearly state, at the outset, that I have absolutely no criticism whatsoever of the Royal Hospital Haslar. The staff, at this hospital, handled my mother's case in a very professional way both medically and so far as the quality of nursing was concerned.

I also believe that my sister and I received effective psychological support. The staff were open and honest. They fully answered our questions and freely volunteered information.

We were well aware of the situation my mother was in and the possibility that she may not survive the operation. Naturally, when my mother began to recover, we were delighted with her progress.

At the Haslar Hospital my sister and I discussed with, I think, a Dr REID what would happen when she was discharged. Neither my sister nor I were happy at the thought of her going back to the 'Glen Heathers' Nursing Home. The Social Services Department subsequently carried out an investigation into the Nursing Home care.

It was decided that our mother would be transferred to the nearby Gosport War Memorial Hospital for rehabilitation for about four weeks. She was, by then, using a zimmer frame. Following this period of recuperation a decision would then be made as regards where she would go after that.

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Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I think another hospital was mentioned. I'm not sure but it may have been the Queen Alexandra Hospital, or similar, and she would receive care there.

Following her stay at the Haslar Hospital my mother she was certainly far more alert than she had been in the 'Glen Heathers' Nursing Home but, of course, we were under no illusions regarding her survival chances bearing in mind her age.

Whilst at the Haslar Hospital my mother was not given the Trazadone drug which had been administered to her at the 'Glen Heathers' Nursing Home. She seemed far happier, more alert, and could certainly recognise myself and my sister. Furthermore, on occasions, she could speak coherently. Not very long sentences but she was coherent. My mother was eating well and looking far better than she had done for months.

I returned home, to Eastbourne, just before my mother was transferred from the Haslar Hospital to the Gosport War Memorial Hospital. My sister rang me and said that my mother had settled in.

However, within a couple of days I received a telephone call, late one evening, from my sister Mrs LACK. She was very distressed. She told me that my mother had suffered a fall at the Gosport War Memorial Hospital. She was going to be x-rayed the following morning and would possibly be transferred back to the Haslar Hospital.

The following morning I travelled, from my home, to the Gosport War Memorial Hospital. I discovered that, in fact, my mother had already been transferred to the Haslar Hospital. I then went on to the Haslar Hospital.

On arrival I discovered that, in fact, my mother's new hip, which had been dislocated again at the Gosport War Memorial Hospital, had been manipulated back into place. She remained at Haslar Hospital for two or three days and she was then transferred back to the Gosport War Memorial Hospital.

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Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

During her stay at the Haslar Hospital my mother made a good recovery and became quite alert again.

It was mentioned to me, but I can't remember who by, that my mother had been dehydrated when she was admitted to the Haslar Hospital from the Gosport War Memorial Hospital. I did not find that altogether surprising in view of the fact that, at the Gosport War Memorial Hospital, my mother had been tranquillised again.

I was told by my sister, Mrs LACK, that she had made her views known to the Nursing and Medical Staff at the Gosport War Memorial Hospital that such strong medication would not aid rehabilitation, eating, drinking, physiotherapy or walking with a zimmer frame.

My sister and I arranged to be at the Gosport War Memorial Hospital when our mother was transferred. We wanted to meet her when she arrived. In the event we were, in fact, about quarter of an hour late.

We had firstly gone there, on the morning of her transfer, at about half past ten only to be advised that she would, in fact, be there at twelve o'clock. We arrived at about quarter past twelve.

As my sister and I went through the doors of our mother's ward we could immediately hear her moaning. I am a lay person but I would say, quite confidently, that my mother was moaning in pain.

We went into our mother's room which, I think, was room number 3, to find a female care assistant, or someone of that category, attempting to feed her with lunch.

The care assistant's first words to us were, "Well thank goodness you've come because she won't eat what I'm trying to make her eat and maybe you'll have more success".

Frankly, I was not surprised that my mother did not want to eat the food. It was an absolute mush. She had, a short time before, been perfectly happy eating vegetables in the normal cooked state, and other food, whilst at the Haslar Hospital. This is confirmed in the Royal Hospital Haslar Medical Record (AF 1/C/63).

Signed : Gillian MacKenzie Signature witnessed by : _____

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I told the care assistant that I was not surprised that my mother was unwilling to eat because it was obvious to me that she was in pain. My sister was with me on this occasion. The care assistant said, " Well no it's not, it's dementia".

Once again I expressed the view that my mother was obviously in pain and I asked a care assistant to go and get a qualified nurse.

I pulled back the sheet, which was covering my mother, and I could see that she was lying in a very awkward position with weight onto her newly replaced hip which had been, so recently, subject to yet further treatment as a result of the fall at the Gosport War Memorial Hospital. (See AF/1/C/34)

I expressed the view, to my sister, that it appeared as if our mother had been rolled off the stretcher, during the transfer process, onto her bed. The bed was beside a wall and it would have been necessary to move it out in order to effect a transfer from a stretcher onto the bed.

With that a qualified nurse came into our mother's room whose name, I believe, was Margaret. I can't recall her surname at the moment. By this time I had covered my mother up. My sister told this nurse that our mother was obviously in pain and she pulled back the sheet in order to show her the position that she was lying in.

The nurse then, with the aid of my sister, repositioned my mother so that her leg was straight. (See AF/1/C/34) This resulted in my mother assuming a more appropriate position. My sister told the nurse that our mother should have a cushion between her legs. We also told the nurse that it was obvious, to us, that our mother was in great pain. We asked her what had happened but she didn't really make any comment.

Signed : _____ Signature witnessed by : _____

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

However, from that point we had a great deal of attention given to us by the nurse manager who was called Philip BEED. He acknowledged that my mother was in pain and that something should be done. He gave our mother an injection the purpose of which, I believe, was to ease her pain.

We asked Philip if a doctor could be called to examine our mother and whether she should be x-rayed. Philip appeared to do everything possible then. He got the forms necessary for my mother to have an x-ray but, in the first instance, they were not acceptable as they had to be signed by a doctor who was not due in until half past three that afternoon.

Eventually a Dr BARTON arrived and she examined our mother. Dr BARTON agreed that she should be x-rayed. My sister and I accompanied our mother to the x-ray department. She was still moaning in pain despite having been given pain killers but she was able to speak coherently at times.

When we arrived at the Gosport War Memorial Hospital x-ray department the staff would not allow my sister to stay with our mother during the x-ray process. We could hear her moaning, through the door to x-ray department, throughout the time she was having the x-ray taken.

After the x-ray process had been completed my sister and I asked what had been seen on the x-rays. My sister asked, specifically, if she could see the results, whilst in the x-ray department, but this request was refused. My mother was then taken back to her room in the ward.

In the meantime my sister made enquiries at the Haslar Hospital in order to establish whether our mother could, once again, be transferred there. Whilst she was doing this I sat with my mother.

Around this time Philip BEED came into my mother's room. He told me that I would be reassured to know that my mother has not dislocated her hip again, " but she may have suffered some bruising".

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Signed : ..... ature witnessed by : .....

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : Mrs Gillian MACKENZIE

Later, after my sister had returned, Philip returned to our mother's room where we sitting with her. He said, "I'm going to make her life easier and give her an injection of Diamorphine".

I immediately reacted and said, "No, you're not giving her Diamorphine. Are we talking about a case of euthanasia here because I warn you I will not tolerate euthanasia".

A few moments later I saw Dr BARTON pass by my mother's room. My sister and I went out into the corridor to speak to her. My sister told Dr BARTON that she had spoken to the staff at the Haslar Hospital and established that they were quite happy to have our mother referred back to them.

In reply Dr BARTON said that she thought our mother had experienced quite enough trauma for that day and she didn't think it was right to send her back to Haslar then. She stated that they would keep her pain free overnight. The decision, regarding the referral back to the Royal Hospital Haslar, would be reviewed in the morning and that we should come in early when the review was going to be carried out.

I would like to highlight, for consideration, the appropriateness of an apparent 'policy' which effectively prevents patients being referred after working hours.

My sister and I arrived back at the Gosport War Memorial Hospital on the Tuesday morning. We were seen by Philip BEED who took us into his office. He told us that nothing could be done for my mother. She had, according to Philip, developed a massive haemetoma on the site of her hip operation and the only possible means of treating our mother was to put her on a syringe driver with Diamorphine so that she would have a pain free death.

The impression given to me, by Philip BEED, was that my mother's death was imminent. He stated, when I asked him later that afternoon how long it would be, that it was not possible to be sure. It could be hours or longer.

Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I was aware of the implications of a syringe driver and so was my sister. We had both agreed that a syringe driver could be used. We went into my mother's room when Philip came in and set up the syringe driver with the Diamorphine. My sister was greatly distressed at this because my mother would not regain consciousness or see us again and we wouldn't have a chance to speak to her.

Later on during that morning, at about half past eleven, my niece Rebecca arrived with her baby. Dr BARTON came to the doorway of the room and said, "Presumably things have been explained to you about the syringe driver".

My sister and I both said, "Yes".

Dr BARTON then said, "Well, of course, the next thing for you to expect is a chest infection".

My sister and I said, "Yes, we realise that".

I have been present, when death has occurred, and I know that pneumonia, or a chest infection, or a 'dead man's rattle', as the moment of death approaches, can be a normal thing. That was the only conversation we had with Dr BARTON.

There was no mention whatsoever, by Dr BARTON, of surgery or intervention by surgery to relieve the haemetoma or, indeed, any reference to the fact that she didn't think my mother would stand a general anaesthetic.

If such a conversation had taken place I would have pointed out to Dr BARTON that my mother had withstood a hip replacement procedure, without a general anaesthetic, and that when it had been dislocated again, at the Gosport War Memorial Hospital, she had been transferred back to Haslar Hospital where the new hip had been manipulated back into place without a general anaesthetic.

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Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I stayed with my mother until very late that Tuesday night. It was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat in with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening when my mother died.

During that time Dr BARTON did not visit my mother. I am quite certain of this because our mother was not left alone, in her room, at any time apart from when she was washed by nursing staff. Either my sister, or I, was with her throughout.

I slept in a chair beside my mother's bed and at no time did I notice, in her, any signs or symptoms of pneumonia.

During the Wednesday night and Thursday morning there was a particular nurse on duty. I think her name was Sue. At about four o'clock in the morning, when she came in, she was of the opinion that our mother would probably only survive for another half hour or so. She delayed going off shift. However, my mother rallied and continued to live until the Friday.

I am of the opinion that if my mother had been near death, as we were led to believe by Philip BEED on the previous Monday, she would not have survived until the Friday night. I believe that this is a strong indication of the actual state of her health.

It seems to me that she must have had considerable reserves of strength to enable her to survive from the Monday until the Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.

As a result of what I had been told by Philip BEED on the Tuesday morning I had been expecting our mother to die within 24 hours or so. It troubled me that she was not on a drip as the week progressed.

Signed : Gillian MacKenzie Signature witnessed by : _____

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I think that she was dehydrated and, with the Diamorphine, this was probably the cause of death although, of course, with a haemetoma, if action isn't taken very speedily, that can cause death as well. I was at a loss to understand why action wasn't taken, promptly, as soon as a haemetoma was discovered.

It is my understanding that just such a complication should have precipitated an immediate referral back to the Royal Hospital Haslar (AF/1/C/75).

As regards the issue of transferring our mother back to the Haslar Hospital my sister had mentioned it to Dr BARTON who had told us, on the Monday evening, that a decision about that would be made on the Tuesday morning. However, when my sister and I arrived at the Gosport War Memorial Hospital, on the Tuesday morning, a decision had been made that, as my mother was dying, the only thing to do was to give her a pain free death. I think the haemetoma would have shown up on the x-ray that was taken on the Monday afternoon.

The staff at the Haslar Hospital had told my sister that they would be willing to accept our mother if she was referred back to them for treatment although we didn't know she had a haemetoma at the time this was discussed.

My sister clearly told Dr BARTON, in my presence, about the offer that the Haslar Hospital had made to her. In the circumstances I don't think that Dr BARTON who is, I believe, a GP was qualified to make the decision to deny our mother the chance to receive treatment at the Haslar Hospital.

I believe that it is possible that my mother could have been effectively treated at the Haslar Hospital where she had, only recently, twice undergone, and survived, hip treatment. Furthermore, on each occasion, her general health had improved considerably whilst under the care of staff at the Haslar Hospital.

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Signed : Gillian MacKenzie Signature witnessed by : .....

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

In my view a Consultant's opinion should have been sought when the haemetoma was discovered

It is also my view that Dr BARTON's decision not to refer our mother back to the Haslar Hospital where the causes of her condition, and not merely the symptoms, could have been addressed, effectively denied her the opportunity of having a chance to be treated, to survive and to recover even if this was for a short time.

I believe that a decision was made, for reasons which I do not accept, to reject treatment options which would have given our mother a chance to recover and, instead, a course of palliative treatment was commenced which, effectively, condemned her to death without any chance of recovery. Palliative treatment does not necessarily have to cause unconsciousness.

I have been shown, by Detective Chief Inspector BURT, some hand-written notes bearing a Hampshire Constabulary Exhibit Label, marked LFL/2, which I have signed.

I was aware of the fact that these notes were being made by my sister, Lesley LACK, because she was making them in our mother's room at the Gosport War Memorial Hospital. Frequently, I was sitting beside our mother, holding her hand and trying to reassure her, whilst my sister was sitting in the same room making her notes.

We agreed that my sister should make the notes because of the increasing concerns we had over the quality of care that was being given to our mother at the Gosport War Memorial Hospital. Obviously, therefore, my sister began to make her notes before our mother died and before we became aware of various other things since.

I was not a direct party to the writing of the notes. The comments and observations made are those of my sister. I was, however, in the company of my sister during most of the period, and during most of the incidents she refers to in her notes. My sister and I discussed particular issues as she wrote about them.

Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I recall that a copy of my sister's notes were given to Lesley HUMPHREY, the Quality Manager of the Portsmouth Health Care Trust, on Wednesday 19th August 1998 after we had complained.

I recall that I read through the notes, which my sister had made, prior to them being copied for Mrs HUMPHREY. It is possible that some additions were made to the notes, by my sister, at that time which would account for the way the notes are written. The notes embody a series of questions in respect of which, as part of our complaint, we sought answers from the Portsmouth Health Care Trust.

The notes do not incorporate any of my handwriting. All the handwriting is that of my sister, Lesley LACK.

The original notes which I have been shown (LFL/2) comprise of five numbered pages (1-5) plus an additional page which is un-numbered (LFL/2A). I note that the page numbered '5' has been signed by my sister. I cannot say whether the additional, un-numbered, page was copied to Mrs HUMPHREY or not. Whilst I agree with its content I do not recall seeing it before.

My sister provided me with a copy of the Notes, on or about the 28th September 1998, which I produce. Attached to my copy is a Hampshire Constabulary Exhibit Label bearing the reference GM/1 which I have signed.

I have, once again, read the notes (LFL/2), including the additional un-numbered page. I would like to make the following general observations drawing on the contents and other recollections.

My sister has commenced her notes by referring to the occasion when my mother was admitted to the Gosport War Memorial Hospital, from the Haslar Hospital, on Tuesday 11th August 1998.

I was not in Gosport at that time but I would like to comment on, and echo the concern expressed by my sister about, the fact that 'Oramorph' was almost immediately administered to our mother when she was, in all probability, exhibiting signs of her dementia which were, perhaps, 'misread' as pain.

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Signed : Gillian MacKenzie Signature witnessed by : _____

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Whilst at the Haslar Hospital, a matter of hours before, our mother had been pain-free and was not rendered unconscious by any form of pain relief medication except for surgery and shortly afterwards.

I have to say that I have serious concerns about the possible and inappropriate use of 'Oramorph', at this stage in my mother's treatment, as a means of suppressing the 'inconvenient' aspects of her anxiety and dementia.

I note that there is a reference in the notes, under the date of Thursday 13th August, to my niece Mrs REED. I would like to point out that Mrs REED is not only a trained nurse but she has worked in the Orthopaedic Ward at the Haslar Hospital where my mother underwent treatment. I am appalled, given her credentials, that more attention was not paid to Mrs REED's comments and concerns by the staff at the Gosport War Memorial Hospital shortly after lunchtime on Thursday 13th August 1998.

I would like to clearly state that, having read through the notes (LFL/2), I am in complete agreement with them. This would, of course, have been my position on Wednesday 19th August 1998 when I examined them prior to a copy being made and given to Mrs HUMPHREY.

Whilst I did not write the notes (LFL/2) and whilst I did not sign them I was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.

On the 19th August 1998 I wholeheartedly adopted the contents of the notes (LFL/2) as representing the basis for a joint complaint, with my sister, about the way our mother was being treated at the Gosport War Memorial Hospital.

Signed : Gillian MacKenzie Signature witnessed by :

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

In due course, following my mother's death, I received a copy of the Portsmouth Health Care Trust's response to the copy of my sister's notes (LFL/2) which had been given to Mrs HUMPHREY on the 19th August 1998.

The response was in the form of a letter, dated 22nd September 1998, which was addressed to my sister, esley LACK, and signed by a person named Max MILLETT designated the Chief Executive.

I have been shown, by Detective Chief Inspector BURT, the original letter which bears a Hampshire Constabulary Exhibit Label, marked LFL/3, which I have signed.

I will comment on this letter, in greater detail, later in my statement.

Initially there was some reluctance, on the part of the Portsmouth Health Care Trust, for me to see the letter (LFL/3). Only after I made it clear that I was a joint complainant did I receive a copy.

In fact, when I returned home, after my mother had died but before the funeral or just afterwards, I telephoned, I believe, Mrs HUMPHREY's office. I told her or Barbara ROBINSON, who was possibly dealing with the matter in Mrs HUMPHREY's absence, that I knew about the notes which my sister had prepared and asked her to address a further question.

I wanted to know why a decision was made for my mother to be administered pain relief only without hydration. It had taken my mother five days to die and I don't think any fit person would have been able to survive solely on a diet of Diamorphine with no hydration. This question was not answered fully by the subsequent report from Mr MILLETT (22-9-98).

When I raised this issue with Mrs HUMPHREY she said that would have been explained at the time. I told Mrs HUMPHREY that it certainly wasn't explained to me.

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Code A

Signed : Gillian MacKenzie Signature witnessed by : .....

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

When I received a copy of the letter from the Portsmouth Health Care Trust, commenting on the points raised in my sister's notes, I immediately phoned my sister because I was not happy with it. Some paragraphs seemed to be totally untrue. My sister expressed similar concerns.

As an example the notes (LFL/2), which were copied to the Portsmouth Health Care Trust, raised the question, "At what time did Mrs RICHARDS fall?

The letter in response (LFL/3) states, in response to that question, "She fell at 13:30 on Thursday, 13th August 1998, though there was no witness to the fall". Her door was kept open and there was a glass window onto the corridor opposite the Nursing/Reception Desk.

In the Health Record (LH/1/C), to which I will refer in greater detail later in my statement, the time of my mother's fall is confirmed as being 13:30 and the venue is given as her room. However, my niece, Mrs REED, had apparently seen her, as I understood it, in the patient's sitting room but I may be wrong. If my mother had been in the patient's sitting room, by herself, this was neglectful because the staff knew she would attempt to get out of her chair if she wanted to use the toilet and she couldn't possibly do it by herself. (See AF/1/C/21)

By further reference to the letter of response (LFL/3) I note that in reply to the question, "Who attended her?" There is a response, "She was attended by a Staff Nurse Jenny BREWER and a Health Support Worker COOK." This is followed by a further question, "Who moved her and how" Which drew the response, "Both members of staff did, using a hoist".

If my mother had fallen from a chair, onto her bottom, surely the obvious thing to do, as she had only recently undergone surgery for the fitment of a new hip, was to have her thoroughly examined by a qualified doctor before moving her at all. In the letter of response (LFL/3), page 2, point 4, the comment is made.

Signed : Gillian MacKenzie Signature witnessed by :

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Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

"Your mother had been given medication, prescribed by Doctor BARTON, who was present on the ward just after her fall. I understand that it was not your wish for your mother to be given stronger medication because it made her drowsy".

In my view this does not make sense at all. If someone has possibly dislocated their new hip you don't give them a medication to make them quiet you examine them and you do something about it.

Did Doctor BARTON examine my mother? Or, perhaps, was she just asked to look at Mrs RICHARDS, who was making a noise, and give her some more tranquilliser.

If Doctor BARTON did not examine my mother that, in my view, was, in the circumstances, pure negligence. The first thing any lay person would do if someone falls onto a new hip is to ensure that no damage has been done. You wouldn't simply give them a tranquilliser to keep them quiet.

Turning to the question, in the notes (LFL/2), which queried the delay in dealing with the consequences of the fall, page 2, point 5, in the letter of response (LFL/3), "With the benefit of hindsight it is possible to assume that your mother's dislocation could have been identified much earlier....etc". I would comment that it most certainly could. When she was later undressed they apparently discovered that she'd dislocated her hip. That was a very long time to wait.

I now refer to the question, re-iterated in the letter of response (LFL/3) on page 2, point 7, "Why, when she was returned to bed from the ambulance was her position not checked?".

I have spoken to two health care support workers, who were working at the Gosport War Memorial Hospital at the time, one is named Jean, I think, and one is named Linda. They told me that when my mother returned to the Gosport War Memorial Hospital, from the Haslar Hospital, on Monday 17th August 1998, they were not happy as she seemed to be in pain. They believed that there was a problem and they went to get

LINDA GLM

Signed : Gillian MacKenzie Signature witnessed by :

Code A

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

professional advice. I believe that this was at a quarter to twelve. My sister and I did not arrive until a quarter past twelve.

If, as the reply to our question suggests, Staff Nurse COUCHMAN, in fact, attended to my mother at the request of the health care workers why didn't she notice the awkward position in which my mother was lying.

I would suggest that Staff Nurse COUCHMAN did not properly attend to my mother or did not, perhaps, come until my sister and I asked, half an hour later, and actually pointed out to her how my mother was lying.

Moving to another point, after my mother had been x-rayed at the Gosport War Memorial Hospital, on the afternoon of Monday 17th August 1998, I recall that Philip BEED advised me that my mother had not dislocated her hip but she might have bruised herself.

I asked Philip BEED how my mother could have been bruised. He did not provide me with an explanation of how it could have happened.

What, I believe, Philip failed to tell me at that time was that, in fact, my mother hadn't been transported on a stretcher. When I later spoke to the two care workers one of them, Linda, who didn't want me to mention to anyone that she'd told me, said that, in fact, my mother had arrived back in the ward on a sheet on a trolley. It is possible, I would assume, that she was not rolled off the stretcher, as I had thought, but she had been rolled off a sheet into the position we found her in and not checked until we raised the issue with staff. There appears to have been an avoidable delay, on the part of Staff Nurse COUCHMAN, to identify this problem.

Code A

Signed : Gillian MacKenzie Signature witnessed by : .....

MG11A(Tricont)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I note that in the letter of response (LFL/3) on page 2, point 8(c), it states, in reply, "The ambulance crew commented that she showed signs of being in pain as she was put into the ambulance.....etc" I would ask why was it, then, when she arrived at the Gosport War Memorial Hospital, did they accept her? In my view they should have sent her back to the Haslar Hospital there and then. She had left the ward at Haslar pain ..ee.

In response to the question (LFL/3) page 3, point 8(d), "Why was my request to see the x-rays denied?" The reply tendered is not satisfactory. My sister specifically asked to see the x-rays when we were in the x-ray department and we were not allowed to see them.

With regard to the response to question (LFL/3) 8 (e) page 3, "Doctor BARTON felt that the family had been involved at this stage as she discussed the situation fully with you....etc". I emphatically deny that. She did nothing of the sort. It goes on to state, "She made sure you were aware that the surgical intervention necessary for the haemetoma would have required a general anaesthetic...etc". This is not true. That was never discussed. The only discussion we had about the haemetoma was with Philip who said nothing could be done except give her pain relief to aid her in dying.

My sister and I were not consulted, whatsoever. When they saw that she had a haemetoma they should have sent her back to the Haslar Hospital there and then. We were not told that our mother had a heamatoma until the Tuesday morning.

I feel, very strongly, that this reply represents an attempt to cover up the truth, by Doctor BARTON, and I would go as far as to say that her gross negligence resulted in the death of my mother.

I have been shown, by Detective Chief Inspector BURT, a copy of a Portsmouth Health Care Trust Health Record which relates to my mother. It bears a Hampshire Constabulary Exhibit Label, marked LH/1 C.

Signed : Gillian MacKenzie Signature witnessed by : _____

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

which I have signed. I note that each page has been marked with an individual reference. Having examined this document I would like to make the following observations.

I refer to page LH/1/C/7 and I would like to comment in relation to the remark, "Deaf in both ears". This is true. My mother could hear with a hearing aid but the staff at the 'Glen Heathers' Nursing Home had lost it and it had not been replaced.

Further, "Cataract operations in both eyes". This is true but my mother could see with one eye, with her glasses, but, again, the staff at the same Nursing Home had lost my mother's glasses.

Further, "Six month history of falls". This is true. Since my mother was administered the tranquillisers Trazodone and Haloperidol.

As a result of the Social Services investigation I discovered that my mother had suffered 17 falls at the Nursing Home during the previous 6 months. My sister, who had visited our mother daily in the Nursing Home, was unaware of the extent of the falls.

Further, "Alzheimer's, worse over the last six months". I would challenge the accuracy of the diagnosis. As I understand it, it is not possible to be certain of Alzheimer's disease unless a post mortem on the brain is carried out. I would challenge the comment, "Worse over the last six months". I would suggest that my mother's condition was probably attributable to dementia and the added risk of tardive dementia due to the two drugs in question.

I now move to LH 1/C/8 which is a note made by, I think, Philip BEED, the Charge Nurse in my mother's ward at the Gosport War Memorial Hospital. He mentions that in addition to the treatment, i.e. drugs that the staff at the Haslar Hospital had recommended, the staff at the Gosport War Memorial Hospital had added 'Oramorph'. I challenge the need for 'Oramorph'. My mother had not needed it whilst she was being

Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

treated at the Haslar Hospital except for pain. Why did she need it at the Gosport War Memorial Hospital within 48 hours of arrival except for dislocation of new hip later on.?

I move to LH/1/C/9 which is a letter written by a Dr R I REID. In this letter Dr REID comments that my mother's mobility had deteriorated over the previous six to seven months and I have already indicated why I think that was the case. Furthermore Dr REID states that my mother's "daughters" had indicated that my mother had been 'knocked off' (out) by the prescribed medication for months and had "not spoken to them for six or to seven months". Well, in truth, my mother did speak to us. Not long conversations, not always full sentences, but she certainly did speak. She also recognised who I was.

Dr REID also mentions that since the "Trazodone has been omitted" we had indicated that our mother had "been much brighter mentally". In fact I would say that my mother had been more bright, mentally, than she had been during the last six months in the 'Glen Heathers' Nursing Home although I only saw her occasionally, usually after a bout of ill health or a recorded fall.

Further, Dr REID says that my mother, "....was clearly confused and unable to give any coherent history".

I would suggest that when you are questioning a lady who has dementia, and cannot hear a thing without a hearing aid, she is likely to be confused plus the fact she couldn't lip read because she hadn't got her glasses.

Moving to LH/1/C/11, which I think contains notes made by Doctor BARTON. In an entry, dated 11th August 1998, the date on which my mother was transferred to the Gosport War Memorial Hospital, from the Haslar Hospital, Dr BARTON has made a surprising statement, "I am happy for nursing staff to confirm death".

Signed : Gillian MacKenzie Signature witnessed by : .....

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

There was no indication, from the staff at the Haslar Hospital, that my mother was anywhere near death. Why should Doctor BARTON assume that she was going to die?

The plan for my mother was that she should remain for about four to six weeks at the Gosport War Memorial Hospital before she was referred, for rehabilitation with her zimmer, to another hospital. I do not understand why Dr BARTON should feel it necessary to make this comment at the outset unless, of course, she had already had it in her mind that she had got a 91 year old patient who was, in her opinion, a damn nuisance and that this was going to be the outcome.

Further, in respect of LH/1/C/11, under date of the 14th August 1998, "Is this lady well enough for another surgical procedure?". I would point out that this was prior to the successful referral back to the Haslar Hospital. Perhaps it is fortunate that Dr BARTON relented, on that occasion, otherwise my mother could, perhaps, have been placed on a syringe driver earlier than, in fact, she was and I make the point that Dr BARTON was making decisions which, I suggest, she was not qualified to make.

Further, in an entry dated the 18th August 1998 Dr BARTON states that, "I will see daughters today". Well she might have said she was going to but she certainly didn't except for brief reference to syringe driver at approximately 1130 am.

I have to say that I suspect that these notes (LH/1/C/11) were not made as per the dates. I believe that they could, in fact, have been made retrospectively.

I must say that the notes in the Portsmouth Health Care Trust Health Record are very scant. I notice that there is a gap between the 18th and 21st August 1998.

Moving to LH/1/C/14 I note an entry, dated 11th August 1998, which states, "Admitted from E6 ward Royal Hospital Haslar, into a continuing care bed". For me the issue is 'continuing care' and not 'terminal care'.

Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : Mrs Gillian MACKENZIE

Moving to LH/1/C.15 there is a comment, "Patient has no apparent understanding of her circumstances due to her impaired mental condition". My mother knew she was in pain. She couldn't hear what anybody said to her. It is no good asking somebody a question when they cannot hear a thing and then say it is due to dementia.

Moving to LH/1/C.21. There is an entry dated the 13th August 1998 which is timed at 1300 hours. It states, "Found on floor at 13.30hrs checked for injury none apparent". I would ask who it was who checked for injury. It should have been a qualified doctor.

I note that a recorded time, later in the same entry, has apparently been changed from 2000 hrs to 1930 hrs. There is a reference to the fact that a Dr BRIGG was contacted, presumably he or she did not attend in person, but this does not, apparently, correlate with the time my sister was contacted. Dr BRIGG is recorded as having advised, "X-ray AM (and) analgesia during the night. Inappropriate to transfer for x-ray this PM. Daughter informed."

I would strongly query whether it was, in fact, inappropriate or simply contrary to 'policy'.

I wish to draw attention to the fact that Dr BARTON was apparently in my mother's ward shortly after she fell. She therefore had the opportunity to, and should have, put in hand steps to properly diagnose and rectify the 'cause' of my mother's pain and distress immediately. She did not. This resulted in my mother having to endure hours of unnecessary suffering. There is no reference, in the clinical notes, to the fact that Dr BARTON attended to my mother after her fall. I question what, in fact, Dr BARTON actually bothered to do at that stage apart from, perhaps, advocating painkillers or tranquilisers.

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Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(Recont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Further, on LH/1/C/21, under the date 17th August 1998 and timed 1148 hrs, there is an entry which states, "Returned from R.N. Haslar, patient very distressed and appears to be in pain". However, when we arrived we were told that our mother was not in pain, it was her dementia.

I would like to draw attention to the fact that there is an addition to this entry as follows, "No canvas under patient - patient transferred on sheet by crew". I would suggest that it is possible that this has been added later and after, perhaps, I had spoken to the two care support workers who told me what had really happened. There is a further entry, under the same date, which states, "To remain in straight knee splint for 4/52....pillow between legs at night". There was no pillow put between my mother's legs, when we arrived half an hour after she had been admitted, and her leg was certainly not straight. There is a further entry, "No follow up unless complications." Surely a haemetoma is a serious complication.

Further, on LH/1/C/21, under the date 18th August 1998 and timed 'a.m.', "Reviewed by Doctor BARTON. For pain control via syringe driver". It appears, to me, that Dr BARTON had not given any serious consideration to the option of surgical intervention. The entry goes on, timed at 1115, "Treatment discussed with both daughters". That is not correct. We were there at 9 o'clock in the morning and we had the conversation with Philip BEED who told us nothing could be done and discussed the use of the syringe driver and Diamorphine.

He said that my mother had developed a massive haemetoma and that the kindest way to treat her was to put her on Diamorphine, to ease her pain, until she died.

The entry goes on, "They agree to use of syringe driver to control pain and allow nursing care to be given". Yes, we did agree the syringe driver because we were under the impression she was going to die within 24 hours or very soon.

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Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(Tr.cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

Further, on LH/1/C/21, under the date 21st August 1998, ..."Daughters visited during morning". In truth we were there the whole time. We were virtually living there.

I have been shown, by Detective Chief Inspector BURT, a copy of a Portsmouth Health Care NHS Trust 'Risk Event Record' attached to which is a Hampshire Constabulary Exhibit Label , marked LH/2, which I ve signed.

I would like to comment on an entry on page 1 under section 7, "Patient sat in chair in room 3 found on floor by the nursing staff". I have already queried where she fell.

I would like to comment about the fact that, after the 18th August 1998, staff members continually expressed their surprise at the length of time our mother continued to live. I believe that this was indicative of her strength and, as a critical factor worth mentioning, her ability to potentially cope with a further referral to the Haslar Hospital for surgical intervention, had she been granted this opportunity by Dr BARTON.

I have been shown, by DCI BURT, a copy of a Royal Hospital Haslar Medical Record. Attached to this document is a Hampshire Constabulary Exhibit Label bearing the reference AF/1/C which I have signed.

I would like to make the observation that, as a lay person, this Record appears to me to be far superior to the Health record (LH/1/C) in terms of content and detail.

I would also like to observe that each time my mother was discharged from the Royal Hospital Haslar the outlook, in terms of her health, seemed positive but, upon admission and re-admission to the Gosport War Memorial Hospital, it seemed to me that her condition quickly deteriorated.

I have been shown a copy of a Report, made by Dr LORD, which has attached to it a Hampshire Constabulary Exhibit Label bearing the reference LH/4, which I have signed.

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Signed : Gillian MacKenzie Signature witnessed by : .....

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

If this Report purports to be an objective assessment of the medical and nursing care and attention given to my mother at the Gosport War Memorial Hospital then I would challenge its value as such. Dr LORD did not, apparently, have any dealings with my mother and she prepared her Report on the basis of reading other documents and contact with colleagues.

I have been shown a copy of an Enquiry Report to which is attached a Hampshire Constabulary Exhibit Label bearing the reference LH/4 which I have signed.

I have been provided, by DCI BURT, with a typed copy of the Enquiry Report (LH/4). The copy, to which is now attached a Hampshire Constabulary Exhibit Label bearing the reference GM/2 and signed by me, was constructed to enable me to add hand-written comments which I have done.

I would like to point out that where I have chosen not to comment on a particular reply or issue this does not imply that I necessarily agree with, or accept, what has been stated.

I would like to raise an issue regarding the cause of my mother's death as recorded on the Death Certificate. At the time of her death and, so far as I am concerned, for 2 or 3 days before hand, my mother was not seen by a doctor.

On the 15th August 1998 Dr BARTON had commented that, "The next thing will be a chest infection", suggesting to me that, so far as this doctor was concerned, there was no chest infection present on that day, the 18th August 1998. Furthermore, from my own observations, there was no indication of a chest infection up until the time of my mother's death.

A doctor did not attend my mother upon her death. My sister and my niece laid my mother out, in my presence, and then we waited while she was prepared to go to the mortuary.

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Signed : Gillian MacKenzie Signature witnessed by : _____

Code A

MG11A(T)(cont.)

HAMPSHIRE CONSTABULARY

WITNESS STATEMENT

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

Continuation of Statement of : **Mrs Gillian MACKENZIE**

I find it hard to understand how a doctor could have certified death as being attributable to bronco-pneumonia in these circumstances and with no reference to the heamatoma.

I would like to draw attention to the fact that no reference to the alleged onset of bronco-pneumonia appears in the Health Record (LH/I/C) prior to my mother's death.

Furthermore there is no reference to the presence of a heamatoma on the 17th August 1998 or, indeed, afterwards.

In conclusion I would ask the question, "Was the cause of my mother's death Diamorphine poisoning and dehydration?

Code A

Signed : Gillian MacKenzie Signature witnessed by : _____

POLICE STATEMENT OF DR JANE BARTON

1. I, am Dr Jane Barton of the Surgery, 148 Forton Road, Gosport Hampshire.

2. I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice initially as an assistant and then as a partner. In 1988 I took up the additional post of Clinical Assistant in Elderly Medicine on a part time sessional basis. This post originally covered three sites but in due course was centred at Gosport War Memorial Hospital (GWMH). I retired from that position this year.

3. As a General Practitioner, I have a minimum full time position. I have approximately 1500 patients on my list. I conduct half of the on call responsibilities of my partners, with one night each fortnight on call and one weekend every quarter. I carry out one morning surgery every day and evening surgeries on a pro rata basis.

4. The GWMH has 48 long stay beds and is designed to provide continuing care for elderly patients. In each week I would carry out 5 Clinical Assistant sessions. When in this post I would attend the hospital every week day morning at an early hour to review patients and would conduct two formal ward rounds each week with the consultant geriatrician. At the time of my retirement from the post there were two consultants attending the wards. Dr Lord was the consultant responsible for Daedalus Ward. In August 1998, however only one consultant was in post; Dr Lord who was thus covering both wards. The other consultant was on maternity leave.

5. The consultant would ordinarily carry out two ward rounds each week; one continuing care and a Stroke round on Daedalus on a Thursday afternoon. Her other clinical commitments were on two other hospital sites, but she was usually available by telephone for advice and assistance.

6. As Clinical Assistant, I was responsible for care of patients in both wards at the hospital. My work involved seeing a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. Many patients had undergone orthopaedic procedures following falls, whether in their own home, sheltered accommodation or

in residential care. They were transferred to our care once their acute management was completed. Many of the patients were also demented. I spent time attempting to forge a relationship with families and helping them to come to terms with the approaching death of a loved one. One of the strengths of our unit is that patients can be offered a level of freedom from pain, discomfort, unpleasant symptoms and mental distress which is much more difficult to deliver in an Acute Unit. One complication for our patients is that the act of transferring someone from one unit to another for whatever reason causes a marked deterioration in their condition, which may last for several days and is frequently irreversible.

7. In carrying out my work I relied on a team of nurses, both trained and untrained, to support the work that I did. Their attitude towards relatives and handing of the patients is crucial to the way the unit works. My work also involved providing support and guidance to my staff.

8. Mrs Gladys Richards was 91 and was admitted to the GWMH on 11.8.98. She had previously been a resident in the Glenheathers Nursing Home in Lee-on-the-Solent where she had fallen and fractured the neck of her right femur. She had been admitted to the Royal Hospital Haslar (RHH) and undergone a right hemi arthroplasty, a major orthopaedic procedure involving replacing the head of her femur with a metal prosthesis. The operation is performed to relieve pain and to give a patient a chance of walking again.

9. Following surgery she was assessed at RHH by Dr Ian Reid, Consultant Physician in Elderly Medicine at the Queen Alexandra Hospital, Portsmouth. Dr Reid provided an opinion to the Orthopaedic Consultant Surgeon at RHH, which gave some of the background information to Mrs Richards' condition. He reported that Mrs Richards had apparently been confused for some years, but was mobile in her nursing home until around Christmas 1997 when she had sustained a fall. She started to become increasingly noisy. She had been seen by Dr Banks a consultant Psycho geriatrician who appeared to have felt that she was depressed as well as suffering from a dementing illness. She had therefore been treated with haloperidol, a major tranquilliser and Trazodone, a sedating antidepressant.

10. Dr Reid reported that according to Mrs Richards' daughters she had been "knocked off" by this medication for months and had not spoken to them for some six to seven months. Her mobility had also deteriorated in that time and when unsupervised she had a tendency to get up and fall. Dr Reid understood that she was usually continent of urine but had occasional episodes of faecal incontinence. Dr Reid noted that following admission, Haloperidol and Trazodone had been stopped. According to the daughters, following the discontinuance of the Haloperidol and

Trazodone she appeared much brighter mentally and had been speaking to them at times. Dr Reid went on to say that when he had seen Mrs. Richards in hospital on 3rd August she had clearly been confused and was unable to give any coherent history. She was, however, pleasant and co-operative. She was able to move her left leg quite freely and, although not able actively to lift her extended right leg from the bed, she appeared to have little discomfort on passive movement of the right hip. Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to re-mobilise and it was his intention therefore to arrange transfer to the GWMH on Daedalus Ward under the care of his colleague Dr Lord in order to give her this opportunity.

11. The admission then took place to the GWMH on 11th August. The RHH would not have been able to keep Mrs Richards as an in patient, as her condition was not appropriate for an acute bed. Dr Reid had also recorded that Mrs Richards' daughters were unhappy with the care she had been receiving at the Nursing Home and that they did not wish her to return there. Her admission was therefore also a holding manoeuvre while it was seen whether she would recover and mobilise after the surgery. In this case she could be transferred back to a nursing home. If, as was more likely, she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a calm environment away from the stresses of an acute ward.

12. I assessed Mrs. Richard on admission. My admission note made on 11th August reads as follows:-

11.8.98 *Transferred to Daedalus Ward Continuing Care*
HPC ® ≠ neck of femur 30.7.98
PMH) Hysterectomy 1955
Cataract operations
deaf
Altzheimers
0/E Impression frail hemi arthroplasty.
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

13. In my view Mrs Richards was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery, in addition to her general frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff.

14. The Barthel score is an assessment of general physical and life skill capability. The maximum score available would be 20, but Mrs Richards was so dependant that she scored only 2. She needed total care with washing and dressing, eating and drinking and was only mobile with 2 people and hoist for transfers to bed from chair etc..

15. When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs, rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give Diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totaling 20mg over the first 24 hours and 10 mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure.

16. On the afternoon of 13th August Mrs Richards was found by nursing staff to have slipped out of her chair at approximately 1.30pm. I was not at the hospital or on duty at that time, and I was not made aware that day that she had injured herself. The duty doctor, Dr M. Brigg was contacted during the evening by nursing staff. He advised analgesia through the night and an X-Ray the following morning. The X-Ray Department at GWMH closes at 5.00pm and he felt that it was not appropriate to transfer and X-Ray the patient at RHH that evening. A transfer that evening would not have altered clinical management and it was left that I would review the patient in the morning. I arrived as usual early on the following morning 14th August and assessed Mrs. Richards. The report I received from the trained staff on duty that Friday morning

stated that she had slipped out of her chair the previous day. I arranged an X-Ray and discussed the position with the ward manager Philip Bede. The plan was that if the X-ray confirmed a dislocation of her prosthesis then Mrs Richards should be transferred to Haslar after confirmation with Dr Lord. The X-ray revealed that she had indeed dislocated her prosthesis. Surgeon Commander Spalding at the RHH was contacted and Mrs Richards was duly transferred back to the Haslar hospital. Although I was concerned, given Mrs Richard's overall condition and her frailty, that she might not be well enough for another surgical procedure; I felt that this clearly would be a matter for assessment by the clinicians at Haslar.

17. My notes on that occasion read as follows:-

"*14.8.98* *Sedation/pain relief has been a problem*
screaming not controlled by haloperidol
but very sensitive to Oramorph.
Fell out of chair last night
Ⓡ hip shortened and internally rotated
Daughter aware and not happy
Plan X-Ray
Is this lady well enough for another surgical procedure?"

18. I later made a further entry in Mrs Richards' records as follows:-

"*14.8.98* *Dear S. Cdr Spalding*
Further to our telephone conversation
thank you for seeing this unfortunate
lady who slipped from her chair at
1.30 p.m. yesterday- and appears to have
dislocated her R hip
hemi arthroplasty was done on 30.7.98
I am sending X-Rays across
she has had 7.5 mls of 10 mg/ in 5 ml oramorph
at midday
Many thanks"

19. This is a copy of the courtesy referral letter I prepared to advise Surgeon Commander Spalding of the position after telephoning him. Once at RHH, Mrs Richards had a closed

reduction of the prosthesis under intravenous anaesthesia. She remained unconscious and unresponsive for approximately 24 hours during which time she was catheterised. Normally a healthy patient would wake up within minutes of the end of an intra-venous anaesthetic (a short acting agent is used). This worrying response to the anaesthetic may well have been an indication of how ill and frail she was.

20. On 17th August it was considered appropriate to transfer her back to the Daedalus Ward at GWMH. The discharge letter from RHH to the nurse in charge gave advice as to how she was to be nursed using a canvas knee immobilising splint to prevent crossing of the legs and further dislocation of the hip as this was a strong possibility. This splint was to remain in situ for four weeks. When in bed it was advised that the hips be kept apart using pillows or a wedge, again to reduce the chances of dislocation. Despite these instructions while she was in bed, she could be stood with 2 nurses and fully weight bear. This instruction was given because when possible it is important to keep elderly patients moving. The surgeon was making it clear that if her general condition did improve then standing her out of bed would pose no dangers for the stability of her prosthesis.

21. I saw Mrs Richards when she was readmitted on the 17th August and my note reads as follows:-

17.8.98 *readmission to Daedalus from RHH*
closed reduction under iv sedation
remained unresponsive for some hours
now appears peaceful
Plan continue haloperidol
only give oramorph if in severe pain
see daughter again"

22. At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain. Her general condition had deteriorated as a result of the further operative procedure and subsequent transfer. For a frail, elderly and demented person, this can have a profound effect on their chances of survival. My

note "see daughters again" indicated that I should explain the position to Mrs Richards' daughters and prepare them for what I believed was to come. In my experience, transfer of an elderly frail patient in such circumstances frequently causes a set back in their condition with a marked deterioration. It can be something from which the patient does not recover.

23. I believe Mrs Richards later experienced further pain as it was necessary for the nursing staff to give Oramorph on four occasions between 1300 on the 17th and 0500 on the 18th August. During that time I was telephoned by the nursing staff out of my contracted hours and informed that Mrs Richards was very uncomfortable and might have suffered a further dislocation. I asked for another X- Ray to be arranged. It transpired that it was not possible for the X-Ray to be carried out simply on the basis of a verbal order; accordingly another GP signed the relevant form and the duty Doctor from my practice viewed an X-Ray with the consultant reporting the film. As far as I am aware he did not see the patient or write in her notes. The X-Ray did not show any dislocation.

24. I then reviewed Mrs Richard early the following morning. My entry for the 18th August reads as follows:-

18.8.98 *Still in great pain*
nursing a problem
I suggest sc diamorphine/Haloperidol/
Midazolam
I will see daughters today
Please make comfortable"

25. To my mind having seen Mrs Richard originally when she had been admitted on the 11th August there was by this stage a marked deterioration. My assessment of Mrs Richards on this occasion confirmed my view reached on readmission the previous day that she was dying. She was barely responsive and was in a lot of pain. By this time she was not eating or drinking. When I examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. There was no evidence of infection at that time, and it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated. This was in all probability the cause of Mrs Richards' significant pain and unfortunately a not uncommon sequel to a further manipulation required to reduce the dislocation. This complication would not have been amenable to any surgical

intervention and again further transfer of such a frail and unwell elderly lady was not in her best interests and was inappropriate.

26. After I had seen Mrs Richards that morning and following morning GP surgery, I then spoke with her daughters in the presence of Philip Bede the Ward Manager. I explained my concern to administer appropriate and effective pain relief and that without this nursing their mother was a significant problem. They understood, but did not like the idea that diamorphine was to be given. However I explained that it was the most appropriate drug. As their mother was not eating or drinking or able to swallow, subcutaneous infusion (a tiny needle implanted under the skin) of pain killers was the best way to control her pain and by titrating the dose over 24 hours frequent injections could be avoided. Both daughters reluctantly agreed to the use of a syringe driver. This drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot safely take medicines by mouth.

27. I believe I would have mentioned fluids and explained that in my view they were not appropriate. I was aware that Mrs Richards was not taking food or water by mouth. It would have been dangerous to try to give her food or water by mouth as her poor conscious state meant that she might have choked. Mrs Richards would have had mouth care and sips of water to aid her comfort. In view of this the only alternative for further nutrition would have been to administer fluids intravenously or subcutaneously. We did not have the facilities to administer iv fluids, and accordingly to do that it would have been necessary to transfer her back to an acute unit. I did not feel that this was appropriate medically. She might well not have survived the journey let alone the process. Given my assessment that she was terminally ill, and that the actual administration of fluid would not affect that outcome, it would not have been in her best interests and could have caused her further pain and distress.

28. I believe I would have explained to the daughters that subcutaneous fluids were not appropriate. Their use would not have altered the outcome and there are several clinical studies showing this in terminally ill patients. Administration of subcutaneous fluids can cause significant tissuing of fluid and discomfort for the patient. There is a risk of oedema and infection and even tissue necrosis. If the kidneys are failing the additional fluids can overload the heart and precipitate heart failure. This would cause clinical distress and require unpleasant treatment. Given these potential complications and the fact that subcutaneous fluids would not have affected the outcome, again I did not consider it would be in Mrs Richards' best interests that subcutaneous fluids be given.

29. I also included in my discussion the opinion that Mrs Richards was likely to develop a chest infection due in part to her immobility despite regular turning by the nurses and partly due to the inadequate clearing of secretions. Antibiotics would not have been appropriate or indeed effective.

30. I said to the daughters that the prognosis was very poor and that she was not well enough for a further transfer to an acute unit. I was concerned in all the circumstances to provide an honest view.

31. When Mrs Richard was admitted to Daedalus Ward for the first time, I think it was suggested by her daughters and reported to me by nursing staff, that she might be sensitive to morphine, hence my mention of it in the clinical notes of 14.8.98. However I had seen no evidence of that when she had been given Oramorph earlier in her admission. In the first 18 hours following her transfer back from RHH she was not responding to a total of 45 mg of morphine orally in less than 24 hours. Therefore to ensure pain relief this would have to be increased. Diamorphine is a more potent analgesic than Morphine. In view of the need to increase the amount of pain relief (45mgs of Morphine in less than 24 hours having been clearly insufficient) and that Morphine (into which Diamorphine is broken down) has a relatively short half life, I consider that 40mgs of Diamorphine was appropriate for her pain relief. Mrs Richards would also have developed a tolerance to opiates through the previous administrations of Oramorph.

32. My use of Midazolam in the dose of 20 mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of Haloperidol to that which she had been having orally since her first admission.

33. I reviewed Mrs Richards' condition with the senior trained staff again on the morning of 19th August. From my assessment it was apparent that she had a 'rattly' chest and had developed bronchopneumonia. This would have been as a result of her frail condition and despite the fact that she was being turned regularly she was vulnerable to an infection developing. I did not make a note of this assessment but did prescribe hyoscine in the dose of 400 mcg and this was duly added to the syringe driver. Hyoscine is an antimuscarinic drug which is given to dry the bronchial secretions produced by the infection. This drug as with the others was reviewed and discussed daily as I visited the ward and assessed her overall condition. I am clear in my mind that there was no apparent depression of Mrs Richard's respiration. Had

there been any such depression, I would have reviewed the drug regime. As it was, Mrs Richards was apparently now out of pain and accordingly I considered the drug regime and the dose used to have been appropriate. In such circumstances, as I was not in position to attend continuously, it was necessary to have reliance on the nursing staff for reports on any problems arising. No further problems were related to me during this period. I saw Mrs Richards again on the morning of 20th August. There was no significant change in her overall condition.

34. I saw Mrs Richards again on the morning of 21st August. My note of that attendance reads as follows:-

21.8.98 *I think more peaceful*
needs hyoscine for rattly chest"

35. In my clinical opinion, by the 19th August Mrs Richards had developed bronchopneumonia. I do not believe that the dose of 40 mg of diamorphine administered over 24 hours had contributed to the development of the bronchopneumonia. It was an appropriate amount required to relieve her of her pain.

36. Sadly Mrs Richards died on 21st August, being pronounced dead at 9.20pm by one of the nursing staff. I gather that her daughters were with her when she died.

37. On the next working day, Monday , 24th of August. I discussed the case with the Coroner's Officer, a police officer at Cosham Police Station. I informed him that Mrs Richards had sustained a fractured neck of femur on the ~~18th August~~ 20th and was subsequently operated on at RHH. I would have told him of the dislocation and the fact that she had returned to RHH and back to our care and had died on 21st August, in my view of bronchopneumonia. The Coroners Officer was happy that no further investigation was required and I signed the death certificate putting bronchopneumonia as the cause of death. I believe that this was the cause of death in all the circumstances.

38. 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 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.

39. Similarly it was not my intention to hasten Mrs Richard's 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. I believed that transfer to another hospital where she would be in a position to receive intravenous fluids was not in her best interests as it would have been too much of a strain and brought about a premature demise. There is clear evidence that the administration of intravenous or subcutaneous fluids would not have prolonged her life and faced with the complications which could arise such intervention was not in her best interests.

40. I explained the position to Mrs Richard's daughters, they did not appear to demur at the time and indeed at no time requested a second opinion.

MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN : ☐ ROTI : ☒ Contemporaneous Notes ☐

Person interviewed : **Althea Eueresta Geredith LORD**

Place of interview : **Interview Room, Fareham Police Station**

Date of interview : **27 September 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1414** Time concluded : **1458**

Duration of interview : **44 mins** Tape reference numbers * : **44/00**

Interviewing Officers : **DC 1484 COLVIN, DC 92 Paul MCNALLY**

Other persons present : **Mr PRIVETT - Solicitor**

Tape Counter Times*	Person Speaking	Text
	DC COLVIN	This interview's being tape recorded, I am DC 1484 COLVIN, the other police officer is.....
	DC MCNALLY	DC 92 Paul MCNALLY.
	DC COLVIN	I'm interviewing Doctor LORD, please can you give your full name and date of birth?
	LORD	I'm Althea Eueresta Geredith LORD, my date of birth is 18/10/54.
	DC COLVIN	Thank you and also present is....
	SOLICITOR	Richard PRIVETT, Doctor LORD's solicitor.
	DC COLVIN	Thank you. The date is Wednesday the 27th of September, the year 2000 and the time by my watch is 14.14. This interview is

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

MG15(T)(con.

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 1

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text

being conducted in an interview room at Fareham Police Station. At the conclusion of the interview I'll give you a notice explaining what will happen to the tapes and whilst entitled to legal advice throughout the interview and at any time you can delay the interview to take that advice, okay so if you want to stop at any time to seek further advice you only have to say and we'll leave the room and you can take that advice, okay. Okay the next part is the caution, you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court, anything you do say may be given in evidence, okay. Right just to let you know that this room can be remotely monitored and I'm just going to read this notice up here, it's capable of being remotely monitored when the tape recorder is in record mode only as it is at the moment, which basically means any other time when the machine is not recording then it can't be, okay and of course it, the explanation of that is when you want to speak to Mr PRIVETT nobody can hear that conversation, okay. What I'd like to do just briefly is just to reiterate why we've asked you to come in today,

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		okay, before I do that I will tell you that you are here voluntarily, you've come here voluntarily and as such you can leave at any time, okay, you understand that?
2.16	LORD	Yeah.
	DC COLVIN	Right, okay, the reason that we've asked you in is obviously surrounding an allegation basically of the unlawful killing of Gladys RICHARDS at the Gosport War Memorial Hospital between the 17th of August 1998 and the 21st of August 1998, okay and what we'd like to do today is to discuss your role within the hospital at that time and some of the points that have been raised by the family and other points that we've looked at and to seek an explanation from you on those points, okay, yep. What I'd like to do first...what I'd like you to do first if you may is if you can explain the position you hold at the hospital and in particular what roles and responsibilities go with that position and then from there whether it has changed from 1998, whether there's any differences at all.
	LORD	I've been a Consultant Geriatrician since '82 so it's about sic and half, eight and half years.

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

MG15(Record)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	DC MCNALLY	Eighteen and a half years.
3.20	LORD	Close, can I start again, I'm sorry.
	DC COLVIN	Yes certainly, certainly, yeah.
	LORD	I've been a consultant since '92, since March, since end of March '92 that's about eight and half years now erm my duties would include being res..being responsible for an acute ward which is based at QA, and I do a certain amount of community hospital work at Gosport War Memorial Hospital where we've got two wards, Daedalus ward and Dryad ward. Back in '98 Dryad ward was a continuing care ward and still is, Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke, rehabilitation. I was responsible usually responsible for Daedalus ward, for the continuing care and these stroke patients but about..in about July '98 the colleague was Dr TANDY who was doing Dryad ward went on [redacted] leave and the department decided because we'd had problems with poor quality locums covering leave before that we would try and cover the duties internally, we had another part-time post come up as well so we had a few extra hands on board well we had half a

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of Althea Euaresta Geredith LORD

Tape Counter Times *	Person Speaking	Text
		consultant on board erm so I then took on just to cover the [redacted] leave I did Daedalus ward and Dryad ward alternate Monday afternoons and I was a consultant responsible. I also did out patient clinics supporting Gosport and as St Mary's and I also had a day hospital once a week again in Gosport which is Dolphin Day Hospital in addition to that and this is not timetabled anywhere we also do ward visits to all other departments medical, surgical, orthopaedic psychiatry throughout all the hospitals in Portsmouth and that would include St Mary's, QA, St James' and Haslar, we also visit people at home on domicile consultations.
5.33	SOLICITOR	I don't know if it would help but erm Doctor LORD's provided me with a copy of the rota that sets out her duties on a weekly basis as at August 1998 along with the rest of the consultants that she works with....
	DC COLVIN	Oh right.
	SOLICITOR	...so there's her working week as such at the relevant time.
	DC COLVIN	Okay, is this something you've produced yourself or is this come from a ....

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

MG15(Tabular)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	This is saved what happens is that if there's a change in the consultants timetable's required the Consultant Body needs as many people as possible preferably (inaudible) and we know what areas we need to cover because of the set areas and then we see how we can divide it so that we don't have much travelling in between keep up interest going because I've always done quite a lot in Gosport erm and that's where my interest and my work lies.
6.25	DC COLVIN	Sure, sure, okay. Where has this come from this rota?
	LORD	Er this is saved on the, the, one of the secretary's in the admittance office at QA er she does the final draft once we've scribbled in what we want and she saves the, she saves almost everything so we can go back to any moment in time and get out work the on call rota and we'd call this our timetables.
	DC COLVIN	Sure, okay.
	LORD	And we would have them for the graded staff or grades.
	DC COLVIN	Where are you based or where were you based at that time?
	LORD	My office is at QA and that's where I have a secretary er and my acute ward is there, I do a..twice a month I do a clinic at St Mary's but all the other...the rest of the time is in Gosport and in

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		general terms I would be in Gosport on a Monday and Thursday.
7.17	DC COLVIN	Right, okay. So focusing on Daedalus and Dryad ward, what would your role be there on a Monday when you would visit? What would things you'd (inaudible)?
	LORD	It would be a consultant ward round usually with a clinical assistant we've now got a staff grade in post and a nurse er if the therapists had been involved with patients we would start off with what we call a multi disciplinary case conference if there are patients to discuss, mostly involving patients who are either having complicated rehabilitation or where we have to undertake the complex discharge planning, getting dependant people say home for example er so we would start at half two because my morning session often overran in the day hospital on a Monday so I'd start at half two, we would discuss any patients also if the social worker wanted to come in, any discussion would be before the round then I would see each individual patient on their bed or in their, in their room nothing in public and at the end of it I would see any relatives who need to be seen and those relatives can be booked in by the nursing staff they don't have to make an

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		appointment, they don't need to check with me they can book the appointment with the relative to turn up at the end of the round.
8.39	DC COLVIN	Sure, okay. So would you...what sort of things would you be looking at in terms of each patient? What would be the things you would actually attend or..?
	LORD	If it's the first time they've come down and often these people have had quite protracted journeys through the health system they could have been seen on orthopaedics, then on an acute ward then ended up back say in Gosport so we would need to review the medical notes, try and find out what is the main problem, what are the other problems and we fill out that sheet that we fill in and that's called a problem sheet that often is useful for summarising the persons problems, then we try and sort out what treatment they're on medication, what is their present con...you need to examine them first, make sure there's no, there's nothing like an infection or something simple that can be treated, review their investigations, review the treatment and then have a rough plan preferably with a, with a name of what you want for the patient, either they could be something like we'd observe for four weeks

Signature(s) : DC 1484 COLVIN

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		see what happens maybe for a nursing home or maybe for gentle rehabilitation or maybe this patient has advanced cancer. this patient is for palliative care so it depends on what the patients there for, what their condition is and we certainly try to say what way for someone then you need to get the relatives on board because someone might have an advanced cancer but it may be that the family very much want them home erm so you've got to then sort of find ways of getting everything else together and in '98..in august '98 I would do each ward every fortnight, only once a fortnight because I did Daedalus ward one day and then Dryad ward one Monday and then Dryad ward the next Monday.
10.33	DC COLVIN	So you did alternate...
	LORD	Alternate Mondays.
	DC COLVIN	...alternate Mondays, okay.
	DC MCNALLY	Is it different now is it?
	LORD	Yes because erm when Doctor TANDY came back from leave we juggled the timetables round again and Doctor REED does Dryad ward weekly and I do Daedalus ward weekly.
	DC MCNALLY	Right is that as a direct?

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RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	The turnover was going up anyway...
	DC MCNALLY	Right.
	LORD	...the Health Authorities criteria for providing people hospital continuing care changed so instead of people staying in hospital. going back about five years if there was someone very dependant. say with a very bad stroke we would say that yes this is a bad stroke, they're very dependant they cannot move out of bed at all, you offer them a bed for life. About five years ago the Health Authority said that doesn't apply anyone who's stable for four to six weeks and doesn't require what they call specialist medical and nursing intervention can be discharged to a nursing home and that had a huge implication in the numbers that were going through the ward because prior to that people were just there for life, you had time to assess them medically, you had time to get to know them, you were more susceptible to changes in their condition, you knew the families and between about sort of from about '95-'96 gradually the turnover kept increasing as we kept discharging people, it's almost as though the, the whole focus of the ward was changing as well at that time. We were aware that

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Tape Counter Times *	Person Speaking	Text
		the turnover was increasing and in fact the figures for that year show that we had 273 through both wards which is quite high it was about I think 210 the year before and we were aware that the work load was high, that we couldn't get on top of problems that were cropping up and I was finding that even though I was doing the wards alternate weeks I was having to go to the other ward anyway at the end and it was sort of 7-8 o'clock before you could get back home so the wards were..the ward rounds were every fortnight but we were having to pop into the wards on a, on a weekly basis.
12.40	SOLICITOR	What would trigger those additional visits to the ward?
	LORD	It would be the nurses or Doctor BARTON was the clinical assistant then mentioning that there was a problem and that there was something that needed sorting so it would be contact from nursing or medical staff.
	DC COLVIN	Moving up just briefly to Doctor BARTON then, what, how do you understand her role to be?
	LORD	She was the clinical assistant er she's also a local GP and she would be there on the consultant ward round, she also popped in

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Tape Counter Times *	Person Speaking	Text
		in the morning and in between sort of, between surgeries and was available for full contact in between, when she wasn't around her partners covered that practice still covers out of hours but we've now got a full time staff grade whose in post now Monday to Friday at the hospital for both wards and the day hospital that's only been since August this year.
13.38	DC COLVIN	Right so there's actually a permanent clinical assistant on the ward?
	LORD	Yeah and that again was on the back of increasing activity finding that even when I was not in say on a Tuesday having been there on a Monday that there were issues that were cropping up...
	DC COLVIN	Yeah.
	LORD	...plus it's likely now with all the changes in intermediate care that Daedalus ward will actually become a rehabilitation ward as from the 1st of November so the whole focus of the ward is changing as well.
	DC COLVIN	Right, okay so what's the diff...the rehabilitation ward sounds fairly obvious but can you just explain what that involves?
	LORD	Yes basically you're looking at people who will need to be in

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Tape Counter Times *	Person Speaking	Text
		hospital to have in-patient multi disciplinary rehabilitation, what that means is you're probably going to need more than one therapist and they probably have medical problems as well, if someone say just fractured their arm and needed physiotherapy they could come to out-patient physiotherapy but for a lot of the elderly it might be that they've just fractured their, their arm but it might have been a heart attack that caused to fall and it might be that they've got heart failure anyway, it might be that they're living on their own with no relatives and it may be that they're are partially sighted whatever so they need the input of..medical input to make sure that we can get them the best general health we can and then you also need physio occupational therapists maybe speech therapist if they've got problems with swallow, social workers it's quite complex and often they're not things that you can snap your fingers and say yes you can go home tomorrow all these will be in place so Daedalus ward from the 1st of November will have patients for in..in-patient rehabilitation with a view to moving them on.
	DC COLVIN	Okay. So when you did these rounds as I understand it Doctor

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		BARTON would be responsible for prescribing drugs and treatment during ....
15.43	LORD	Yes we would decide that together.
	DC COLVIN	That would be taken together?
	LORD	Yeah.
	DC COLVIN	Would it ever be taken by one or the other alone and then discussed later on?
	LORD	No because I would see the patient, the idea of that round was for, for them to have my input.
	DC COLVIN	Certainly I mean sorry I mean other than that round, I mean obviously you weren't there...
	LORD	Oh yes, no but if I wasn't there then Doctor BARTON would make the decisions...
	DC COLVIN	Yeah.
	LORD	...and I would have every confidence in her.
	DC COLVIN	Okay and that would be reviewed by you?
	LORD	On the, on the next round.
	DC COLVIN	On the next...which would be every other Monday?
	LORD	Yeah as it was then.

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Tape Counter Times *	Person Speaking	Text
	DC COLVIN	As it was, as it stands but obviously I appreciate that it's changed now.
	LORD	Yeah
	DC COLVIN	Okay, okay so in terms of visiting patients like you have...we have discussed about who would be present, but what extent would you check each patient in terms of their treatment and physical well being?
	LORD	I wouldn't do what I'd call a complete examination on everyone it would depend on what's happened, if people were breathless I would listen to their chest, listen to their heart, the nurses often do a blood, would do a blood pressure what they call a functional school before the round which is something that is called a Bartel scope and we would discuss the few things like continence and feeding and nutrition and again I would rely on, on them to say what's changed, I would talk to the patient and they would say what, what's changed from the last week and there might be certain trigger things that they would say for argument say someone's in pain, their necks been very painful this week, we've tried this we don't know what to do next because often a lot of

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RECORD OF INTERVIEW

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Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		the treatment would have been initiated or they'd say that someone's in heart failure we've tried this and then we would review the drugs together so we would decide with the nurse, the nurse that was present, Doctor BARTON and myself we would decide on what treatment to write up. I mean often if Doctor BARTON was there she would write it up on the chart but it would be on, on my instructions.
17.52	DC COLVIN	But it would be a joint call?
	LORD	Yeah, and I..yeah.
	DC COLVIN	I mean in terms of hierarchy then in terms of who has the final...
	LORD	I would.
	DC COLVIN	...say, you would say so? Okay, has there ever been an occasion where you've had to erm question Doctor BARTON's actions over a particular patient in terms of either the level of treatment given or the type of treatment?
	LORD	Not that I can recall.
	DC COLVIN	Okay is there ever been any disagreements between the two of you as to you know what to do about a particular patient?
	LORD	Not at all. If Doctor BARTON rang for advice she'd follow what

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RECORD OF INTERVIEW

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Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		was, what was recommended.
	DC COLVIN	Okay.
18.38	SOLICITOR	What sort of experience are you aware of that Doctor BARTON has in geriatric medicine?
	LORD	She's been a clinical assistant certainly longer than I've been a consultant it must be at least ten, twelve years she only left us in June, June or July this year erm she's an experienced GP the...in Gosport there's also a GP ward to which the, to which the GP has right of admission and I certainly know quite a few patients in Gosport I admitted under her care say for palliative care and things like that directly onto the GP ward so she's sort of a very dependable, sensible GP.
	DC COLVIN	Okay in terms of the pharmacy which I understand is at QA?
	LORD	Yeah.
	DC COLVIN	What or do you have any control over any part of that pharmacy? What are your responsibilities in relation to the running of the pharmacy?
	LORD	The stock items are agreed and again that's been reviewed with the wards that are changing tempo if you like and what is, what

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Tape Counter Times *	Person Speaking	Text
		we require we can usually get down within by the next working day so if we fax something through this afternoon it will come down by lunchtime the next day, if we need anything urgently they will taxi things down straightaway from QA, if we need to get supplies say for argument like antibiotics we don't stock and it seems a long way to get a taxi and it's something that the local chemist would stock we also have prescription pads that...DFP10's that we can write a prescription on and get it from the pharmacy across the road.
20.21	DC COLVIN	Okay what is your understanding of the pharmacists role at Gosport hospital at that time in'98?
	LORD	The pharmacy cover hasn't improved and this is something we've been asking for. The pharmacist with it's I think it's a couple of time a week looks at the charts and picks up what's required sometimes mentions this is a possible interaction but it's, we don't have a daily visit and he just checks the stocks and makes sure things are all right.
	DC COLVIN	Okay, when you mention charts is that individual patient charts?
	LORD	Yeah but I don't think they check everyone's I don't know what

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		system they've got for that.
	DC COLVIN	Okay, I appreciate that. When you mention interaction between drugs can you explain what that means?
	LORD	Er just say sometimes say someone's on Wolverine which is something you use to thin the blood and a lot of people are on now for prevention of strokes, certainly antibiotics could interfere with that and then by, they usually write in green and they'd write something in the...on the side to say what interaction you might that the Wolverine controlled was here by so it's just alerting doctors to the possibility the systems different at QA where we've got a technician visit every day and erm it's a case of staffing and funding.
	DC COLVIN	Moving on to Mrs RICHARDS and she was in the hospital on two separate occasions, what contact did you have with Mrs RICHARDS during those periods?
	LORD	I had no contact with her or her family at all and I haven't any contact since.
	DC COLVIN	Mmm, okay. Why was that? Are there reasons for that?
	LORD	The first admission if I remember right was a... I would have

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Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		done a round on Daedalus on the 10th and I've checked the ward diaries to see when I did the ward rounds. She was admitted on a Tuesday the 11th of August would have been a Tuesday and she went back to Haslar on the Friday, with hindsight I would have been on the ward shortly after she fell on the Thurs..13th afternoon but I wasn't alerted to the fact that there was someone with a fall that the nursing staff were worried about but with hindsight I was on the ward that afternoon the 13th and theoretically could have seen her but wasn't alerted to the fact that there was a problem.
	SOLICITOR	So you're on the ward on the Thursday in relation to the slow stream stroke patients?
	LORD	Stroke, stroke patients I wouldn't have seen her, she wouldn't have been a patient...she wouldn't have been a patient for that afternoon, a regular review that afternoon.
	DC COLVIN	And you're saying unless you...
	LORD	Yeah.
	DC COLVIN	...it was highlighted you wouldn't have seen her?
	LORD	No.
	DC COLVIN	And in fact that was....

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RECORD OF INTERVIEW

Continuation Sheet No : 20

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Tape Counter Times *	Person Speaking	Text
	LORD	Yes.
	DC COLVIN	...the case, okay. On the second period...
	LORD	Yeah.
	DC COLVIN	...which was between the 17th and the 21st?
23.37	LORD	Again on the 17th and 18th I was on study leave in London, I attended a course on Parkinson's disease and I should have been on Dryad ward on the 17th but I would have been in hospital on the 17th, I would have been in the hospital so if there was a problem they would have probably asked me to see Mrs RICHARDS...
	DC COLVIN	Right.
	LORD	...but I wasn't around erm I was back at work on the 19th, the Wednesday erm and would have been there on the Thursday afternoon again but again she was not a patient for review and again neither the nursing or the medical staff sort of alerted me to the fact that they wanted me to see either Mrs RICHARDS or the daughters.
	DC COLVIN	Okay so the fact you weren't there on the 17th and 18th would somebody have taken over responsibility for your rounds on those

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Tape Counter Times *	Person Speaking	Text
		days?
	LORD	It is not possible the department's so busy if they mess around particularly when it's short, short term leave the acute work gets covered by registrars because we've got two other tiers er on the acute side, in the community hospitals it's..if we're not there for a round basically it's very difficult with the time, where the timetables are to make that round up at another time, the...all the geriatricans are very accessible and during the day if the ward phoned through to the admissions office at QA could have spoken to anyone who was available, out of hours there's a duty rota which all the wards in our department get including the community hospitals and they would know which consultant was on so after five and that consultants always contactable through QA switchboard er for advice so no-one would have done my ward round when I wasn't there and I could not make that up any other time in the week but there was someone available for advice but again no-one was contacted.
	SOLICITOR	That was Doctor GRUNDSTEIN...
	LORD	Doctor GRUNDSTEIN, STEEN.

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Tape Counter Times *	Person Speaking	Text
	SOLICITOR	...on call?
25.46	DC COLVIN	So he's a generally if someone needs to...needs advice from a consultant it would be to call him?
	LORD	Yeah.
	DC COLVIN	But his role wouldn't be to perform the role that you would normally be doing on those days?
	LORD	No, no.
	DC COLVIN	Okay, so the Thursday then that's a day allocated...
	LORD	Yeah.
	DC COLVIN	...I've got your rota here for...
	LORD	Yeah.
	DC COLVIN	...purely for slow stream...
	LORD	Yeah.
	DC COLVIN	...stroke patients, okay. In terms of when you make your visits on a Monday would you and you mention you look through every, every patient so on a Thursday, it's purely you focus on the slow stream...
	LORD	Yeah.
	DC COLVIN	...patients.

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Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	The reason we split it is that it was too mu..it was two different nursing teams that with the strokes and the continuing care patients and I think they used to have quite a busy Monday morning and (inaudible) have to return at about 6 o'clock after I'd finished Daedalus to finish paperwork off in the morning so really putting the strokes in there would have meant I'd have been there until about 10 o'clock.
26.55	DC COLVIN	Okay.
	LORD	It would just...I split it to the Thursday because also because I'm in Gosport on Thursday morning alternate, first thing Thursday mornings I've got a clinic so it also meant there was a consultant presence in Gosport twice a week.
	DC COLVIN	Okay and at that time you were not made aware of..
	LORD	No.
	DC COLVIN	...any concerns or anything regarding Mrs RICHARDS or...
	LORD	Not at all.
	DC COLVIN	Okay. What I'd like to do now is I've got the notes here for Mrs RICHARDS during the time she was in the hospital and I'd like to show you the drugs that were prescribed and administered to

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		Mrs RICHARDS during her time and which my colleague is just getting out there.
27.57	SOLICITOR	I think we've probably got..
	LORD	Yeah.
	DC COLVIN	You may well have a copy of this anyway.
	LORD	Yes.
	DC COLVIN	I'm just wondering if you could talk us through the drugs that are there, what your perception is of what they are there to do and then we'll discuss some more issues about them after that.
	LORD	Right we'll start...
	DC MCNALLY	I think we're just concentrating on the 17th aren't we?
	DC COLVIN	We are, yeah so the four drugs in particular I'm interested in is the diamorphine...
	LORD	Yeah.
	DC COLVIN	...the hyoscine, the midazolam and the haloperidol which I understand were all loaded onto a syringe driver?
	LORD	Yeah. The oramorph within that she's had if we got back to the 17th you can give er liquid morphine which is the oramorph preparations that have had four hourly intervals and if because it

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is short acting and if you're looking for pain control then you look at giving at least five to six doses a day unless they're very sleepy in between and cannot, and cannot take a dose so she'd had a total of it is 10 milligrams per 5 mils and if you work it out it works out to 45 mils over a 45 milligrams over a 24 hour, 24 hour period. The, if you stick with the morphine, that was followed by diamorphine which is administered in a syringe driver now the syringe driver is better for continuous control, it is also better if people cannot swallow and it, you've got room to adjust the dose on a daily basis if you so wish, with any morphine preparation it is inevitable that you'll get some amount of drowsiness but it is good being controlled and it is something we use quite a lot of in our day to day work. The dose of diamorphine in the syringe driver was almost static at 40 milligrams over the next 4 days, she was on haloperidol, on haloperidol when she came in I think she'd been on haloperidol probably since about Christmas the previous year, the psychiatry correspondence that we've seen erm so because of that it's usual to keep some amount of anxioulitic going and the haloperidol

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		recommendation would be sort of about 5, 5 to 10 which is over a 24 hour period.
	DC COLVIN	And what is that specifically supposed to target that drug?
30.47	LORD	It is more the sort of behaviour, agitation, more the dementia side that people can get, when someone is...who's demented is restless it's like a baby crying you've got to work through the, the things that could be distressing them starting from the most simplest things to other things and often if someone with dementia very restless, then pains, pains a problem, it depends on what you think of the patient when you see them, so that's the haloperidol. The midazolam is an anxioulitic, it's sort of a valium equivalent that's used intravenously really mostly for anaesthesia, it can be used in syringe drivers over a 24 hour period and again it's more for sedation reducing anxiety, it can also be used as an anti-convulsant say for arguments sake someone was an epileptic for whatever reason is not able to swallow and take their medication you can use midazolam subcutaneously in syringe drivers as an added convulsant as well, I would suspect that in Mrs RICHARDS case it was used as an anxioulitic rather than as an

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Tape Counter Times *	Person Speaking	Text
		anti-convulsant. The hyoscine really is for secretions in throat what's commonly known as the death rattle and this would be an extremely low dose and the recommended is usually 8 to start with 800 over 24 hours because what happens is once people are really very ill and secretions that can get in their throat you can suck them out using a suction catheter but that is often distressing and very difficult for the person and also for the people who are watching and you can just dry up secretions a little bit with it, it just makes people a bit more comfortable.
32.45	DC COLVIN	Okay, you comment on the fact that the hyoscine is a...the dosage there, in terms of the other levels of dosage for the others, comment on the strength of those?
	LORD	Erm the haloperidol again er there is no direct conversion of haloperidol orally to subcutaneous, I second the recommendations in the palliative care guidelines would be 5 over 24 hours.
	DC COLVIN	Okay, what about the diamorphine and the midazolam?
	LORD	Erm the midazolam I can again I think it depends on the clinical judgement at the time because to a certain extent haloperidol

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		would have a calming effect as well and really without seeing Mrs RICHARDS and knowing how agitated and distressed she was it is difficult to know why er the midazolam and the haloperidol were used.
	DC COLVIN	Combined, okay. In terms of the diamorphine?
	LORD	Erm the top dose for diamorphine that's recommended is up to 250 erm and again it depends on people's clinical judgement as to how much pain, distress people are in as to how much you, you do prescribe.
	DC COLVIN	Okay.
	LORD	And again I, I think if you've seen someone you can see yes I, I did see them, they were really, really agitated and when having seen someone I just...you can't guess really.
	DC COLVIN	Certainly, okay. In terms of..I appreciate what you're saying that you didn't see Mrs RICHARDS but I take it now you've got an understanding of some of the problems she had and her age and etc...
	LORD	Yeah.
	DC COLVIN	...In terms of those four drugs would that be symbolic of someone

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Tape Counter Times *	Person Speaking	Text
		who's on palliative care, on a course of palliative care treatment?
	LORD	In what way?
34.53	DC COLVIN	In your judgement would you look at that knowing what you know about ....
	LORD	Yeah.
	DC COLVIN	...Mrs RICHARDS now and think this looks like she's on a palliative care regime, this lady is...you know what the condition of her or whatever, could you comment on that?
	LORD	I think it's highly very unusual for someone to require that amount of someone who's up and walking wouldn't, wouldn't require this degree of sedation erm and the fact that some...that this dose was administered and that they've kept the administration went on for a few days means that we've now got into the, into the palliative care situation.
	DC COLVIN	Okay. And again this is to get an explanation from you generally, in terms of palliative care could you just explain what exactly that means? What the term it actually covers?
	LORD	What it means is that you're trying to keep the person as comfortable as you can while accepting that this is probably the

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Tape Counter Times *	Person Speaking	Text

beginning of the end if you like, or they're nearing, now nearing the end and together with that you really call them symptom control as your main target so try to keep the person as comfortable as you can and address all the issues that would affect that comfort so in addition to just washing and bathing them, is there anything that's distressing them, try and alleviate that and sometimes I don't really know it's a case of what is...what's going on, someone's really very distressed is it pain, is it distress because they're in an unfamiliar environment, is it discomfort from bowels, see you address the symptoms as much as you can, try and target the problems if you think someone's constipated then that needs to be relieved, if someone's not emptying their bladder then maybe they need a catheter erm and address the issues as, as quickly and as simply as you can because you know you haven't got much time to wait and see and if together with that you've got to get all the psychological things on board, do they know they are dying, do they want to fact the fact that they are dying, do their families accept that they are dying so there are the other sort of psycho social aspects to it as

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Tape Counter Times *	Person Speaking	Text

well. Are all the family members aware, you know have they made their peace you know they're quite a lot to the dying process then and then you've also got to and again this is time consuming is to work out which family knows, how best are we going to keep mum comfortable, any sort of pain killer you use has side effects, any form of heavy sedation will make them drowsy and will inevitably cause a deterioration, do we go for that, what happen if they spike her temperature do you want them moved back to acute at this stage for intravenous antibiotics so there are few what if situations to address as well and there will inevitably be the sort of what if they have a cardiac arrest, what is the resuscitation so you try and deal with the symptoms you've got, you try and prevent things like say pressure sores which could be really distressing and which you know will be a problem with someone dependant so there are really quite a lot of issues around that and it's difficult to know what you prioritise first, you try and get everything on board but someone sometimes that someone deteriorated very rapidly you don't really have time and then you've got to make quick decisions.

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	DC COLVIN	Okay, so I mean in terms of palliative care, in terms of setting up that level of treatment...
	LORD	Yeah.
	DC COLVIN	...and the decision taking that this person is dying. Who's responsible for making those decisions within that amount of hospital at that time?
39.11	LORD	At that time it would be on, on a day to day basis it would be between the nursing staff, whichever senior member of the nursing staff that was on and Doctor BARTON. If they were concerned at all they could always make phone contact and get advice erm usually they had a fair grasp of the situation and I can't think of an instance where it's required me to come down in between when I wouldn't have been there er ....
	SOLICITOR	Erm I'm sure its not the impression that you left that the palliative care regime would presumably grow gradually it wouldn't be a decision to implement palliative care as from today for instance.
	LORD	No, no I mean you've got to take someone's previous history when their...what they're suffering from before, what they were like before into consideration.

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 33

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	DC MCNALLY	On this particular page here obviously are you saying that at that...looking at those drugs and the quantity and the type of drugs that a decision was made on or around the 17th, 18th of August that Mrs RICHARDS was dying and therefore the role of the hospital staff at that time, from that point was to make her comfortable and pain free as possible?
40.30	LORD	That would be my interpretation from this.
	DC MCNALLY	Yeah. Are you able having to..having looked at the notes, I appreciate you have looked at these notes before haven't you, this isn't the first time sorry the first time that you've seen these patient notes. Are you able to indicate from the patient notes and I do appreciate that you never saw Mrs RICHARDS, are you able to indicate a cause or a reason or what Mrs RICHARDS was dying of?
	LORD	It's difficult because she's been a lady who was severely demented er who from psychiatrist notes did spend a lot of time asleep but then could walk unaided as well...
	DC MCNALLY	Yeah.
	LORD	...and people with fractured hips particularly people who are

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		demented do quite badly following surgery, now I know she came through surgery the first time and came through a replacement, a dislocated hip the second time, the third time it's difficult to know what the deterioration was from and in quite a lot of patients you can't say yes this is a, b and c that's causing the deterioration and a lot of it is on clinical judgement how you see the person.
41.43	DC MCNALLY	Yeah but so having read her notes you can't indicate to us of any particular thing that Mrs RICHARDS was dying of?
	LORD	No.
	DC MCNALLY	No, no. It's a blunt question but the four drugs that were administered from the 17th, 18th ...
	LORD	Mmm, mmm.
	DC MCNALLY	...would they have possibly been a direct cause of her death, would they cause her to die?
	LORD	I don't think they would have been a direct cause of her death but they're not drugs that would..any drug that is sedating will, and once people are sedated the problem with it then is they end up with things like chest infections, stasis in the lungs and it's not a

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		sort of healthy environment to be in.
	DC MCNALLY	But am I right in saying that the...the..you mentioned her lungs and (inaudible)...
	LORD	Yeah.
	DC MCNALLY	Is that as a direct result of the administration of those drugs? They cause the fluid on the lungs?
42.46	LORD	Not the drug, the drugs do cause some element of it..
	DC MCNALLY	Yeah.
	LORD	...but if someone's deteriorating anyway the bodies sort of shutting down at the same time it's a clinical thing...
	DC MCNALLY	Yeah.
	LORD	...it's not like there's someone what's the easiest thing to say that has high blood pressure you can take a reading...
	DC MCNALLY	Yeah.
	LORD	...and if someone's got high blood pressure or they haven't got high blood pressure...
	DC MCNALLY	Yeah.
	LORD	...when someone's dying it's, it's your clinical impression of someone...

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 36

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	DC MCNALLY	Yeah.
	LORD	...and it's probably something we don't write down in detail but it...
	DC MCNALLY	I take it what you're trying to say is experience would tell a doctor who's dealt with...
	LORD	Yeah.
	DC MCNALLY	...elderly people for many, many years that they'd form an impression at that stage of I've been here before this lady is dying, let's make her pain free and comfortable?
	LORD	Yeah.
	DC MCNALLY	Yeah, hypothetically.(buzzer sounds for end of tape) we'll make this the last question for the time being, hypothetically I think we all appreciate that Mrs RICHARDS was in pain, if Mrs RICHARDS was given diamorphine and diamorphine only would she have lived longer than what she did?
	LORD	I don't know the answer to that.
	DC MCNALLY	You don't know, okay, okay.
	DC COLVIN	Okay that buzzing noise means we've got about two minutes left so what we'll do is conclude the interview and give you a chance

Signature(s) : DC 1484 COLVIN

* Not relevant for contemporaneous n tes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		to have a break and then we'll probably have some further questions on another tape, okay?
	LORD	Yes.
	DC COLVIN	Is there anything at this stage you want to add or clarify anything you've said so far?
	LORD	No.
	DC COLVIN	Okay the time by watch is 1458, I'm turning the recorder off.

MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN : ☐ ROTI : ☒ Contemporaneous Notes ☐

Person interviewed : **Althea Eueresta Geredith LORD**

Place of interview : **Fareham Police Station**

Date of interview : **27 September 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1519** Time concluded : **1554**

Duration of interview : **35 minutes** Tape reference numbers * :

Interviewing Officers : **DC 1484 COLVIN and DC 92 MCNALLY**

Other persons present : **Richard PRIVETT (Solicitor)**

Tape Counter Times*	Person Speaking	Text
		(Sound of buzzer to indicate the start of the tape).
	COLVIN	This interview is being tape recorded and is a continuation of an interview of Dr LORD. The time by my watch is fifteen nineteen. I will remind you that you are still under caution, okay, and I'll just read that out again. You do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in Court. Anything you do say may be given in evidence, okay? What we were discussing before we took that break was the, the treatment that was prescribed to Mrs RICHARDS and some of the issues surrounding palliative care and just before the break we asked you

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		for a definition of what that means, which you've given us. Just a couple of other issues I want to cover on that, there was one point made which was related to the hydration of a patient? And when it would, would be appropriate to hydrate a patient and when it wouldn't. I wonder if you could give me some examples of those two, when it is appropriate and when it isn't?
	LORD	Probably everyone requires some degree of hydration, particularly if you're awake and if it, it's something difficult to assess, if someone's distressed purely because they've got a dry mouth. Now, if people can swallow that's going to be best way to hydrate them. But either, because the swallow is uncoordinated, happens in a lot of people with dementia or people with strokes or because they are in bed and the positioning is not right or they've got neck problems and can't really straighten their neck to swallow, then swallowing something orally would be, would be difficult. So alternatives to that would be, the best form to hydrate and probably provide nutrition would be using a gastric tube which is a tube skipped in through the nose right down into the stomach and if you've got a tube down there, you might as

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
		well give feed as well, proteins as calories as well as liquids. In order that you can satisfactorily feed someone through a nasal gastric tube, you need to be able to sit up in a chair or at least be able to sit upright in bed, because if you're pour feed into someone who's flat in bed, they'll just aspirate or they get it into their lungs and get a chest infection anyway. And someone's who's confused and restless, there's also a risk that they tug at the tube, because even if you tape it to their nose and forehead, anything in front of your face you're aware of and a small tug and the tape can come out. So, that form of feeding and hydration we probably wouldn't embark on in someone like Mrs RICHARDS where there will be behavioural problems with dementia. The intravenous road we cannot carry out at Gosport, even at present, because the nursing staff do not have the training for it, that's something that'll happen in the next few months and certainly we wouldn't have had the medical staff during the day to set up intravenous...
	COLVIN	Mmmm.
	LORD	... which is hydration directly into the veins. The other form that

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		would be available is something that's called Supplitaneous Fluid whereby we choose a very fine needle just under the skin and you can give people sort of two litres of fluid a day. That'll provide just the water and you can add something like Potassium salts and a little bit of Dextrose. You can't give too much Dextrose because it causes irritation under the skin. And that's something that you could you in a palliative care setting, again it is usually used if people are awake and you feel that hydration is going to be of benefit to them. It's a clinical issue...
	COLVIN	Mmmm.
	LORD	... yet again.
	COLVIN	Certainly.
	LORD	So, you wouldn't have a blanket, there is not blanket policy and no definite one, two, three, four, you will do or you won't do...
	COLVIN	Sure..
	LORD	... (inaudible).
	COLVIN	... I do appreciate there's no, you know...
	LORD	Yeah.
	COLVIN	.. set, it's, it's based on...

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* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 4

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
	LORD	Yeah.
	COLVIN	... every patient.
	LORD	Yeah.
	COLVIN	But I wonder if you could describe some of the scenarios that would exist for not hydrating, just, you know, based on a decision ...
	LORD	One is...
	COLVIN	... a doctor would take?
	LORD	.... one is if the person is really very poorly and not, not expected to survive very long, because the hydration probably just gives them a degree of comfort, we think. We think if your mouth is dry...
	COLVIN	Mmmm.
	LORD	... it is uncomfortable, there's no way of checking that out and we think if you're hydrated, your, your skin's just a bit better. Your pressure areas don't, don't break down, so if someone was really awake and distressed, it might be one of the issues...
	COLVIN	... to consider.
	LORD	Probably the person being away would be the most significant

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		that would sort of say, 'Let's put some fluids up and keep them hydrated.'
	COLVIN	Okay. And for not doing that, what's the...
	LORD	Again, someone who's, who's very poorly, if they can take small amounts orally sometimes, just to keep themselves, keep them going and the other would be if they said they did not wish to have it.
	COLVIN	Mmmm.
	LORD	You know, some people are quite clear as to what they will have and won't have.
	COLVIN	Okay. It's been explained by some members of staff that their understanding of, of reasons why they wouldn't, and I want to ask you if you would agree with this or not, is that it can on occasions be cruel or considered cruel to actually hydrate if it's considered the patient is, is dying. Is that something that you would subscribe to?
	LORD	It would depend on the behavourial problems the person is experiencing. If someone's very confused and agitated and it is possible to slip, to slip the needle, say between the shoulders or or

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		the thighs where they can't actually see the needle rather than on an arm.
	COLVIN	Mmmm.
	LORD	... but if, if people who are restless tend to pull at things, then it must restraining them to keep fluids going and I think in that situation that wouldn't be very kind to someone. If someone's pulling the lines out to persevere, try to give fluids in any form...
	COLVIN	Yeah.
	LORD	... but it's six of one and half a dozen of the other, how do you know that they're not pulling the tube out because they're distressed because they're thirsty.
	PRIVETT	Can I just ask, Doctor, did you contribute to the guidance of fluid replacement?
	LORD	Yeah, I've drafted that in oh, about eighty five or thereabouts.
	PRIVETT	Oh, right, can you just, I'll hand you a copy of this, can you just take us through what that document deals with?
	LORD	Right, this is, this has now been employed by both Portsmouth Hospitals and Portsmouth Healthcare Trust but certainly back, since about the nine, mid nineteen eighties, late nineteen eighties

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		would have been effective in our, in our department. Because we found that a lot of people say like the strokes, who needed therapy during the day to put drips up, you can't actually get them walking there with the drips down, the therapists can't actually get to them.
	PRIVETT	Mmmm.
	LORD	So, we use subcutaneous fluids in palliative care and if people after strokes and because you can give, probably, about two litres very easily certainly not more than three litres, it's to correct mild dehydration or maintain dehydration. If someone is severely dehydrated you need to, you need to use an intravenous line and the advantage is either you don't need to get into a vein so the nurses can administer that. It's not uncomfortable 'cause it doesn't involve a limb. You can put it in a restless patient but it's amazing how good people with stiff arthritis can get taking things out, either back or wriggling against the cot side or...
	PRIVETT	Mmmm.
	LORD	... something like that. And you can use it just for one litre overnight, so for argument's sake, if someone's able to take about

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text

eight hundred, nine hundred during the day, and particularly people with the strokes, that's something good to encourage, so that they're swallowing is maintained, then you can just top them up overnight, take it off in the morning so they can have their therapy again. So, the nurses can decide, they don't need to call a doctor out to change. And the contra indications would be the tendency to bleed. If they're swollen, if the skin's infected and again, there's a, the dehydration is quite severe, the method of administration really that's a guideline for the nurses, the size of needle you use and that the needle needs to be changed every forty eight hours, that's a guideline of what fluids can be used and you can give Potassium as well, so if someone's, needs a little bit of Potassium and sometimes, most of the elderly people who don't have their bananas and orange juice do get short of Potassium, you can add a small amount into the bags. It's, sometimes you find, particularly in older people, where the skin's sort of very, and the elastic has stretched, that what, the principle is that to give this fluid under the skin and eventually gets absorbed into the veins, into the system, the circulation and then

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		excreted as urine, is that that whole process gets very delayed and instead of this getting absorbed it just ends up in sort of lumps...
	PRIVETT	Mmmm.
	LORD	... all over and after a couple of days you sometimes have just got to stop if they're not absorbing it.
	PRIVETT	Mmmm.
	LORD	You can add something that's called Hyuronedes (?) which helps it to spread a bit, but if they're not absorbing it often adding hyorenedes doesn't really add a lot more to it. This doesn't, this really tells you, once you've made the decision to give it, how to set about it. The decision to use it, again, needs to remain a clinical one and one that you need to see, does this person...
	PRIVETT	Mmmm.
	LORD	... would there be an alternative that would be more acceptable.
	PRIVETT	So, with the exception of those, or that guidance there, in your view, the rest of the decision would be a clinical one for the...
	LORD	Yeah.
	???	... doctor with care.
	LORD	Yeah.

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MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 10

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	PRIVETT	Can I hand that in to you?
	COLVIN	Certainly, okay. That's the drug therapy, that's just the cover sheet.
	LORD	(inaudible)
	COLVIN	Subcutaneous fluid replacement.
	LORD	Mmm.
	MCNALLY	If someone in the palliative care course of treatment, if I take it, they're not usually considered for hydration and nourishment in they're in that phase that is accepted that they are dying?
	LORD	I think only if you feel that they're far advanced down the line.
	MCNALLY	Yeah.
	LORD	Some people take three weeks to die.
	MCNALLY	Yeah.
	LORD	You can't predict with people.
	MCNALLY	Right, so if, if that, hypothetically that person who took three weeks to die, I take it that they're deprived of hydration and nourishment?
	LORD	Not always.
	MCNALLY	No?

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	It depends on how awake they are. If someone's awake but still very poorly...
	MCNALLY	Right.
	LORD	... you'd probably set up subcutaneous fluid.
	MCNALLY	Right.
	LORD	That would be my criteria for giving someone fluids or not.
	MCNALLY	Mmmm.
	PRIVETT	Equally, I presume someone could be on a palliative care regime and still able to...
	LORD	To swallow.
	PRIVETT	... to swallow?
	MCNALLY	Yeah.
	LORD	Yeah.
	PRIVETT	Mmmm.
	LORD	That would always be the preferred way of...
	COLVIN	So, in a case where someone is unconscious...
	LORD	Yeah.
	COLVIN	... and therefore unable to swallow because of the fact they're not conscious, would there still be a case for not hydrating?

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MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 12

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
	LORD	Yes, if I felt that someone was unlikely to survive more than a few days, then I wouldn't necessarily put fluids up.
	COLVIN	Mmmm.
	MCNALLY	Right, okay.
	COLVIN	And what would you reasons be for that?
	LORD	That the person wasn't distressed by being dehydrated...
	COLVIN	Mmmm.
	LORD	And that there, there was so many other things that were going wrong and if the body was failing any way, that given them this bit of fluid wasn't going to put that right. A lot of relatives seem distressed when they don't have fluids up and strangely although subcutaneous fluids does give them a bit of fluid, seem much happier...
	COLVIN	Mmmm.
	LORD	... because they personally see fluids going through.
	COLVIN	Mmmm.
	LORD	But it doesn't really provide much calories at all because you can't keep the 5 percent and Dextrose which is the strongest we can, we can give, we can only use four percent Dextrose which is

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		(inaudible) Dextro saline...
	COLVIN	Right.
	LORD	... so you can't give a lot of calories that way.
	MCNALLY	So, there's nothing to say really that somebody who is unconscious and in a palliative care situation, that, if they were hydrated and nourished, would make them live longer?
	LORD	I don't think there's, any, any evidence to prove that either way.
	MCNALLY	Either way, right.
	LORD	And often I think if people are dying it is, particularly the very elderly and the people with the dementia, the other organs are failing as well.
	MCNALLY	Yeah.
	LORD	And it is a sort of, it's probably cruel to say, just like an old car.
	MCNALLY	Mmmm.
	LORD	When does an old car give up?
	MCNALLY	Mmmm.
	LORD	It's probably that all the little bits are, are beginning to break down and then one event and the whole thing just goes.
	MCNALLY	So, by asking the body, I take it, to process nourishment and

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Althea Eueresta Geredith LORD

Tape Counter Times *	Person Speaking	Text
		water is giving it extra work to do and it could be, have an adverse affect on somebody's health?
	LORD	I wouldn't go as far as...
	MCNALLY	No?
	LORD	... to say that.
	MCNALLY	I'll never become a doctor.
	LORD	I think the evidence is not there.
	MCNALLY	No?
	LORD	I think our bodies do like food and water and I don't think it protests too much if it's given it, if I think that the situation and the circumstances are right.
	MCNALLY	Yeah.
	LORD	I mean, a lot of the feeds produce gastrics, you can, again you can get diarrhoea, that's pure carbohydrate and some people can't tolerate the feeds because of that.
	MCNALLY	Yeah.
	LORD	So, yes, sometimes the body can't take it.
	PRIVETT	Would it be right that, at consultant level there hasn't been any directive given as to when and when not...

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	No.
	PRIVETT	... to introduce hydration therapy?
	LORD	You couldn't really, there's no, you couldn't give or have a written policy or written guidelines.
	PRIVETT	No.
	LORD	Because I think, anything to that effect, no two people with the same condition will be the same.
	PRIVETT	Mmmm.
	LORD	And you really couldn't have guidelines that were acceptable by the medical bodies, people relevant.
	PRIVETT	Sure.
	LORD	So, you've got to take each person as you find them.
	MCNALLY	Certainly.
	COLVIN	(inaudible)
	MCNALLY	Yeah.
	COLVIN	Okay, just a few more points. We've obviously taken receipt of this report...
	LORD	Mmmm, yeah.
	COLVIN	... which I'm showing you now, which was compiled by yourself?

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	Yeah.
	COLVIN	Back in December ninety eight. Can you tell me the reasons for this report being drawn up? What...
	LORD	Well, basically, I was vaguely aware that the nurses had been questioned about various nursing issues about Mrs RICHARDS dying but again I, no one contacted me and the nurses even. after she'd died didn't mention that there could be a medical come-back.
	COLVIN	Mmmm.
	LORD	And I was unaware that one of the daughters, I can't remember which, had made a complaint to the trust and that complaint had been investigated by a senior nurse who had formulated a report and submitted it at (inaudible) with various medical, with various comments in it. I wasn't contacted by her for the interview at all and I also wasn't aware that the family had been offered an interview to be seen and presumably I would have needed to have been at that. The first contact I had was from Lesley HUMPHREY, who is the...
	MCNALLY	Quality controller.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	(Laughs) Yeah, for Portsmouth Health Care Trust, to say that, and I think she, this was certainly over a weekend, just before Christmas, she contacted me on the Thursday or Friday and said can I prepare a statement on this, because I was the consultant in charge on Gladys RICHARDS, so it meant getting the notes and asking people a few questions very quickly and I, this was compiled in (inaudible) certainly over a couple of days.
	MCNALLY	Mmmm. On that point, were you asked, were you asked specifically, because you were the consultant for the ward?
	LORD	Yeah.
	MCNALLY	So, you weren't approached as a, like an independent...
	LORD	No, well, not that I'm aware of.
	MCNALLY	No.
	LORD	The request came through Lesley HUMPHREY, I might have a copy of her letter here... I can't remember, it might have been I suppose.
	MCNALLY	So, I take it you weren't asked as an independent body to have a look at this patient and ....
	LORD	No, no, no, no.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	MCNALLY	... the matters that had been, or the issues that had been raised to form your opinions or anything. This was a case that....
	LORD	No.
	MCNALLY	... it's your ward.
	PRIVETT	Yeah. The letter from Mrs HUMPHREYS to Dr LORD says, 'On reflection I think the best way forward would be for you, as consultant in charge, to prepare a statement explaining the decision with regards to Mrs RICHARDS' care etceteras.
	MCNALLY	Have you the...
	LORD	We've got the letter, yeah.
	COLVIN	Mmmm, I wonder if we could have copy of that.
	PRIVETT	I've only got one. Can we take a copy here?
	MCNALLY	We can get a copy made from it, yeah.
	PRIVETT	Have you got the original one?
	LORD	It must have been, to have given it to you, haven't I? Here's mine...
	PRIVETT	Carry on and I'll...
	LORD	Yeah, yeah.
	PRIVETT	That's it.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	And that's probably the background...
	COLVIN	So, this report would have been based on, summarising what you said, based on looking at the notes and talking to the ...
	LORD	Yeah.
	COLVIN	... various members of staff?
	LORD	Yeah.
	COLVIN	Who would that have included?
	LORD	Dr BARTON and Philip BEAD mostly, I can't remember speaking to any of the more junior nurses.
	COLVIN	Mmmm.
	LORD	I might have done, but I can't remember that.
	COLVIN	Okay. Was there ever, were you ever made aware, you know, was there any, why you weren't contacted? Was that ever brought up, why you weren't aware of it?
	LORD	I complained about it. Because one of the conclusions was that the medical consultant team had said that there was a policy not to move people out of hours and that was never so. And I wrote to about three people about it, I, one manager acknowledged that that wasn't correct, but no one, no one's mentioned why they

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		didn't contact me.
	COLVIN	Right, okay. So where does the, where does the fault lie there then, that you weren't notified?
	LORD	I think both with the Trust and with the person who was investigating it, the senior nurse, who was investigating it.
	COLVIN	Right. Okay.
	LORD	Because the Trust was going to set up a meeting with the family. As it happened they didn't make, they didn't take up any of the appointments that were offered, but I'd have been horrified if they'd actually have met without me being present.
	COLVIN	Mmmm.
	LORD	Neither would I have wanted to go to a meeting where there is two days' notice with the family so, I, to be honest, I wouldn't have had the notes and it's only because I picked the notes up to do the report that I realised there'd been another complaint.
	COLVIN	Mmmm.
	LORD	To the Trust, through the normal complaint system.
	COLVIN	At the time, in ninety eight, would you, I mean, bearing in mind what you know now about this thing and what, what your

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MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
		knowledge is of what happened at the time in relation to the family concerns, are you concerned that you weren't aware of, of what was happening at that time, in August ninety eight, with Mrs RICHARDS?
	LORD	While she was alive?
	COLVIN	Yeah, while she was alive.
	LORD	I think with hindsight I would have, I think I'd have preferred the nurses to have contacted me or contacted someone else because, or Dr BARTON to have contacted me at any stage and say there were, there were concerns.
	MCNALLY	Are there many families that raise issues with other members of family that are in hospital about the treatment they're getting, do you get many complaints at all?
	LORD	People get anxious at different stages.
	MCNALLY	Right.
	LORD	Some people get anxious just by view of the fact that they're in Gosport War Memorial Hospital particularly if they're not Gosport residents.
	MCNALLY	Mmmm.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	'Cause sometimes the only beds available are in Gosport and they could be from Hayling Island.
	MCNALLY	Mmmm.
	LORD	So sometimes people sort of come down, think, Oh, gosh, what's going to happen to Mother now? If the communication hasn't been good before.
	MCNALLY	Yeah.
	LORD	Sometimes you find families that haven't really got on, you find a member of the family sometimes appearing when someone's poorly and people get very distressed. You haven't seen a parent say for a couple of years, you get a phone call and then you come down and they're, and they're dying. It's distress, it's distressing.
	MCNALLY	Mmmm.
	LORD	And I think in general, a lot of sudden deaths, people find very difficult to handle and take a lot of time. A lot of people on transfer don't take the journey well even from Haslar to the War Memorial.
	MCNALLY	Mmmm.
	LORD	And they might have been stable when they left but sometimes

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		they come in and they're very poorly.
	MCNALLY	Mmmm.
	LORD	They're gasping and they pass away, so you get people at all stages.
	MCNALLY	Yeah.
	LORD	Reacting to people who are dying.
	MCNALLY	That was going to be a question, later on I'll ask you about the transfer, where, if they leave Position A, does it sometimes cause them, when they arrive at Position B, that they are a different patient that left the...
	LORD	Could well be.
	MCNALLY	Yeah.
	LORD	Could well be. We've seen people that we transferred say from QA where I've seen them that morning and they've been stable...
	MCNALLY	Mmmm.
	LORD	... and they've been really poorly in the ambulance going down, just down to Gosport. For some reason people don't take the move very well, which is why we have probably been over protective about moving people unnecessarily.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	MCNALLY	Mmmm.
	LORD	It's again something that's very difficult to predict. Some people are just sort of sick en route and that's all that's happened but you can't tell when you see them. And if the people sort of sending them, weren't, didn't give them sort of something for travel sickness....
	MCNALLY	Mmmm.
	LORD	... they could be quite poorly when they, when they get there.
	MCNALLY	Mmmm.
	COLVIN	Okay. Just a couple of things, I didn't ask about the drugs. And those four drugs, which is the Hyoscine, Midazalam, the Diamorphine and ...
	LORD	Helaperidol.
	COLVIN	... the Helaperidol, that's it. Are you aware of any side effects with those, anything that would...
	LORD	Well, they would, apart from the Hyoscine can cause some amount of agitation but not in the small doses that we used.
	COLVIN	Mmmm.
	LORD	The Helo..., all the others could be sedating, if you was moving

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
		for any length of time you always get problems with constipation and dry mouth and things like that.
	COLVIN	Mmmm. And what about combinations of those four, is there anything...?
	LORD	I, as far as I know, they don't particularly interact. Except they could all be sedating in their, in their own right and certainly there, you can use all three of them in a syringe driver. Though sometimes we add in something else for sickness but if you've Helaperidol also acts as an anti (inaudible) for sickness as well...
	COLVIN	Right.
	LORD	... because Morphine can cause a lot of sickness. Usually with the first few doses rather than when you're giving for a little, for a little while and there's something called Cyclozine that we can use over twenty four hours which we didn't use in her, that causes things to precipitate and often we would use a second battery operated syringe rather than mix it in with the others, but I think as far as administration goes, you can use all three in the same syringe.
	COLVIN	Okay.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	MCNALLY	Are you aware of any guidelines from the, the manufacturing company, especially in relation to Med...
	LORD	Midazalam?
	MCNALLY	Midazalam and Hyoscine?
	LORD	Yeah.
	MCNALLY	Regarding possible respiratory affect?
	LORD	With all of them probably in syrine drivers could cause respiratory problems.
	MCNALLY	Right.
	LORD	Particularly Midazalam given intravenously. Strictly speaking Midazalam is not licensed for palliative care use and subcutaneous, but it's again good practice.
	MCNALLY	Mmmm.
	LORD	And all the palliative care teams and physicians use it and they have certainly been using it for a long time. It's a drug that's mostly used for anaesthesia, intravenously and that's where the main problem with respiratory depression and things, been of concern.
	PRIVETT	It's used as a heavy sedation?

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
	LORD	Yeah.
	MCNALLY	On, on that vein, so to speak, are there any items of equipment available on the ward or at the hospital for resuscitation or...?
	LORD	They're is a resuscitate, it's basic resuscitation that's available at Gosport and we've got all the resuscitation and emergency trolley and resuscitation equipment. They are looking at getting in automated defibrillators...
	MCNALLY	Right.
	LORD	... to treat at the hospital fairly quickly.
	MCNALLY	Right.
	LORD	So, if someone, it's basic, you do basic CPR...
	MCNALLY	Mmmm.
	LORD	... which is the same as you would probably do in Fareham Down Centre...
	MCNALLY	Yeah.
	LORD	... and ring 999.
	MCNALLY	Yeah, 'cause I mean, I think what we've understood talking to some of the nursing staff, that if there is an emergency, the basic policy is immediate first aid...

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	LORD	Yeah.
	MCNALLY	... and a 999 call to get an ambulance?
	LORD	Yeah.
	MCNALLY	Yeah.
	LORD	Because I mean, I need to have doctors inside. I need some good people who can (inaudible) and ventilate. The basis for the defibrillators now is that it's the same as would apply to any place that has them, is that you would have is what's called as VF arrest, the changes of getting someone out of it is quite good and it doesn't do any harm if it wasn't. The problem with it all is that you've got to spot the sudden cardiac arrest.
	MCNALLY	Mmmm.
	LORD	Not everyone that dies has a cardiac arrest. Some people fade away.
	MCNALLY	Mmmm.
	LORD	And that's something that the public now are finding difficult to handle. 'Mum died, why wasn't she resuscitated?'
	MCNALLY	Yeah.
	LORD	It never came to that. Because she faded away. You've got to be

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		quick to pick up the arrest and you've got to be quick to get all the equipment in...
	MCNALLY	Mmmm.
	LORD	Get things going.
	MCNALLY	And you obviously need the equipment to identify the arrest in the first case...
	LORD	Mmmm.
	MCNALLY	... unless you've got twenty four hour monitoring?
	LORD	Mmmm.
	COLVIN	Okay, so, just one final question. It's a hypothetical one. You got a ninety one year old, who's frail, demented, has had effectively two operations and has been moved from pillar to post, basically, from Haslar back to Gosport and then back again. In relation to the treatment she was on in her final days, is that someone who's dying at that time.
	LORD	My prediction from the notes of what I've discussed with people is that the impression, clinical impression was that this was a lady who was, who was dying.
	COLVIN	Okay. And is that through the treatment given or is that through

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 30

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		the condition, whatever she had, at that time? I haven't worded that very well really. Let me rephrase that. I mean, it's difficult...
	LORD	Yeah.
	COLVIN	Because I appreciate you weren't there at the time. So, that level of drugs, that level of, of treatment for that particular type of individual, would be indicative of someone who is dying with the palliative care situation?
	LORD	It would be unusual to have, extremely unusual to have someone who was say, up and walking, like very agitated on that combination of drugs, well, the drugs wouldn't have helped, but the impression I got is that people were trying to give her as peaceful as they could...
	COLVIN	Mmmm.
	LORD	... and inevitably with any form of sedation, as the whole body gets quieter, everything else gets affected as well. All the other systems are beginning to melt down if you like.
	COLVIN	Mmmm.
	LORD	So, they certainly wouldn't have helped but I certainly wouldn't have thought that they were the cause of her death.

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* Not relevant for contemporaneous notes

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 31

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	COLVIN	Okay, okay. Anything else you want to...
	MCNALLY	It's a similar sort of question. Hypothetically, we have a lady who is ninety one. she's fit and healthy, she lives at home. she goes, she does her own shopping, does her own cooking and she can look after herself. If that lady was taken to a hospital and put on a bed and a syringe driver with those same drugs with the same quantities was administered to her, what would happen to that lady, who, for all intents and purpose is fit and healthy?
	LORD	The argument would be that if she is someone who hasn't had what we call psychotropics, the Heloperidor....
	MCNALLY	Mmmm.
	LORD	... which in fact Mrs RICHARDS has already had before, it's again impossible to predict.
	MCNALLY	Mmmm.
	LORD	People who haven't had any medication before are often very susceptible. On the other hand they could be someone who tolerated it so you, you don't know.
	MCNALLY	Right.
	LORD	But probably they'd have got quite drowsy anyway. Probably.

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MG15(Thcont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 32

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	MCNALLY	Mmmm.
	COLVIN	Okay.
	MCNALLY	All right?
	COLVIN	Okay. Is there anything you'd like to add?
	LORD	No.
	COLVIN	Is there anything you wish to clarify, anything you said that...
	PRIVETT	Sorry, there's just that one point in relation to the validity or otherwise of the locum consultant having done a ward round at Gosport. Can you just pick up from that?
	LORD	Yeah. When I'm away, there was a duty rota that there would be Dr BRANSTEIN who would be covering in case of emergencies.
	MCNALLY	Mmmm.
	LORD	He was a regular full time consultant as well. And he wouldn't have been able to do the ward round for me, because his time table would have already been, is already booked.
	COLVIN	Yeah.
	LORD	So, he was there for nominal cover and basically (inaudible) in the community hospitals. If the consultant is not there, on our own time tables it is impossible to make the time up later in the

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : **33**

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		week and it is impossible for a covering consultant....
	COLVIN	Yeah.
	LORD	... to actually go and do the round for you, for me. In addition, he wouldn't have known the patients from before at all, so he would have ended up seeing sixteen patients from new with problems he didn't know. Just for that one day.
	COLVIN	Yeah.
	LORD	So, though there was cover, it wasn't sort of, it is difficult within our department ...
	COLVIN	Mmmm.
	LORD	.. even with, though we have seven consultants, to actually cover each others' duties because we're so busy.
	MCNALLY	I think, I think we all appreciate the difficulties and the pressure that everybody in the National Health Service is under...
	LORD	Mmmm.
	MCNALLY	... and I appreciate what you're saying. On, I don't know the question, I've forgotten it. Never mind, it couldn't have been that important. It's gone.
	PRIVETT	I think, I think the point we were making was that it wouldn't be

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
		practical for a consultant to pick up the ward round, fill in...
	MCNALLY	Yeah.
	PRIVETT	... is the (inaudible)
	MCNALLY	Yeah, physically...
	PRIVETT	Yeah.
	MCNALLY	... because of the amount of work he's got on his plate on his own....
	PRIVETT	He wouldn't know any of the patients.
	LORD	(inaudible)
	MCNALLY	... but he would have been available...
	LORD	... (inaudible)
	MCNALLY	... on a phone call for advice...
	LORD	... for advice.
	MCNALLY	... or even go to the ward if he was needed.
	LORD	Yeah.
	MCNALLY	Yeah. And I think it's fair to say that, I've one more point, you probably don't get to see every patient that goes through the Gosport War Memorial because they may be only there for two or three days before they're sent on to somewhere else?

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times ◆	Person Speaking	Text
	LORD	Yeah, I mean, people who come in and die the same day they arrive so we wouldn't seen them.
	MCNALLY	So that you may never see them any how, yeah.
	LORD	Or it may be that they come in and something happens and they, they go back or if they need surgery within two days of coming down.
	MCNALLY	Mmmm.
	LORD	So, we're trying to have a daily consultant present in Gosport, but that's a long way away.
	MCNALLY	And obviously we're all governed by money.
	LORD	Aren't we?
	PRIVETT	Did you want to pick up on anything about the transfer aspect. I know you mentioned it earlier on, are you happy we've dealt with that?
	MCNALLY	It's just that, I don't know whether you are aware, we interviewed the ambulance crew...
	LORD	Mmmm.
	MCNALLY	... and they're...
	PRIVETT	Mmmm.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	MCNALLY	We've spoken to them and I think it was an issue at the hospital on the second occasion, the seventeenth, when she arrived and obviously that all going to be encompassed in the package that's sent off to the guy in London who's gonna look at it all.
	PRIVETT	Mmmm.
	MCNALLY	And I think, having been investigating this for the last three months I think we're all happy that travelling from A to B can cause major upsets in patients.
	PRIVETT	But there wasn't, I think you confirmed, officer, that there wasn't any set policy in relation to when to transfer, when not to transfer so again, it was a question of clinical judgement and the individual patient.
	LORD	Yeah.
	COLVIN	Mmmm. So, in terms of a judge it would be based obviously on the patient's well-being....
	LORD	Yeah.
	COLVIN	... as opposed to a guideline saying you can't do it at this time or that time or...
	LORD	You couldn't have guidelines, can you?

Signature(s) : .....

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Althea Eueresta Geredith LORD**

Tape Counter Times *	Person Speaking	Text
	COLVIN	Okay. Allright...
	LORD	Did you want...
	COLVIN	... anything else? Anything else you want to say?
	LORD	No.
	PRIVETT	No, thanks.
	COLVIN	Okay. I'll hand you a notice explaining the tape recording procedure which is there. The time by my watch is fifteen fifty four and I'm turning the recorder off.

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* Not relevant for contemporaneous notes

MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN ☐ ROTI ☒ Contemporaneous Notes ☐

Person interviewed : Philip James BEED
Code A

Place of interview : Fareham Police Station

Date of interview : 24 July 2000

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : 11.00 Time concluded : 11.45

Duration of interview : 45 minutes Tape reference numbers * :

Interviewing Officers : Detective Sergeant David SACKMAN, DC 1484 COLVIN

Other persons present : Mr GRAHAM - Saulet & Co Solicitors, Portsmouth - Legal Advisor

Tape Counter Times*	Person Speaking	Text
	DS SACKMAN	This interview is being tape recorded, I am Detective Sergeant David SACKMAN, the other police officer present is..
	DC COLVIN	DC 1484 COLVIN.
	DS SACKMAN	Right, I'm interviewing Philip BEED. Philip would you mind giving me your full name please and your date of birth for the tape?
	BEED	Philip James BEED, 21st of March '63.
	DS SACKMAN	Right also present today is....
	SOLICITOR	Mr GRAHAM from Saulet and Co Solicitors, Portsmouth - Legal Advisor.
	DS SACKMAN	Today's date is Monday the 24th of July in the year 2000 and by

Signature(s) : DS David SACKMAN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
		my watch the time is exactly eleven o'clock (11.00). This interview is being conducted in an interview room at Fareham Police Station. At it's conclusion I'll give you a notice explaining what happens to the tapes. All the time you're in the room here Philip, you're entitled to free legal advice, Mr GRAHAM's here to provide you with that. If at any time you want to stop the interview to take some advice or to talk to Mr GRAHAM let me know and I'll stop the interview, also today you've come here voluntarily which means you're not under arrest and if at any time that you feel you just want to get up and go then that is your right. Okay?
	BEED	Okay, yeah.
	DS SACKMAN	Right, before I start to question you at all, I have to go through and give you what we call a caution and that is, that you do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court and anything you do say may be given in evidence. Do you understand the caution?
	BEED	Yes.

Signature(s): DS David SACKMAN

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 2

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times ◆	Person Speaking	Text
	DS SACKMAN	What do you understand by that caution?
1.31	BEED	That I don't have to answer any questions but if I, if I choose not to erm and later erm say anything then that can be used against me.
	DS SACKMAN	Right, are you happy with that Mr GRAHAM?
	SOLICITOR	That's pretty good for somebody who's never been questioned before.
	DS SACKMAN	That's pretty good and it's probably a better understanding than I had of it. One other thing I need to point out is that this interview room is capable of being monitored when the tape recorder is in the record mode only and with the tape running, and a warning light would indicate when monitoring is taking place. At no other time can our conversations be overheard. Now that red light there means that this interview is being monitored and it's by Kevin, the chap that you spoke to a few minutes ago. Right Philip, can you tell me what your job is and what you do?
	BEED	Yeah I'm a Clinical Manager which is the Charge Nurse in charge of Daedalus ward at Gosport War Memorial Hospital.
	DS SACKMAN	Right and what are your day to day duties?

Signature(s) : DS David SACKMAN

◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
	BEED	Er I've got erm over...24 hour accountability for the nursing care of the patients on the ward er and the management of the nursing team delivering that care. So I manage a team of nurses and support workers on day and night duty in delivering nursing care for patients on Daedalus ward.
2.51	DS SACKMAN	Right, how did you end up in that role? You didn't just apply for that as a job, you've obviously got some experience before, can you take me through your experience?
	BEED	Erm I've...yeah I've been nursing for erm twenty years erm training in the Royal Navy at Haslar erm working as a Deputy Department Manager and Department Manager in Haslar er I've worked for BUPA hospital at Havant as a Senior Nurse er and at Oxford Radcliffe Infirmary, Brooks University as a Senior Nurse and Lecturer er and then I applied for this position working in elderly care.
	DS SACKMAN	Right, did you have any specific training in care of the elderly?
	BEED	Er not specific in care of the elderly, my experience is broad based across erm acute surgery and a particular type of surgery I did before this job was ophthalmic surgery where the majority of

Signature(s) : DS David SACKMAN

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No. 4

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
		patients are elderly so it's mainly experience working with elderly patients.
	DS SACKMAN	Right so you've a broad based experience in nursing going back over twenty years?
	BEED	Yeah.
	DS SACKMAN	Right, what does a Ward Manager do?
	BEED	Erm responsible for nursing care of patients on a day to day basis but also responsible for the erm management of the ward erm and making sure everyone is up to date and doing their job properly erm, making sure they've got the right resources, making sure we're staffed properly, er reporting any problems to my managers erm so it's a, it's a combination of nursing care and the overall management of the ward and looking after the budget for the ward.
	DS SACKMAN	Okay. Can you tell me a little bit about the War Memorial Hospital?
	BEED	Yeah erm it's a community hospital so we..we've got erm don't actually have medical cover on site, we've got six in-patient wards and day hospitals and outpatients er the particular ward I'm on is

Signature(s): DS David SACKMAN

* Not relevant for contemporaneous notes

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
		erm continuing care around slow stream stroke rehabilitation. We're consult...we've got 24 beds, we're consultant lead so we've got a consultant who takes over all responsibility for the patients and a clinical assistant who provides day to day medical cover.
5.11	DS SACKMAN	Who...bearing in mind that we're interested in the events of 1998, who was the consultant in charge then?
	BEED	That was Doctor LORD.
	DS SACKMAN	Right and does that continue to the present day?
	BEED	Yes she's cons...she's still consultant in charge now.
	DS SACKMAN	Right, what contact do you have on a day to day basis with Doctor LORD?
	BEED	Doctor LORD attends twice a week to conduct a ward round, that's on a Monday and a Thursday erm and we can get in contact with her at other times by the telephone if required, she's actually based at Queen Alexander so erm contacting her depends on where she is at any given time er but it's usually not a problem to get in contact with her if I need to.
	DS SACKMAN	Right and when would you get in touch with Doctor LORD?
	BEED	Erm if we had any particular problem that we couldn't erm sort

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		out with the clinical assistant erm, erm or we needed, particularly needed consultant advice for any particular reason.
	DS SACKMAN	Right and that's over a whole range of..
	BEED	It could cover a whole range of things, usually it would be if the patient was particularly poorly and we weren't sure of what other action to take and that either because er we couldn't get in touch with the clinical assistant because the clinical assistant obviously could be on house calls or duties erm or because the problem couldn't be sorted out with the expertise of the clinical assistant.
	DS SACKMAN	Okay. Tell me about the clinical assistant?
	BEED	Er at that point in time it was Doctor Jane BARTON er and she's a local GP. works in Gosport er and she comes in Monday to Friday on a daily basis erm to see...to review all the patients er and then midday to clerk in any admissions and then outside those hours during working hours, office hours we would call on Doctor BARTON if she's not on duty er and then weekends and evenings we would call on one of the other partners in the practice that she works in
	DS SACKMAN	As in Doctor BARTON's practice?

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* Not relevant for contemporaneous notes

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RECORD OF INTERVIEW

Continuation Sheet No : 7

Record of interview of: **Philip James BEED**

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Tape Counter Times *	Person Speaking	Text
7.14	**BEED**	Doctor BARTON's practice, yeah.
	DS SACKMAN	Okay, does Doctor BARTON receive patients or did she receive patients or is it just...?
	BEED	For ad..for admission?
	DS SACKMAN	...Yeah.
	BEED	They'd all admissions go through the elderly services office and either Doctor LORD or one of her colleagues actually agree to admit them so they all have to be...the admission has to be agreed by a consultant from elderly services.
	DS SACKMAN	Right and where do you take your patients from?
	BEED	Er nearly always from transfers from other wards erm so that's either in Queen Alexander or Haslar, sometimes from other hospitals occasionally we take admissions from the er day hospital or outpatients and occasionally we've taken admissions from home but that's, that's quite unusual, nearly always transfers.
	DS SACKMAN	Right and are those transfers normally for ongoing medical care?
	BEED	There usually for assessment or rehabilitation but sometimes patients just aren't well enough for rehabilitation but the, the plan was always to assess them and see erm what we can do in the way

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		of rehabilitation.
	DS SACKMAN	Okay. As the ward manager you're obviously responsible for the staff that are in there, can you tell me a bit about the staff, how many you have? Who works on...?
	BEED	It's approximately thirty staff because it depends whenever I've got vacancies and when I've done with the hours but I've got on days at the moment I've got five trained staff who are either registered general nurses or enrolled nurses and eleven health care support workers so it's nursing auxiliaries they were previously known as and on night duty I've got four trained staff and I think six health care support workers, the numbers vary a little bit from day to day with people on maternity leave and so on.
	DS SACKMAN	Okay and how many patients would you be expected to provide care for?
	BEED	We've got twenty four beds on the ward, we are...we've only actually been full on about three or four occasions in three years I've worked in the War Memorial but usually we run about seventeen, eighteen patients.
	DS SACKMAN	Right, is that adequate staffing then?

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Tape Counter Times *	Person Speaking	Text
9 23	BEED	For eighteen patients the ward gets very busy erm so you have to prioritise your work erm if we went above eighteen we need to bring in banked staff to, to have enough staff.
	DS SACKMAN	So (inaudible) like all things there are occasions when you're pressed and..
	BEED	Yeah, yeah.
	DS SACKMAN	..there are occasions when you cope? In your own estimation where does that figure..where do we cross the line between coping and not coping?
	BEED	We shouldn't, we should never cross that line because I can bring in banked staff but occasionally and it also depends on not just the number of patients but what's happening at any time, so if you get erm several patients being poorly at the same time or needing attention for one reason or another er a lot of our patients aren't continent erm we can have patients who erm fall out of bed or those sorts of things so if those sort of things, or relatives that are very anxious who need to speak to us so sometimes when you think you're going to manage things occur and then that means that you're actually very, very pushed. That doesn't happen too

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		often because I usually try and ke..that's my responsibility to make sure the ward is properly staffed and the work is properly prioritised and managed so I'm, probably we...occasions when we sort of cross the line when we're not managing and really need to, to do some, to do something to make sure we are coping, once a month or so erm which compared to places like Queen Alexander and (inaudible) I expect that happens, where I know that happens a lot more er on the busier acute wards.
10.55	DS SACKMAN	Right, is it your responsibility to get banked staff?
	BEED	Yeah, yeah erm I delegate that as well so my Senior Staff Nurse and Staff Nurse's know that they can call in banked staff if they need to as well.
	DS SACKMAN	Right so they're empowered to make that decision?
	BEED	Yes, oh yeah, yeah.
	DS SACKMAN	Okay, am I right in just...to the hierarchy as it's established is that in overall command is Doctor LORD, then perhaps assisted by the clinical assistant who at that, the time we're interested in was Doctor BARTON...
	BEED	Yeah.

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	DS SACKMAN	...then yourself...
11.29	BEED	Yeah.
	DS SACKMAN	...then you've got your registered nurses...
	BEED	Yeah.
	DS SACKMAN	...and your auxiliaries...
	BEED	Yeah.
	DS SACKMAN	...Is that about right?
	BEED	Yeah.
	DS SACKMAN	Okay. Who's responsible for prescribing the drugs that you use on the wards?
	BEED	Doctor BARTON or Doctor LORD and also the other erm doctors in Doctor BARTON's practice if they come in, if we call them in.
	DS SACKMAN	Right and they would assess each patient and prescribe...
	BEED	Yep.
	DS SACKMAN	Can you explain to me the procedure that happens when you're approached by QA or Haslar to accept a new admission, what processes do we have to go through?
	BEED	They erm the...either Haslar or QA would contact the elderly

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		services office and ask for a consultant to assess a patient and take them on. One of the consultants, erm I think sometimes they use a Senior Registrar as well would go and see the patient, assess them erm and if appropriate agree for them to come to erm the War Memorial er they would then give that to the elderly service office who will actually phone us and arrange a date erm a date for the admission and give us all the details, and a copy of the er letter which the consultant's have written which gives us all the information of the patient erm and then we we're, on that date, agreed date then the patient will be transferred across to us and we'll take over their care.
	DS SACKMAN	Right, are there occasions when the consultant or in your experience says no this person's not fit to come to us?
	BEED	There might be but we wouldn't know because they wouldn't get as far as us...
	DS SACKMAN	Right
	BEED	...if that had happened because they would, they would, like they would...that information would be directly between the consultant and the particular ward. I do know that does happen from time to

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		time, either the patient is too well to come to us and doesn't need rehabilitation or the patient isn't well enough erm the other thing that happens is patient...is that conditions on the patients progress are made before transfer so the same patient can come to us but these things, these tests or these things must be sorted first before they come over to the War Memorial.
13.46	DS SACKMAN	So generally speaking a patient arriving at the War Memorial is stable and able to be nursed?
	BEED	They should be, yep.
	DS SACKMAN	Okay. What paperwork accompanies a person?
	BEED	Erm if they come...at that point in time if they came from QA they would come with their notes, if they came from Haslar they would come with their Haslar notes and we would obtain the Portsmouth notes and there should be a transfer letter as well and they should have any medications which they're required to be on, what we call T-T-O's
	DS SACKMAN	So and what is a T-T-O?
	BEED	Er to take out so that's...so as if they've been discharged to home they come to us with the tablets and medicines they're on because

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		we haven't got a pharmacy on site so they need a weeks supply of whatever medication they're actually on.
	DS SACKMAN	Okay. Can you tell me about the pharmacy side?
	BEED	We, all our pharmacists are supplied by Queen Alexander Hospital in Portsmouth so we're, we have our own stock of things that we use regularly erm things that we don't, that we don't hold as stock then we order on a named patient basis erm and we have a weekly delivery and then we can phone up daily and order extra supplies if we need them and they get delivered just after midday.
	DS SACKMAN	Right, did you have a pharmacist?
	BEED	We've got a pharmacist who visits once a week and her name's Jean DALTON and she, she goes through all the drug records and all our stocks and just checks everything erm in terms have we got the right stock and the medication the patients are actually on.
	DS SACKMAN	Okay, does she advise?
	BEED	Yes, yes if erm if she see's erm medication which contradict one another or the doses are erm above or below or not what would normally be prescribed erm or things that might interact then she points them out to us to point out to Doctor LORD er and we

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Continuation Sheet No : 15

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		pass that information on and act on it.
15.48	DS SACKMAN	In your experience of twenty years, can you individually identify when the drug regime isn't proper?
	BEED	Yes, you would usually you'd know when something isn't proper erm the exception would be some of the more unusual drugs erm and then you would have to look it up what we call the BNF, which is a book which tells us all about medications...
	DS SACKMAN	National Formulary.
	BEED	...yeah and we would do that if there's a drug that you haven't encountered before you would do that as part of your normal regime before erm actually given the drug to a patient.
	DS SACKMAN	Would you consider that to be part of your role...
	BEED	Yes.
	DS SACKMAN	to keep an ongoing...
	BEED	Yeah because when you give out a medicine you, what...your responsibility is to know that you're giving it to the right person at the right time and that you know what that medication is doing so if you don't know what it's doing then you need to look it up and make sure you do before you give it erm and that the dose is the

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		normal dose because you can appreciate it's quite with the range of dose that's given and it's quite easy for someone to write up erm an extra nought or whatever to and prescribe an incorrect dose.
	DS SACKMAN	Right so I mean part of your role you'd see it as being in some way responsible for just for ensuring is that, that last safety check?
	BEED	Yeah, yeah and that's the role of any trained nurse on the ward as well because any...we all erm undertake the drug erm round at different times.
	DS SACKMAN	Right so am I right in saying that individually there's a number of fail-safes if any individual thinks that the drug regime isn't right they can highlight that?
	BEED	Yeah.
	DS SACKMAN	Who would they highlight that to?
	BEED	Erm well initially you would check for your own sake when you're giving the medication if you then think it's wrong then you would report it to someone senior on the ward so if it was one of my staff they would report it to myself or a senior staff nurse. If it was myself, I would, or they could go directly to the doctor and

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		check it with them, if I thought it was incorrect I'd go to a doctor or I could go to one of my er senior nurses, usually the sorts of things you encounter you can go to a doctor and check er as to and either correct it or understand why a particular dose has been given because sometimes doses are given that aren't in the er formulary range for but for particular reasons erm or, and or it might be a mistake and that can be corrected.
18.08	DS SACKMAN	Right, why would that be? Why would people be given doses outside of those guidelines?
	BEED	Erm because those are guidelines but there are drugs where tests have been done in particular situations with particular patients where erm there are established erm doses outside of those regimes which are appropriate er and there's lot's of examples but one would be in the turn pin, in erm when people have a mental health problem and mental health team regularly give er doses of drugs which are actually much higher than you would normally give er to patients because it's knowing that the higher dose is necessary to actually erm treat the patient effectively.
	DS SACKMAN	Right so I mean the guidelines are only guidelines...

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	BEED	Yeah.
	DS SACKMAN	...they're not ...
	BEED	Yeah, yeah.
	DS SACKMAN	...hard and fast rules?
	BEED	Yeah.
	DS SACKMAN	And on your wards there's three definite checks that a dose is right, your nurse can highlight it...
	BEED	Yep.
	DS SACKMAN	...You can highlight it...
	BEED	Yep.
	DS SACKMAN	...and as can the doctor highlight it but ultimately the consultant is...
	BEED	Overall responsible.
	DS SACKMAN	...is overall responsible but there are a number of checks before we get there...
	BEED	Yeah, yeah.
	DS SACKMAN	...and a number of opportunities for people to identify...?
	BEED	Yeah.
	DS SACKMAN	Okay. Can you tell me about named nurses and what that's all

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		about?
19.32	BEED	The named nurse is actually the nurse with the specific responsibility for individual patient and each patient has a named nurse erm and we allocate it so we each have usually about three or four patients erm and that nurse will be responsible for generally overseeing the patients care so any major change that takes place in, in..take effect in how we care for a patient er they will be involved in the decisions erm and also things like referral to Social Services, erm communicating with relatives and so on erm because we work a shift pattern, we also work in teams erm and other nurses can actually erm be involved in that patients care as well so erm if something is happening with the patient and the named nurse is off for two days then someone else will automatically take over so it doesn't, we use it to make sure patients get the best care and they have someone specifically responsible for their care but we make sure that that doesn't prevent the patient having erm their care reviewed or decisions made or actions taken when they're not around.
	DS SACKMAN	Okay so I mean the named nurse is the person who is expected to

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Tape Counter Times *	Person Speaking	Text
		made or actions taken when they're not around.
	DS SACKMAN	Okay so I mean the named nurse is the person who is expected to take a day to day responsibility...
20.47	**BEED**	Yeah.
	DS SACKMAN	...but then people are not on duty 24 hours a day...
	BEED	Yeah, yeah.
	DS SACKMAN	...Right, how are they allocated?
	BEED	Erm we've got three teams, one for slow stream stroke patients and then two for continuing care each with a roughly equal number of nurses and what we do when a patient comes in, is we look at what team they're going to go, need to go in and who's got a vacancy so we've roughly got all...an equal responsibility erm so if one pa...if one persons got less patients than someone else at that point in time because someone's been discharged or died then usually we've been allocated to them...
	DS SACKMAN	It almost picks itself?
	BEED	...Yeah, yeah it's on who's got the space really erm or if someone's likely to have a space because we've got a discharge pending those sorts of things.

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	DS SACKMAN	Yeah.
	BEED	Erm when they come from Queen Alexander they would come with erm their nursing notes and medical notes and drug record, if they come from, sorry did I day Haslar or QA there?
	DS SACKMAN	You said QA but I mean if ...
	BEED	QA they would come with notes, Haslar they would come with their Haslar notes and they would come with their Haslar nursing records and the transfer letter and drug record, so it's the same, if it's a QA one we, we erm keep hold but if it's a Haslar one at that point in time we kept it for a week and then returned it and raised our own documentation.
	DS SACKMAN	Okay I understand. So the patient arrives on the ward and you know what their history has been and you know what the plan is..
	BEED	Yeah.
	DS SACKMAN	...Can you tell me about the plan and how many plans are there and..?
22.34	BEED	Erm they usually the medical and nursing plan should run together and we would look for it, that would be summarised in the transfer letter so we would usually use the transfer letter from

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		the nursing staff to. .and the consultants letter to give us a broad view of what was happening. If there wasn't anything we weren't sure about and we needed to clarify such as drug regime patients on or what, any aspect of their care then we could go back into the, the medical nursing notes and actually read through that and find specific information that we needed erm and then from that we would raise our own nursing documentation and then in assessing the patient and in discussion with them if we could and their relatives look at the plan of care while their on Daedalus ward.
	DS SACKMAN	Right and how many sort of separate plans are there?
	BEED	Erm well there's usually an overall plan of what we hope to achieve with the patient and that may be er developed over a period of a few days 'cos it usually takes time for a patient to settle in with us and to see er to assess and see what's practical and what we might achieve and then that's sub divided into specific care plans for specific aspects of the patients needs such as nutrition, er preventing pressure sores, er continence, er hygiene, night care so that's what...and that's what we would call

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		the nursing care plans, so that's the...and we actually base that on the activities of daily living so that erm up to twelve things the patient may need to do for day to day living.
	DS SACKMAN	Up to twelve things, I mean it's not an exam, I wouldn't want to...could you sort of as many of those as you can name for me?
	BEED	Er so nutrition, erm breathing, erm feeding, erm elimination which is continence er hygiene erm relationships, communication, erm sexuality, erm religious needs, sleeping so that's the and there's another two there somewhere but I'm not sure but we would...not all of those would be applicable to all patients so...
	DS SACKMAN	No so I mean is there a mobility?
	BEED	...Mobility is one, yeah.
	DS SACKMAN	Is it?
	BEED	Yeah.
	DS SACKMAN	So and when a person comes in who assesses how many of these plans are applicable to a patient?
25.10	BEED	That would usually be the named nurse and if not someone acting on their behalf so it would be a qualified nurse and we would assess and initiate as many care plans as we could initially the

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Record of interview of Philip James BEED

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Tape Counter Times *	Person Speaking	Text
		patient came in but it might...but that doesn't have to be done immediately, we usually...I would expect all our patients to have a full set of care plans within 48 hours of admission for some of the things it may take a day or two to assess what their needs are and to actually erm introduce the care plans properly.
	DS SACKMAN	Right so the care plans are something that develop...
	BEED	Yeah.
	DS SACKMAN	...over a period...
	BEED	Yeah and then they're reviewed and cha...and changed as, as time goes by as well.
	DS SACKMAN	...right so some are quite deliberately not installed...
	BEED	Yeah.
	DS SACKMAN	...in the early stages...
	BEED	Yeah.
	DS SACKMAN	...but perhaps we could expect them to...
	BEED	Later on, yeah, yeah.
	DS SACKMAN	Okay, are they...what I'm intending to was just get an initial overview of what your job is and what your job is all about. I think I've covered the points that I wanted to initially, if I go to

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		Lee if there's anything that...in that area.
26.19	DC COLVIN	Just a couple of things just to get...you mention in relation to Doctor BARTON and the set up when she comes in every morning and there's a single clerk admissions...
	BEED	Yeah.
	DC COLVIN	...can you just describe what that is?
	BEED	Clerking admissions?
	DC COLVIN	Yes please.
	BEED	Erm admissions come to us, should come to us before midday erm and they need to be seen by a doctor when they arrive so when the patient arrives we would call Doctor BARTON and she would come and see them usually within an hour er and look at the transfer letter, see the patient, write up the medications on one of our charts er from the prescription that we got from erm (inaudible) that comes with the patient er and just cover any, any details that we need to such as erm medical advice on how we care for the patient really between then and the next consultative ward round.
	DC COLVIN	So she would generally oversee what had been instigated...

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	BEED	Yeah.
	DC COLVIN	...or reported to instigate...
	BEED	Yeah.
	DC COLVIN	...treatment...
	BEED	Yeah
	DC COLVIN	...from the point they were admitted...
	BEED	Yeah, yeah.
	DC COLVIN	...Okay. I think that was it for the moment.
	DS SACKMAN	Right, I've a couple of other things that I wanted to cover that I didn't but having had the opportunity for that quick break I've got them again. One of the things that will become important in this particular case I understand is the use of a syringe driver at some point. Can you explain to me what a syringe driver is? What experience you have of it, training and stuff like that?
	BEED	Right erm syringe drivers are, it's used to give erm to give medication over a continuous period of time er there's various models but in Portsmouth, in Gosport we use only one model which is the MS26 and that's a 24 hour driver and it's used to give any medication barr...but the medication has to be erm

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soluble and given subcutaneously so it goes under the skin and then that can deliver the dose over usually a 24 hour period erm we can set it for a shorter period if we want to and the idea is that the medica.. rather than giving erm a dose of medication which then wears off and then giving another dose which then wears off, we can give a very small dose over a continuous period of time over can be 24 hours erm. Various medications we can use it for but the most common one is for pain control, sedation and control of secretions when people are erm in a great deal of pain and usually when they're having palliative care which is when we would recognise that the patient's dying and erm that death is a painful process for them erm so we usually use analgesia, sedatives and sometimes erm medicine to erm reduce secretions erm and it loaded into the driver, delivered subcutaneously over 24 hours so the patient always has a continuous amount erm of pain relief, we can vary that amount according to the patients needs reducing it or increasing it er if the patient is either sedated or is in pain er and we can monitor that very carefully erm and change it quite effectively and the benefit for the patient is that

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		they get continuous pain relief and shouldn't become anxious or in pain at any time once we've got the dose right and maintained it at the right level. Erm they do start getting any pain it's not in...they're not in absolute agony and a lot of pain because it's usually what we call breakthrough pain which is when they're just getting a little bit of pain but obvi...so they're obviously not quite enough analgesia erm rather than the full pain they would be in if they...if they'd had a four hourly dose of analgesia which had worn off erm or not had any analgesia whatsoever.
30.09	DS SACKMAN	Right you used the term over sedated, how would you know if someone's over sedated?
	BEED	Erm it would depend what sort of care you're giving to the patient 'cos usually with palliative care people erm the level of sedation that keeps them pain free, keeps them sedated and, and conscious or semi-conscious but sometimes you might use it for other reasons so if we were us...we often use a drug called midazolam for people who are fitting erm and we can give that via a syringe driver erm and in that case we'd want to prevent fits but we wouldn't want to erm like render the patient unconscious so we,

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		we would just let...judge that on level of consciousness and ability to communicate and so on.
30 52	DS SACKMAN	What's an ideal state for someone to be in?
	BEED	If depend...it depends on what, what the problem is that you're, you're managing erm if it's palliative care then there is..there isn't really erm if you're managing a transient problem erm then you would try and reach a level where the patient's pain is or the problem is controlled but they're not, not asleep or unconscious.
	DS SACKMAN	So again it's dependent on the patient?
	BEED	Depends on the patient, yeah, yeah. We usually find in palliative care which is when we recognise that someone's dying and we're keeping them comfortable erm then we use, when we usually achieve the right level of pain control, they're usually fairly heavily sedated as well.
	DS SACKMAN	Right. What is Palliative Care?
	BEED	That, that's when we recognise that someone is dying erm through various, their overall condition and what we know to be wrong with them erm and it's the care of someone during that process of dying, you keep them comfortable and pain free and clean and

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Tape Counter Times *	Person Speaking	Text
		dignified so it covers everything in looking after someone who is dying.
32.04	DS SACKMAN	Right, when you say that we recognise someone is dying, who's we?
	BEED	That's the, the medical and nursing team erm and, and in consultation with the family so although the family wouldn't necessarily recognise what's going on but we from our nursing and medical experience would recognise that.
	DS SACKMAN	Is it fairly easy in your experience with to recognise when that moment comes?
	BEED	Yes, yeah.
	DS SACKMAN	And what kind of things are you looking for?
	BEED	Erm usually er could be a whole range of things erm but erm uncontrollable pain, erm difficulty with breathing, erm refusing to eat and drink, erm poor mobility, erm very anxious and it could be other things as well but those would be the, the sort of key things.
	DS SACKMAN	On a day to day basis at the War Memorial Hospital, who would identify that in the majority of patients?
	BEED	It, it's a combination of medical and nursing staff but the nursing

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RECORD OF INTERVIEW

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
		staff are the one's that work closely with erm patients whereas the medical staff are coming in so we would see how the patient has been over a continuous period of time erm so over a shift or over several shifts so we would...it's the nursing staff who really have the full picture about how a patient has been and then we would discuss and talk about how we'd do it with the medical staff in making decisions about care.
	DS SACKMAN	So initially if the patient reaches that point, I mean that may be 20 odd hours away from seeing a doctor but are you empowered to move to palliative care without reference to the doctor?
	BEED	Yeah, I mean we could, we could call a doctor if we needed to erm but we would have discussed the patients ongoing care and prognosis and outlook on each occasion we saw the doctor so we are empowered to initiate a syringe driver erm because what would have happened is on a previous occasion when they've been reviewed by the doctor where the patient hasn't been looking good erm we think their condition may deteriorate erm and the syringe driver would be written up or have been written up and the instruction would be if this patient condition worsens and you

Signature(s): DS David SACKMAN

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No 32

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
		can utilise the syringe driver er to keep that patient pain free.
34.33	DS SACKMAN	Right so it's once again you're empowered to make that and the doctor says that you know this is perhaps a natural route to go down...
	BEED	Yeah.
	DS SACKMAN	...and it's an individual decision for you that we've reached that point now and perhaps...
	BEED	Yeah.
	DS SACKMAN	..and you're empowered to initiate a syringe driver on...
	BEED	Yeah, yeah, yeah because the controlled drugs have to be checked by erm two nurs...two qualified nurses erm then actually the decision is a team decision erm and you'd make it in discussion with erm a nursing colleague before actually initiating that so we're empowered to but it's usually done by two people rather than just the one.
	DS SACKMAN	Okay, to the untrained mind, is the onset of using a syringe driver normally a signal to all concerned that...?
	BEED	It normally is but not, that's not absolute and I, I've not say for the majority of patients that we initiate a syringe driver then we're

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Record of interview of: **Philip James BEED**

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Tape Counter Times *	Person Speaking	Text
		going down the palliative care route but I have seen syringe drivers used and discontinued on erm some occasions when a patients made an improvement.
35 46	DS SACKMAN	Okay so that is a decision that's reversible?
	BEED	If, yes certainly if the patient no longer needed to be on a syringe driver they could come off it.
	DS SACKMAN	Right but in your experience it's unusual?
	BEED	That's unusual.
	DS SACKMAN	Is that peculiar to that hospital or is that peculiar to nursing in general?
	BEED	That's, that's nursing in general.
	DS SACKMAN	Okay so and I guess the doctor would invariably agree with your decision because it's all part of the plan?
	BEED	Yes, yeah, yeah.
	SOLICITOR	Can I just clear up a point on syringe drivers because I think the view at the moment is if you're on a syringe driver that's the end of it. Can you confirm that syringe drivers are used for other things?
	BEED	Oh it can be used for a whole range of other things as well so

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 34

Record of interview of: Philip James BEED

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Tape Counter Times *	Person Speaking	Text
		yeah, I mean we're...the patient group we're dealing with then we're common using it for that but, but there's a whole... all sort of other things and tip...the other thing that we use them a lot for is erm a drug called Appamorph which is for Parkinson's so someone might be on a syringe driver for Parkinson's Disease and that's to deliver the Parkinson's medication. Erm over a period of time we could use er midazolam to control fitting erm and then when the patient, when the fitting has settled down then er we might go on to oral medication or discontinue altogether so.
37.03	DS SACKMAN	Right, but in the case of palliative care generally that's one of the last thing, one of the last stages?
	BEED	Yeah.
	DS SACKMAN	So although it's fair to say that syringe drivers have a whole range of uses..
	BEED	Yeah.
	DS SACKMAN	...in your hospital and the use of the syringe driver in palliative care generally is one of the later stages?
	BEED	Yeah.
	DS SACKMAN	You spoke briefly about handovers and there...do you have a

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Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
		briefing process, you know if I'm the late turn nurse and your the day turn do we have an opportunity to discuss what's gone on?
	BEED	Yeah we have a, we have four shift handovers a day so we handover from night staff to day to morning shift, morning shift to afternoon shift, erm and then afternoon shift to night shift and that inter...that er handover is erm nurses who looked after the patients going through all the, all the patients and what's happening and if there are any points for discussion erm they can be raised at that one and in particular on midday handover we have a little bit more time when the patients are being, we've been heavily involved with the patients throughout the morning then with our little bit of extra time there for discussion of any particular points that we need to work on or consider or think about both that day and in the ongoing care of the patient erm and we usually have a little update about half nine in the morning as well after the doctors been round as to what's going to happen with the patients that day and in general as well if there's any new information we need to discuss or work on.
	DS SACKMAN	So having that many opportunities to discuss the day it's fairly

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Record of interview of: **Philip James BEED**

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Tape Counter Times *	Person Speaking	Text
		safe to assume the majority of the staff on the ward at a particular time are fully aware of what's going on to all the patients not only their own?
38.50	BEED	Yeah, yeah, they should know specifically because we work usually in the mornings particularly we look after a group of patients but all staff should know what's happening and certainly qualified staff erm should have an overview of what's happening of all the patients on the ward erm and what we usually do as well is at some point in the morning or afternoon wander round the whole ward and just see all the patients and see that all is well as well. So we do that on one or even more occasions as well as when we go round with the drugs as well that's an opportunity when you see every single patient and just check that all is well and you're up to date with what's happening and what's going on.
	DS SACKMAN	Okay and the other thing I haven't covered is the nursing notes and on those we've got Mrs RICHARDS one's here. Can you explain to me who...the entries are they...in policing and Jim will understand what I mean we've got a thing called a custody record..

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
	BEED	Yeah.
	DS SACKMAN	...now where everything happens to a person who's in police custody gets recorded and written down obviously...
	BEED	Right.
	DS SACKMAN	...in nursing it's along similar lines but perhaps I mean is there a requirement to write everything that happens down?
40.00	**BEED**	Erm there should, anything that's relevant erm and erm needed we should er these are the nursing care plans which, which cover specific aspects of the patients care, the other activities of daily living so nutrition and elimination and there should be a record of any significant, any significant that happens on the shift all day erm and then the contact record here erm is erm is anything that's not covered by the care plan so that's other events such as discussions with the family, erm accidents, er particular investigations, erm information from the doctor,erm patients condition in general and so on. One of the things that was picked up on this when we had the investigation, the initial complaint by the family is that the nu.. the medical, the nursing records weren't terribly good and we acknowledged that and we knew that erm and there were, there

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No. 38

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
		were some mitigating circumstances why the records weren't as complete as we would have liked them to have been.
10	DS SACKMAN	All right what we'll do is we'll talk about that later. I think what I want you to do initially was just to get I mean what are you expected to write and when are you expected to write it?
	BEED	Yeah, anything really that's significant that happens in the care of that patient, we should have a record of erm us...in summary if possible but it might need to be in more detail.
	DS SACKMAN	Right, but the key word is significant?
	BEED	Yep.
	DS SACKMAN	It's not..
	BEED	Yeah 'cos there's a whole..I mean there's all sorts of things that happen with a patient over a 24 hour period erm and you needn't necessarily record every single thing happens so if someone's having erm ongoing rehabilitation they'll make, we would expect them to make er daily or weekly progress erm but what we record is when there's been a significant change so when they've gone from erm walking with assistance to walking unaided would be a significant change which you would want to record...

Signature(s): DS David SACKMAN

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* Not relevant for contemporaneous notes

MG15(T)(con)

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RECORD OF INTERVIEW

Continuation Sheet No 39

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Yeah.
42.06	BEED	...erm and you might have conversations with a family on a day to day basis but they, they might just be a erm yeah things are as we expect them to be but if there was a specific conversation about some particular aspect of care that we ought to...that we felt needed a record kept of it then we would put it in there because we obviously talk to, talk to relatives and patients all the time but we wouldn't necessarily record everything we'd said...
	DS SACKMAN	No and I guess some families are more demanding than others?
	BEED	Mmm, yeah, yeah. Erm some you spend an awful lot of time with and others erm you rarely see so it really varies.
	DS SACKMAN	Right, okay, what you've done is you've given me a nice overview of the day to day regime that's employed at and I can't say War Memorial without stumbling over it. I think what I'd like to do now is just to stop for five minutes, take a quick break, make sure that I haven't missed anything and then perhaps we'll come back in a few minutes and we'll talk specifically about Gladys RICHARDS and the care plans that were appropriate to her and her treatment but Lee has got something that he's just got to say.

Signature(s) DS David SACKMAN

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Code A

Tape Counter Times *	Person Speaking	Text
	DC COLVIN	Just to clear up the background to it. In relation to the syringe driver, what's the level of training you receive?
	BEED	Erm well qualified nurses will have used syringe drivers in various settings and I, I've used them in, in this hospital and last two hospitals I've worked in erm for various things. When I came to Portsmouth I, part of my induction programme I spent on George ward which is the palliative care ward over at Queen Alexander erm and I've sent several of my staff over there, there's also training days which are put on by the local hospice who use syringe drivers even more than we do in updates and that and how they're used and what happens and in the year prior to my coming to the ward there was a training day put on particularly..specifically for our ward so all staff have had a training day somewhere at some point er and then new staff that come to us we actually spend time er when we have a patients going on a syringe driver going through how it's used, how it's set up, the situations in which we would use it and making sure that they're familiar so they...new staff would use it with supervision with us...

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: Philip James BEED

Code A

Tape Counter Times *	Person Speaking	Text
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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

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Tape Counter Times *	Person Speaking	Text
	DC COLVIN	Right.
	BEED	..erm and then when they feel they were competent and we feel they're competent then they would use it, erm then they would be able to, to initiate a syringe drivers (inaudible).
	DC COLVIN	Okay so in terms of updates and training, do you receive regular updates?
	BEED	We, we have a regular update on using...on drugs in particular but the syringe driver would be erm regular but depending on, on what particular needs are because there's a whole range of things that we (buzzer sounded) erm update on.
	DC COLVIN	That buzzer just tells us that we've got a couple of minutes left so I'll leave it there.
	DS SACKMAN	Okay, are you happy with that, the syringe driver part of it?
	BEED	Yeah.
	DS SACKMAN	Yeah, okay is there anything else we need to know about the syringe driver before we turn the tape off.
	BEED	Don't think so.
	DS SACKMAN	No is there anything I've forgotten to ask you? Okay it's quarter to twelve, what I'll do is I'll turn the machine off and we'll have a

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MG15(T)(cont.)

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED** Continuation Sheet No: 42

Code A

Tape Counter Times *	Person Speaking	Text
		five, ten minute break. Do you want a cup of tea or something?
	BEED	Yes please.
	DS SACKMAN	Do you?
	SOLICITOR	(inaudible) the tape is listening.
	DS SACKMAN	He's listening.
	SOLICITOR	Coffee with no sugar.
	DS SACKMAN	And what about you?
	BEED	Tea with two sugars please.
	DS SACKMAN	Right we'll do that, give us five, ten minutes and we'll sort that out for you.
	BEED	Right.
	DS SACKMAN	Right quarter to twelve and I'm going to turn the tape recorder off.
		END OF TAPE

gnature(s): DS David SACKMAN

* Not relevant for contemporaneous notes

MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN : ☐ ROTI : ☐ Contemporaneous Notes ☐

Person interviewed : **Philip James BEED**

Place of interview : **Fareham Police Station**

Date of interview : **24 July 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1214** Time concluded : **1250**

Duration of interview : **36 minutes** Tape reference numbers * :

Interviewing Officers : **DS 5104 SACKMAN**
DC 1484 COLVIN

Other persons present : **Mr GRAHAM - Solicitor, Saulet & Co, Portsmouth**

Tape Counter Times*	Person Speaking	Text
	DS SACKMAN	This is a continuation of our interview with Philip BEED. The time by my watch now is 1214pm. Philip we've had a break for what 15/20 minutes, we've not spoken about this at all during the break, you've been with Mr GRAHAM down here. Same rules still apply, you can get up and walk out any time you want you're here voluntarily and if you want to talk to Mr GRAHAM then do so, let me know and I will leave the room for a short while and the caution still applies throughout. A couple of things that I'd like to cover from our previous interview. What's the arrangements in place at Gosport if Dr LORD isn't available?

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* Not relevant for contemporaneous notes

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	At that point in time when Dr LORD wasn't around we just had clinical assistant cover. If we needed the advice with a consultant then either nursing staff or a clinical assistant would call a consultant at QA and ask for their advice and ask for advice over the telephone or ask for them to come and see the patient or relatives if that was required.
	DS SACKMAN	Would Dr BARTON ever assume that higher role?
	BEED	No if we need a consultant's advice we would seek it but I've not known very many occasions when we've actually needed to do that, but there have been occasions when I've contacted the consultant and arranged for him to come to ward or got their advice over the telephone.
	DS SACKMAN	I've not been in a position to disclose to you this but I have had a sight of Dr LORD's report which says that Dr LORD was asked to do a report on behalf on the hospital and she said that during that week she had no knowledge of Mrs RICHARDS because she was on a course. Now I can't formally give you anything to prove that but please accept that that does exist. Is there any particular about that week that might ...

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* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 2

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	In terms of consultant cover?
	DS SACKMAN	Yeah.
	BEED	Dr LORD actually was there on ... was on the ward on the Thursday during Mrs RICHARD's first admission and that was the day when she feel from the chair. But she was actually conducting a ward round looking at the stroke patients and therefore wasn't planning or required to see Mrs RICHARDS on that day. If we've got Dr LORD on the ward and we would like her to see a continuing care patient then we can say 'can you see this patient'. In retrospect it would have been helpful if the nurse who was looking after Mrs RICHARDS had actually asked Dr LORD to look at Mrs RICHARDS but she didn't because she'd assessed her and found nothing to be untoward, and falls aren't an uncommon thing.
	DS SACKMAN	Let's move on to that in a little while, I'm still clearing up from last time.
	BEED	Right.
	DS SACKMAN	But we will get ... you'll get every opportunity in a few minutes to get on with that. But one of the things they were keen to clear up

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		was what formal arrangements are undertaken at Gosport in the training of use of the syringe drive. I know you said that you send people off to the George Ward, but are there formal training requirements in place?
	BEED	Every member of staff is expected to be competent in every aspect of their work and if their not then they need to identify training needs. But there isn't a formal course that every nurse must go on with regarding to syringe driver but they must have gone through out to use it and proper use of it, either with another member of staff or attended a course.
	DS SACKMAN	How do you know your staff are competent?
	BEED	We have what we call supervision so all staff are supervised when they ... both when they start on the ward and then on an ongoing basis with annual appraisals. So we look at all aspects of their work and what their training needs are, so ... and it's the individual nurses responsibility to identify what sort of training support they need along with myself as Clinical Manager. So if the syringe driver wasn't something they'd used before then they would say to me 'this is not something I'm familiar with', then I

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		would make sure they got the appropriate training in how to use the syringe driver.
	DS SACKMAN	Do you monitor your staff throughout the year?
	BEED	On an ongoing basis so we have an annual appraisal but monitoring is an ongoing thing that happens all the time, day to day and week to week.
	DS SACKMAN	I mean not understanding much about the syringe driver do practices change, I mean have they changed in two years?
	BEED	Not really ... syringe drivers have only been in really common use for about the last 10 - 15 years before ... and it became more common in usage but in terms of the actual use of the syringe driver, the way it's used, that hasn't really changed over the last few years. As I say they've become more common in the last say 10 years.
	DC COLVIN	I may have covered this point but what size of driver do you use in terms of the syringe.
	BEED	It's a ... well it's a 24 hour driver, it's a grade B MS26, and for most .. for the common doses we use, we use a 10 ml syringe but the important thing is the amount of medication which is in it

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		which is actually 60 millimetres in length. So you can use any size syringe but the total travel of the syringe is 60 millimetres which you measure up against the gauge on the syringe driver itself. And the doses we were using on Mrs RICHARDS we would use a 10 ml syringe.
	DC COLVIN	What would you use generally across the board?
	BEED	Usually a 10 ml syringe made up to 60 millimetres of travel which actually makes 10 ml.
	DC COLVIN	What other sizes do you use?
	BEED	If we needed either greater dilution or if we needed to ... the dose came to a volume greater than 10 ml we would either use a 20 ml or a 30 ml syringe but again it's the length of travel that's significant and it's 60 millimetres for 24 hours.
	DC COLVIN	What would cause something to use greater dilution, what sort of ...
	BEED	There are some drugs which actually can be an irritant if they're not diluted enough and I can't think what those are off the top of my head. One is the Parkinson's drug which we use needs to be diluted to a bit more than 10 ml, but also if we're using very very

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

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Tape Counter Times *	Person Speaking	Text
		high doses of diamorph...of the drug; so we're usually using a high dose, a combination of diamorphine and medazalam and hyoscine and if you were using above a certain ... I think over about 80 milligrams of medazalam you need to ... you need a volume greater than 10 ml so you can use a larger syringe.
	DS SACKMAN	Moving on you were on about Dr BARTON comes in every morning.
	BEED	Yeah.
	DS SACKMAN	How long for?
	BEED	Usually for about 20 to 30 minutes.
	DS SACKMAN	What does she do during that 20 to 30 minutes?
	BEED	The nurse in charge will go through all the patients on the ward with her and usually in the ward office and talking about how they've been in the previous 24 hours or over the weekend if it's been a Monday. Discuss any changes in care and medication, get tests written up, get drug charts changed and discuss any particular aspects of their care, and if there are particular patients which need to be seen personally by the doctor then the nurse in charge and Dr BARTON would go together and actually see him,

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Tape Counter Times ◆	Person Speaking	Text
		examine the patient or talk to the patient or whatever's required. Then back to the office and writing any notes and any change in care plans that are needed.
	DS SACKMAN	So there are occasions when ... if nothing changes the doctor wouldn't see the patient?
	BEED	She wouldn't specifically see every patient every day only patients which as nurses we've identified need to be seen or Dr BARTON feels that she needs to see.
	DS SACKMAN	So the doctor relies on your judgement?
	BEED	Yeah.
	DS SACKMAN	In an ideal world is that common practice?
	BEED	It varies but in our particular ward it's quite relevant because most of our patients are fairly stable and their condition isn't changing much on a day to day basis and there isn't any real change, any major change on a ... just from one day to another. So we don't need to actually see a doctor unless there's anything particular the doctor is going to check and do, and we know of those patients where there is a particular problem, a particular issue. So I'm quite happy from a nursing point of view that that's an acceptable

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Tape Counter Times *	Person Speaking	Text
		practice and appropriate to the needs of our patients. If all patients have been got up and toiletted at that time of the morning, so to actually see if it wouldn't affect their care or there wouldn't be anything to be found but it would disrupt time for them which is quite personal when they are having assistance with washing and dressing and using the toilet and so on.
	DS SACKMAN	How would the doctor know if a patient was improving or deteriorating?
	BEED	From the information we supply to her.
	DS SACKMAN	Is it not realistic to expect that the doctor is looking after you actually sees you to make that judgement?
	BEED	The nursing staff actually work very closely with the patient so we actually get a very good picture of how a patient is doing and any particular problems they have and how they are. So they are actually getting a better picture talking to us about how the patient has been over the past 24 hours than actually seeing the patient at one point in time. So it's about working as a team working together and we work very very closely with our medical staff and the care of patients.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Is there a great deal of trust between yourself and Dr BARTON?
	BEED	Yes.
	DS SACKMAN	How long have you worked with Dr BARTON?
	BEED	As long as I've worked in the War Memorial, so three years.
	DS SACKMAN	Three years?
	BEED	Yeah.
	DS SACKMAN	Is that a good sort of professional relationship?
	BEED	Yes.
	DS SACKMAN	Is there a social element to it?
	BEED	No.
	DS SACKMAN	But it's someone that you deal with day in day out?
	BEED	Yes.
	DS SACKMAN	Have you ever disagreed?
	BEED	Yeah on some issues yes, yeah. And if we do disagree then we discuss that and hopefully come to a resolution. I mean that's not just with Dr BARTON but also with Dr LORD and other nursing colleagues there are some things where a decision is not absolutely straight cut so you want to discuss and agree on what the appropriate course of action is.

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Is it a healthy regime when you feel able to?
	BEED	I think so yeah. I think if you are always agreeing on everything you could be agreeing on something that's incorrect so yeah. And there isn't ... neither of us have a problem with pointing out to one another that we're not happy with a decision or an agreement or whatever and we think it needs to be discussed further or looked at.
	DS SACKMAN	Are there any examples you could give where you and Dr BARTON have disagreed?
	BEED	Certainly there's times when looking at whether patients should go home or not. A lot of our discharges home are very very risky and the patient is wanting to go home but the safety of the patient and their likelihood of success at home is very questionable. One of us may think yeah they should go, go ahead and give it a try and the other just saying we shouldn't even be contemplating at home. So quite often that's an area where we would say ... where one of us would be saying one thing and the other saying something different and would have to decide what we were going to do. Although usually the agreement is in line with what the

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		patient wants to do.
13.17	DS SACKMAN	That's one of the other points I wanted to clear up with you is are there many instances where the medical opinion as to the course of treatment differs from that of the family and how do you reconcile that?
	BEED	There are a lot because of the nature of the work we do and we've got people who are very dependent, often with very poor prognosis and relatives often are quite unrealistic as to what might be practical and achievable. So that's ... the way of dealing with that is one to pick it up very early to know what the family ... say one of my first things would be talk to patients and their families and find out what they're expecting and what they think will happen, hope will happen. And carry out our own assessment with the medical staff and Physiotherapist and Occupational Therapist as what we might actually be able to achieve. Then you have to go into discussion and also the care we do is often geared around actually exploring what people ... you know what can be achieved and what might happen. So it's a matter of working together, it's what we call multi-disciplinary team on trying to get

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		the best outcome for the patient within the scope of what's possible.
14.36	DS SACKMAN	Can families influence that decision?
	BEED	It depends what the decision is, but if it's a very ... we would always want to make decisions which are right for the patient and if a family is really wanting something which is not right for the patient and not in the patient's best interest then we would have to be quite up front about what we need to do and what's appropriate. But we would still always take into consideration the relatives and try and work towards meeting what they and the patient want and where we can't making sure they understand what we can't ... what we need to do or what we can't do or what we have to do.
	DS SACKMAN	Who makes that decision ultimately. If it comes to telling the family 'no'?
	BEED	If it really came to a difficult decision then it would be passed on to the consultant. So where we get into a real difficult decision that we can't ... I mean if it can be resolved at a nursing level or a medical assistant level then that's what we do, but if it really can't

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		be resolved then we pass it up the level to the consultant who will make the final decision and convey that to the family.
15.52	DS SACKMAN	On occasion if it's ... this is a bit hypothetical, but if families have a request that it really doesn't fit in with your nursing plan would you alter the nursing plan to accommodate that if it was a little bit detrimental?
	BEED	We would also try and work with the patients and the family and there's been lots of occasions where we try to do things which we actually know professionally from our own experience we're not likely to succeed at, but we give it a try anyway. And times when we've instigated courses of treatment for patients which we know actually won't benefit them and actually probably aren't necessarily the best treatment for them but it's what the family are saying they would like, so we try and meet the relatives where we can.
	DS SACKMAN	It's difficult ...
	BEED	Yeah. It is difficult because in those situations you've got to decide do you do what the family want which is not necessarily best for the patient but the family don't want the same. There's a

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		compromise there somewhere that you have to achieve
17.02	DS SACKMAN	It's a skill that you develop over ...
	BEED	Over 20 years and will continue to develop over another 20 years I suspect.
	DS SACKMAN	I think as far as the background goes I'm fairly happy. I've a nod from Lee whose not got any supplementary questions for me.
	DC COLVIN	Not at the moment no.
	DS SACKMAN	The notes are on the tape in front of us and we're here because of Gladys RICHARDS. Can you just in your own time and take your time, you know you said that there were perhaps some things in her notes that weren't fully recorded. Make reference to the notes please do, again it's not an exam, but can you just tell me all about this particular case, nice and slowly.
	BEED	Has this got the duty rotas in it as well?
	DS SACKMAN	I'm sure we can get hold of ...
	DC COLVIN	I've got a copy of the duty rotas here.
	BEED	Cause that would just give me an idea of the dates we're talking about.
	DS SACKMAN	Now this particular tape has got about 30 minutes on it, is that

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		gonna be enough time for you to do that?
18.07	BEED	I think so yeah.
	DS SACKMAN	What I want you to do is really as much as you can and get as much detail and information out of you as I possibly can.
	DC COLVIN	For the purpose of the tape there's the duty rotas, copy of with the relevant dates there.
	BEED	Mrs RICHARDS was transferred to us on the 11th August which was a Tuesday, that was Val who was on a late shift with an enrolled nurse by the name of Monica CRAWFORD. She came to the ward sometime around lunchtime and was admitted by enrolled nurse CRAWFORD when she came on duty at 3.30. She was a very confused lady, very agitated. She'd had a fractured neck of femur fixed surgically at Haslar and had come to us for assessment and gentle rehabilitation. The note from Dr REID who is a consultant who saw her in Haslar gave us the background information about her confusion, her falls over the last six months and the fact that she was already in a nursing home and that the family were unhappy with the nursing home and didn't want her to return there. So our overall picture at that time was someone

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whose prospect of regaining mobility was going to be limited because of her confusion and her poor hearing and the fact that she already had a history of falls. So even when we got her mobile that history of falls wasn't likely to change and that if we were able to provide her with some rehabilitation we would have to, with the family, look for a nursing home which was suitable to her needs and acceptance of the family. She was in a single room. We screened her for MRSA which is a anti-biotic resistant bacteria, I mean that's routine for patients coming from an orthopaedic ward. It was very apparent that she was quite confused. She was also, in my judgement, in considerable pain from that hip and myself and Monica CRAWFORD actually gave her some analgesia and that was oromorph and we gave her a fairly small dose. We gave her a 10 milligram dose of oromorph that afternoon to try and make her comfortable. Her daughter came in later that afternoon and talked about not wanting her mum to go to Glenheathers and also talked about the fact that she felt her mother communicated and when she was getting agitated it was because she wanted to go to the toilet. My professional

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view was that if she could communicate with her daughter, it wasn't certain, but she certainly wasn't ... Mrs RICHARDS certainly wasn't able to communicate very effectively with us either understanding what we were saying or pass anything meaningful to us. She had a further dose of oromorph at a quarter to midnight given by the night-staff, that's Staff Nurse MARJORAM at night and a further dose at 6.15 in the morning. I was on a half day on the Tuesday and really saw no great change in her that day. On the Thursday I was actually a day off and I came back to work on the Friday morning to work a long day which was a 7.30 start and was advised on arrival at the ward that this lady had a fall from her chair the previous day, which initially had looked to be, not to have caused any injury or any problem and was actually helped back into a chair, but later on in that evening had noticed that the hip appeared to be dislocated. So the nurse in charge that evening had contacted the duty doctor whose advice had been to keep the lady comfortable over night and to arrange an x-ray and treatment the following morning. Dr BARTON was on the ward not long after that so we immediately

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saw her examine the lady, made sure she was pain free and started plans to arrange an x-ray. Her daughter had been contacted the night before and arrived in ... whilst Dr BARTON was there so advised her what we were planning to do. I arranged an escort to go with Mrs RICHARDS to x-ray and her daughter accompanied her as well. That x-ray was completed later on in the morning and confirmed that the hip was dislocated. So Dr BARTON came back to the ward and we arranged for the lady ... Mrs RICHARDS to be transferred to Haslar with a view towards having dislocation reduced under sedation. Talked to the daughter Mrs LACK and explained what we planned to do. Gave Mrs RICHARDS oromorph analgesia again to make her comfortable with her hip and that would already initiate the sedation process so hopefully they wouldn't have to wait too long for her to be sedated when she got to Haslar. I then arranged transport and then arranged one of my nursing staff to actually escort the patient to Haslar and she went accompanied by .... went to Haslar accompanied by one of my nursing staff and daughter's followed. Later on that Friday Mrs RICHARDS' daughter Mrs

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LACK came back to the ward to collect some wash gear for her mother who was going to stay in Haslar, certainly overnight. I think at that time it was thought that she would come back to us on the Saturday and advised us they'd reduced the dislocation and would place her mum back. I knew that Mrs LACK was very angry about the fact that her mum had dislocated her hip and that there had been a delay in notice.. when that dislocation had been noted and x-ray and treatment. And one of the things I specifically asked Mrs LACK is whether she was happy for her mum to come back to us which she said she was and I was quite clear in that in that she had the option of looking to alternative arrangements if she didn't want her mum to come back to our particular ward. I was at that point not only looking after Mrs RICHARDS but actually looking after Mrs LACK and her sister Mrs McKENZIE who were getting quite upset and fraught and I could see potentially they could be quite angry and difficult relatives. I knew that we needed to make sure we've provided them with the care they need as well as their mother. Mrs LACK actually came back ... didn't come back to us straightaway cause I

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knew that she didn't recover from the sedation very quickly at Haslar so she actually came back to us on Monday lunchtime. I was on duty at 12.15, I'd probably ... I usually arrive for my shift a little bit early just to make sure I'm all sorted out and ready to start and Mrs RICHARDS arrived round about the time I arrived on the ward and was uncomfortable and in pain really from the time she arrived on the ward. Her daughters arrived a little while afterwards. The nurse actually looking after ... the nurses were already on duty actually settled her into her bed and I quickly became aware that there was something going on there with daughter saying that ... 'why is mum uncomfortable and what's going'. And really from that point in time I made sure as nurse in charge that I was heavily involved with Mrs RICHARDS care cause I could see potential difficulties with the both the patients care and the family. One of my nursing staff looked at the position of the leg and couldn't anything appear to be dislocated which was one of the concerns the family were bringing up that the hip had dislocated again as soon as she got back to the ward. But nevertheless what we did was got in touch with the doctors ...

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I'll just refer to the notes because I think ... I think she settled down after coming to us. One of my difficulties is that it's so long ago and the sequence of events is ... I believe what happened is she actually settled down whilst Dr BARTON came and clerked her in and then as soon as Dr BARTON had left the ward again she was again screaming in obvious pain and distress. So we contacted Dr BARTON and agreed to have another x-ray of the hip taken to check whether there was anything we needed to do or if all was in order there. There was a difficulty in getting that x-ray done because we needed a doctor's signature on the x-ray form and we don't have a doctor actually on site, and it took a while to get a doctor to actually come into the hospital and sign the x-ray form. But the x-ray took place at quarter to four and we gave Mrs RICHARDS some pain-killer 2.5 milligrams of Oramorph prior to that just after 1 o'clock to try and make her comfortable. The x-ray was done, the daughters were upset they weren't allowed into the x-ray room but that's not a decision that I'm responsible for that's up to the duty radiologist. That was seen by Dr PETERS who is one of the partners in Dr BARTON's

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practice and he looked at it and said there was no dislocation and that we need to make sure Mrs RICHARDS has proper pain control, and for Dr BARTON to review her the next morning. Mrs RICHARDS at this point was in a lot of pain, a lot of distress, generally looking unwell. She was refusing to eat and drink anything other than a very small amount, any attempt to try and provide her with the nursing care she needs so she was incontinent or needed washing or needed repositioning was making her ... causing even more pain and distress, it made it very difficult to nurse her. We used the oral medication overnight so we gave her oromorph at 1 o'clock, again at quarter past three, yeah I gave a dose at quarter past three and that wasn't effective so I actually had to give another supplementary dose at quarter to five to increase the effect of that and another dose at eight thirty and then more overnight. Throughout that time I was talking with the family about mum being poorly and what we were going to do and the fact that priority ... the agreement with the family was the priority here was to keep the mum pain free and comfortable. There was a certain amount of difficulty in that ... there was

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obviously something going on between Mrs LACK and Mrs McKENZIE in that they were saying ... different daughters were saying different things to me at different times and it was an obvious dispute and disagreement going on between them but I tried to keep them both involved and both informed of what was happening and what I needed to do. There was really no improvement overnight and the pain control was obviously keeping her comfortable but still not eating and drinking and still looking unwell. She was reviewed by Dr BARTON on the following morning which would have been me Tuesday 18th at which point the view was that the transfer to Haslar wasn't appropriate because there was dislocation that was going to be fixed and that the likely cause of the pain was a haematoma and that the pain control wasn't effective as it was and this lady's overall condition was very poor and likely to deteriorate further and the appropriate course of action was to use a syringe driver so we would could give continuous analgesia, kept Mrs RICHARDS comfortable as opposed to giving doses which we were having to give every four hours and top up if they weren't quite right. The

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family arrived ... I held off initiating that because we knew that it would ... that sedation would cause a drop in level of consciousness. I wanted to discuss that with the family before we actually started it so when the family came in that morning I presented the overall picture to the family, discussed with them just how poorly mum was and that we were looking at palliative care to keep her comfortable and that we wanted to use a syringe driver to keep her pain free. The family agreed to that and we started that at 11.30 in the morning and that quickly established a level of pain control which allowed us to look after Mrs RICHARDS properly, keep her clean, keep her dignified. And really from there through to the rest of the week we kept Mrs RICHARDS comfortable and looked after her needs and made sure we looked after the family. So the daughter stayed with her throughout but we made sure they somewhere they could rest, they could eat and drink, but they were looking after themselves, kept them informed as to what was happening, tried to provide appropriate level of support as they were going through a difficult time. They did require an awful lot of our time and we have to

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balance our time between all our patients and relatives and if people ... some people need more time than others then that's what we give but they did tie up an awful lot of my time, our time. Myself and one of the night staff were spending a much larger amount of time with them than we perhaps would with other relatives. I knew they were ... I was fully aware that one of the daughters was intending to make a complaint about the incident when mum, Mrs RICHARDS, had fallen from the chair. I spoke to her myself about it and what we'd done and what we'd not done and when you're dealing with a complaint if you can resolve it on ward level you do but if you can't resolve it then it needs to go on to a higher level and Mrs LACK clearly decided that she wanted to take this complaint to a higher level. So my role at that point, although like complaints, is to actually support her in doing that and I'm quite happy to do that so I actually put her in touch with the appropriate people to take her complaint to and gave her the resources to photocopy the complaint and I actually looked through the complaint that she'd made but I didn't ... other than the things I'd already discussed with her I didn't respond to it at

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		that time cause I knew that it would need a proper investigation. Really it was then a matter of looking after Mrs RICHARDS as her condition gradually went down hill over the next five days. I think I was mainly on late shifts thereafter so ... spending time with her and she eventually passed away late on Friday night, and the nursing staff on duty at that time would have just dealt with that in the normal way we deal with. The family wants to be very involved with ... after mum had died with ... laying her out and taking her to the mortuary and so on. The time we spent with the family did make it difficult to keep nursing records up to date and we knew that was a problem at the time, particularly that the ward was very busy at that time, I don't think any patient didn't get the care they needed but when the ward is very busy you have to sort of prioritise your work and decide what you're going to do and what you're not going to do and make decisions in that respect. It certainly was a very busy time for us, I had people on annual leave and loads of people go off sick as well which made hard work. Anything else you need to ....
37.36	DS SACKMAN	I think on that you've led us through. Obviously we're gonna

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		come back to you on some points and just say can you explain this in a bit more detail, can you explain that in a bit more detail. It's ten to one, you've spoken for twenty minutes, do you want to take a break?
	BEED	I don't mind.
	GRAHAM	It's all in your hands.
	DS SACKMAN	I tell you what let's take a break for lunch and then we can sit back and see what we want to come back and you can have a stretch anyway. Okay. If everyone's happy with that by my watch the time is ten to one and we're turning the tape recorder off.

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SDN ☐ ROTI ☒ Contemporaneous Notes ☐

Person interviewed : **Philip James BEED**

Place of interview : **Fareham Police Station**

Date of interview : **24 July 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1412** Time concluded :

Duration of interview : Tape reference numbers * :

Interviewing Officers : **DS 5104 SACKMAN** **Code A**

Other persons present : **Mr GRAHAM - Solicitor**

Tape Counter Times*	Person Speaking	Text
	DS SACKMAN	This is a continuation of our interview with Philip BEED, the time is now 12 minutes past 2 o'clock in the afternoon, we've had a lunch break and we've not communicated about this at all have we since you went to lunch.
	BEED	No
	DS SACKMAN	Right, and the same people are present and the same things apply, still under caution as is interview and once again you're free to leave at any time or to seek the advice of Mr GRAHAM. Philip on the tape before lunch we gave you the opportunity just to read through all of the history of Mrs RICHARDS, without interruption from us and you appreciate that there's perhaps some

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		questions that we want to ask and what we'll do now is, with your permission is perhaps just to just re-cap on that but both myself and Lee will ask a couple of questions, as and when we see relevant.
	BEED	Right.
	DS SACKMAN	And pertinent to it. If I can perhaps start the clock at a point on the morning of the 11th when you first had word that Mrs RICHARDS is about to arrive at the hospital, can you take me through that, and feel free to make reference to the notes again.
1.25	BEED	Right, well we would have known erm prior to that that she was coming, we usually know of an admission at least a day in advance, so we would have had a room allocated and the bed prepared, everything in place and then the time that the patient arrives is really dependent on when the ambulance is available, so we really expect them any time from 9.30 in the morning till, should be before midday, sometimes a little bit after, so she would have just arrived at some point around midday, I can't remember now what time she actually arrived on the ward.
	DS SACKMAN	Okay, and she's accompanied with paperwork.

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	BEED	Yes
	DS SACKMAN	And I understand in the case of Mrs RICHARDS on that day it was a letter from Doctor REID.
	BEED	Yeah, the letter from Doctor REID would have come separately from our elderly services office, so we would have had that in advance of Mrs RICHARDS coming, so we would have been able to read through that ahead.
	DS SACKMAN	Is it on the notes.
	BEED	The letter from Doctor REID.
	DS SACKMAN	Yeah.
	BEED	It should be there. That looks to be the first half of it. Yeah, that's that letter there.
	DS SACKMAN	Okay, so it shows, what does that tell you about the patient you're receiving.
3.00	BEED	It gives, it tells us, erm, about her, this is from when he visit, Doctor REID visited Mrs RICHARDS in Haslar on the 5th August, so that was 6 days before, about her history, that she's had a fall, is confused that he felt the medication had knocked her off, he'd actually stopped the triazadom, erm, deteriorated

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		mobility, erm, the actual incident that brought her into Haslar which was a fractured neck of femur, that she's incontinent, that's she's on Haloperidol to help with her confusion, he's said that she's clearly confused and unable to give a coherent history, erm, he found her pleasant and co-operative, moving her leg freely and lifting it, lifting the right leg from the bed and that he says he, we should give her the opportunity to try and re-mobilise and that he recommends transfer to the War Memorial and that the daughters are unhappy with care at Glen Heathers nursing home and that want to arrange for her future care to be in a different nursing home.
	DS SACKMAN	Okay, so that letter arrives with you, on your ward before Mrs RICHARDS.
4.30	BEED	Yeah.
	DS SACKMAN	So you're , so what's your expectation.
	BEED	We have an overall picture from, from. from that sort of picture I would expect someone confused and with limited mobility and I would prepare, because it's from an orthopaedic ward I would prepare a single room so that we can screen and isolate MRSA

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		bacteria, if she's carrying it, an air mattress, I would make sure it was under a hoist so we can hoist her in and out of bed and onto a toilet if we need to, erm, and make sure, erm, and I'd know that she's, and, and, somewhere where we can keep a reasonable eye on her, it's difficult to keep an eye on all of our patients all the time but the rooms closest to the office and the nursing stations are the ones that we can most easily observe on the most frequent basis, er, in fact the room that we got ready for this lady was room 3, which is immediately adjacent to the ward office and the nursing station.
	DS SACKMAN	Right, so your expectation was for a lady who was stable enough to be transferred and therefore you could make plans about.
	BEED	Yeah.
	DS SACKMAN	And were any plans made on that occasion.
5.43	BEED	Well we were still need to wait and see the actual person theirself to see exactly what we could do, and it usually takes the patients 2 to 3 days minimum to sort of settle into the ward so you can't really make any firm progress on rehabilitation until the patient's had a chance to settle into the ward.

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	DS SACKMAN	So it wouldn't be upmost on your list of priorities to, to think of a plan for the future, immediately.
	BEED	No, no, not until we've actually met the patient and had a few days to assess them and see how they are.
	DS SACKMAN	Okay, Mrs RICHARDS arrives at the hospital, erm, what happens next.
	BEED	The ambulance crew would take her to room and pop her into either bed or chair depending on how she is, I know she was in a chair that afternoon so I think we probably put her straight into a chair rather than a bed, er, we would.
6.34	DS SACKMAN	Would that have been out of choice.
	BEED	We would choose whichever, if the patient came laying flat on a stretcher we would probably put them into the bed, if they came onto the ward in a wheelchair we would probably put them into a chair, unless they were indicating to us, so, if, if, we want, unless they indicated to us I would rather be in a chair or I would rather be in bed.
	DS SACKMAN	I don't know the answer to this question, is there anywhere in the notes that indicate how she was transferred.

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	BEED	Erm, no there wouldn't, wouldn't be, expect, and I can, I can't remember whether I was there when she actually arrived on the ward or not, so I don't know, er, if she was transferred immediately into a chair it's likely that she actually came to us in a wheelchair but I can't, I don't know cos I can't recall and I'm not sure whether I was there or not at that time.
	DS SACKMAN	Okay, what's your first contact with Mrs RICHARDS.
7.26	BEED	I would have seen her sometime after she'd arrived on the ward, I can't remember how soon but it would have been sometime between 12.15 and 3.30, I would have gone to, and sometime fairly soon after she'd got there to see how she was and to assess her and see whether she had any immediate needs that she needed taking care of.
	DS SACKMAN	Is there a Doctor available for admissions, I think you said earlier on..
	BEED	Yes, we called Doctor BARTON, so we, once we settle the patient into the room one of the first things we would do is call Doctor BARTON actually let her know that Mrs RICHARDS has arrived on the ward.

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	DS SACKMAN	And what's your expectation of Doctor BARTON.
	BEED	Usually would come in within half an hour, erm, if she was actually doing something then it could be later than that she would usually tell us that, erm, and I would, I would, if there was any problem with the delay I would let her know, on this occasion I know she was in fairly promptly and she would come in, see Mrs RICHARDS, write the notes up and write the medication charts up.
	DS SACKMAN	and you can tell that from the notes can you, that the Doctor arrived when.
	BEED	Erm, I can't tell what time she arrived, erm, because, except for, erm, I, I gave a dose of analgesia at 14.14, er, so Doctor BARTON must have been and gone by 2.15, because I couldn't have given that without the chart being written up.
9.03	DS SACKMAN	Okay, so relying on your notes there and message, tell me about Gladys RICHARDS, when you did see her.
	BEED	Very anxious, very confused, and appeared to be in pain from the hip that she'd had operated on, erm, difficult to tell exactly, what, what was going on because she was so confused but I, I felt that

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times ◆	Person Speaking	Text
		she was in pain and certainly very difficult to communicate with.
	DS SACKMAN	Can you distinguish between pain and dementia.
	BEED	It's, it's, sometimes very difficult, erm, one of the things that would tell us is if that, erm, the shouting got worse when we went to transfer the patient, and we would have had to do that at some point in the afternoon to pop her on a commode, if she wanted to spend a penny and, erm, daughter was actually saying that when she's agitated she want to use the toilet, so that would be one indication, erm, sometimes it's very difficult to distinguish.
	DS SACKMAN	Did you have much experience of, of, erm, patients who have dementia.
	BEED	Yeah, I have, I, all my previous posts I've look after patients with dementia so I've seen lots of patients with dementia and it presenting in all sorts of different ways.
	DS SACKMAN	Does it present itself in difficult grades, different severities.
	BEED	Yes, yeah, you can have patients who've got mild dementia, erm, or dementia that's sort of worse at some time than others and are rational in between and patients who have dementia and are just quietly confused with it and you can have patients who are very

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Record of interview of: **Philip James BEED**

Tape Counter Times ◆	Person Speaking	Text
		noisy and very agitated and Mrs RICHARDS would come at the severe end of the scale.
	DS SACKMAN	Right, is there any doubt that that could be confused with pain.
	BEED	It's difficult to differentiate but I, I, the sort of actions that I was seeing from Mrs RICHARDS and the difficulty with transferring her and so on indicated to me that as well dementia and confusion that she had pain.
11.06	DS SACKMAN	Right, okay, does Doctor REID's letter give you any indication, he goes on about some drugs there, was it, how, Haloperidol and Trasadom, what do they do.
	BEED	Erm, Haloperidol is, is, erm, sedates people and helps the confusion. Trasadom does much the same things, it's a anti-depressant and, and helps with confusion.
	DS SACKMAN	But they're (inaudible), the Trasadom anyway.
	BEED	Yeah, stopped the Trasadom, the family said that that, that they felt that had over sedated her, so, so he's actually discontinued that, and that had been discontinued before she came to us.
	DS SACKMAN	And that regime, I mean what he says and what he can see, she'd been much brighter mentally.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	Yeah.
	DS SACKMAN	So perhaps there was an element of accuracy in their diagnosis, the family's.
	BEED	Erm, certainly if you reduce the sedation then, then the patient is going to be more responsive, one of the, one of the difficulties there is that you may increase the risk of falling along with that, so that might have been one of elements in, in the initial prescription of Trasadom, to perhaps try and reduce the risk of falls.
12.24	DS SACKMAN	Okay, but initially you see Mrs RICHARDS sometime between 12 and 2.15 then.
	BEED	Yeah, yep.
	DS SACKMAN	That would be most likely.
	BEED	Yeah.
	DS SACKMAN	And she presents herself to you and you're concerned that she's in pain.
	BEED	Yeah.
	DS SACKMAN	And you're happy that the pain outweighs the..
	BEED	Confusion.
	DS SACKMAN	The confusion and dementia.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	Yeah.
12.47	DS SACKMAN	So what do you do next.
	BEED	I gave some analgesia, I gave, erm, 4 at 2.15 and I gave Oramorph, I gave 10 milligrams in 5 mils, orally.
	DS SACKMAN	Right, to the layman is that a big dose, is that a small dose.
	BEED	It's a fairly small dose.
	DS SACKMAN	I mean there's obviously grades of analgesia, as I understand it it's sort of aspirin is perhaps at the bottom end of the scale to Diamorphine at the opposite end, how did you gauge the appropriate level.
	BEED	It's on the amount of pain the patient is in, so you've got a scale from, from minor discomfort up to very severe pain, intolerable pain, erm, and you'd go on that scale, so Oramorph would be for more severe pain.
	DS SACKMAN	Right, so you considered at that time that she was in severe pain.
	BEED	Yep.
	DS SACKMAN	Right, would Haslar have let her go in severe pain.
	Mr GRAHAM	I think that's a question you should be asking the hospital.
	BEED	Yeah, you'd have to ask Haslar that really.

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RECORD OF INTERVIEW

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Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Right, in your experience, do Haslar send patients to Gosport in severe pain.
	BEED	Well, the actual transfer can cause discomfort and pain and upset patients, so that the transfer itself can be quite a difficult thing for patients, it can actually bring on pain, I have had patients transferred from Haslar who have been very poorly, erm, on numerous occasions so it wouldn't, it doesn't, it wouldn't surprise me to have a patient with me and find that they're in a lot of pain. I would expect them to be comfortable but in my experience that's not always the case.
15.00	DS SACKMAN	Have you challenged Haslar about that...
	BEED	Yes.
	DS SACKMAN	..in the past.
	BEED	We always, we, we, go back through that with our Consultant, erm, because it is the Consultants who deal with the transfers, so if there's aspects of the transfer we're not happy about, erm, I talk to my Consultant, I've also memo'd my manager on several occasions when I've had a transfer which I've been unhappy about on a particular aspect and that's it, and over 3 years I've probably,

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

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Tape Counter Times *	Person Speaking	Text
		I mean, there's varying degrees of being unhappy, there's things that, that you might leave, let ride and there's things that you need to challenge and I've probably sent about 5 or 6 memos about different issues of transfers which I've not been happy about and need to be brought to Haslar's attention.
	DS SACKMAN	Did either of Gladys's subsequent admissions provoke you to, to write.
	BEED	The fact that she was in pain, because of the fact that she'd had the hip operated on and she was very confused, that didn't actually, I, I, felt that amount of pain was appropriate to the sort of surgery she's had and her general condition. On the second transfer she was in a lot of pain when she came back and there was an issue about how she was transferred and the fact that she was on a sheet rather than a canvas, the other issues that were involved in dealing with Mrs RICHARDS and her family actually really foreshadowed worrying about whether Mrs RICHARDS should have been on a canvas when she came to us, so that wasn't something that I actually took up with Haslar at that point in time.
	DS SACKMAN	Okay, so quickly winding the clock back, I don't mean, I don't

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		mean to jump from one thing to the next, Doctor BARTON sees Mrs RICHARDS prior to 2.15
	BEED	Yep.
	DS SACKMAN	Because she needs to do the prescription.
	BEED	Yeah.
16.49	DS SACKMAN	Have I understood that correctly.
	BEED	Yeah, yeah.
	DS SACKMAN	So was it a shared decision to give Oramorph or was it your decision.
	BEED	She wasn't actually in pain at that point in time when she was seen by Doctor BARTON but she was written up for analgesia if she should become in pain and she did subsequently to Doctor BARTON leaving.
	DS SACKMAN	So she wasn't in..
	BEED	Immediately on arrival at the ward she wasn't in pain, it was a little while later after she'd sort of settle in that she was in pain.
	DS SACKMAN	Is that unusual.
	BEED	No, not really, quite often see patients presenting differently when they're examined by a Doctor than they do half an hour, hour or

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		so later, erm, for a variety of reasons.
	BEED	So Doctor BARTON sees Mrs RICHARDS, who isn't obviously in pain.
	BEED	At that point in time.
	DS SACKMAN	That comes on at some point.
	BEED	Yeah.
	DS SACKMAN	Probably over the next hour.
	BEED	Yeah.
	DS SACKMAN	Is that too fine a time.
	BEED	No that's, that would probably be about right.
	DS SACKMAN	Would she have written up a prescription for someone who wasn't in pain.
	BEED	She would, cos the history of erm, erm, recently having a, a hip repaired is something that could cause pain, we, we look after quite a few patients who've had broken hips repaired and it can be quite painful, even several days post-operatively, particularly if we try to mobilise and transfer them, say getting them from chair to bed and chair to toilet and so on, so it would be appropriate for them to have analgesia should they require it.

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Right, would Mrs RICHARDS have been subjected to much in the way of moving about.
	BEED	We would need, because she didn't have catheter we would have needed to move her whenever she needed toilet and we have needed to move her to the bed and in and out the bed, so moving about but within the confines of the room at that point in time.
18.48	DS SACKMAN	But she didn't go into a bed initially did she.
	BEED	She was in a chair initially, yep.
	DS SACKMAN	So at some point it manifests itself that she's in pain.
	BEED	Yeah.
	DS SACKMAN	And the prescription is already written up.
	BEED	Yeah.
	DS SACKMAN	So you give, what you consider to be an appropriate measure relating to her condition at that particular time.
	BEED	Yep.
	DS SACKMAN	Have I missed anything in that first bit.
	DC COLVIN	Not really on the general admission, I mean we've covered the general admission here, do you know who was responsible for filling in the paperwork in terms of care plans.

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RECORD OF INTERVIEW

Record of interview of: Philip James BEED

Tape Counter Times *	Person Speaking	Text
	BEED	Yeah that was enrolled nurse Michael CAWFORD, cos we're very, she came, she was on duty as well that afternoon, and I actually asked her to do the admission when she came on duty.
	Code A	So it was done a little later
	BEED	Yeah, yeah.
	Code A	In the afternoon.
19.58	DS SACKMAN	Initially Doctor BARTON writes up her note on the 11th.
	BEED	Yep.
	DS SACKMAN	Can you go, and refer to the notes for that.
	BEED	Yep.
	DS SACKMAN	Now I understand that the reason for her transfer to Gosport is, how did you describe it earlier on, it's for gentle.
	BEED	Assessment and gentle rehabilitation.
	DS SACKMAN	Gentle rehabilitation, if, can, would you mind reading that note out and telling me what that means to you.
	BEED	Transfer to Daedalus ward, continuing care, the hemi-arthroplasty of her right hip on the 30th July, history, hysterectomy in 55, cataract operations, deaf, Alzheimer's, so from that, that she's, her hearing is poor and that she's confused, on examination

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		impression frail, demented lady, not obviously in pain, please make comfortable, which is, she's not in pain at that time but if she is in pain or if her condition worsens then we should give analgesia, transfers with hoist, erm, we would have been looking at using a hoist to transfer initially and maybe try her out without the hoist and see how she got on, we have to be very aware of Health and Safety for the safety of patients, usually continent, needs help with activities of daily living, Bartel of 2 and 2, that's the index of what she can and can't do for herself.
	DS SACKMAN	Who does that.
	BEED	That's done by nursing staff, at that point would have been taken from the transfer information, cos we would have re-assessed the Bartel later, erm, because when we assessed it later in the day we made it to be 3 rather than 2, but, but 3 is, anything below 4 is very highly dependent. That was assuming that she was continent of urine in fact and it made her 3, if she wasn't then she would have been below that, erm, I'm happy for nursing staff to confirm death.
22.42	DS SACKMAN	To us as lay people that seems to be an awfully massive.

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	Statement.
	DS SACKMAN	Do you agree with that.
	BEED	It's to do with the fact that at the War Memorial, because we don't have on call Doctors, erm, that patients conditions can worsen and nursing staff can confirm that death has taken place and then a Doctor, a Doctor actually certificates death at a later stage and the way I always interpret that is that if a patients condition worsens and I feel that they need to see a Doctor or a patient's condition worsens and they die and I need a Doctor I will call one and my staff are instructed to do likewise. Sometimes, with someone who is very elderly and frail their condition deteriorates and they die but, but, in caring for the patient you don't necessarily need the support of a Doctor, because you can see what's going on, their being seen by a Doctor doesn't mean, and it's about their care throughout their stay not just at that point in time, erm, so had Mrs RICHARDS condition deteriorated significantly that afternoon or that evening, with it being so soon after admission and not expected I would have called, erm, the Doctor in, but if erm the condition worsened over the period of a

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Tape Counter Times *	Person Speaking	Text
		few days and we'd spoken to the on call Doctor each day saying not as well as yesterday do you want to see her and what do we want to do, erm, her condition had continued to worsen and then she died in the middle of the night, erm, and we'd seen that and we'd spoken to family and it was expected we wouldn't then call a Doctor out in the middle of the night to confirm something which we'd seen happening and was known to happen.
24.28	DS SACKMAN	The way it gets read by someone like me, this lady gets sent to you.
	BEED	Yep.
	DS SACKMAN	To recover from a hip operation and then it says I'm happy for you to tell me she's dead.
	BEED	I can see that, it's, it means something different to us or to me as Clinical Manager then it does to, to a lay person.
	DS SACKMAN	Would that be a regular entry on notes.
	BEED	It would depend how the patient is, if the patient is, is, erm, obviously fit and well then no but anyone with any degree of frailty it would be, but, erm, if, but otherwise it would be left and it would be entered in at a time when the patient became poorly, if

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		that happened. I think one of the reasons Doctor BARTON probably does it there and then, well you'd need to speak to Doctor BARTON really as to why but there is, if it's, if it's not put in it could be then that there's a time when it needs to be written in and it's overlooked, erm, so if the lady had worsened, say over the course of the week, erm, we could then end of calling a duty Doctor in on a, on a, over a week-end for something that actually doesn't need a Doctor in, erm, because we could have seen that situation arising so it's sort of written then but not actually, erm, necessarily relevant at that point in time, it's looking at the overall likely pattern of what may happen with the patient, their condition may worsen, it may stay the same or they may get better over a period in time and obviously if the patient is getting better then it becomes a totally irrelevant statement.
26.08	DS SACKMAN	Yeah, it does. Does anyone have access to those notes, can..
	BEED	Not the, the medical notes, relatives can see, on request, erm, and what would, if they do request to see them, erm, it usually gets done through the elderly services office and they usually get to see them with a Doctor present to explain and help them with

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No 22

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		anything that they don't understand so that, that the meanings of things can actually be made sense of for them.
26 44	DS SACKMAN	It's still a fairly significant thing to write in someone's notes.
	BEED	Yeah, yeah.
	DS SACKMAN	..within 2 hours of them arriving for rehabilitation, is it, is it not.
	BEED	It is, erm, but I would see it in the context of that patients overall care and the likelihood of what may or may not happen, erm, patients come to us some of them get better and some of them don't, given their overall condition.
	DS SACKMAN	What sort of percentage get better and what don't.
	BEED	With stroke patients, and this lady wasn't a stroke patient but stroke patients it's roughly a third, a third get better and go home, a third plateau and don't do anything and a third die. I can quote those figures fairly accurately, I think probably of the continuing care patients. erm, the likelihood of getting better is slightly less.
	DS SACKMAN	Is it.
	BEED	Yeah, but they may, they may stabilise or they might die, I couldn't give you exact figures.
	DS SACKMAN	Okay, right, so if, if we sort of move on a bit now then, we've got

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		the Doctor's been, she's signed up that initial regime, she's prescribed Oramorph should it become necessary.
	BEED	Yep.
	DS SACKMAN	Mrs RICHARDS is, becomes in pain.
	BEED	Yep.
	DS SACKMAN	So you prescribe Oramorph at the rate of 2.5.
	BEED	Erm, I gave 10 milligrams in 5 mils.
	DS SACKMAN	And you say that's a reasonable dose because of the level of pain that she was experiencing..
	BEED	Yeah, yeah.
	DS SACKMAN	..at that time.
	BEED	Yep.
	DS SACKMAN	And that's the overall effect of dementia versus pain and, okay, do you know what effect that had on her.
	BEED	Erm, well that kept her comfortable, erm, and throughout the rest of the afternoon she was comfortable and she certainly, at that point in time, wasn't over sedated.
	DS SACKMAN	Yep, can you tell me what level of sedation she was in, was she conscious, unconscious.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No 24

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	She was conscious, she was eating and drinking, she was communicating as much as she was able to do, I mean her communication was very poor but she was conscious and with us and just more settled and appeared to have been reasonably pain free.
	DS SACKMAN	Right, but demented never the less.
	BEED	Oh yes, yeah.
	DS SACKMAN	So was there a change in the way that that manifested itself.
	BEED	Only in that she was more settled, noticeably less agitation.
29.16	DS SACKMAN	Is that a side effect of Oramorph.
	BEED	Well she was on Haloperidol also, she had erm, she had Haloperidol also at 1800, so the Haloperidol and the, the Oramorph principally was to keep her pain free but it does actually relax and settle people down as well so it would have helped with her general agitation as well.
	DS SACKMAN	So it's just two pronged.
	BEED	Yeah.
29.52	DS SACKMAN	On the drug sheet there in front of you, has Doctor BARTON prescribed all of those drugs.

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RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	Erm, yeah.
	DS SACKMAN	Is that all of those drugs on the 11th, on admission.
	BEED	Erm, she's prescribed the Oramorph, she's prescribed drugs which we could give via a syringe driver on the 11th, the regular drugs, the lady was on Lactlose, Haloperidol, yeah, she's prescribed really up to there on the chart on the 11th.
	DS SACKMAN	So when you say up to there that's the second set of drugs down on the middle page.
	BEED	Yeah, yeah, so the Lactlose, so Oramorph, Diamorphine, Hyoscine, Midazolam, Lactlose and Haloperidol have been prescribe on the 11th.
	DS SACKMAN	Did you take that as an indication that perhaps she, that perhaps Doctor BARTON would be amenable to the use of a syringe driver that early.
30.53	BEED	Again, the syringe driver is something which often gets written up if the patient looks overall to be very poorly that can be used if, erm, in the judgement of nursing staff patient's condition deteriorates and that's required to keep them comfortable.
	DS SACKMAN	Right, so what it is, it's an authorisation to proceed to that if.

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Tape Counter Times *	Person Speaking	Text
	BEED	If we think it's necessary.
	DS SACKMAN	If in your judgement.
	BEED	Yeah.
1.12	DS SACKMAN	So Doctor BARTON gives you on the 11th the flexibility to adopt that regime.
	BEED	Yeah, yeah, and again, I mean if, if, if, Mrs RICHARDS condition was to worsen in the middle of the night it would have meant we could have used that without the need to call out a Doctor, or if we didn't, or alternatively leave the lady in pain overnight and not being able to do anything until the following morning.
	DS SACKMAN	You mentioned she was drinking and did you say eating or have I imagined that.
	BEED	She was eating and drinking but only with assistance and her daughter came in and actually erm fed her that evening, so, erm, she was needing help to eat and drink and it wasn't very big amounts.
	DS SACKMAN	Right, but her swallow reflex was fine.
	BEED	Yep, yeah. The reason she wasn't eating was partly due to her confusion as much as anything.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Because she'd never been there before had she
	BEED	No, no, it was a strange environment for her
	DS SACKMAN	Okay, right, I don't think I've been that dis-jointed, we've got the 11th is, she's been seen by the Doctor, the drug regime has started, you're able to go down that syringe driver route if you feel it's appropriate but she has a swallow reflex, she can eat and drink and the family are in taking care of her. Is there anything else significant about the 11th of August, are there any things that you feel I should know about.
32.40	BEED	That was when I first met Mrs LACK, her daughter.
	DS SACKMAN	Tell me about that.
	BEED	Just generally talked with her about how her mother was and she informed me about Glen Heathers nursing home and not being happy with that and that erm doesn't want her Mum to return there and she also said that Mum takes medicine that she takes it best off a spoon, so I've written there, she also talked to me about the fact that she thought her Mum could communicate with her and that when she was agitated it was meant that she needed the toilet.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
33.22	DS SACKMAN	Okay, was there any discussion about the dementia and pain angle then.
	BEED	In, within erm her saying about her Mum she felt that her agitation was due to Mum needing the toilet rather than erm, rather than general confusion so having put her on the toilet when she was confused I wasn't sure that I entirely agreed that the agitation meant she wanted the toilet cos I'm, I've a recollection of putting her on the toilet when she was agitated and not actually getting any result, so, I didn't quite seem to tally with what her daughter was telling me.
33.56	DS SACKMAN	Were her family aware that you'd gone onto Oramorph.
	BEED	I did tell erm the daughter that I'd used Oramorph to pain, to keep comfortable..
	DS SACKMAN	And what was her reaction to that.
	BEED	I, I really can't remember, in time.
	DS SACKMAN	Were you aware that she'd taken Oramorph on previous occasions.
	BEED	No, don't think so.
	DS SACKMAN	Right, okay, has that .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	I would have, I would have looked back through her Haslar notes but I can't, I can't remember.
	DS SACKMAN	Okay, but it's not an unusual drug.
	BEED	No it's a fairly common.
	DS SACKMAN	Was she sensitive to Oramorph.
	BEED	Erm, well at that, Doctor, er, we actually continued using Oramorph to keep her pain free for a couple of days and actually one of my colleagues, staff nurse JOICE actually discontinued that, erm. on, erm, I think on the, on the 13th or 14th, erm, and Doctor BARTON at that time wrote that Mrs RICHARDS was quite sensitive to Oramorph.
	DS SACKMAN	Right, what does sensitive mean.
	BEED	It, it has a more sedating effect on some people than it does on others, so, erm, and of course it can build up in the system a little bit so staff nurse JOYCE actually thought that we'd actually probably given a little bit too much pain killer to Mrs RICHARDS and it wasn't appropriate, the appropriate thing to do was to stop it at that point in time.
	DS SACKMAN	What to enable it to..

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HAMPSHIRE CONSTABULARY

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Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	To come out of her system and then review what we gave her in the way of pain control from there.
	DS SACKMAN	Okay, so what drugs did she take over the next couple of days, we're on the 11th.
	BEED	Yeah she had a further dose of Oramorph at 1145 at night on the the 11th, a further dose at 0615 in the morning on the 12th, erm.
	DS SACKMAN	Had she been reviewed by any member of staff, had her pain lessened.
36.16	BEED	She'd, erm, what we'd have done was looked at her overall condition and, and erm, whether she was in pain and erm how the pain was, so whenever you go to give a dose of analgesia erm you look at the patient's pain and how well that's controlled and whether they, they need, so you always carry out a review before and when you're giving pain control.
	DS SACKMAN	So what you said earlier was that the beauty of the syringe driver is the fact that you can ensure there's constant level.
	BEED	Yeah.
	DS SACKMAN	But with Oramorph of course it's a quick fix.
	BEED	Yeah and then it would wear off.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	So is it recorded that on each and every occasion that the effects wore off that she needed more.
36.54	BEED	It wouldn't necessarily be recorded specifically.
	DS SACKMAN	Is that unusual.
	BEED	Erm, it wouldn't give, if I look, what I need to do is look at the night care record cos that might, erm, we haven't actually made a specific record of it but we can give, we can give the analgesia up to 4 hourly, erm, you usually do 1 or 2 things with analgesia, either you give it regularly every 4 hours without fail so that the pain doesn't come back, erm, or if you're not sure then you give the analgesia when it's required, erm, and the fact that we gave it at 0215 and it wasn't given until 1145, erm, would make, to me would give the conclusion that the staff nurse who was on duty that night actually found Mrs RICHARDS to be in pain, the analgesia having worn off and then would have given some more to settle her and keep her comfortable over night.
38.10	DS SACKMAN	Yep I understand that, I mean had she been in pain at 8 o'clock in the evening you'd have been quite entitled to give her more.
	BEED	I would have given her some more, yep.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	But the lady in charge of her care then thought it appropriate later on, that's fine, and again in the morning.
	BEED	and again in the morning, yeah.
8.28	DS SACKMAN	What other drugs is she taking at this time.
	BEED	At this, on, at this time, erm, Lactlose, which is to keep her bowels regular and Haloperidol which is on 1 milligram twice a day.
	DS SACKMAN	Okay, so that's not an unusual drug regime..
	BEED	No.
	DS SACKMAN	..for this lady.
	BEED	No, no.
	DS SACKMAN	Okay, is there anything else we need to know about the 11th August.
	BEED	I don't, I don't think so.
	DS SACKMAN	Right, so the 12th, you on duty on the 12th were you.
	BEED	Have we got the duty rotas.
	DC COLVIN	Certainly.
39.12	DS SACKMAN	I have them here.
	DC COLVIN	To hand.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	I know I was on duty, I can't remember what time I was on duty
	DS SACKMAN	Does it help referring to the notes at all.
	BEED	I think I was on duty from 0730 till 0100 but I.
	DS SACKMAN	Whilst we're looking for that, this tape is rapidly coming to an end, if I hit the button to save anyone from further embarrassment we'll come back in a couple of minutes, is that okay.
	BEED	Yeah.
	DS SACKMAN	Right by my watch the time is 1452 and I'll turn the tape recorder off.

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MG15(T)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

SDN : ☐ ROTI : ☒ Contemporaneous Notes ☐

Person interviewed : **Phillip James BEED**

Place of interview : **Fareham Police station**

Date of interview : **24 July 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1458** Time concluded : **1541**

Duration of interview : Tape reference numbers ◆ :

Interviewing Officers : **DS 5104 SACKMAN &** **Code A**

Other persons present : **Mr GRAHAM - Solicitor (Saulet & Co.)**

Tape Counter Times◆	Person Speaking	Text
0.09	DS SACKMAN	This is a continuation of our interview with Phillip BEED and the time by my watch is 1458 hours. Same persons present. I'm glad to announce that we've found the missing duty roster. And the question was Phillip on the 12th of August.
	BEED	Yeah.
	DS SACKMAN	Can you go through your duties and Gladys' notes.
	BEED	I was on duty from seven thirty till one o'clock on Wednesday the 12th, Mrs RICHARDS would have been reviewed along with all the other patients that morning and at that point um Doctor BARTON's actually written up, because we needed to give the analgesia through the night she's actually written it up on a er a

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◆ Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		regular er four hourly basis with 2.5 mils through the day and 5 mils at night. Although and it, but that's written up PRN so we don't give it unless we need to and in fact....
	DS SACKMAN	Sorry what does PRN stand for.
	BEED	Means as and when required, um, in fact we've never, we've, all we've done, other than the dose at six fifteen in the morning on the 12th we've not actually needed to give any more out during that day so although it's been written up regularly, er PRN, we haven't given it. Um.....
	DS SACKMAN	This is Oramorph?
	BEED	Yeah the Oramorph.
	DS SACKMAN	So it's safe to say that that the Oramorph has had the desired effect and her condition perhaps has stabilised and she isn't presenting in pain.
	BEED	No.
	DS SACKMAN	On the 12th.
	BEED	Yeah.
	DS SACKMAN	Right.
	BEED	Yeah. Um I can't remember any other specific aspects of um Mrs

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		RICHARDS' care um during that day, um and I probably wouldn't have been greatly involved because my um biggest priority on that particular day was making sure the ward was staffed adequately the next day because I knew it was going to be a very busy shift, um, so that, that would have been the major priority for me as Manager of the ward.
2.28	DS SACKMAN	Ah ha, and indeed she's, she's stabilising.....
	BEED	Yeah.
	DS SACKMAN	So she's.....
	BEED	Yeah.
	DS SACKMAN	.....so she's not a problem.
	BEED	No.
	DS SACKMAN	Okay. Do, is there anything else in the notes for the rest of the twelth that, that perhaps with hindsight alerts you to something being amiss. (fire bell starts ringing). I hope that's a test.
	BEED	No nothing in particular, everything was very fairly straight forward on that day.
	DS SACKMAN	Okay and then the 13th I understand that she has a fall.
	BEED	Yeah.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times ◆	Person Speaking	Text
	DS SACKMAN	And do you know much about the circumstances of that.
	BEED	I, I do but, but from coming on duty the following day when um staff involved sort of filled me in the background.....
	DS SACKMAN	Right.
	BEED	.....of everything that happened.
	DS SACKMAN	Because you weren't on duty on that certain day.
	BEED	I wasn't on duty on that day.
	DS SACKMAN	Okay, by making reference to the drugs.....
	BEED	Yeah, yeah.
	DS SACKMAN	.....that were used on that day, what can you tell me about, you're off on the 13th.....
	BEED	Yeah.
	DS SACKMAN	.....what drug regime.
	BEED	Um, was given er her normal regular drugs and at ten to nine in the evening er of the 13th er she was given some more Oramorph, that was after the hip had been dislocated so she didn't have any more Oramorph or other pain killers up until the point in which it was discovered that she had a dislocated hip.
	DS SACKMAN	What time would she have had that fall, do you.....

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◆ Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 4

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
4.06	BEED	The fall took place about one thirty um the nurse who examined her at that time didn't find anything abnormal um and a dislocated hip is fairly obvious so um going on the information I had the hip wasn't dislocated immediately after the fall, um, but once Mrs RICHARDS was helped into bed after she'd had her supper which was some time around eight, um, seven thirty, eight o'clock, that evening, um the hip was out of position and was obviously dislocated at that time.
	DS SACKMAN	So, do you suggest that the dislocation could have occurred at some other time rather than the fall.
	BEED	Um, it's obviously occurred sometime during the afternoon. Um, it may have been, I mean the fall may have weakened the, the joint or whatever and then the act of transferring, hoisting her out of the chair back into bed or some other action may have actually made the dislocation happen.
	DS SACKMAN	I think it would be quite unfair of me to go on about that because.....
	BEED	Yeah.
	DS SACKMAN	.....you weren't there, you weren't on duty and can't therefore

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		be.....
	BEED	No.
	DS SACKMAN	.....responsible for that. In your experience is it unusual for someone not to be given pain relief over that period.
	BEED	Um not really because we would give pain relief if someone was in pain and if someone wasn't in pain we wouldn't give it, um, so it really depends and, and people's responses and, and pain does vary from time to time depending on what's happening, what we're doing in the way of transferring them and how they are overall, so um, but she needed analgesia and then once she said that she didn't need it doesn't, doesn't surprise, it's not an unusual pattern.
	DS SACKMAN	Okay. No I except that. What's your next contact with Gladys RICHARDS.
5.49	BEED	Er that was on the morning of the 14th when I was on duty from seven thirty until four fifteen um and then I came on duty to find, um to be, um given all the background to the, about the fall the previous day and the fact that it was suspected that she had a dislocation, um so I went and examined the patient with Doctor

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		BARTON who was there about that, about that time um and then arranged for x-ray and talked to daughters, Mrs LACK, the daughter and discussed what we were going to do um to see if there was a dislocation and what we would then do if um we did find the dislocation which we were fairly certain at that time had occurred.
	DS SACKMAN	What does it look like a dislocation.
	BEED	Um.
	DS SACKMAN	Can you tell.
	BEED	Usually the leg um rotates inwards and you can see that the hip doesn't look correct, so if you look at one side and look at the other you can see a very obvious difference and deformity.
	DS SACKMAN	Right, so it's a fairly visual diagnosis but with experience you can say well (inaudible).
	BEED	Yeah, yeah.
	DS SACKMAN	When did you know there was a dislocation.
	BEED	We knew for certain once the x-ray had been taken place because then we could see it on x-ray.
	DS SACKMAN	Right, and that was done, during the day.

Signature(s) .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	That was done sometime around mid morning.
7.07	DS SACKMAN	Okay, what drug regime was she on in the morning.
	BEED	Um still the same, um, um in fact she'd been given some analgesia at ten to eight the previous night which she hadn't, she hadn't needed any that morning. As I say we gave her some um gave her some Oramorph at eleven fifty and that's after the dislocation had been um discovered, er or x-rayed and, and confirmed.
	DS SACKMAN	What do the notes reflect that she's in pain then or...
	BEED	Um well, reason we gave um Oramorph at that point in time is because we knew that a dislocation does cause some degree of pain. We were going to transfer her to Haslar which would involve transfer um to an ambulance and in and out of the ambulance and would cause pain and also that she would need pain relief and sedation for the hip to be relocated so we were starting the sedation process there so if they want, if they were in a position to put the hip back in fairly quickly when she got to Haslar then she would actually already have had analges, some analgesia to cover that process.
	DS SACKMAN	Right and you did say that earlier, and what dose was, was that

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		the same dose or had we increased the dose.
	BEED	Um, we gave, no we gave 10 milligrams which is the same dose as she's been having throughout.
	DS SACKMAN	Okay and then she's off to.....
	BEED	Transferred to Haslar er with one of my health care support workers escorting her and staying with her.
	DS SACKMAN	Was there much of a problem with the family at this time.
	BEED	Um, daughter was obviously anxious and upset but probably no more or no less than I would expect of someone whose mother has come to us and then has suffered a dislocation of a recently operated on hip (inaudible) except that someone in that situation is going to have a degree of anger and upset at the situation.
	DS SACKMAN	Okay. So she's off to Haslar and then you've no contact with her at all for 2, 3 days.
	BEED	I, I saw the daughter later on that afternoon when she came back to collect um some wash gear for her mother, because we did think her mother might come back the same day or might stay a while at Haslar, um so her daughter had come back and collected some wash gear um and spoke to me at that time.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
9.28	DS SACKMAN	Okay, so the next contact we have with Mrs RICHARDS is on the 17th.
	BEED	On the, yeah.
	DS SACKMAN	Now, this is where the letter from Mr EDMONDSON comes in isn't it. The, and we've disclosed that to you the other day. The Flight Lieutenant.
	Mr GRAHAM	I've got it.
	BEED	Yeah.
	Mr GRAHAM	(inaudible).
	BEED	No there would have been two because there would have been initial transfer letter and then another one from.....
	Mr GRAHAM	Tenth August.
	DS SACKMAN	Of EDMONDSON and there was a statement of EDMONDSON which was put along with it.
	Mr GRAHAM	(inaudible).
	DS SACKMAN	Can I ask you to have a look at Mr EDMONDSON's statement.
	BEED	Yeah.
	DS SACKMAN	If I summarise it.
	BEED	Yeah.

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* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 10

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
10.16	DS SACKMAN	Just quickly.
	BEED	Yeah.
	DS SACKMAN	It says that she came to us, she got fixed up , stabilised and then was able to go back.
	BEED	Yeah.
	DS SACKMAN	And she was ready for further rehabilitation. Just take a couple minutes to have a read of that.
	DS SACKMAN	Have you got that accompanying letter.
	Mr GRAHAM	Which one.
	DS SACKMAN	From EDMONDSON.....That's the one.
	BEED	Yeah.
	DS SACKMAN	It is in there is it.
	BEED	Yeah it's in here. Yeah.
	DS SACKMAN	Yeah.....(inaudible)
11.53	DS SACKMAN	Can I refer you to the letter.
	BEED	Yeah.
	DS SACKMAN	And I guess that accompanies Mrs RICHARDS, it's dated the 17th.....
	BEED	Yeah.

Signature(s) : _____

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 11

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
12.03	DS SACKMAN	.....so I guess it came back with her.
	BEED	Yeah. Yeah.
	DS SACKMAN	If you have a quick read through that.
	BEED	Yeah.
	DS SACKMAN	Right and what's particularly pertinent perhaps is the very last sentence which was she can however mobilise, fully weight bearing. What, what do you infer by that.
	BEED	Um that she, that she can um stand, we know or already knew she would need assistance with standing, so she would need nurses to help her but she can take her full weight on, that, on the effected leg.
	DS SACKMAN	Right okay so her readmission to Haslar has been an unqualified success then.
	BEED	Well, that, that says that she can transfer um from a, from a medical point of view so if we wish to stand her and take weight on that leg then she can, it doesn't necessarily say that she's going to be able to do that and you would need to assess that with the patient initially and they um, but it would indicate that they felt she was able to transfer and stand.

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Signature(s) .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
13.23	DS SACKMAN	So at worse there's a significant improvement in her overall, well certainly in the leg.
	BEED	The hip is back in place yeah, yeah.
	DS SACKMAN	The dementia is something with which I've got no idea but.....
	BEED	Yeah, yeah but that's not going to change that's going um be the same throughout.
	DS SACKMAN	So although not fully fit she's perhaps improved significantly in the couple of days she's been away.
	BEED	Yeah.
	DS SACKMAN	Right were you on duty on the morning of the 17th.
	BEED	I was on duty from twelve fifteen on the 17th
	DS SACKMAN	Right and what can you tell me about the events of the 17th.
	BEED	Er that I would have arrived a little bit before then, before twelve fifteen and Mrs RICHARDS had either just arrived or arrived a little while after I got there um but the nurses actually who had been on duty that morning er would have received her and taken care of putting her into a room which had already been made ready for her. Um that she was in pain and discomfort, very obvious pain and discomfort when she arrived um that actually

Signature(s) .....

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No : 13

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		settled down when she was seen by the doctor but then re, made itself apparent again not long after Doctor BARTON had gone um in distress and discomfort and the daughters arrived and could see her in discomfort and they were getting very anxious and uptight, as well, and wanted something done.
14.54	DS SACKMAN	Now there are some issues around that transfer which I'm not really fully au fait with, and I don't, something to do with the stretcher, a sheet.....
	BEED	Yeah.
	DS SACKMAN	.....what is a street. Can you just explain to the, to the uninitiated.....
	BEED	Yeah.
	DS SACKMAN	.....exactly what went on.
	BEED	Usual, usually if some one comes on a stretcher they'll be on what we call a canvas, which is a er, which literally is a length of canvas with holes up either side and you can slide poles into those holes and it then becomes a stretcher which you can lift from the stretcher, one person either end.....
	DS SACKMAN	Yeah.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
15.26	BEED	.....over onto the bed so the patient comes up nice and easily, and over um Mrs RICHARDS came to us on a sheet instead of a canvas and I'm given to understand that they couldn't find a canvas and that they'd phoned to say sorry she's not on a canvas um and therefore the ambulance crew when they arrived picked her up on the sheet which doesn't give the same level of support because they're just sort of grabbing the sheet which is going to sag and be uncomfortable and transfer you in that way.
	DS SACKMAN	So it's a sheet before it has the poles inside.....
	BEED	Yeah.
	DS SACKMAN	.....and then it's a canvas.
	Mr GRAHAM	No.
	BEED	No. No it's.....
	DS SACKMAN	I still haven't got.....
	BEED	If it's, if it's a, when someone's on a canvas it's actually a very thick canvas material.....
	DS SACKMAN	Right.
	BEED	.....length of the patient, um and it just curls back on itself either end.

Signature(s): .....

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MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No: 15

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
16.14	DS SACKMAN	Yeah.
	BEED	And then you can slip a pole up there and it's very, and then when you lift it it's very firm and rigid and it makes a temporary stretcher.
	DS SACKMAN	Yeah.
	BEED	But she was just on a ordinary bed sheet underneath her and that was just rolled up and lifted and that wouldn't have provided the same sort of support because it would have sagged in the middle and sagged (inaudible).
	DS SACKMAN	Is that an improved way to transfer a patient.
	BEED	Um, I would always try, if I'm transferring a patient on a bed I would transfer them on a canvas, um if a patient arrived, now I wasn't actually involved when the patient arrived and the transfer on the bed but if they arrived and they weren't on the canvas then I would have to decide do I now put a patient, a canvas under the patient's bed mind they've already been moved and that's going to involve quite a disruption to get that under them um or do I transfer them as they are and I would much rather, I, really patients should always be transferred on a canvas.

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
17.14	DS SACKMAN	It just seems ridiculous that for someone who's had this hip operation is going to be.....
	BEED	Yeah.
	DS SACKMAN	.....lifted up.
	BEED	I think the other difficulty is the ambulance crews are always, always under pressure to get on and do the next job because they've got a backlog and I gather from talking to people that they were in rather a rush and weren't going to wait while we found a canvas but I don't know that anyone specifically stood there and said you must wait um while we get a canvas to do this.
Code A		If that was the case, you must wait, are they duty bound to remain.
	BEED	It really depends who's involved, um, if it's one of my more junior staff they may not be enough sort of, you know, may be more difficult I mean they're not there, there a set, a team in their own right and if it was me as the nurse in charge I would have made it, if I'd wanted him to do that I would have made it very clear to them that I wanted to do that but it, I wasn't there so I.....
	DS SACKMAN	Yeah sure.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	.....but if they're transferring the patient it is their responsibility really up until the point when the patient is on the bed, as it is, if they, if they're, if I'm transferring a patient it's my responsibility to look after that patient up until the moment that the ambulance crew take over so, it's absolutely, it's still their responsibility at that point in time.
	DS SACKMAN	Okay thanks for that. Was Doctor BARTON called out to readmit.
	BEED	Yeah, um (looking at some papers) I can't, what, what I can't remember, there was so many things going on at that point in time is exactly when Doctor arrived, when Doctor BARTON arrived but I think Doctor BARTON saw her soon after arrival er and clerked her in but she then became very unsettled and obviously in pain not soon after Doctor BARTON had lift.
	DS SACKMAN	So initially, uncomfortable.
	BEED	Yeah.
	DS SACKMAN	Was she given pain relief because of her transfer.
	BEED	Um, I gave, I gave pain relief at one o'clock er which is when um the daughters came and when she really started to demonstrate the

Signature(s) .....

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
		signs of being in pain.
20.02	DS SACKMAN	So Doctor BARTON had been before that.
	BEED	Yeah, yeah.
	DS SACKMAN	Because.....
	BEED	Yeah.
	DS SACKMAN	Had she written another prescription at that point.
	BEED	Um no as we still had the existing prescription so we used, that would have.....
	DS SACKMAN	How long's a prescription valid for.
	BEED	Um it needs to be um reviewed, reviewed regularly um, I'm, what the time limit is I don't know but I mean that would be well within it. If someone's written up for Oramorph that would be, be and remains on the ward or goes off a few days and comes back, be valid for a good number of weeks but needs to be reviewed during that period.
	DS SACKMAN	Ah ha. Okay she's in pain but she's able to take Oramorph.
	BEED	Yeah.
	DS SACKMAN	So her swallow reflex is still there.
	BEED	Yeah.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	And up and running.
	BEED	Yeah. She was refusing to eat lunch at that point in time um but she was swallowing.
	DS SACKMAN	Right is that significant do you think.
	BEED	May have been because she was in pain and unsettled or it may have been just her general dementia and overall condition so you know it was just one of the things that we noted at that point in time that some food was prepared for her but she refused to eat it.
	DS SACKMAN	Okay. Right. How did she progress throughout the rest of the, the 17th.
	BEED	Arranged an x-ray because the family was worried that the hip was dislocated although it didn't appear to be um and that took place.....
	DS SACKMAN	Didn't one of your nurses, have I read somewhere that the, the leg looked like it was a figure four.
	BEED	The, yeah, one of the, Staff Nurse COUCHMAN actually went in with the daughter and actually repositioned the leg because she thought it wasn't in er a very comfortable position but it wasn't in a position that looked like it was dislocated, um, so she made Mrs

Signature(s): .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Phillip James BEED**

Tape Counter Times ◆	Person Speaking	Text
		RICHARDS in a comfortable and appropriate position um and with her daughter, um, and generally examined her to check, because if she'd spotted an obvious dislocation at that time again we would have um, it's definitely x-rayed, it definitely needs x-raying.
22 14	DS SACKMAN	Yeah.
	BEED	But it looked in an odd position but not in a dislocated position.
	DS SACKMAN	Right.
	BEED	Er. So really (inaudible) that afternoon was to give analgesia to try and make Mrs RICHARDS comfortable and to get her x-rayed to try and find out if it had dislocated again, um, or if it hadn't to find out if it was anything else we could do anything particular about.
	DS SACKMAN	Okay. So what's the drug regime for the rest of the 17th.
	BEED	Um we carried on, we actually um, because we thought there was a sensitivity to the Oramorph we were giving a slightly lower dose so we were giving 5 milligrams, we gave that at one o'clock, we gave it attain at ten to seven, er sorry, gave it again, I can't read my own writing, looks, I think it was about quarter past three and then but that wasn't, that obviously wasn't enough, so I gave a

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Record of interview of: **Phillip James BEED**

Tape Counter Times ◆	Person Speaking	Text
		higher, a second dose of 5 milligrams at quarter to five and then we went back to giving the 10 milligram dose at eight thirty and then she had some in the early hours of the morning.
	DS SACKMAN	Are the family happy at this point that she's in pain as opposed to dementia.
	BEED	Yeah, yeah, I had specific discussions with the daughter and Mrs LACK in particular was very concerned about how much pain um her mum was in and that we need to get that pain under control so I was working very much in conjunction with the family to um try and provide um what, the sort of care that they wanted for their mum.
	DS SACKMAN	So at this particular moment in time on the 17th you're all singing off the same hymn sheet.
	BEED	Yeah, yeah.....
	DS SACKMAN	Everyone's quite happy with what's happening.
	BEED	Yeah, um and that, that's one of the reasons I gave the second dose and I, I distinctly remember looking very carefully at how much can I give and when and what, and looking at the option of the syringe driver at that time should I need to proceed to it and

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Tape Counter Times ◆	Person Speaking	Text
		saying to um Mrs RICHARDS' daughter that I wanted her mum to be comfortable before I went off duty that evening.
	DS SACKMAN	Was there a consideration to the use of a syringe driver then.
	BEED	It would have been one of the options could we not control the pain with the Oramorph.
	DS SACKMAN	Right, how, how high, or how far along that ladder were you prepared to go on Oramorph.
	BEED	Because you're giving, because you're giving quite high doses and it's wearing off um the difficulty is you, you can't just give Oramorph and then say it hasn't worked you need to give it time to build up and I needed to give a second dose so, I think had I, had I gone for that um second dose which topped the Oramorph up to 10 milligrams at quarter to five, had she not been comfortable by the time I went off at eight thirty I would have, at that point been looking whether the use of a syringe driver was the next appropriate step because obviously if I'd gone to the full amount of Oramorph and that hadn't kept Mrs RICHARDS comfortable then the next logical step was whether a syringe driver would allow me to give um a more dose and a slightly

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		stronger dose of pain killer.
25.28	DS SACKMAN	Right and what's your objective behind that.
	BEED	In going to a syringe driver.
	DS SACKMAN	Yeah.
	BEED	To keep Mrs RICHARDS pain free.
	DS SACKMAN	Purely pain free and that.....
	BEED	Yeah, yeah. Yeah.
	DS SACKMAN	Okay thanks for that. And then what happens next.
	BEED	Um, she was cared for over night. I came, um, I was on duty again the following morning, the 18th when she's reviewed by er Doctor BARTON.
	DS SACKMAN	Had anything significant happened over night.
	BEED	Um she had another dose at, of Oramorph, I gave a dose at eight thirty, she needed another dose at twelve thirty which is, so she's only going 4 hours and another dose at four thirty, so she's going only the 4 hours between doses of Oramorph, um, so that's, we're giving the maximum amount we can, um, if I find the night (inaudible) records that might tell us how she was over night.....haven't got a specific record but I would have

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Tape Counter Times *	Person Speaking	Text
		got handover from the night staff and obviously they would have told me that um they needed to give the Oramorph um every 4 hours and um that she hadn't been comfort, completely comfortable on that.
27.12	DS SACKMAN	The reasons for those being omitted from, from the record sheet is that an oversight or is.....
	BEED	An over, yeah.
	DS SACKMAN	Yeah, and nothing, nothing else.
	BEED	No.
	DS SACKMAN	Just straight up oversight. What other drugs had she taken....
	BEED	Um.
	DS SACKMAN	.....at the same time.
	BEED	That's on the um on the 18th, she actually hadn't, we've left off the Lactalose um, but she's had, she's having, no she did have Lactalose on the 17th and she had Haloperidol.
	DS SACKMAN	Right, what did the Haloperidol do for her.
	BEED	Haloperidol is to help with her confusion and agitation.
	DS SACKMAN	Right. I think you told me that once.
Code A		Is that in an oral form at that time.

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Tape Counter Times *	Person Speaking	Text
	BEED	Yes. Yeah.
	DS SACKMAN	Okay so up until the 17th.....
	BEED	Yep.
	DS SACKMAN	.....what's her condition, is she getting better, is she getting worse.
28.35	BEED	She's, she's really overall she's worse, her fluid and her diet intake is poor um she's, we're not really controlling the pain even with the regular dose of Oramorph um and she's quite agitated and uncomfortable and it's making it difficult for us to, to nurse her and look after her overall care.
	DS SACKMAN	So generally the scenario is one of, it's becoming increasingly difficult.
	BEED	Yeah.
	DS SACKMAN	Right, Doctor BARTON comes in.
	BEED	Yeah.
	DS SACKMAN	Then what happens.
	BEED	Um, we'd have er reviewed her with myself, we'd have gone and seen the patient and looked at how she was um looked at the x-ray that was done the previous day and then um discussed Mrs

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		RICHARDS care and what Doctor BARTON felt was this lady's overall condition was deteriorating er quite significantly, that we weren't controlling the pain and the only way we would control the pain was by a syringe driver er and that she felt the lady's overall condition indicated that she was in, in such poor health that she was actually dying um and that we ought to keep her pain free and make sure we were meeting all her nursing needs but that, that we, that rehabilitation at this point wasn't going to be something that we were going to achieve and that we were likely to be looking at a patient that was going to die fairly shortly.
	DS SACKMAN	Right and that's a decision that, that's not taken lightly.
	BEED	No.
	DS SACKMAN	I would assume.
	BEED	No.
	DS SACKMAN	And in conjunction with the family.
	BEED	I, the family weren't present at that point in time, so what I would then have done is discuss things with the family when they arrived um and try to do that in a sensitive and tactful way um, because you start building up a relationship with a family sometimes it can

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		be just done er by nursing staff, sometimes you'd have to arrange for them to come back and see the doctor if you didn't think that their questions had been answered or you'd um answered all their concerns or they till had worries or whatever. Um but I met with them um sometime around mid morning when they came and discussed their mum's overall condition and um the fact that we needed to use a syringe driver to control her pain um and that we didn't' think her, or we thought her prognosis was very poor and that she was actually going to die, sometimes.....
	DS SACKMAN	So it was cards on the table.
	BEED	Yeah, oh yes, yeah.
	DS SACKMAN	Right, what was their reaction to that, can you recall.
	BEED	Upset, as, as you would expect, the, I, I knew from previous discussions with them that they had worries about use of um strong analgesias, I believe Mrs MCKENZIE actually had experience of, of someone close actually um being in a hospice and having strong analgesia, er so I did in that sort of discussion which you try and make sense, tactful, allow them time to voice their fears and anxieties and to answer any questions they had. Um

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		but overall my impressions was that they understood the situation and they agreed with, the, the kind of care which we were um wanted to proceed with.
	DS SACKMAN	Did they say at any stage, no we don't agree with this.
	BEED	No, no, um if they had then I would have taken, I would, I wouldn't have proceeded and I would have taken advice from elsewhere, I would have go to a Nurse Manager or um a consultant to get their advice. So although I knew that was the care that Mrs RICHARDS needed I wouldn't have gone ahead with that sort, that care um if they were in direct opposition.
31.59	DS SACKMAN	And what would have been the alternative to the syringe driver.
	BEED	Er carry on giving Oramorph, um could have given higher doses of Oramorph, so that would have been one alternative.
	DS SACKMAN	Because she is still capable of taking it.
	BEED	Yeah. Yeah. Um the problem with that is it wasn't keeping her pain free for um the interval between the doses so it wasn't giving her adequate, it was giving her some level of pain control but it wasn't adequate pain control.
	DS SACKMAN	But, was there still some way to go before you reached the

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		maximum dose of Oramorph.
	BEED	Um we could have increased the dose, I think the, it's it's, it's more a matter of the interval inbetwen that, that Oramorph then wears off, um makes it difficult.
	DS SACKMAN	Do people become immune to it, not immune to it but.....
	BEED	The effects of it do lessen over time yes.
	DS SACKMAN	Do they.
	BEED	Yeah, yeah.
	DS SACKMAN	(inaudible) with junkies you know they start off and they take more.....
	BEED	Yeah, yeah. Yeah. They, they, um the effect isn't heightened they get used to it.
	DS SACKMAN	So it's likely that she becomes less resistant to, have I got that right.
	BEED	Yeah. She...
	DS SACKMAN	I don't think I have, it has less of an effect.
	BEED	Has a less effect yeah, yeah.
	DS SACKMAN	And for a lesser period of time.
	BEED	Yeah, yeah.

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Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Right.
	BEED	And the other thing we find when we're trying to control patient's pain it's easier with pain if you can stay on top of it all the time, so if you, if you allow someone to become in pain it's then harder to control, get that pain back under control when if you don't allow someone to get in pain in the first place.
	DS SACKMAN	Okay.
	BEED	So if you give a continuous dose that, that never lets that pain come through or if it does come through it just keeps it at a controlled level um then it's much, you don't actually need so much of the medication to keep it under control.
	DS SACKMAN	Right, where's this pain coming from.
	BEED	It's obviously from the hip, there's no doubt she was getting pain from the hip but she also gave the impression of someone who was in general discomfort and agitation because anything you tried to do with her was causing her to get upset and distressed. And again that's something that's quite common with people who are very poorly and dying that, that they have specific pain somewhere but they've also got very generalised pain and discomfort.

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Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	Yeah okay I'm, I'm with you there. Right, so we, a team decision is referred to . .
	BEED	Yeah.
	DS SACKMAN	And that team, who's in that team.
	BEED	Um, that's um Doctor BARTON reviewing the patient, myself as one of the nurses looking after the patient and Staff Nurse COUCHMAN who's the named nurse er of Mrs RICHARDS and was on duty um at morning, um, who, so together we reached that decision and, and the family of course, er so we make that decision and then um at.....
	DS SACKMAN	That's fairly comprehensive in the, the interested parties.
	BEED	Yeah, yeah, yeah.
	DS SACKMAN	And there's no dissent there from anyone.
	BEED	No.
	DS SACKMAN	Okay. Who, who fixes up the syringe driver.
	BEED	That was myself and Staff Nurse COUCHMAN um and we started that at eleven forty-five.
	DS SACKMAN	And what was the contents of that.
35.38	BEED	Um that was Diamorphine, 40 milligrams, Haloperidol, 5

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		milligrams, and Midazolam, 20 milligrams.
	DS SACKMAN	Right, how does 40 milligrams of Diamorphine compare to the idiot with 10 milligrams of.....
	BEED	It, it's calculated on the basis of um the amount of um Oramorph that's been needed in the previous 24 hours so what Doctor BARTON would have done would have been total up the amount, the total amount of Oramorph we'd given really since um one o'clock the previous day um and then there's a, you can look in the, the formulary book BNF or we've got a booklet produced by the local Hospice which then gives you a conversation for how much Diamorphine to give over 24 hours bearing in mind whether the Oramorph had actually kept someone comfortable or not, so if that Oramorph had kept Mrs RICHARDS completely comfortable we would have gone for a lower dose but she wasn't, she was still getting periods of discomfort so we wanted to go slightly higher to make sure that she was pain free.
	DS SACKMAN	Right just to make absolutely sure.
	BEED	Yeah.
36.54	DS SACKMAN	Okay, and the other drugs, Midazolam that's a new one.

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	BEED	Yeah, the Midazolam's um a, a hypnotic and that basically deals with agitation and relaxes um patient, keeps them calm, um and the Haloperidol she's already on and that's, that has a similar effect and that's kept because it's actually something Mrs RICHARDS is on already um and Doctor BARTON felt that if that was omitted from the driver we'd, it's something you can give through a driver um and giving it through a driver would make sure that she didn't get withdrawal symptoms from the Haloperidol.
	DS SACKMAN	Cos that could have had a knock on detrimental effect.
	BEED	Yeah.
	DS SACKMAN	Okay I understand that, and was there one other drug in there.
	BEED	Um not at that point, we used, we started Hyoscine, but we didn't' start using Hyoscine um, may be we didn't use Hyoscine at all, yes we did, yeah, we didn't start using Hyoscine until the 19th of August which was the um the Wednesday.....
	DS SACKMAN	(inaudible) and that's, Hyoscine, correct if I'm wrong is for secretions.
	BEED	Yeah, yeah.

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38.05	DS SACKMAN	(inaudible).
	BEED	Yeah, yeah.
	DS SACKMAN	I've read somewhere there's a potential problem using Midazolam and Haloperidol in respiratory function. Are you aware of that.
	BEED	Er well, all, all the drugs we are using with the driver can, are known to cause some degree of depression of respiration, so that's a known side effect um and something you'd watch for, when someone's poorly their respiration becomes depressed as they start to pass away anyway so that's one of the difficulties knowing whether the medication you're giving is causing depression of respiration or whether it's the patient's overall condition.
	DS SACKMAN	Right.
	BEED	So, but the key thing we're looking at is how comfortable is the patient and comfortable is their breathing.
	DS SACKMAN	Okay if they do go into arrest or their respiratory function slows down to a stop, do you have any equipment to use to bring that back.
	BEED	We, the doses we're sort, we're using would depress respiration

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		but I've never know it to actually to stop the respiration so in fact and you wouldn't um, so we wouldn't, shouldn't be using doses that actually cause that to happen and if you're, if you're giving Palliative care um you don't, and you help the patient, relatives come to terms with the fact that someone's dying you wouldn't want to put yourself in a position where you're suddenly having to take resusative measures because that would be very confusing and upsetting for the family.
	DS SACKMAN	So it's a conscious decision that if, if, if it's a natural by-product of that, that they stop breathing then that's death and...
	BEED	Yeah, yeah.
	DS SACKMAN	.....that's inevitable.
	BEED	Mmm, yeah.
	DS SACKMAN	Right, Midazolam used subcutaneously, is it.
	BEED	That's, that's very common, we usually use that in, it's the Haloperidol is the one that we don't usually use but we usually use Midazolam because the relaxes, quite a lot of patients if they're in a lot of pain, they're also, and very well, there's a lot of fear and anxiety going on as well, so it just relaxes them and calms

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		them down, takes away some of the, some of the fear that's associated with their condition.
40.27	DS SACKMAN	Right, that's not a product that's licensed for subcutaneous use. Were you aware of that.
	BEED	Um, I'm, um, the information we work on is produced by um the local hospice and they do say in that, that the doses that are used and the medication that are used are sometimes being used outside of their er normal dosage range and where they'd be used but it's established, well established practices in Palliative care.
	DS SACKMAN	It's common practice.....
	BEED	So yeah. Yeah.
	DS SACKMAN	.....so the although the fact that it isn't licensed.....
	BEED	That's it.
	DS SACKMAN	.....for the use is not a bar to using it.
	BEED	No, no.
	DS SACKMAN	Because experience tells you.
	BEED	Because it's being, it is being used in a lot of cancers in that way.
	DS SACKMAN	Right, so you're, we've reached that point where we're on the syringe driver with the, the combination of drugs, how long does

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		that continue.
41.29	BEED	Given that we're recognising that Mrs RICHARDS is in Palliative care we would expect that to continue up until the time she passes away um because if anything sensitivity to the pain killers is going to (inaudible) or, or the pain, level of pain may increase, so you may need to increase the pain killers. If you withdrew um the analgesia then the patient would again be in the level of pain they were before you started it um, so it's expected to continue but it's constantly under review to check the level that you're giving is appropriate to the patient's needs, so really every time you go into the patient and every time you go to change the driver, every 24 hours, um you'll be monitoring how the patient is whether they're comfortable or uncomfortable and how they are over all.
	DS SACKMAN	What, what steps are taken to insure that she remains hydrated.
	BEED	Our, our practice um with hydration is, is the patients are conscious and able to take food and fluids then we encourage them and help them, make sure they're not thirsty, um if patients become unconscious and we're delivering Palliative care um we base our work on studies that show that giving patients by

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		alternative means actually doesn't do anything to effect the outcome, um the fluids aren't likely to absorbed and they become uncomfortable so we don't usually hydrate patients when we're delivering Palliative care, um, unless there was a partic, a specific indication that it was the appropriate thing to do.
	DS SACKMAN	Right. When did we stop actively treating Gladys and move on to Palliative care.
	BEED	Um, that was on the morning of the 17th.
	DS SACKMAN	Right, then on the morning of the 17th .....
	BEED	Sorry, that was on the morning of the 18th. Tuesday the 18th.
	DS SACKMAN	And at that point, did her death become a matter of time.
	BEED	Yes.
	DS SACKMAN	Right were any steps taken in the ensuing 3 days by yourself, Doctor BARTON or any of the nursing staff to ensure her level of pain hadn't decreased to enable her to come off of that drug regime.
	BEED	We would have monitored that when we, every time we looked after her so when you, when you go to wash someone, check there clean and so on that's when you start getting pain if you're

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		going to get any so you could see that if you were, um, cos you have to roll and turn people to get them clean and to change their bedclothes and their night clothes and so on, so if she was showing, showing no signs of pain whatsoever then that would say right you might need slightly less, far more normal that someone shows some indication of being in pain when you start to move them and you have to judge is that a lot of pain that we're, you know we're, we're putting them through agony and we need to increase things or is it just the normal amount that you would associate with moving someone in which case level of pain killers you're giving is about right.
44.36	DS SACKMAN	Right, is it recorded anywhere in the notes that those checks were undertaken on Gladys.
	BEED	It's, it's not specific but it's integral with um the nursing care plan so um on the 18th um for her night care but she's comfortable and the daughter stayed. Um on the, on the hygiene that she's had, she's had bed bathes and she's had oral care. Um, on the 19th she's had a night change and wash, repositioned, apparently pain free during care.

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	DS SACKMAN	So if she's pain free during that period, is it not then a proper consideration to reduce.....
		(the tape buzzer rings)
	DS SACKMAN	I think we've got two minutes left, but don't, don't rush your answer because of that.
	BEED	Right, okay. Right, okay. The difficulty was if you start then reducing the pain, reducing the analgesia and the pain breaks through um you're then right back to square one where you've not got the pain controlled um and you're having to go in with high doses again, so if the patient is, recognising that the patient's condition is deteriorating and dying anyway, if they're pain free then you continue at the dose you're at.
	DS SACKMAN	But that doesn't give them the opportunity to recover.
	BEED	But we're all, we're recognising that this lady, we didn't feel this lady was likely to recover anyway at this point in time.
	DS SACKMAN	Right, but she was never given the opportunity to recover was she.
	BEED	(inaudible).
46.36	DS SACKMAN	Had, had someone said hold on she's not in pain let's.....

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	BEED	Yeah, right.
	DS SACKMAN	.....reduce this to half the dose.
	BEED	Yeah.
	DS SACKMAN	And see what happens.
	BEED	Yeah.
	DS SACKMAN	Because if she was in pain from a broken hip.....
	BEED	Yeah.
	DS SACKMAN	.....that may have well subsided over the 2 or 3 days. Is there a straight forward answer.
	BEED	We, well, we, we didn't' expect that the pain would have resided, we would have expected if we'd reduced, reduced the analgesia that the pain would have came back at the same level.
	DS SACKMAN	Right and that decision is based on experience.....
	BEED	Yeah.
	DS SACKMAN	.....in.....
	BEED	Yeah.
	DS SACKMAN	Between yourself and Doctor BARTON.
	BEED	Yeah, yeah.
	DS SACKMAN	Right. With hindsight, was it not considered, was it not

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		appropriate that.....
	BEED	No wouldn't have.....
		Tape ends as BEED is talking, at 1541 hours.

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RECORD OF INTERVIEW

SDN ☐ ROTI ☒ Contemporaneous Notes ☐

Person interviewed : **Philip James BEED**

Place of interview : **Fareham Police Station**

Date of interview : **24 July 2000**

Police exhibit no. :
Number of pages :
Signature of interviewing officer producing exhibit :

Time commenced : **1552** Time concluded : **1604**

Duration of interview : **12 mins** Tape reference numbers ◆ :

Interviewing Officers : **DS 5104 SACKMAN** **Code A**

Other persons present : **Mr GRAHAM - Solicitor**

Tape Counter Times◆	Person Speaking	Text
	DS SACKMAN	This is a continuation of our interview with Philip BEED. The same people still present, Philip. The time by my watch is three fifty-two p.m. You can leave at any time if you want or speak to Mr. GRAHAM get your legal advice. We got to the point at the end of the last tape where we were speaking about the drug regime over the last three/four days of Mrs RICHARDS's life and my question was that, having settled on a particular drug regime, why was no consideration given to, to reducing that dose, just to see?
	BEED	At, I've just erm, come to, there's an entry in the contact record by Staff Nurse JOYCE at eight o'clock on the 18th, which was the,

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		so that was 24, that's 36 hours after we had started that drug regime, er that she is sleeping in peace, that Mrs RICHARDS is peacefully sleeping but she reacted to pain when she was moved and that pain appeared to be in both the legs. So that's 36 hours in and we, we actually know that Mrs RICHARDS is in pain when we are moving her.
	DS SACKMAN	Is, is that right? If that was on the 18th, it only started..
	BEED	That, we started at er eleven forty-five on the Monday so that was, and that was, this is eight o'clock on ..
	DS SACKMAN	No, on the Tuesday you started didn't you? She came to you on the 17th
	BEED	Sorry, started on a Tuesday, yeah, er sorry eight o'clock on the Tuesday night, yeah, that's right. So that, that's been assessed em..
	DS SACKMAN	So twelve hours into .
	BEED	Twelve, twelve hours in, yeah, yeah.
	Code A	Are you aware at that time how that pain manifested itself, how..
	BEED	As Staff Nurse JOYCE has said its er, it appears to be in both legs when Mrs RICHARDS was moved, but she's, she's obviously

Signature(s) .....

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No: 2

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		comfortable when she is not being moved.
	DS SACKMAN	Right. She is not given any other hydration?
	BEED	No.
	DS SACKMAN	So, is it safe to assume that is an inevitability?
	BEED	Yeah.
	DS SACKMAN	At one point she's going to die?
	BEED	Yeah, yeah.
	DS SACKMAN	On the drug doses, right, is that a particularly high....
	BEED	No, that, that's er the bottom end of the scale really, erm, we, we sometimes up patient, patients on lower doses but we, we could, on the prescription here we could have gone up to two hundred milligrammes of diamorphine and eight hun...and eighty milligrammes of er midazalam I've known patients go up to even higher doses than that, so five hundred milligrammes of diamorphine would not be er, an uncommon dose to give to someone who was in that much pain.
	DS SACKMAN	Right. Was there any other evidence of, of other illness?
	BEED	Er, it was, it was more a general overview of the patient's condition, a combination of er, the severe pain, the, the er

Signature(s): .....

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		reluctance to eat and drink, the appearing frail, er and difficulty moving, so it wasn't one specific thing but (inaudible) the overall picture that she presented of being a very poorly lady.
	DS SACKMAN	Right. What did she die of?
	BEED	Er, Doctor BARTON had er, er, stated she died of Bronchopneumonia and certainly on the, on the 19th she was getting a very rattley chest er, which is caused when you have got actual secretions in your chest and we had started er Hyocine at that point.
	DS SACKMAN	Right, Did, did the sisters agree with that?
	BEED	Er, in the statements that I have seen then they haven't but of course if Mrs RICHARDS had developed a chest infection then the, the drugs which we are using to control her pain, keep her comfortable, would have masked a lot of the symptoms of a chest infection. So. .
Code A		Can I just ask a question? So, I mean the decision is made on the 13th, bearing in mind her condition and that pain, that, that she is dying?
	BEED	Yeah.

Signature(s) :

* Not relevant for contemporaneous notes

MG15(T)(cont.)

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Continuation Sheet No: 4

Record of interview of: Philip James BEED

Tape Counter Times *	Person Speaking	Text
	Code A	So, the decision to go down the road of palliative care is taken then?
	BEED	Yeah, yeah.
	Code A	So, but she is dying then
	BEED	Yeah.
	Code A	But she is not dying of..
	BEED	A chest infection at that point.
	Code A	at that stage?
	BEED	At that point, no
	Code A	But later on, which is, I mean is that caused by the drugs she's on? The, the chest infection?
	BEED	No, but, but when the, its er really to do with being, being very frail and very susceptible and her respiration not being so good and of course the, the drugs she's on do have an effect on respiration, depressed respiration but her overall condition would have affected the respiration as well.
	Code A	Right. In terms of the 18th at the time, the, the consultation occurs and a decision is taken, what was she dying of then? Or what was you impression of what she was dying of then?

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	BEED	Just a combination of factors. There wasn't one specific factor.
	Code A	Yeah.
	BEED	Er that she was dying of.
	Code A	Can you, can you just go over those?
	BEED	Just that she was very frail, that she wasn't eating, she had been very reluctant to eat and drink, she was in pain which wasn't controllable er and that she wasn't able to mobilize or, or doing anything to meet her own needs.
	Code A	Okay.
	DS SACKMAN	If I went into hospital, as fit and healthy as I hope to be, and were put immediately on a syringe-driver, with that combination of drugs, would I die?
	BEED	No. I don't think so. Er but you wouldn't, you wouldn't go on that if you were fit and healthy.
	DS SACKMAN	(Laughter) I know. But, if I were to put another ninety-one year old woman without any, I mean would that kill her?
	BEED	No. Patients have been on this, these levels of sort of pain control and sedation er we've upped conditions and have gone on to recover so, no, not necessarily.

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* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	In your experience, that's, that's happened
	BEED	Yeah, yeah.
	DS SACKMAN	In terms of..
	Code A	In terms of recovery process for other patients, and this may be a hypothetical question, how do they come out of that? How was that accessed that they could, they can come out of that situation? If in particular they are sedated as a result of what they are on?
	BEED	Um. You probably wouldn't be (inaudible). If someone was going to er recover you wouldn't see, er and given that levels of sedation um, so its a bit difficult to answer really.
	Code A	Right. So really those four...
	BEED	Are.....
	Code A	.....taken together.....
	BEED	.. are appropriate to palliative care, they wouldn't. I don't know that, that those, that combination would be appropriate to anyone in anything other than a palliative situation.
	Code A	So someone who there, there's a consideration that they may well recover that would not be a combination?
	BEED	No, you, you would, may use one or more of those drugs but

Signature(s) .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		probably not the entire combination.
Code A		But all taken together. So if you were to look at some notes, you've never seen the patient but you've seen they're on a driver and on those sort...
	BEED	Yeah.
Code A		.....of drugs, would your impression be well this is someone who, who may well be, be dying.
	BEED	Yeah.
Code A		..and try and assist in giving her a comfortable, painfree death?
	BEED	Yeah, yeah.
Code A		Okay.
	DS SACKMAN	I was just going through Mrs LACK's statement at the end of the day. She, she mentions a conversation about euthanasia - do you recall that?
	BEED	Does.. does she say what day that was on? Was that on the, Monday the 17th?
	DS SACKMAN	Yeah.
	BEED	Yeah, yeah she, I, I remember. Was that Mrs LACK or Mrs MacKENZIE?

Signature(s): _____

* Not relevant for contemporaneous notes

HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
	DS SACKMAN	My sister, so. Mrs MacKENZIE.
	BEED	Yeah, I remember Mrs MacKENZIE um, asking about euthanasia um and of course I advised her that that's not something what we would ever contemplate or consider. Its, its not er something we can do and not something we would do.
	DS SACKMAN	What's the difference between euthanasia and palliative care?
	BEED	Palliative care is when we recognize that someone's dying um and the care we are providing is to make that death um a comfortable and dignified experience and meet someone's nursing needs. Um, euthanasia is, euthanasia as I understand it is actually actively um assisting someone in dying.
	DS SACKMAN	Yeah. One thing we haven't covered. I am drawing to a close now, is a suggestion of a massive haematoma. Do you recall this or.
	BEED	Dr. PETERS, who was the G.P. who looked at the xray um said that he felt the cause of the pain was a massive haematoma. Um, as I understand it that's um, bruising as a result of the dislocation and the manipulation to put it back in. Um and, and that could be quite painful. I think Mrs RICHARDS' level of pain, to me

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		seemed to be much more than just a haematoma, she, she was in a awful lot of uncontrollable pain, and distressed from the pain as well, but, but cos I expect anyone, and we have seen patients have dislocations put back it and they do have bruising and some discomfort but not on the level that Mrs RICHARDS was experiencing yeah.
	DS SACKMAN	Okay. Just somebody has written down a question here which I am not quite sure is appropriate is why was Mrs RICHARDS not given fluids subcutaneously during the period 18th, 19th and 20th? Well then.. it wasn't..
	BEED	That's, that's because we, we don't feel that's an appropriate course of action with palliative care and that it doesn't make anyone any, it doesn't change the outcome. Um, it makes them uncomfortable cos the fluids don't get absorbed properly, they, they collect under the skin and don't get absorbed and um, you're just, just adding another intervention which is making a patient uncomfortable um and isn't changing what's actually happening. Am I right in saying that, at that time, the hospital wasn't licensed

Code A

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		to, or authorize to, provide fluids through a subcutaneous route?
	BEED	We, we, no we could give fluids subcutaneously. What we couldn't do is give fluids intravenously and um that's cos we haven't got a doctor on site who could re re-establish an intravenous line.
	Code A	Right.
	BEED	Subcutaneously is, is an alternative route at giving fluids and that's, that's what we can ...
	Code A	And you always been, as far as you are aware..
	BEED	Always been able to give subcutaneous fluids and that doesn't need a doctor to set it up, the nursing staff can actually establish subcutaneous fluids, so we could have, if, if, if it had been appropriate to Mrs RICHARDS care we could have established subcutaneous fluids er and run them.
	DS SACKMAN	Phil, what I intend to do in a second is, is to, to kill the tape, run upstairs just to see if there is any other points that I may have missed that they feel need covering, but I am getting to the point now where I think we've had a fairly thorough going over of, of your actions throughout that period, is there anything that, that

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		you wanna, we want to add to your account so far? Is there anything that you feel that either myself or Lee have missed or misunderstood. Just so you can leave here saying well I, I've told them everything that they wanted to know.
	BEED	Yeah. The only thing really is, is that some of, is that I spent an awful lot of time with, with er Mrs LACK and Mrs MacKENZIE talking to them and answering all sorts of questions and I, I just find it strange that they're now asking questions which they had lots of opportunity to ask at the time and didn't, and I, I find that, that puzzling.
	DS SACKMAN	I think, I think that's explained if, if explanation is the right word, with the fact that they perhaps found it difficult to deal with what they termed as the early stages of the loss, dealing with the loss of their mother, and perhaps with the benefit of hindsight, that they felt that some things weren't addressed properly and perhaps there was a case. With hindsight, would Philip BEED have done anything differently at all?
	BEED	There, there were things that happened with Mrs RICHARDS when I wasn't on the ward, um, when she fell, which um it would

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		have been better if Mrs RICHARDS had been transferred earlier than she was for the dislocation to look at - I don't know whether that would have changed. I don't believe that would have actually changed anything but it would have um answered one of the big questions that the family had, er more than anything. In terms of Mrs RICHARDS' care when she returned to us, then no, we. we, we looked at Mrs RICHARDS um and examined her thoroughly and made decisions appropriate to her and we discussed things with the, the family and tried to get, keep them involved um in what was happening and make sure that, that they were understanding the care we were giving and in agreement. So um I can't see that um, in terms of the overall care of Mrs RICHARDS, er there was anything er that we'd have done differently now if we were in the same situation again.
	DS SACKMAN	One last thing for me, is, is a point that is raised by Mrs LACK in her statement where, and if I read the paragraph out it is on Page 13, she says I told Dr. BARTON and the Ward Manager that I'd been to Haslar that morning and explained what happened and told them that Haslar would be prepared to re-admit my mother. I

Signature(s) .....

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times ◆	Person Speaking	Text
		considered that this was essential so that the cause of my mother's pain could be treated and sim..not simply the pain itself. Dr BARTON said that it was inappropriate for a ninety-one year old who had been through two operations to go back to Haslar where she would not survive further surgery.
		(inaudible) ... contact this has been at some point on the 17th. Was it ever a consideration to return?
	BEED	Yeah, that was after Mrs RICHARDS been x-rayed and Dr. BARTON had come back in, um Dr. PETERS had looked at the xray and Dr. BARTON had then come back in so DR. BARTON looked at results of the xray on Mrs RICHARDS, um and discussed it with Mrs LACK, the daughter, um. I, I can't remember Mrs LACK um saying those particular words to Dr. BARTON but know, I know it was, that was in looking at Mrs RICHARDS' care we consider the options what do we, what do we do here um and Dr. BARTON's view was the...there was nothing specifically wrong that Haslar would be able to treat um and heal and thought that transfer would be more traumatic. That, that Mrs RICHARDS might not even survive the transfer er, cos

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		we know the transfer itself is quite traumatic, and that they wouldn't be able to do anything when she arrived there so the most appropriate thing to do was to keep Mrs RICHARDS in our care er and she discussed that with the daughter at that time.
	DS SACKMAN	So it would have been to the detriment of her health had she been transferred....
	BEED	If we had transferred her back.
	DS SACKMAN	..cos, and there was nothing wrong with her to look at
	BEED	(inaudible) cos, when she got there, if there was an obvious, if the hip dislocated again then yeah that would have been an obvious indication or if there was something else that, that Haslar could have er done that we couldn't have done, then it would have been appropriate to transfer.
	DS SACKMAN	Great. I am ever so grateful you are taking (inaudible)...no, there's someone with a finger up in the corner (laughter)
Code A		Just one there is more. Just a, just to go over, back to the 11th and a very quick question on the care plans and the letter in relation to consideration being given to the immobilization.

Signature(s) : _____

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		Now it's not docu..there is no care plan for the mobilization. Is there any particular reason for that?
	BEED	Um, what we. we were working on mobilize..we didn't have a care plan but we were trans . trying to transfer Mrs RICHARDS where we could and, had things not gone in the direction they'd gone in, we would have got a physiotherapist involved in looking at transfers over the, the next few days. er but the fact that she fell and dislocated really overtook the plan to mobilize because obviously once she had re-dislocated we couldn't do anything but we would, at that point in time we were assessing well what sort of level of mobilization er was Mrs RICHARDS actually capable of.
Code A		In terms of instructing the physio, who, who does that fall down to on the ward to, to do that.
	BEED	Er, nurse in charge of any particular shift, cos the physiotherapist comes on ev..we've got our own physiotherapist and we're saying we've got a patient here that we want you to, to look at please and, and see how they are
	DS SACKMAN	Great. Anything else that you would like to say at this point?

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HAMPSHIRE CONSTABULARY

RECORD OF INTERVIEW

Record of interview of: **Philip James BEED**

Tape Counter Times *	Person Speaking	Text
		Right, I will run upstairs to make sure there isn't any points but I am sure if we have missed anything we'd better resolve those quickly, but thanks for taking the time and trouble to answer the questions so fully. All things being equal, the time is eight minutes past four....
	Mr. GRAHAM??	I am quite happy for you to leave those tapes in there while you run upstairs (inaudible)
	DS SACKMAN	That' very kind of you, you are all heart.
		(inaudible) etc.. ...

Signature(s): _____

* Not relevant for contemporaneous notes

In reply please quote 2000/2047

Please address your reply to the Fitness to Practise Directorate
Fax: 020 7915 3696

11 July 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

A member of the Council, who is appointed under Rule 4 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 to give initial consideration to cases, has asked me to notify you, under rule 6(3) of those Rules, that the Council has received from Hampshire Constabulary information which appears to raise a question whether, as a registered medical practitioner, you have committed serious professional misconduct within the meaning of section 36(1) of the Medical Act 1983. A copy of the relevant provisions of the Act is enclosed, together with copies of the Procedure Rules, the GMC's publication "Good Medical Practice" and of a paper about the GMC's fitness to practise processes.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Hasiar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Copies of information from Hampshire Constabulary may be found in the enclosed bundle of papers which is indexed at page 2.

The member has directed, in accordance with the Procedure Rules, that the information received from Hampshire Constabulary be referred to the Preliminary Proceedings Committee of the Council. That Committee will consider the information any written explanation provided by you, to determine whether the case should be referred to the Professional Conduct Committee of the Council for inquiry into a charge against you.

AGENDA ITEM: 17
Confidential
(2000/2047) Barton, J
(continued from page 403)
'Explanation'

icating with us about this matter

THE MDU
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Code A

27th August 2002

FAO: Lorna Johnston
General Medical Council
178 Great Portland Street
London, W1

Also by fax: 0207-915-3696

Dear Madam

Re: Dr Jane Barton

I act for Dr Jane Barton, and write with reference to the letter to her from Mr Leighton of 11th July 2002. I would be grateful if this letter could be placed before the Preliminary Proceedings Committee meets to consider this matter on 29th – 30th August, representing Dr Barton's response in relation to the various matters raised in Mr Leighton's letter.

It may be of assistance to the Committee to have some general information at the outset about Dr Barton, the Gosport War Memorial Hospital and in particular about the working environment in which Dr Barton had to practice at the Hospital at the relevant time in 1998. Dr Barton's case was in fact considered by the Interim Orders Committee in March this year. At that time the Committee determined that it was not satisfied it was necessary to make any order affecting Dr Barton's registration. Dr Barton gave evidence on oath before the Committee, which evidence dealt very much with these matters. It may therefore be of considerable assistance for the Committee to have access to Dr Barton's evidence then, and I have pleasure in enclosing a copy of the transcript of the proceedings on the 21st March from pages 5 to 23. The initial pages of the transcript involve representations from Counsel instructed for the GMC, raising issues within the expert reports to which the PPC already has access.

It may nonetheless be helpful for the Committee to have brief further review of Dr Barton's position here. Dr Barton qualified in 1972. She entered General Practice in 1976, joining her present practice in 1980, where she has practised in partnership on a minimum full-time basis. From 1996 to 1998 Dr Barton was a locality Commissioner, seconded to the Health Authority to assist in relation to purchasing issues, and from 1998 to 2000 she was the Chair of the local Primary Care Group.

In addition to her general practice duties, Dr Barton took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital, a cottage hospital, in 1988. As the Committee will appreciate, the position of Clinical Assistant is a training post, and for Dr Barton it was a part-time appointment. Initially the position was for 4 sessions each week, one of which was allocated to Dr Barton's partners to provide out of hours cover. This was later increased, so that by 1988 the Health Care Trust had allocated Dr Barton 5 clinical assistant sessions, of which 1 ½ were now given

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27th August 2002 2

to her partners in her practice for the out of hours aspects of the post. Dr Barton was therefore expected to carry out her day to day responsibilities in this post in effect within 3 ½ sessions each week.

Dr Barton worked on two of the wards at the Hospital, Daedalus, and Dryad Wards. The two wards had a total of 48 beds. About 8 of the beds on Daedalus Ward were for 'slow stream' stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients.

Two Consultants in elderly medicine were response for each of the wards. Dr Althea Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both Consultants, however, had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital, conducting outpatients on Thursday when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998 followed immediately thereafter by [redacted] so that she did not return to work until February 1999. The Trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover, but the reality was that given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. The Committee will appreciate therefore that for much of the relevant period in 1998 with which it is concerned, Dr Barton had no effective consultant support on one of the two wards for which she had responsibilities, with the consultant role on the other ward already being limited.

Dr Barton would arrive at the Hospital each morning when it opened about 7.30am. She would visit both wards, reviewing patients and liasing with staff, before she then commenced her General Practitioner responsibilities at 9am. She would return to the Hospital virtually every lunchtime. New patients, of whom there were about 5 each week, would usually arrive before lunchtime and she would admit patients, write up charts and see relatives. Quite often, in particular if she was the duty doctor, Dr Barton would return to the Hospital after GP surgery hours at about 7pm. She was concerned to make herself available to relatives who were not usually able to see her in the course of their working day. She would attend the Daedalus ward round on Mondays with Dr Lord, but was unable to attend the round for stroke patients on Thursdays.

Further, Dr Barton was concerned to make herself available even outside those hours when she was in attendance at the hospital. The nursing staff would therefore ring her either at her home or at her GP surgery to discuss developments or problems with particular patients. In the event that medicine was to be increased, even within a range of medication already prescribed Dr Barton it would be usual for the nursing staff either to inform Dr Barton of the fact that they considered it necessary to make such a change, or would inform her shortly thereafter of the fact that that increase had been instituted.

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When Dr Barton first took up her post as clinical assistant the level of dependency of patients was relatively low. In general the patients did not have major medical needs. However, over time that position changed greatly. Patients who were increasingly dependent would be admitted to the wards, so that in time, and certainly by 1998, many of the patients were profoundly dependent with minimal Bartell scores. There was in consequence a considerable increase in the medical and nursing input required to care for such patients.

Further, at the relevant time the bed occupancy was about 80%. That was then to rise to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by Dr Barton when she attended each day.

As the Committee might anticipate over the 10 years in which she was in post, Dr Barton was able to establish a very good working relationship with the nursing staff at the hospital. She found them to be responsible and caring. They were experienced, as indeed Dr Barton herself became, in caring for elderly dependent patients. Dr Barton felt able to place a significant measure of trust in the nursing staff.

Over the period in which Dr Barton was in post there was no effective increase in the numbers of nursing staff. With the significant number of patients and the considerable increase in dependency over the period, the nurses, like Dr Barton, were faced with an excessive workload.

The picture therefore that emerges by 1998 at this cottage hospital is one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on Dr Barton were considerable indeed given that she was expected to deliver this significant volume of care within a mere 3 ½ sessions each week. As the Committee will appreciate from Dr Barton's evidence to the Interim Orders Committee, she raised this matter with management, albeit verbally, saying that she could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course Dr Barton felt unable to continue. She resigned from her post in 2000.

The Committee may feel it is of some significance that her position was then replaced, not with another part-time clinical assistant, but a full-time staff grade. Indeed, Dr Barton's present understanding is that this post may be increased to two full-time positions, and is a clear reflection of the very considerable demands upon her at the relevant time when she was struggling to cope with the care of patients. In addition, the Consultant cover to the two wards was increased to ten sessions per week in 2000. In 1998, Dr Barton had tried to raise the issue and could have walked away, resigning her position at that time. However, she felt obliged to remain, to support her colleagues, and more particularly, to care for her patients. In reality she was trying to do her best in the most trying of circumstances.

For Dr Barton caring for patients on a day by day basis therefore she was left with the choice of attending to her patients and making notes as best she could, or making more detailed notes about those she did see, but potentially neglecting others. In the circumstances, Dr Barton attended to her patients and readily accepts that her note

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keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point.

Similarly, in relation to prescribing Dr Barton felt obliged to adopt a policy of pro-active prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance in particular out of hours. It was a practice adopted out of necessity, but one of which Dr Barton had trust and confidence in the nurses who would be acting on her prescripts, and indeed in which the nurses would routinely liase with her as and when increases in medication were made even within the authority of the prescription.

The Committee may feel that it is also of some significance that prescriptions of this nature by Dr Barton were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was Dr Barton ever informed that her practice in this regard was inappropriate.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, Dr Barton is anxious to emphasise the evidence which she gave at the Interim Orders Committee in this regard – that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload, and she did what she could given the constraints upon her.

Professor Ford comments in his report that there may have been inadequate senior medical input into the wards and that it would be important to examine this in detail. It does not appear from this that Professor Ford, or indeed the other experts, were informed by the police of the levels of nursing and medical staffing on the two wards in question. Such information would be of particular importance in evaluating properly any perceived failings on the part of 'junior medical staff' - Dr Barton. Indeed, as the committee will see from the questioning and responses on page 13 of the transcript of the IOC hearing, it may even be the case that Professor Ford was unaware that Dr Barton was the only member of the "non-consultant medical staff" and that she was part time at that.

It was in this context then that Dr Barton came to treat and care for the patients in question, and the committee will no doubt wish to consider that context carefully. With reference to the patients the committee may be further assisted by the following information:

Eva Page

Mrs Page was admitted to the Victory ward of the Queen Alexandra Hospital on 6th February 1998 suffering with anorexia, cachexia, depression and a 2 inch mass in her left hilum which was diagnosed on chest x ray as lung cancer. She had a history of heart failure and was receiving medication accordingly. It was felt that she was too ill to undergo bronchoscopy by way of further examination and on 12th February it was noted that she should receive palliative care and was not for resuscitation.

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On 16th February she was noted to be confused and deteriorating gradually. She was later transferred to Charles ward, a palliative care ward at Queen Alexandra Hospital, and from time to time was noted to be confused, frightened and calling out.

On 25th February Mrs Page was seen by Dr Lord who stopped all medication and commenced Thioridazine, before she was then admitted to the Gosport War Memorial Hospital 2 days later. Dr Barton saw her the same day, clerking her in and assessing her condition. By this stage Mrs Page was totally dependent with a Bartell score of zero. Dr Barton reviewed the notes from the Queen Alexandra Hospital and was aware of the assessments which had been made, including that relating to palliative care.

Dr Barton prescribed Thioridazine and Oramorph on an 'as required' basis. Although she was not in pain at the time, Dr Barton appreciated that given the diagnosis of lung cancer, pain relief with opiates might become necessary. Mrs Page was clearly very ill. In Dr Barton's view she was indeed in terminal decline as others had assessed her to be. Dr Barton recorded in the notes that she was happy for the nurses to confirm death.

It was Dr Barton's practice to record this in a patient's notes if it was felt that the patient was likely to die. This in no way reflected the nature or quality of care to be given to a patient. If a patient died unexpectedly, the nursing staff would be required to call out a duty doctor, there usually being no medical presence at the hospital. If a death was not unexpected - recorded by Dr Barton in this way - Dr Barton was content the nurses should confirm death in the first instance, with Dr Barton or Dr Lord to certify death when next available at the hospital.

In any event, the following day Mrs Page was noted by the nursing staff to be very distressed, calling out for help and saying that she was afraid. Thioridazine was given, but with no effect and it appears to have become necessary to call out the duty doctor.

By 2nd March it seems that Mrs Page was now also in pain. She was assessed by Dr Barton in the morning, who recorded that there had been no improvement on major tranquillisers and she suggested adequate opioids to control Mrs Page's fear and pain. Dr Barton prescribed a Fentanyl patch which would have the effect of a continuous delivery, but which can take some time to be effective. To cover the intervening period, Dr Barton also prescribed 5mgs of Diamorphine intramuscularly, to be given then, with a further 5mgs at 3pm.

From the records it is clear that Dr Lord saw the patient later that day and was aware of the medication which had been given. Dr Lord made two entries in the notes, and in the second she recorded that she had spoken with Mrs Page's son. It is apparent from the note that there had been a further deterioration in Mrs Page's condition and that Dr Lord believed she was dying.

Dr Barton was concerned that Mrs Page might require medication via a syringe driver as a more effective way of alleviating her pain and distress. She prescribed Diamorphine in a 20 - 200mgs/24 hours range as required, together with Hyoscine and Midazolam for subcutaneous delivery. On 3rd March, before the syringe driver was set up by the nursing staff, Mrs Page was noted to have deteriorated still further, and a left sided CVA was

suspected. Midazolam and 20mgs of Diamorphine to be delivered over 24 hours was commenced by syringe driver at 10.50 that morning. That would be the equivalent of the 60mgs of Oramorph she had received in the previous 24 hours. Mrs Page died peacefully at 9.30 that night.

Alice Wilkie

Mrs Wilkie was admitted to the Queen Alexandra Hospital on 31st July 1998 with a history of severe dementia. Her Bartel score was recorded at 1. She was reviewed again on 1st August and the clinician attending her then considered her condition was such that she should not be resuscitated in the event of emergency. She was seen by Dr Lord on 4th August who recorded that her overall prognosis was poor and confirmed that she should not be resuscitated. The plan was for Mrs Wilkie to be admitted to the Gosport War Memorial Hospital for observation.

That transfer took place on 6th August, and Mrs Wilkie was seen initially By Dr Peters, one of Dr Barton's partners, Dr Barton being on sick leave at the time. Dr Lord assessed Mrs Wilkie again on 10th August, recording that her Bartel score was now 2, confirming that she was profoundly dependent.

The nursing records contain no entries for the period 6th August - 17th August, suggesting that this was a time when the staff were profoundly stretched, but on 17th August Mrs Wilkie was noted to have deteriorated over the weekend and that her condition was worsening, from a state which had already been poor.

Dr Barton believes that she saw the patient on 20th August. Although she has not made an entry in Mrs Wilkie's notes, a prescription of subcutaneous Diamorphine - 20 - 200mgsover 24 hours, together with Midazolam and Hyoscine is recorded. 30mgs of Diamorphine over 24 hours with 20mgs of Midazolam was commenced at 1.30 that afternoon, via syringe driver.

Dr Barton saw Mrs Wilkie the following morning, noting the marked deterioration over the past few days and that subcutaneous medication had been commenced. A nursing entry shortly before 1.00 that afternoon recorded that Mrs Wilkie's condition had deteriorated during the morning but she was said to be comfortable and free from pain. Mrs Wilkie died later that day at 6.00pm.

Mrs Gladys Richards

Dr Barton has of course made a lengthy statement concerning the treatment of Mrs Richards, contained in the Committee's papers at pages 153 - 163. The Committee will no doubt consider that statement in detail, being Dr Barton's explanation.

Arthur Cunningham

Mr Cunningham, who suffered from Parkinson's disease and depression, was admitted to the Gosport War Memorial Hospital on 21st September 1998, having been reviewed that day at the Dolphin Day Hospital by Dr Lord. As Dr Lord recorded in her letter to Mr

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Cunningham's GP dictated the same day, Mr Cunningham had a large necrotic sacral ulcer which was extremely offensive. Dr Lord stated that he continued to be very frail.

In her notes in the hospital records, Dr Lord confirmed this, stating that the prognosis was poor and that Mr Cunningham should have 5 - 10mgs of Oramorph if he was in pain. 5mgs of Oramorph was then given at 2.50pm.

Dr Barton saw Mr Cunningham on 21st September, after his admission, and noted that he should have adequate analgesia. She was aware of Dr Lord's view of the poor prognosis and, agreeing with that assessment, Dr Barton recorded that she was happy for the nursing staff to record death.

The notes contain photographs of the sacral sore at the time of Mr Cunningham's admission, which are far from clear in the photocopies of the medical records now available. Dr Barton recalls, however, that it was about the size of a fist. Concerned that Mr Cunningham might require further pain relief in due course, through increasing pain and tolerance, Dr Barton prescribed Diamorphine - 20 - 200mgs, Midazolam 20 - 80mgs and Hyoscine over 24 hours subcutaneously, to ensure a continuous delivery of pain relief and that there would be no breakthrough pain.

A further dose of Oramorph was given at 8.15pm, but the nursing records show that Mr Cunningham appears to have remained in pain and required assistance to settle for the night. The syringe driver was commenced at 11.10 that night, delivering 20mgs of Diamorphine and 20mgs of Midazolam, following which Mr Cunningham slept soundly. He was noted to be much calmer the following morning.

Dr Barton would have seen Mr Cunningham each day. On 23rd September the nursing notes record that Mr Cunningham had become chesty and Hyoscine was added to dry the secretions on his chest. The records make clear the view that by this stage Mr Cunningham was dying. At 8pm on 23rd September the Midazolam was increased to 60mgs to maintain Mr Cunningham's comfort.

On 24th September Dr Barton noted that Mr Cunningham's pain was being controlled by the analgesia - just. The nursing records show that the night staff had reported Mr Cunningham was in pain when being attended to, and the day staff also noted pain. The Diamorphine was increased to 40mgs and the Midazolam to 80mgs accordingly. Mr Cunningham was then noted by the nurses to have a peaceful night.

The following day Mr Cunningham was seen by Dr Brooks, one of Dr Barton's partners, who confirmed that Mr Cunningham remained very poorly. Dr Barton also saw Mr Cunningham that day, writing up a prescription for Diamorphine for 40 - 200mgs, Midazolam at 20 - 200mgs, together with Hyoscine. In fact it was necessary to administer 60mgsof Diamorphine and 80mgs ofMidazolam/24 hours via the syringe driver in order to control the pain.

The following day, 26th September, Mr Cunningham's condition continued to deteriorate slowly. Diamorphine was increased to 80mgsover 24 hours, and the Midazolam to 100mgs to control the pain. Mr Cunningham then died peacefully at 11.15 that evening.

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Robert Wilson

Mr Wilson was admitted to the Queen Alexandra Hospital on 21st September 1998 with a fracture of the humerus. He had a history of alcohol abuse and heart failure, for which he was receiving medication. X ray revealed displacement, but Mr Wilson was unwilling to undergo surgery. He was in pain, receiving a range of painkillers, including opiates in the form of Morphine and Diamorphine.

On 29th September it was noted that resuscitation was considered inappropriate in view of the poor quality of life and the poor prognosis. On 8th October he was assessed by a psychogeriatrician who said that he was in low mood, presenting with a wish to die and disturbed sleep, possibly secondary to pain. She diagnosed early dementia, possibly alcohol related, and depression.

A decision was then made to transfer Mr Wilson to the Gosport War Memorial Hospital and Dr Barton clerked him in following his arrival on 14th October. Dr Barton noted the plan as gentle mobilisation. She believes Mr Wilson was in a degree of pain following his transfer, and she prescribed Oramorph in addition to Paracetamol on an 'as required' basis. Oramorph was given for pain relief at 2.45pm and 11.45pm on 14th October.

Dr Barton wrote a further prescription for Oramorph on 15th October, for 10mgs 4 hourly and 20mgs at night to control the pain in Mr Wilson's arm, which persisted. As a result of that Oramorph, Mr Wilson was noted to have settled and slept well.

Later that night Mr Wilson appears to have suffered what was thought to have been a silent myocardial infarction. Dr Knapman was called to see him on 16th October, and he increased the dose of Frusemide Mr Wilson was already receiving for his pre-existing heart failure. Dr Knapman noted a decline overnight with a shortness of breath, bubbling, and a weak pulse. He had significant oedema in the arms and legs, and was unresponsive to the spoken word.

Dr Barton believes she may have come in to see Mr Wilson later in the day. The nursing record for 15th October had noted that Mr Wilson had difficulty in swallowing, and as he would have had difficulty in taking Oramorph, Dr Barton decided in view of his condition now that he should receive pain relief subcutaneously, converting to Diamorphine via syringe driver. She prescribed 20 - 200mgs of Diamorphine, 20 - 80mgs of Midazolam, together with Hyoscine for the chest secretions. The Diamorphine was then commenced at 20mgs over 24 hours, entirely consistent with the 60mgsofOramorph which had been required for pain relief the previous day. As a result, the nursing records show that after the Diamorphine was commenced, Mr Wilson had not been distressed and appeared comfortable.

On 17th October Dr Peters was called to see Mr Wilson. Dr Peters noted that he was comfortable, though he had deteriorated. Dr Peters also recorded that the nursing staff should verify death if necessary. Later that day the Diamorphine was increased to 40mgs over 24 hours and Midazolam added at 20mgs/24 hours. Mr Wilson was producing significant secretions, requiring suctioning, apparently being in heart failure, and the Hyoscine was also increased. In consequence, the secretions were noted not to disturb him, and he appeared to be comfortable.

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The following day he was seen again by Dr Peters. The nurses noted that there had been a further deterioration in his already poor condition. The syringe driver was reviewed at 2.50 that afternoon, and the Diamorphine increased to 60mgs and the Midazolam to 40mgs. Mr Wilson continued to require regular suctioning and Dr Peters prescribed a further increase in the Hyoscine.

Mr Wilson continued to deteriorate in the course of the afternoon, and he died peacefully that night at 11.40pm.

Summary

Dr Barton endeavoured to care for her patients in what were clearly very difficult circumstances. She did not wish to abandon her consultant, her nursing colleagues and the patients. She raised her concerns with management, but to no avail. The information above about the individual patients will hopefully assist the Committee in considering this matter, coupled most importantly with an understanding of the situation in which Dr Barton found herself. I respectfully suggest that the Committee can reasonably conclude that this is not essentially a matter of professional conduct, but rather an issue of lack of resources and proper management.

Yours faithfully

Code A

Ian S P Barker
Solicitor

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.

A 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.

B 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 C 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?
D 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.
E 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 F 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?
G 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.

H Q Did that position change as time went on?
T A Reed & Co A That position changed.

A 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
B 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
C 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,
D 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
E commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on [redacted] 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...?
F 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
G 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
H 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.

T A Reed & Co

A 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.

B 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 C 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.

D 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 E 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 F 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.

G 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* H *Palliative Care Guide* and we all carry the *Wessex Palliative Care Handbook* around with us, which contains a sort of—

A

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.

B

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.

C

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.

D

E

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.

F

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.

G

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.

H

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

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?

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 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 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 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 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—
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.

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

A 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
B 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
C 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".

D 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
E 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
F 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.

G 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.

H 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 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. 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.

B

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 me.

C

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 sorry that you have not been given it in advance.

F

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 us", he says,

H

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
E letter reads,

"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.

Less than a month after I wrote a letter to the clinical director expressing my
F 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.

As a result, I am unable to do the clinical assistant job to a safe and
H 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".

B 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.

C 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
D 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
E 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".

F 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
G 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.

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

A 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 [redacted] who commenced her annual leave on 27 April 1998 and followed on with [redacted]
B leave from 1 June until 8 February 1999. So basically she was [redacted] and then she was gone for the rest of the year.

Q And no replacement or locum cover?
A No.

C 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!

D 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.

E 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
F 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
G 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.

H 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

A 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.

B 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.

D 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.

E 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.

F 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.

G 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.

H 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, 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. 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. 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 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.

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 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.

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
Protecting patients, guiding doctors

In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

12 September, 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

On 29 August 2002 the Preliminary Proceedings Committee considered the allegations about your conduct described in our letter of 11 July 2002, and the observations set out in your solicitor's letter of 27 August 2002.

The Committee determined that a charge should be formulated against you on the basis of the information and that an inquiry into the charge should be held by the Professional Conduct Committee.

In considering this case, the Committee noted that the case related to five patients between the ages of 75–91 who were attending Gosport War Memorial Hospital, mainly for rehabilitation. One person (Mrs Lack) who was an experienced nurse in elderly care was concerned about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. The Committee noted the fairly brief report of Dr Mundy, and Professor Ford's report which looked at all five cases. It noted the background to the case as a whole, which was that you were a visiting clinical assistant who was responsible for the day-to-day management of these five cases. It noted that overwork had apparently affected patient care.

It noted that in the case of Mrs Richards she had lost a hearing aid and her spectacles, and was brought in in an agitated state, probably because of sensory deprivation. She became ambulant with a Zimmer, but her hip replacement became dislocated following a fall. This patient was prescribed the same set of drugs which was used in each of the other cases: Oramorph, hyoscine and midazolam. It noted that some patients had up to 60–80 mg in 24 hours via subcutaneous injection with a syringe driver.

The Committee noted that Mrs Richards received no foods or fluids between 18 – 21 August and died because of the combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened

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the patient's life. It noted Professor Ford's comments about the prescribing regime. It noted with concern that the medical records are not signed regarding the subcutaneous drugs regime and it noted the pattern in which an elderly group of patients were the subject of apparently reckless and inappropriate prescribing. The Committee agreed that death appeared to have been precipitated if not caused by the drug regime in each case.

In considering this case, the Committee was mindful that palliative care is now a well-developed clinical area. If death is accelerated as a result of carefully titrated, good symptoms control, then as a side-effect it may be acceptable. This did not appear to be the case here, and the Committee was of the view that the matter unequivocally needs to be tested by the Professional Conduct Committee. The Committee was concerned that you appear to have moved patients very quickly onto a regime where they were receiving terminal care, and ignored the recommendations regarding doses in the BNF, rapidly prescribing excessive doses.

Every effort is made to give reasonable notice of the date of a Professional Conduct Committee hearing. Notice of the date and time of the proposed inquiry, and of the exact terms of the charge to be considered, will be sent to you by the Solicitor to the Council at least twenty-eight days before the date fixed for the hearing. No date has yet been fixed for the hearing of your case. If there are any particular dates which you would prefer the GMC to avoid, could you please let Michael Keegan know **in writing** as soon as possible.

If you intend to consult your medical defence society, your professional association, or take other legal advice, you should do so without delay. It is in your best interests to begin as soon as possible the preparation of your case for the Professional Conduct Committee hearing, notwithstanding that the exact date and time of the hearing have not yet been specified. You should also notify your advisers as soon as you receive the formal notice of the date of the inquiry.

Code A

c.c. The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ
(Your Reference: ISPB/TOC/9900079/Legal)

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In reply please quote VC/MK/2000/2047

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

13 September 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

I am writing to notify you that the information about your conduct received from Hampshire Constabulary and referred by the Preliminary Proceedings Committee on 29 August 2002 for an inquiry by the Professional Conduct Committee, has now been considered by the President of the GMC under Rule 4(a) of the General Medical Council (Interim Orders Committee) (Procedure) Rules 2000.

The information considered by the President is as was considered by the Preliminary Proceedings Committee, a copy of which I enclose. The President was also made aware that the Police and the Crown Prosecution Service are now considering all five cases against you.

The President has noted the powers vested in the General Medical Council by the Medical Act 1983 (Amendment) Order 2000 and the General Medical Council (Interim Orders Committee) (Procedure) Rules 2000 and considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee in order that it may consider whether it is necessary for the protection of members of the public or is otherwise in the public interest, or is in your own interests that an interim order should be made suspending your registration or imposing conditions on your registration in exercise of the powers under section 41A(1) of the Medical Act 1983 as amended.

The President reached his decision having considered the information that the Police and Crown Prosecution Service are now investigating five cases and the fact that the Preliminary Proceedings Committee considered it necessary to refer this case for an inquiry by the Professional Conduct Committee.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

You are invited to appear before the Interim Orders Committee at 11.30 on 19 September 2002 at the Council's offices at 44 Hallam Street, London, W1, if you so wish, to address the Committee on whether such an order should be made in your case. You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may be a member. You may also be accompanied by not more than one medical adviser. The Committee is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of Adam Elliott, Committee Section (fax no 020 7915 7406).

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The Interim Orders Committee normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Adam Elliott, Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Adam Elliott (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, and a paper about the procedures of the Interim Orders Committee.

The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

Code A

cc: **By Courier**
Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
(your reference: ISPB/TOC/9900079/Legal)

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF: BARTON, Jane Ann

PROCEEDINGS

T.A. REED & CO.

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF:

BARTON, Jane Ann

MS F HORLICK, Counsel, instructed by Messrs Field Fisher Waterhouse, Solicitors to the Council, appeared to present the facts.

MR A JENKINS, Counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

PROCEEDINGS

Transcript of the shorthand notes of T A Reed & Co,
13 The Lynch, Hoddesdon, Hertfordshire, EN11 3EU
Telephone No: 01992 465900

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 [redacted] 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.

A

> "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:

B

> "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."

C

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.

D

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.

E

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.

F

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."

G

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

H

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

A 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.

B 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.

C 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.

D 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:

E

> "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."

F 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

G 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.

H 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.

MG11

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WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

Home Address:

Post Code :

Home Telephone No: **Mobile / Pager No:**

E-Mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Contact Point *(if different from above)*:

Address:

Work Telephone No:

Male ☐ **Female** ☐ **Date and Place of Birth:** Place

Maiden name: **Height:** **Ethnicity Code:**

State dates of witness non-availability:

I consent to police having access to my medical record(s) in relation to this matter	**Yes** ☐ **No** ☐ **N/A** ☐
I consent to my medical record in relation to this matter being disclosed to the defence	**Yes** ☐ **No** ☐ **N/A** ☐
The CPS will pass information about you to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services.	☐

Does the person making this statement have any special needs if required to attend court and give evidence? *(e.g. language difficulties, visually impaired, restricted mobility, etc.).* **If 'Yes', please enter details.**	**Yes** ☐ **No** ☐
Does the person making this statement need additional support as a vulnerable or intimidated witness? If 'Yes', please enter details on Form MG2.	**Yes** ☐ **No** ☐
Does the person making this statement give their consent to it being disclosed for the purposes of civil proceedings *(e.g. child care proceedings)*?	**Yes** ☐ **No** ☐

Statement taken by *(print name)*:

Station:

Time and place statement taken:

Signature of witness: .....

Signed : S.A.WATTS. Signature witnessed by : .....

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Statement of : STEVEN ALEC WATTS

Age if under 18: *(if over 18 insert 'over18')* **Occupation:**

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature: ..... **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Detective Chief Superintendent Steven WATTS, Head of Hampshire Constabulary Criminal Investigation Department and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

Signed : **S.A.WATTS.** Signature witnessed by : .....

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Statement of : STEVEN ALEC WATTS

On the 9th November 2000 Professor Brian LIVESLY reported on the death of a patient, Mrs. RICHARDS.

On the 12th February 2001 Professor FORD reported in respect of the deaths of five patients RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE.

On the 18th October 2001 Professor MUNDY reported on the deaths of patients CUNNINGHAM, WILKIE, WILSON and PAGE.

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

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Statement of : STEVEN ALEC WATTS

All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Dr Jane BARTON prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr BAKER, commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

Category one- There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.

Category two - Specific concerns that these patients had received 'sub optimal' care.

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

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have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three **Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.**

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of in the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

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Statement of : STEVEN ALEC WATTS

investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

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In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"***Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation.***"

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Argent (1997). The court commented in this case that the police have

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no obligation to make disclosure. In R v Imran and Hussein (1997) the court agreed that it would be wrong for a defendant to be prevented from lying by being presented with the whole of the evidence against him prior to interview.

R v Mason (1987) covers disclosing or withholding information, the process must be justifiable and conducted in the full knowledge of the likely consequences. These consequences could affect not only any subsequent interview but also potentially the whole investigation and any subsequent trial.

Article 6 Human Rights Act deals with the right of an individual facing criminal charge to have a fair and public hearing

Advance disclosure of documentation prior to interviews under caution gives any potential suspect the opportunity to interfere with the interviewing of other witnesses who may have information beneficial to the case.

Furthermore the suspect does not have the opportunity to respond to questioning in an uncontaminated way. They may well respond with answers that they think the police wish to hear. This is unfair to the individual concerned.

Finally early disclosure of material can lead to a suspect fabricating a defence or alibi.

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The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Dr BARTON and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

'Dr BARTON has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients 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.

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During a 13month periods from April 2003 Dr BARTON had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'

' have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Arthur CUNNINGHAM - this has been assessed as a category three case and is being investigated accordingly.

Robert WILSON - again a category three case.

Gladys RICHARDS.- Assessed as a category two 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.

Alice WILKIE. – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

Signed : S.A.WATTS. Signature witnessed by : .....

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HARRY HADLEY

Harry Hadley

Date of Birth: Code A
Date of admission to GWMH: **5th October 1999**
Date and time of Death: **06.50 hours on 10th October 1999**
Cause of Death:
Post Mortem:
Length of Stay: **5 days**

Mr Hadley's past medical history:-

Code A

Code A

On admission an assessment sheet was completed noting that Mr Hadley appears fully aware of his condition stated that he is dying but wishes it was sooner rather than later. It noted that he wore glasses for long distances and reading and that he had a small appetite and had difficulty with chewy food. Care plans were commenced on 5th October 1999 for hygiene, catheter care – penis oedematous and scrotum swollen and skin excoriated, pain in pressure area – broken area x 2 to left buttock, cleft of buttock excoriated and heels discoloured and at risk, constipation, reduced appetite and help to settle at night.

A nutritional screening tool was also completed on 5th October noting a score of 17.

A Waterlow score of 15 was recorded on 5th October, pressure sore documentation noted that Mr Hadley was nursed on a Pegasus mattress and that dressing of duoderm was applied to buttocks.

A Barthel ADL index also dated 5th October scored 3.

A handling profile on 5th October noted that Mr Hadley was able to communicate effectively, that he had pain in the lower half of his body when turned, that he had 2 broken areas on his left buttock and that the cleft of his buttock was excoriated. It also noted that Mr Hadley needed the help of two nurses and nursed on a Pegasus airbed.

5th October 1999

Clinical notes state CA bladder with metasteses. Has been in a little discomfort. For TLC. Family concerned re: change in medication.
Summary states admitted from C3 Royal Haslar Hospital admitted there on 22th September 1999 with acute retention of urine.
15.00 hours seen by Dr Pennels MST discontinued for diazepam 5mgs.
19.30 hours relatives expressed concern over medication and analgesia control. Dr Shawcross to rewrite MST.

6th October 1999

Clinical notes state that Mr Hadley is fine to have MST.

7th October 1999

Summary states seen by Dr Pennells commenced on syringe driver 60 mgs diamorphine 100mg cyclomize happy for that to be increased. Daughter visited and explained about syringe driver and poor prognosis.

8th October 1999

Summary notes seen by Dr Shenton second syringe driver commenced.

9th October 1999

Clinical notes state agitated, restless, twitchy ++, seems unable to speak yet looking around. Rattly chest.
Was on 20mg MST bd changed to syringe driver from past 48 hours with 60mg diamorphine for past 24 hours.
Wonder if agitation is due to rapid increase in diamorphine or hyoscine. Try reducing diamorphine back to 30 mgs in 24 hours (equiv to 50mg MST bd).
PM – getting chesty and distressed increase rate from 60mm/day to 99 and then change to 60mg diamorphine over 24 hours when it runs out.
Hyoscine can be given 4-5 hourly.
Summary state seen by Dr Yeo diamorphine reduced to 30 mgs very chesty.
21.30 hours distressed seen by Dr Chilvers syringe driver increased from **60mm to 99mm over 24 hours**. When infusion complete resume to 60mm with 60mg diamorphine.

10th October 1999

Patient confirmed dead at 06.50 hours by S/N Pe?

Expert Review

Harry Hadley

No. BJC/22

Date of Birth: Code A

Date of Death: 10 October 1999

Mr Hadley was admitted to Gosport War Memorial Hospital on 5 October 1999. At the time he was fully aware of his condition having been diagnosed with carcinoma of the bladder in July 1999. Mr Hadley was immobile and required the assistance of nurses plus aides.

Mr Hadley died on 10th October 1999. In the last five days before his death Mr Hadley was inexpertly treated with opioid analgesics although this did not in any way substantively alter the prognosis.

ALAN HOBDAY

Alan Hobday

Date of Birth: Code A Age: 75
Date of admission to GWMH: **24th July 1998**
Date and time of Death: **22.45 hours on 11th September 1998**
Cause of Death:
Post Mortem:
Length of Stay: **50 days**

Mr Hobday's past medical history:-
1990 – TURProstatectomy

Mr Hobday lived with his wife in a bungalow. They had a son and daughter and very supportive family. Mr Hobday was a very well man prior to his collapse. He was allergic to penicillin.
Mr Hobday collapsed while out eating and was taken by ambulance to St Mary's Hospital and diagnosed with suffering a left CVA and right hemiplegia. Mr Hobday was admitted to Gosport War Memorial Hospital on 24th July 1998.

On admission care plans commenced on 25th July 1998 for sleep, catheter, shoulder pain, dysphagia, elimination, hygiene and communication.
A lifting/handling risk calculator was taken on 24th July 1998 scoring 23. So a handling profile was completed on 25th July 1998 noting that Mr Hobday needed the assistance of 2 nurses and a hoist, that his skin was intact and that he was to be nursed on a Pegasus biwave plus mattress.
A nutritional assessment plan was completed on 4th September 1998 with a score of 12 recorded.
An assessment sheet was completed noting that Mr Hobday was unable to communicate,
A Waterlow score of 25 was recorded on 24th July 1998.
A Barthel ADL index wad recorded weekly starting on 24th July 1998 scoring 0 and the last one recorded on 9th September 1998 also scoring 0.

24th July 1998

Clinical notes admitted to Daedulus ward. Barthel 0 needs all help with ADL. In view of poor prognosis please make comfortable. **Happy for nursing staff to confirm death.**

25th July 1998

Contact record – wife and daughter seen aware of condition and prognosis and recovery will be limited.

30th July 1998

Clinical notes state catheterised. Pulling out S/C fluids does not want NG feed. Prognosis poor. Wife and daughter seen they feel he has settled and improved from a week ago. Poor swallow, aspiration and possible chest infection. Diamorphine/haloperidol PM if distressed.

31st July 1998

Clinical notes seen by SLT continue with puree diet and thickened fluids.

3rd August 1998

Clinical notes remains poorly.

6th August 1998

Contact record – found on floor in lounge. No injury apparent. Accident form completed.

12th August 1998

Clinical notes has made some progress. Family seem realistic about future.
Contact record – discussion with wife and daughter definite improvement made with physical condition. Discussed future care they seem realistic about his capabilities.

16th August 1998

Contact record – found on floor in day room. Put back to bed. Accident form completed. Wife informed.

17th August 1998

Clinical notes very agitated at times. Suggest S/C haloperidol.

20th August 1998

Clinical notes seen by dietician continue on puree diet and thickened fluids.
Slow progress can push himself out of chair.

22nd August 1998

Contact record – found on floor in day room. No apparent injury. Hoisted into bed. Accident form completed.

7th September 1998

Contact record – twitching (facial) complaining of not feeling well. Dr Barton and wife informed.
Seen by Dr Barton commence **diamorphine 20mgs via syringe driver.** Wife and daughter seem to understand may deteriorate.

9th September 1998

Contact record – **diamorphine increased 40mgs** became very restless and appeared in discomfort.

10th September 1998

Clinical notes extended stroke on 6th September 1998 with facial seizures affecting right side of face. Now on syringe driver secretions +++ but seems comfortable. He's dying, family aware.
Contact record – seen by Dr Lord coughing and bubbling chest. Move to continuing care bed.

11th September 1998

Contact record – syringe driver renewed at 9.45 diamorphine 40mgs.
Clinical notes condition deteriorated rapidly.
Pronounced dead at 22.45 hours by S/N Roberts relatives present.

Expert Review

Alan Hobday

No. BJC/26

Date of Birth: Code A

Date of Death: 11 September 1998

Mr Hobday had suffered a stroke in July 1998 and was admitted to hospital. He was transferred to Gosport War Memorial Hospital on 24 July 1998 for further rehabilitation.[AH1]

On the clinical notes it would appear that he extended his stroke on 6 September 1998 and thereafter developed focal seizures with increased pain in his arm.

Diamorphine was started via a syringe driver and Mr Hobday died on 11 September 1998.

The expert report confirmed that although higher doses of opiates were used than may have been necessary, Mr Hobday's cause of death was due to his stroke.

HAMPSHIRE CONSTABULARY

EVA PAGE

Eva Page

Date of Birth: Code A Age: **88**
Date of admission to GWMH: **27th February 1998**
Date and time of Death: **21.30 hours on 3rd March 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **5 days**

Mrs Page's past medical history:-
Confusion
1995 - Atrial fibrillation
CCF
1995 – LVF
1997 – TIA
1995 – Digoxin Toxicity

Mrs Page was widowed and lived at Chesterholm Lodge Residential Home. She had a son.
Mrs Page was admitted to Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility, sleeping a lot and becoming dehydrated. She was transferred to Gosport War Memorial Hospital on 27th February 1998 for palliative care.

On admission a Barthel ADL index score was recorded of 2. Care plans commenced on the day of admission for settle at night, constipation, catheter care and personal hygiene.
An handling profile which noted Mrs Page can make her wishes known, she had pain on movement, dry paper thin skin, to be nursed on Pegasus biwave mattress, she had a catheter insitu for retention of urine and needs help of 2 nurses and a hoist was completed on 28th February 1999. A Waterlow score of 27 recorded also on 28th February 1999.

27th February 1999

Admitted from Queen Alexander Hospital for palliative care. It was noted that Mrs Page was withdrawn and anxious. That she would call out frequently and needed reassurance. Also noted was that Mrs Page was on a normal diet and fluids was incontinent of faeces had a catheter for retention of urine and needed help with all hygiene needs.
The transfer form noted that Mrs Page has bio? to red sacrum, an old facial wound from 15th February 1998 after fall (scabs on nose) and swelling inner left eye.

Summary – admitted from Charles Ward for palliative care.
Clinical notes – opiates commenced. **Happy for nursing staff to confirm death.**

28th February 1999

Summary – very distressed, calling for help and saying she is afraid.
Oramorph 2.5mgs given with no relief. Thioridazine given with no effect
Clinical notes – jerks a lot agitated. Not in pain.

2nd March 1999

Summary – commenced fentanyl 25mgs this am. Very distressed. Seen by Dr Barton to have diamorphine 5mgs IM given at 8.10. Seen by Dr Lord diamorphine 5mgs IM given for syringe driver with diamorphine.
Clinical notes – no improvement. Quieter PM S/C diamorphine. Fentanyl patch started today.
Agitated and calling out even when staff present.
Ct fentanyl patches. Son seen concerned about deterioration today. Explained agitation and drowsiness was probably due in part to diamorphine accepts mother is dying and agrees continue present plan.

3rd March 1999

Summary – rapid deterioration this AM. Neck and left side rigid. Syringe driver commenced at 10.50 with diamorophine 20mgs and midazolan 20mgs.
Son stayed all day aware of poor prognosis.
Condition deteriorated died 21.30 for cremation.
Clinical notes – Died peacefully verified by SN Dorrington. Son informed for cremation.

Expert Review

Eva Page

No. BJC/35

Date of Birth: Code A

Date of Death: 3 March 1998

Mrs Page was transferred to Gosport War Memorial Hospital on 27 February 1998 for palliative care having been treated at Queen Alexander Hospital as an emergency suffering with anorexia, decreasing mobility and dehydration.

On admission to Gosport War Memorial it was apparent that Mrs Page was dying of carcinoma of the lung. She was confused and agitated to begin with and a trial of tranquillisers did not produce any improvement. She was treated with Diamorphine and a Fentanyl patch mainly for sedation although the expert questioned whether this was appropriate in view of the lack of pain complained of. The experts agree that the cause of death was natural.

HAMPSHIRE CONSTABULARY

GWENDOLINE PARR

Gwendoline Parr

Date of Birth: Code A Age: **87**
Date of admission to GWMH: **31st December 1998**
Date and time of Death: **13.10 hours on 29th January 1999**
Cause of Death:
Post Mortem:
Length of Stay: **30 days**

Mrs Parr's past medical history:-

Dementia.
June 1991 – Heart block - pacemaker
Cholecystectomy
Appendicetomy
Basal cell carcinoma left cheek
1998 – Fracture neck of femur – dynamic hip screw
1998 – Repair umbilical hernia
Insulin dependent diabetic (diet controlled)

Code A

Code A Mrs Parr was admitted to Gosport War Memorial Hospital on 31st December 1998 for gentle rehabilitation after being admitted to Haslar following a fall where she sustained a fracture neck of femur and underwent surgery for dynamic hip screw on 14th December 1998. During her stay at Haslar Mrs Parr developed acute abdominal pain and on 24th December 1998 underwent an umbilical hernia repair.

On admission to Gosport War Memorial Hospital care plans commenced for hygiene, settle at night, catheter care, constipation.
A lifting/handling risk calculator was completed on 31st December 1998 and 17th January 1999 both scoring 10. A handling profile was completed on 1st January 1999 noting that Mrs Parr needed the help of 2 nurses and a hoist, she had dry skin but intact and was to be nursed on a biwave mattress.
A mouth assessment form was completed.
A Barthel ADL index was completed weekly from 31st December 1998 to 24th January 1999 ranging from 2 at the start and then 1 at the end.
A weekly Waterlow score was taken from 31st December 1998 to 11th January 1999 scoring from 25 to 32.

HAMPSHIRE CONSTABULARY

31st December 1998

Admitted To Gosport War Memorial Hospital from Haslar following fall on 11th December 1998 and dynamic hip screw surgery on 14th December 1998. Mrs Parr developed acute abdominal pain on 24th December 1998 and later the same day underwent an umbilical hernia repair. Mrs Parr also had been catheterised. She was admitted for gentle rehabilitation. Transfer letter noted that Mrs Parr needed help with personal care, encouragement to mobilise and her skin was in tact.

Clinical notes – for gentle rehabilitation probably needs long term care either at Dryad Ward or Nursing Home. Left buttock ulcer.

4th January 1999

Summary – right leg remains externally rotated and shortened. Seen by Dr Barton. X-rays taken.

5th January 1999

Summary – seen by Dr Lord to have left knee X-rayed.

6th January 1999

Summary – found sitting on floor in lounge at 21.30 no injuries, not distressed.

18th January 1999

Summary – grand-daughter aware of poor prognosis. Deterioration.
Frusemide given and 850 mls urine passed.

23rd January 1999

Summary – general deterioration. Oramorph 5mgs given at 15.00 with little effect. Daughter Margaret very ill, for terminal cancer care. Family will try and bring Margaret in to see Mrs Parr.

24th January 1999

Summary – remains poorly.

25th January 1999

Summary – syringe driver commenced 19.45 hours diamorphine 20mgs.
Fentanyl commenced at 8.40 25mgs removed at 19.00.

27th January 1999

Summary – condition remains ill and deteriorating. Comfortable at present. Dose in syringe driver. 21.35 syringe driver reprimed with 20mgs diamorphine.

28th January 1999

Summary – syringe driver recharged 20.20 diamorphine 20mgs.

29th January 1999

Remains very poorly. Happy for nursing staff to confirm death.
Summary – died peacefully at 13.10 hours. Verified by SN Shaw and Sister Hamblin.

Expert Review

Gwendoline Parr

No. BJC/36

Date of Birth: Code A

Date of Death: 29 January 1999

Mrs Parr had been admitted to the Royal Haslar Hospital in December 1998 following a fall where she sustained a fractured neck of femur. She underwent surgery for a dynamic hip screw on 14 December 1998. During her stay at the Royal Haslar Mrs Parr developed acute abdominal pain and underwent umbilical hernia repair on 24 December 1998. She was admitted to Gosport War Memorial Hospital on 31 December 1998 for rehabilitation.

The family note in the officer's report that they visited Mrs Parr daily at the Hospital and stated that "she was very chirpy and stated that she would soon be walking and going home".

Mrs Parr was noted to have deteriorated by 23 January 1999 and was commenced on Oramorph and thereafter remained poorly.

Mrs Parr died on 29 January 1999.

Dr Naysmith notes that Mrs Parr was deteriorating before the opioids were started but that the first dose of Diamorphine given would have been high even for a lady with normal renal function. This contrasted with Dr Ferner who records the treatment as being optimal with the drugs being given in "proportional doses".

Code A

Code A

Code A

Code A

DAPHNE TAYLOR

6.50 BJC/47 Daphne Taylor

Date of Birth: Code A Age: **70**
Date of admission to GWMH: **3rd October 1996**
Date and time of Death: **01.25 hours on 20th October 1996**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **18 days**

Mrs Taylor's past medical history:-
Hypertension
Vertigo of central origin
Bilateral visual impairment due to ischaemic retionpathy

Code A

Code A Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a stroke. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

On admission care plans commenced for sleep, pain right arm left leg, PEG feed, bowels, catheter, personal hygiene, immobile, at risk of developing pressure sores, has scratches on left leg and mouth care.
An assessment form was completed noting that Mrs Taylor wore a hearing aid in her left ear, wears glasses and is blind in left eye, unable to walk, is PEG fed and has been catheterised.
A Barthel ADL index was completed with a score of 0 recorded.
A Waterlow score of 20 was recorded.

3rd October 1996

Transfer form – admitted for rehabilitation after CVA, catheterized, drowsy, PEG fed, understands, but has no speech.
Summary - admitted from A5 Haslar to Daedulus ward with left CVA right hemiplegia. NBM swallowing reflex absent. Seen by Dr Barton medications boarded, chesty and rattly.

7th October 1996

Summary – Seen by Dr Barton appears to be in pain, boarded for Fentanyl patches 25mgs every three days. MRSA swab.
Seen by Dr Lord to be referred to dietician and Speech and Language therapy, seen husband not to be transfused.
Clinical notes – poor prognosis aim to maintain BP.

HAMPSHIRE CONSTABULARY

9th October 1996

Summary – in a great deal of pain boarded for 50mgs Fentanyl patches.
Clinical notes – condition deteriorated. **Nursing staff may confirm death.**
Would not use antibiotics but make comfortable.

10th October 1996

Summary – Fentanyl patch renewed as patch applied on 9th fell off.
Authorised by Dr Barton.

11th October 1996

Summary – more settled. MRSA negative.

17th October 1996

Summary – Left arm elbow still very painful on movement. Dr Barton seen
X-ray from Haslar has requested repeat X-ray.

18th October 1996

Summary – AM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs diamorphine and midazolam 20mgs over 24 hours.
Fentanyl patch removed appears more comfortable.
PM appears more peaceful and relaxed, no pain, rousable on turning.
Family seen by Dr Barton and informed of poor prognosis. Feed to continue.
Clinical notes – condition deteriorated last night S/C analgesia commenced.

19th October 1996

Summary – condition deteriorating, chesty very bubbly. Diamorphine 40mgs via syringe driver. Husband contacted still wishes feeding to continue.

20th October 1996

Summary – 01.25 hours died peacefully for cremation. Verifed by SSN Tubbritt and S/N Nelson.

Expert Review

Daphne Taylor

No. BJC/47

Date of Birth: Code A

Date of Death: 20 October 1996

Mrs Taylor was admitted to the Royal Haslar Hospital on 29 September 1996 after suffering a cerebrovascular accident. She was transferred to the Gosport War Memorial Hospital on 3 October 1996 for rehabilitation.

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed Fentanyl patches.

Mrs Taylor was noted to be in a great deal of pain and the strength of the Fentanyl patches were increased.

On 18 October, following a very unsettled night when Mrs Taylor appeared to be distressed and in pain, a syringe driver was set up with 40mgs of Diamorphine and 20mgs of Midazolam over twenty-four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However, she was prescribed rapidly escalating doses of opioids without there appearing to be a comprehensive assessment made for her pain.

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.

HAMPSHIRE CONSTABULARY

VICTOR ABBATT

Victor Abbatt

Date of Birth: Code A Age: 77
Date of Admission to GWMH: **29th May 1990**
Date and time of Death: **00.05hours on 30th May 1990**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **1 day**

Code A

Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29th May 1990 as an emergency, requested by Dr Barton. His wife could no longer cope with him at home.
On admission Mr Abbatt was assessed and his medication was boarded.
The foot of his bed was elevated because his ankle and foot were oedematous.
During the night Mr Abbatt became very confused and incontinent of urine.
He was given Temazepam 10 mgms at 22.15 hours.
Mr Abbatt died at 00.05 hours on 30th May 1990, his son and daughter were informed and his death certified by Dr A? and S/N Bro?.

Expert Review

Victor Abbatt

No. BJC/01A

Date of Birth: Code A

Date of Death: 30 May 1990

Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Dr Barton requested this as his wife could no longer cope with him at home.

On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him.[VA1]

The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Mr Abbatt was already very unwell.

HAMPSHIRE CONSTABULARY

DENNIS AMEY

Dennis Amey

Date of Birth: Code A Age: **62**
Date of Admission to GWMH: **14th November 1990**
Date and time of Death: **16.30 hours on 20th December 1990**
Cause of Death:
Post Mortem:
Length of Stay: **38 days**

Mr Amey past medical history shows that he suffered from:-
Parkinson's disease

Code A

Code A. He was admitted on 7th November 1990 for terminal care, he suffered from Parkinson's disease.
Mrs Amey requested that her husband was admitted.
Mr Amey had problems with his catheter, he was incontinent and was having spasms and was in pain.
He needed help with feeding and had difficulty with swallowing. He was noted to be irritable by the duty doctor.
He was nursed on a Pegasus mattress and had red sores.
It was noted in the clinical notes that he had pus discharging from his penis and had gangrenous areas around his scrotum and that he needed pain relief.

On 19th December 1990 Mr Amey was written up for **Diamorphine to be administered using a syringe driver**. The dosage was 120mgs over a 24 hours period.
On 20th December 1990 Mr Amey died at 16.30 hours.

Expert Review

Dennis Amey

No. BJC/02

Date of Birth: Code A

Date of Death: 20 December 1990

Mr Amey was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Mrs Amey. Mr Amey at that time had problems with his catheter, he was incontinent and was having spasms. Mr Amey had very severe Parkinson's disease. He was admitted for terminal care.[DA1]

Mr Amey was started on Morphine elixir on 11 December 1990 and by the time of his death on 19 December 1990 he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Dr Lawson notes that Mr Amey was very unwell and in pain.

The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain.

CHARLES BATTY

Charles Batty

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **September 1990**
Date and time of Death: **10.55 hrs on 2nd January 1994**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **3 years 3 months**

Mr Batty's past medical history states that she suffered from:-

1969 – Menieres
1973 – Partial gastrectscomy
1975 - Gastrectomy
1976 – Cervical spondylosis
1981 – Epilepsy
1984 – Prostatectomy benign
1989 – Colostomy – CA descending colon
Parkinson's Disease
History of depression.

Code A

Code A . Mr Batty was admitted to the Gosport War Memorial Hospital in September 1990 for Geriatric long stay and for physio and investigation for his Parkinson's disease. It was noted that as his Parkinson's worsened he was unsteady on his feet and needed a stick and the help of a nurse.

Care Plans for sleep, colostomy, catheter, noting urinary tract infection and retention and mobility noting problem right foot, personal hygiene, epilespy and agitated were completed dated 14th November 1993.
A care plan for commenced on 27th September 1993 for red sacrum.

20th December 1993

Seen by Dr Lord – no change.

28th December 1993

Complaining of generalised pain. Seen by Dr Barton. **Oramorph 10mg 6 hourly.**

30th December 1993

Nightmare end of last week disturbed and agitated. Quick and complete recovery.
Appears in pain **Oramorph increased** 10mg 4 hourly and 20mg nocte. ? whether pain is being controlled, difficulty taking oral medication. Discussed with Carol/Rhonda happy to put syringe driver.
11.30 hours syringe driver commenced **Diamorphine 40mgs.**

HAMPSHIRE CONSTABULARY

CHARLES BATTY

31st December 1993

General condition deteriorates. Nursed on side left buttock very red. Red/blackened area noticed. Syringe driver satisfactory. Assisted when patient turned. Twitching at times.

1st January 1994

Unchanged. Nursed on side. Skin marking also on right heel.

2nd January 1994

Mr Batty died at 10.55 hours. Next of kin informed. For cremation.

Expert Review

Charles Batty

No. BJC/06A

Date of Birth: Code A

Date of Death: 2 January 1994

Mr Batty was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Ménières.

He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear.

In December 1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment.

The experts review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team.

HAMPSHIRE CONSTABULARY

DENNIS BRICKWOOD

Dennis Brickwood

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **3rd February 1998**
Date and time of Death: **21.15 hrs on 12th June 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 weeks**

Mr Brickwood's past medical history:-

Masangio-proliferative glomerulonephritis due to chronic renal failure
Fracture neck of femur
CA prostate
Myeloma diagnosed on bone marrow
Spinal osteoporosis
Artrial fibrillation

Code A

Code A He fell and sustained a fractured neck of femur. Mr Brickwood had been his wife's main carer as she had also had hip replacements and was not mobile. It was hoped that he would be discharged home with a complete care package or go into residential care. He had deteriorating vision and had cataracts in both eyes. Mr and Mrs Brickwood had a son.

It was noted in Mr Brickwood's notes that he was allergic to morphine and was on warfarin.

Prior to his admission Mr Brickwood had a history of falls. He was a very alert man but slow at times.

He was admitted to Gosport War Memorial Hospital from Queen Alexander for rehabilitation following an operation where a dynamic hip screw was inserted.

A Waterlow score of 25 was recorded on 22nd April 1998 going down to 17. A Barthel ADL index was completed noting 11 on 18th April 1998 going up to 17 later. The aim was to rehabilitate Mr Brickwood with a view to him going home with a complete care package.

A nutritional assessment of 3 was recorded on admission.

15th January 1998
Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.

20th January 1998
Operation dynamic hip screw.

3rd February 1998
Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.

March 1998
OT assessment.

5th March 1998
Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine.** Need to be cautious previously been on MST.

6th April 1998
Unsuccessful home visit.

14th May 1998
Sore heels noted. Skin intact.

24th May 1998
Complained of excessive chest pain. Impression musculoskeletal pain.

4th June 1998
No improvement. Chesty very rattly. **For morphine**. Family happy with care and **syringe driver discussed**.

5th June 1998
Higher dose of oramorph given.

9th June 1998
Changed oramorph to MST. Complaining of chest pain.

10th June 1998
Taking MST/oramorph. For syringe driver is pain not adequately controlled.

11th June 1998
Painful back- swallow and appetite poor. Seen by Dr Knapman syringe driver commenced. Family informed.

12th June 1998
Deteriorating pronounced dead by S/N Giffin at 21.15 hours. Relatives present.

15th June 1998
Death certified. For cremation

Expert Review

Dennis Brickwood

No. BJC/06B

Date of Birth: Code A

Date of Death: 12 June 1998

Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.[DB1]

Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.

CHARLES HALL

Charles Hall

Date of Birth: Code A Age: 89
Date of admission to GWMH: **5th July 1993**
Date and time of Death: **11.25 hours on 6th August 1993**
Cause of Death:
Post Mortem:
Length of Stay: **32 days**

Mr Hall's past medical history:-
Peripheral vascular disease
Non insulin dependent diabetic
Iron deficiency anemia

Mr Hall was married and lived with his wife in their own home. They had a daughter and received good help form their neighbours. Mrs Hall was finding it increasingly difficult to cope.
Mr Hall was admitted to the Royal Haslar Hospital where he underwent a sigmoid colectomy and colostomy following diverticullitis and a gangerous gall bladder. He was transferred from Haslar Hospital to Gosport War Memorial Hospital on 5th July 1993 for nursing care and assessment.

Care plan were commenced on 5th July 1993 for a blackened area to left heel, 7th July 1993 right elbow red and flaky, sacrum red and dry, 10th July 1993 sacrum slightly red, 14th July 1993 hygiene, poor mobility, vomiting, urinary incontinence, settle at night and colostomy.
An assessment of daily living was completed noting that Mr Hall had some shortness of breath on exertion, needed a diabetic diet, colostomy satisfactory, mobilises short distances with Zimmer frame.
A Waterlow score of 21 was recorded on 5th July 1993 and one of 22 was recorded on 29th July 1993.

5th July 1993

Admitted to Sultan ward from Haslar for nursing care and assessment.
Sigmoid colectomy and colostomy five weeks ago following diverticullitis and gangerenous gall bladder. Readmitted to Haslar one week ago wife could not cope, appetite down, colostomy working ok.
Nursing report – admitted from Haslar refer to Social Worker.

HAMPSHIRE CONSTABULARY

10th July 1993

Clinical notes state vomited x 3 brown fluid.
Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.
15.10 hours fall getting off commode. Accident form completed.

13th July 1993

Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993

Clinical notes state Mr Hall was in renal failure.

15th July 1993

Clinical notes discussion with wife re poor prognosis.
Nursing report – seen by Dr Walters who has spoken with wife and patient re poor prognosis. Boarded for diamorphine 2.5mg-5mgs IM 4 hourly.

19th July 1993

Clinical notes state slightly better – pain at night from left foot. Morphine 5-10mg 4 hourly as required.
Nursing report – seen by Dr Walters boarded for oramorph 5-10mgs 4 hourly for neck pain.

22nd July 1993

Clinical notes state low R and diet. Continues to vomit. Sleeping better.

23rd July 1993

Nursing report – seen by physio wound treatment to heel discussed.

28th July 1993

Clinical notes state has necrotic heel – gradually improving.
Nursing report – referred to Dr Lord for long term care.

29th July 1993

Nursing report – seen by Dr Lord to be transferred to Daedulus ward.
Transferred to Daedulus Ward.
Clinical notes state seen by Dr Lord, Daedulus ward – renal failure much better. Diuretics stopped. Heel ulcer – black, sacrum red and vulnerable, confused. Suggest oral fluids and oramorph.

2nd August 1993

Clinical notes state black heel – 2" diameter, offensive, surrounding heel very red. Barthel 5. Encouraged fluids and oramorph if required.
Nursing report, seen by Dr Lord dressing to heel changed.

5th August 1993

Clinical notes state further deterioration needs analgesia and chat with wife.
Nursing report – condition deteriorating. Commenced on oramorph patient comfortable and appears pain free. Turned 2 hourly day and night.

6th August 1993

Nursing report – visited by wife at 10.30 hours fully aware of poor prognosis. Died peacefully 11.25hours certified by Sister Jones. Daughter contacted and Dr Barton informed.

Expert Review

Charles Hall

No. BJC/23

Date of Birth: Code A

Date of Death: 6 August 1993

Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

HAMPSHIRE CONSTABULARY

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Code A

Code A It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

HAMPSHIRE CONSTABULARY

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death.** It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

HAMPSHIRE CONSTABULARY

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.

Death verified by SR Hamblin and SN Barrett.

HAMPSHIRE CONSTABULARY

STANLEY CARBY

Stanley Carby

Date of Birth: **31st December 1933** Age: **65**
Date of Admission to GWMH: **26th April 1999**
Date and time of Death: **13.00 hrs on 27th April 1999**
Cause of Death:
Post Mortem:
Length of Stay: **1 day**

Mr Carby's past medical history states that he suffered from:-

Left hemiplegia secondary to CVA
Angina
Obese
Hypertension
Cardiac failure
Non insulin dependent diabetic (tablet controlled)
Prostatic hypertrophy depression.

Code A

Mr Carby was transferred to Daedalus Ward after suffering a CVA. He had undergone a CT scan which showed a right parietal infarct and an old infarct. His speech was slurred and he transferred using a hoist. He was eating and drinking with assistance.

A handling evaluation was completed noting a pressure relieving mattress was in place and his skin intact. It was noted that Mr Carby needed 2 nurses and a hoist for transfers.

On 26th April 1999 a Barthel ADL index was completed and scored 1, a Waterlow score of 23 was recorded noting Mr Carby to be at very high risk of developing pressure sores. A nutritional assessment was also completed with a score of 15 recorded.

Numerous care plans were started on 26th April 1999 including personal hygiene, constipation due to mobility, swallowing, left shoulder pain, pressure sore noting Waterlow score, air mattress pressure relieving cushion and no pressure noted but unable to move to observe all areas, dysplasia, incontinent catheter insitu and assistance to sleep.

26th April 1999

Admitted to Gosport War Memorial Hospital. Daedalus ward for rehabilitation.

Clinical notes state more than happy for nursing staff to confirm death.

HAMPSHIRE CONSTABULARY

27th April 1999

Contact record states Mr Carby is very agitated when family left, unable to get to swallow. Referred to speech and language therapist.
Breath very shallow – colour poor.
Dr Barton contacted and will attend. Seen by Dr Barton and family spoken to.
Cyanosed and clammy. Wife thinks he will not survive.
Dr said **"I will make him comfortable".**
Subcutaneous analgesia commenced.

Clinical notes state further deterioration this AM. Further extension of CVA.
Wife and daughter with him and aware. I will make more comfortable.
Mr Carby died at 13.00 hours. Family present.
Death confirmed by S/N Joyce and S/N Neville.
Family distraught and distressed.

Expert Review

Stanley Carby

No. BJC/07

Date of Birth: Code A

Date of Death: 27 April 1999

Mr Carby was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Mr Carby to have assistance with eating and drinking.

On 27 April 1999 Mr Carby suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke.

A syringe driver was set up with a high dose of Diamorphine and Midazolam. Mr Carby died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of Diamorphine makes the care sub optimal but it had no effect on Mr Carby's prognosis.

Code A

Code A

Code A

In reply please quote PCH/2000/2047

Special Delivery

30 September 2004

Dr Jane Ann Barton

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Barton

Thank you for your letter of 27 September 2004 confirming that you intend to attend the IOC hearing on 7 October 2004. Further to my letter of 24 September 2004, please find enclosed a copy of the item that will be considered by the Committee at that hearing.

It may be helpful if I bring two matters to your attention concerning the information. You will note that in the witness statement from Hampshire Police they state that they have referred 19 cases to the GMC which in their view are what they have classified as Category two cases. However, having reviewed the summary reports, it was the GMC's view that in five of those cases the information available at this time did not suggest that those cases should be considered by the IOC. You will also note at the end of the Item index that copies of the patient records are not in the enclosed papers, but that they will be available at the hearing. The records, as I am sure that you are aware, are volumous and it is our practice in such situations to have the records available at the hearing should either the Committee or the doctor require them. That said, if after considering the enclosed information you are of the view that you require a copy of the records, I will arrange for you to receive a copy expeditiously.

The GMC will be moving from its current premises into new offices on 1 October 2004. Unfortunately, this does mean that it is unlikely we will not be able to provide you with a copy of the records, should you require them, before Monday 4 October 2004. If you do require a copy, or if the MDU require a copy, could you please telephone me either tomorrow before 12:00 pm on **Code A** or on Monday 4 October on my new direct line number, **Code A**

Yours sincerely

Code A

Cc: Mr Ian Barker, The Medical Defence Union, MDU Services Limited, 230 Blackfriars Road, London, SE1 8PJ, ISPB/TOC/0005940/Legal

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

508

Neutral Citation Number: [2001] EWHC Admin 447
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

NO: CO/1643

Royal Courts of Justice
Strand
London WC2

Tuesday, 5th June 2001

Before:

LORD JUSTICE PILL

and

MR JUSTICE SILBER

THE QUEEN ON THE APPLICATION OF DR "X"

and

THE GENERAL MEDICAL COUNCIL

Computer-Aided Transcript of the stenograph notes of
Smith Bernal Reporting Limited,
180 Fleet Street, London EC4A 2HG

T Code A
(Official Shorthand Writers to the Court)

MR NICHOLAS PEACOCK (instructed by Hempsons, 20 Embankment Place, London WC2N 6NN) appeared on behalf of the Claimant
MR MARK SHAW (instructed by Field Fisher Waterhouse for the General Medical Council, 178 Great Portland Street, London W1W 5JE) appeared on behalf of the Defendant

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JUDGMENT
(As approved by the Court)

1. **LORD JUSTICE PILL**: The claimant, Dr X, applies to the court by virtue of section 41A(10) of the Medical Act 1983 ("the 1983 Act") to quash an order of the Interim Orders Committee ("IOC") of the General Medical Council ("GMC") made on 2nd March 2001 following an oral hearing on that day. The IOC ordered that the claimant's registration as a medical practitioner should be suspended with immediate effect for a period of 18 months. It was further ordered that the suspension should be reviewed by the IOC at a further meeting to be held within six months.

2. The claimant is a general practitioner at premises in the south east of England. Allegations of indecent assault are made against him by two of his nieces (now aged 15 and 13 years). Their father complained to the Social Service Department of the County Council and the Health Authority also became involved. The GMC were informed of the allegations. On 28th February 2001 the claimant was charged by the police with six counts of indecent assault. He was granted bail subject to conditions. By virtue of Articles 3 and 10 of the Medical Act 1983 (Amendment) Order 2000, the 1983 Act was amended by the addition of Committee and a new section. Section 41A reads, insofar as is material:

> "(1) Where the Interim Orders Committee are satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of a fully registered person, for the registration of that person to be suspended or to be made subject to conditions, the Committee may make an order (a) that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding eighteen months as may be specified in the order ('an interim suspension order') or; (b) that his registration shall be conditional upon his compliance, during such period not exceeding eighteen months as may be specified in the order, with such requirements so specified as the Committee think fit to impose (an 'order for interim conditional registration')."

3. Subsection (10):

> "Where an order has effect under any provision of this section, the court may (a) in the case of an interim suspension order, terminate the suspension; (b) in the case of an order for interim conditional registration, revoke or vary any condition imposed by the order; (c) in either case substitute for the period specified in the order (or in the order extending it) some other period which could have been specified in the order when it was made (or in the order extending it), and the decision of the court under any application under this subsection shall be final."

4. The "court" is the High Court (section 38 of the 1983 Act).

5. The IOC has it origins in the Amendment Order. Similar, though somewhat different, powers were formerly exercised by a different committee of the GMC. At the hearing on 2nd March 2001 both the claimant and the GMC were represented by counsel. The hearing was conducted by a committee of five members advised by a legal assessor. Some of the argument before the Committee turned upon the possibility of an interim conditional registration. It is common ground that it is not open to the court to take that course upon this application. The power of the court, subject to its power under section 41A(10)(c), is either to quash or to uphold the order of the IOC.

6. The approach to be adopted by the court is not in dispute. In Vale v General Dental Council (unreported) 14th October 1988 Watkins LJ stated at page 5:

> "It is vital to acknowledge in matters of this kind that a committee such as that under review here reaches its decision in circumstances such as concern us as a matter of discretion. Therefore it must be recognised that unless it can be demonstrated that in exercising that discretion the committee has not taken account of something it should have done, or has taken account of something it ought not to have done, it is unlikely that this Court would be in a position to say that the order of the committee appealed

against was wrong unless it concluded that otherwise the decision was manifestly wrong."

7. That approach was followed by Mustill LJ in Reza v General Medical Council (unreported) 23rd March 1990. It is accepted that the approach adopted in the Privy Council when a question arose in relation to the Professional Conduct Committee of the General Dental Council would also apply in this case. In Dad v General Dental Council [2000] 1 WLR 1538 Lord Hope stated at page 1542B:

> "It is well established, for very good reasons, that the Board will not interfere with the exercise of the discretion of the Professional Conduct Committee in matters relating to penalty. The assessment of the seriousness of the misconduct upon proof of a conviction is essentially a matter for the committee, in the light of their experience of the range of cases which come before them. They are best qualified to judge what measures are required to maintain the standards and reputation of the profession and to assess the seriousness of the misconduct. As a general rule therefore the Board will be very slow to interfere with decisions of the committee on matters relating to penalty. As Lord Upjohn said in McCoan v General Medical Council [1964] 1 WLR 1107, 1113, no general test can be laid down, as each case must depend on its own particular circumstances."

8. At page 1542F Lord Hope referred to a speech of Lord Diplock:

> "In Ziderman v General Dental Council [1976] 1 WLR 330, 333A-B, Lord Diplock observed that the purpose of disciplinary proceedings against a dentist who has been convicted of a criminal offence by a court of law is not to punish him a second time for the same offence but to protect the public who may come to him as patients and to maintain the high standards and good reputation of an honourable profession."

9. In Madan v General Medical Council (unreported) 26th April 2001, Richards J considered that the approach in a situation such as the present:

> "...is not materially different from the approach of the court on an application for judicial review."

10. With respect that may be, but I prefer to apply the guidelines expressed in the authorities to which I have referred. Mr Shaw, for the respondent, has described the appropriate approach as a "more hands off" form of judicial review. I agree that the particular knowledge and expertise of the professional body, with its duty to protect the public and concern for professional standards, must be respected.

11. The determination complained of was:

> "...the Committee has carefully considered all the evidence before it today.
>
> In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders Committee has determined that it is necessary for the protection of members of the public, is in the public interest and is in your own interests to make an order suspending your registration for a period of 18 months with effect from today.
>
> In reaching the decision to suspend your registration the Committee has concluded that there is prima facie evidence of indecent behaviour that, if proved, would seriously undermine the trust the public is entitled to place in the medical profession. The Committee has considered the submission made on your behalf that if an order were to be imposed, interim conditions would adequately protect patients. However, after considering all the circumstances in the case, and having regard to its duty to protect the public interest, the Committee has determined that it must suspend your

registration.

In deciding on the period of 18 months the Committee has taken into account the uncertainty of the time needed to resolve all the issues in this case. The order will be reviewed at a further meeting of the Committee to be held within six months. Notification of this decision will be served upon you in accordance with the Committee's Procedure Rules."

12. The criminal charges against the claimant have not yet proceeded to trial in the Crown Court.

13. The grounds of the application are succinctly stated in the particulars of claim submitted:

> "6.1 It was not necessary for the protection of members of the public, in the public interest nor in the Claimant's own interests (whether those three elements are viewed cumulatively or separately) to suspend the Claimant's registration;
>
> 6.2 Further or alternatively, the Interim Orders Committee failed, adequately or at all, to consider imposing conditions on the Claimant's registration;
>
> 6.3 Further or alternatively, the Interim Orders Committee failed to provide any or any adequate explanation for suspending the Claimant's registration and/or for failing to impose conditions on his registration; 6.4 The Interim Orders Committee failed to take any or any adequate account of the following:-
>
> 6.4.1 That the allegations against the Claimant (which have resulted in the commencement of criminal proceedings for indecent assault against him) did not arise in the course of his clinical practice;
>
> 6.4.2 The absence of any evidence of risk to the Claimant's patients;
>
> 6.4.3 That the Claimant had not faced allegations from any patient for indecent assault in 14 years at his practice;
>
> 6.4.4 That his practice and partners... are able to offer chaperones to any female patient as needed;
>
> 6.4.5 That the Claimant had not faced any allegations by any student during 10 years of organising teaching attachments for students at [a medical school];
>
> 6.4.6 That in some previous cases before the Interim Orders Committee orders for conditional registration (rather than immediate suspension) have been made against doctors facing allegations of indecency.
>
> 6.5 Further or alternatively the Interim Orders Committee gave undue weight to the fact that the Claimant had been charged by [the police]."

14. I have referred to the criminal charges faced by the claimant. Five of those result from complaints by the older niece and cover a period from October 1998 to the end of 2000. The sixth results from a complaint by the younger niece as to alleged conduct in 1999.

15. Mr Peacock, who appears for the claimant before this court, also appeared for him before the IOC, and accepted, as in my judgment he had to accept in relation to the charges: "they are plainly very serious and the doctor is well aware that they are, if proved, extremely serious, and if accepted by a jury in a criminal court of trial they are likely to result in a sentence of imprisonment and further conduct proceedings." It is clear that the allegations have been considered by representatives of the relevant

local authorities and by the police, whose code of practice provides that before criminal proceedings are brought there must be "enough evidence to provide a realistic prospect of conviction."

16. In developing the written submissions to which I have referred, Mr Peacock essentially makes three points. The first is that the alleged conduct of the claimant does not relate to his medical practice. Not only is there no direct evidence of a risk to patients but there are positive references as to his good professional conduct over many years. That evidence contradicts, Mr Peacock submits, the suggestion that an order was necessary for the protection of patients.

17. Mr Peacock also makes the point that the IOC have relied upon all three grounds in section 41A(1) and have done so cumulatively. If any of them fail, and Mr Peacock submits that the concept of protection of members of the public and the concept of the interests of the claimant himself must fail, then the entire case falls. I say at once that I do not accept that submission. Based, as it is, on the wording of the second paragraph of the determination, it appears to me that, provided one of the criteria was satisfied, the fact that one or more of the others was not satisfied does not, in the circumstances of this case, invalidate the conclusion of the Committee. The wording does not suggest that the satisfaction of all three criteria were, in the view of the Committee, necessary to a conclusion that an order should be made against the claimant.

18. The second submission is that the Committee were not considering, as the Committee in some of the cases cited were considering, a case where there was a conviction in a criminal court. In this case there is only an allegation or a series of allegations. It is not correct, Mr Peacock submits that, even if the allegations are serious, as he has to accept those in this case are, it was appropriate in present circumstances for the IOC to make an order on the mere making of an allegation. He submits that the fact that the police have decided to charge the claimant makes no difference. The Committee must not be permitted to approach its work on the basis that the police would not have charged the claimant if he had not done it. That approach, Mr Peacock submits, is quite contrary to legal principle. Mr Peacock draws attention to the difficulties facing a defendant before the IOC in circumstances such as the present. There are obvious constraints on calling evidence before a Committee when criminal proceedings have been commenced. I accept that there may well be difficulties, but the IOC must consider the case on the basis of the material which the GMC and the defendant see fit to call before them.

19. I am far from criticising the claimant and those who represented him for not in the circumstances of this case calling evidence. I do not leave the point, however, without stating that there could be cases in which material placed before the Committee when criminal charges were pending might, having regard to the duties of the Committee, place allegations of criminal conduct in a very different light from that in which they might otherwise have appeared.

20. The third submission is as to lack of reasons. Mr Peacock submits that there is only one sentence in the determination which can properly be said to provide reasons for the decision. The IOC were obliged by their rules to give reasons. Rules 14(1)(c) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000 (SI 2000/2053) provides at 14(1)(c) that:

> "as soon as practicable after the hearing, send a copy of the decision and the brief reasons for the decision to-
>
> (i) the practitioner..."

21. I do not see merit in this submission. Having regard to the limited amount and quality of material before them it is difficult to see what further reasoning the Committee could have given. For good reason, no further evidence was called about the conduct which was alleged to have occurred.

22. When pressed on the point, Mr Peacock put his third submission rather as a lack of consistency by the Committee, or of disparity between its decision in this case and its decision in other cases. There has

been some reference to other decisions of the Committee. I acknowledge the constraints which rest upon both parties in giving particulars of other cases. However, it is essential, as Lord Upjohn put it, that each case is considered upon its own particular circumstances. Reference to other cases, which Mr Peacock rightly accepts would not be binding upon the Committee, is of limited value. Moreover, on the limited information which has been provided by the parties, I am far from satisfied that there can be said to be any inconsistency between the decision taken by the IOC in this case and its decisions in other cases. It is not necessary for present purposes to give details of those other cases.

23. Reference has been made to Article 6.1 of the European Convention. In my judgment, in present circumstances, that adds nothing to the duties already required by English law. I see no merit in the submission that the decision of the IOC fails either on the ground of lack of reasoning, or by reason of disparity between this and other decisions.

24. I have referred to the limited nature of the material which was before the IOC. It was for them to examine the material before them with care. It is plainly a worrying situation when a professional man may be suspended on the basis of allegations of criminal conduct which, as yet, are untested in a court of law. I cannot, however, accept that the power to suspend by way of interim order, provided in section 41A, must not be exercised because the allegations are untested in a court. Nor, in my judgment, can it be said that the exercise of the power to suspend was inappropriate because the conduct alleged was not towards patients of the claimant.

25. The allegations in this case are undoubtedly serious. They are of offences against the person. Whether or not they are eventually proved it cannot be said that they plainly and obviously lack substance. They involve an alleged breach of trust towards vulnerable young people. The alleged offences have an obvious impact upon the fitness of the claimant to have that intimate contact with patients which is a necessary part of his duties as a doctor. That being so, it cannot in my judgment be said that the IOC erred in law in reaching the conclusion they did. They were entitled in their discretion to do so on all three grounds in section 41A in my judgment, especially having regard to the breach of trust alleged.

26. The three grounds overlap, reflecting different aspects of the duties of the IOC as a professional body concerned with the protection of the public and with the professional standards of its members. Each of the grounds must nevertheless be considered specifically. In my judgment on each of the grounds there was material upon which the IOC were entitled to reach the conclusion they did. They were also entitled to reach it as a general conclusion. For those reasons, I would refuse this application.

27. **MR JUSTICE SILBER**: I agree and would also refuse this application.

28. **MR SHAW**: My Lord, the GMC applies for its costs.

29. **MR PEACOCK**: I cannot resist that.

30. **LORD JUSTICE PILL**: Yes, costs must follow the event.

31. **MR SHAW**: My Lord, there is one final matter and that is summary assessment of the costs. I do have a schedule which I have given to my learned friend, copies are available for the court. Before your Lordships read any detail at all, can I say that the general rule is that the court should make a summary assessment when the hearing lasts a day or less, unless there is good reason not to do so, where for example there is insufficient time. I have to confess that the schedule was not served upon the claimant's solicitors or filed with the court more than 24 hours before the hearing (that is page 810 of the White Book). In that respect we are, I fear, in breach of the practice direction. So, I will need the court's indulgence, and I suspect the indulgence of my learned friend, to proceed further. That is why I do not invite your Lordships to look in too much detail at the document yet. I have not had the chance to discuss it with my learned friend in detail.

32. I make the application on that slightly tested basis and wait to see your Lordship's reaction and my

learned friend's.

33. **LORD JUSTICE PILL**: We will await your learned friend's. Mr Peacock?

34. **MR PEACOCK**: My Lord, I ask for the determination to be postponed.

35. **LORD JUSTICE PILL**: Yes. Clearly the advantage of doing it now is that if it is adjourned for detailed assessment someone has to meet the costs of that assessment. We would rise for a short time if you thought there were prospects of speaking to those instructing you and Mr Shaw. He is out of time. I think we must accede to your application, unless there are prospects that if we give you a little time further costs can be saved by agreeing something now?

36. **MR PEACOCK**: My Lord, the doctor is funding this privately.

37. **LORD JUSTICE PILL**: Yes, either agreeing it now or so defining the issue that we can properly consider it. I do not want to press you, Mr Peacock.

38. **MR PEACOCK**: My Lord, I am instructed to seek a postponement of this determination.

39. **LORD JUSTICE PILL**: Mr Shaw, anything in reply to that?

40. **MR SHAW**: I do not press it further.

41. **LORD JUSTICE PILL**: So be it. Then the question of costs will be deferred for detailed assessment.

Fareham and Gosport NHS
Primary Care Trust

DI

FILE NOTE

RE: DR JB - MEETING HELD ON 9 OCTOBER 2002

PRESENT:

Dr Gordon Sommerville
Dr Bob Button
~~Dr~~ J Barton
Alan Pickering

Gordon welcomed back Dr Barton to the PCT and to the practice.

Gordon confirmed JB's offer of a continued voluntary ban on OP prescribing. This was agreed despite the fact that the GMC does not require it. It was pointed out that this has implications for the remaining practice members. Dr Barton had been advised by her medical defence society to carry a single vial of diamorphine in case she was presented with an absolute medical emergency.

It was confirmed that the above arrangement does not, in practice, compromise the patients' safety in her practice list, thanks to the partners in the practice for accepting and dealing with this voluntary restriction.

JB agreed her voluntary restriction covers opiates. Benzodiazepines would be prescribed strictly within BNF guidelines.

The monitoring arrangements proposed by the SHA were explained. There was concern that whilst PACT data analysis was acceptable and reasonable, the proposal to visit local pharmacies to review scripts caused concern by Dr Button, who implied that it was both unnecessary and inappropriate. The question of what the letter would say to the pharmacies was not clarified as the letter had yet to be written. AP pointed out that this element of the verification process had not [illegible]d. JB agreed to discuss it with her MDU representative. Pending this, the PCT would not start reviewing FP10's in local pharmacies

Bob Button was of the view that these spot visits to pharmacies had not been agreed with JB nor are they appropriate given the nature of her voluntary restriction.

The issue of a draft press briefing, produced by Dr Simon Tanner, was raised and a copy passed to the PCT. AP agreed that there were no plans for issuing a press briefing in any respect at this stage.

Alan Pickering
Acting Chief Executive

October 2002

D2

Diazepam 2mg Usual GP

USUAL DR: DR A C KNAPMAN

Surname	First Names
B	H
C	S
C	L
D	P
D	E
F	A
F	B
G	M
G	M
H	D
H	C
H	E
J	U
K	D
K	G
K	G
L	S
M	P
M	T
M	B
M	D
P	O
R	M
R	S
R	N
R	C
R	J
W	R
W	M

NHS NumberD.O.B Number

Code A

USUAL DR: DR A J BARTON

Surname	First Names
A	T
B	M
B	K
F	C
J	S
J	J
K	R
M	J
N	S
R	C
S	M
S	A
S	A
T	D
W	M

NHS NumberD.O.B Number

Code A

JSUAL DR: DR E J PETERS

Surname	First Names
A	C
B	E
B	I
B	D
B	L
B	S
C	S
C	L
C	P
C	C
C	F
C	J
D	P
D	M
D	P
F	R
H	R
H	G
J	L
J	S
K	J
M	R
M	I
N	G
N	E
P	D
P	V
S	I
S	C
S	R
T	M
T	F
U	P
V	R
W	S
W	J
W	C

NHS NumberD.O.B Number

Code A

USUAL DR: DR M J BRIGG

Surname	First Names
B	R
C	D
C	S
C	R
C	R
C	M
E	H
G	J
H	J
H	K
J	V

NHS NumberD.O.B Number

Code A

K	A
M	E
M	C
M	M
P	M
P	R
P	L
Q	D
R	N
R	D
S	L
S	M
T	D
W	G
W	M

Code A

USUAL DR: DR P A BEASLEY

Surname	First Names
A	A
A	I
A	P
B	B
B	I
B	P
C	H
C	J
D	R
E	M
F	D
G	S
G	G
H	J
H	G
H	B
H	W
H	K
H	S
H	L
I	M
K	R
M	W
M	G
M	C
P	P
S	A
S	D
S	L
S	A
S	C
W	E

NHS NumberD.O.B Number

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USUAL DR: DR SARAH JANE BROOK

Surname	First Names
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NHS NumberD.O.B Number

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CHRONOLOGY

DR JANE ANN BARTON

February 1998 – October 1998	Original alleged period of inappropriate prescription to 5 patients (aet 75-91) at Gosport War Memorial Hospital, all of whom died at the hospital where Dr Barton was a part-time clinical assistant (Page, Wilkie, Richards, Cunningham and Wilson) (pages 4-8)
28th April 2000	Dr Barton resigned from part-time employment and continued in general practice (pages 413 and 424)
27th July 2000	Hampshire Constabulary first informed GMC of concern re Dr Barton re Richards (page 9)
21st June 2001	**First IOC Hearing** (only re Richards) **No order** (No transcript available)
10th July 2001	Professor Livesley's report re Richards: Death occurred earlier as a result of drugs than it would have done from natural causes (pages 19 – 52)
14th August 2001	Hampshire Constabulary letter: Insufficient evidence to support a viable prosecution against Dr Barton re Richards but continuing enquiries re other deaths and further review re Richards (page 13)
18th October 2001	Report of Dr Mundy re Cunningham, Wilkie, Wilson and Page (pages 53-58)
12th December 2001	Report of Professor Ford re 5 patients (pages 59-97)
6th February 2002	CPS decided not to institute criminal proceedings re Richards and disclose their papers to GMC (pages 15 and 16)
21st March 2002	**Second IOC Hearing** (partial transcript pages 413-431) **No order** (full transcript available)

End March 2002	Dr Barton's undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased (pages 453-4)
11th July 2002	Rule 6(3) Notice (pages 4-8)
27th August 2002	Response from MDU for Dr Barton (pages 404 - 412) (plus partial transcript of second IOC Hearing)
29th August 2002	PPC referred Dr Barton to PCC (hearing still awaited) (pages 1-399)
13th September 2002	Letter from GMC qua "President" to Dr Barton giving notice of third IOC Hearing
19th September 2002	**Third IOC Hearing** (pages 1-455) (transcript pages 437-455) **No order and a judgment that there was no new material since the second Hearing and it would be unfair to consider the matter further**
September 2002 ... to date and continuing:	Police investigation continues (pages 458 and 460). First papers of selected cases likely to go to CPS in December 04 or early 2005
February 2003	5 experts commence analysis of 88 Gosport War Memorial Hospital patients' records (page 460) work expected to finish October 2004. Classification of cases into 3 categories.
May 2004	Other experts (geriatric and palliative care) instructed to judge category 3 cases (page 460)
24th September 2004	GMC Letter of notification of 7th October IOC Hearing to Dr Barton
27th September 2004	Dr Barton's letter confirming intention to attend IOC Hearing on 7th October
27th September 2004	Letter from MDU for Dr Barton seeking adjournment and questioning compliance with rule 5

30th September 2004	Receipt by GMC of electronic copy of witness statement from Detective Chief Superintendent Steven Watts and supplementary documents re 19 further patients (pages 456 – 507). These pages (omitting irrelevant patients) were forwarded electronically forthwith to MDU and delivered in hard copy to MDU on the same day.
30th September 2004	GMC letter to MDU imparting refusal of adjournment by Chairman of the Committee and questioning the challenge to 24th September rule 5 compliance
30th September 2004	MDU letter to GMC re letter of 30th September from GMC maintaining rule 5 non-compliance, concern re absence of documentation and concerning merits e.g. re absence of present cause for concern from Dr Barton's practice
30th September 2004	GMC letter to Dr Barton (page 508)
1st October 2004	Hard copy of statements and documents (pages 456 – 507) delivered to Dr Barton, as agreed with MDU.
7th October 2004	**Fourth IOC Hearing**

Confidential
Addendum (I)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

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.

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,

> "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".

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.

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.

> "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."

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:

> "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".

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

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> "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.

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.

> "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,

> "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,

> "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.

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,

> "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".

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 [redacted] 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 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?

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 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 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 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 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----
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.

Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
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

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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.
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

527

should have been carrying. Therefore it is difficult to criticise. She did what she could, within the constraints that she had available to her.

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",

– 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?
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 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?
A Yes.

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

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 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. 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 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.

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".

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 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.

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 us", he says,

> "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,

"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".

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:

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,

"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.

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.

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.

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.

<u>Questioned by the COMMITTEE</u>

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

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, 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. 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. 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 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.

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 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.

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.

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Code A

Code A It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death.** It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

HAMPSHIRE CONSTABULARY

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.

Death verified by SR Hamblin and SN Barrett.

In reply please quote PCH/2000/2047
Please address your reply to the Committee Section FPD

Code A

COPY

By Special Delivery and First Class Mail

24 September 2004

Dr Jane Ann Barton

Code A

Dear Dr Barton

I am writing to notify you that the President has considered information received by the GMC about your conduct.

The President, exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee (IOC) in order that it may consider whether it is necessary for the protection of members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A of the Medical Act 1983 as amended.

The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved. The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

You are invited to appear before the IOC **at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you so wish, to address the Committee on whether such an order should be made in your case.

You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may

be a member. You may also be accompanied by not more than one medical adviser. The IOC is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of **Adam Elliott, Committee Section (fax no 020 7915 7406)**.

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The IOC normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Adam Elliott, Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Adam Elliott (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of the following: -

- all of your current employers,
- the Health Authority with which you have a service agreement,
- locum agency/agencies with whom you are registered, and
- the hospital/surgery at which you are currently working.
- If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Committee's consideration of the matter.
- If you are approved under Section 12 of the Mental Health Act, or Section 20 (b) of the Mental Health (Scotland) Act 1984, you must also notify us of this fact.

I enclose copies of the relevant provisions of the Medical Act, the IOC Procedure Rules, a paper about our fitness to practise procedures and a paper about the procedures of the IOC.

The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

COPY

Code A

Cc: Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
ISPB/TOC/0005940/Legal

FAO Code A
Committee Section FPD
General Medical Council
178, Great Portland Street
London W1W5JE

Dr Jane Barton
Code A

Your Reference PCH/2000/2047

27th September 2004

Dear M Code A

re Interim Order Committee hearing on 7th October 2004

I am a Principal in General Practice contracted to Fareham and Gosport Primary Care Trust.

I am on the Bed Fund for Gosport War Memorial Hospital, Bury Road Gosport, administered by the same Primary Care Trust.

I am a partner in the practice of Dr PA Beasley and partners,

Forton Medical Centre,
White's Place
Forton Road,
Gosport PO123JP.

I have no other employment or contract either NHS or non NHS and I am not approved under Section 12 of the Mental Health Act.

I propose to attend the hearing on 7th October 2004. I will be represented by my solicitor Ian Barker of the MDU .

Yours Sincerely

Code A

Dr Jane Barton

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

THE MDU

MDU Services Limited
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Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: 0207-915-7406

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Further to the letter from Mr Hylton to Dr Barton of the 24th September, and indeed our telephone conversation today, can I confirm that I continue to act for Dr Barton.

As you know, Dr Barton has previously appeared before the Interim Orders Committee on three occasions. On each occasion the matters raised have been essentially of the same origin and nature.

On each occasion Dr Barton has been represented by Mr Alan Jenkins of Counsel. The matter is necessarily a little complex and continuity of representation, somewhat unusually for the purposes of such hearings, in this instance is of clear importance. Indeed I would respectfully submit that it would only be reasonable and fair for Dr Barton to have that continuity of representation.

I very much regret to advise you that Mr Jenkins is unavailable on 7th October. I have made enquiries to see if it might be possible for his existing commitment to be dealt with on another occasion, but understand this is simply not possible.

In these circumstances I would be most grateful if consideration could be given to the provision of an alternative date for the hearing of this matter. I appreciate that the General Medical Council would not seek to delay the matter for any significant period of time, but it may be relevant to observe that at none of the previous three hearings, in June 2001, March 2002 and September 2002 was considered necessary by the Committee to make an Order affecting Dr Barton's registration.

Can I also take the opportunity to point out that the letter to Dr Barton of 24th September, advising her of the forthcoming hearing does not appear to comply with Rule 5 (1) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000. The letter does not contain a brief statement of the matters which appear to raise the relevant question set out sub sub rule (b).

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Further, Dr Barton has not yet been provided with any documentation. Curiously, it seems to be suggested that the issue of what documentation will be disclosed has still to be determined. Specifically, in paragraph 3 of the letter from Mr Hylton it is said that the GMC is in the process of clarifying with the Police the level of disclosure that can take place. As you will appreciate, Rule 5 (3) of the procedure rules requires that the Registrar shall send a Practitioner copies of any documents received in connection with a case. It is therefore not open to the GMC to be selective – any document received should be disclosed.

I make the points in relation to compliance with Rule 5 (1) and Rule 5 (3) as clearly there are issues to resolve before the matter can reasonably proceed and in those circumstances too brief adjournment might be sensible for all concerned.

I would be most grateful if this application could be given urgent consideration and if I can assist with the provision of any further information, including further details of Mr Jenkins' availability, I will be pleased to do so immediately.

It may assist if I mention now that Mr Jenkins would be available both on the 13th and 15th October, when I understand the IOC will be sitting to consider cases generally.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

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Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – 020 7202 1663

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

30 September 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Thank you for your letter of 27 September 2004 in which you request that the Chairman of the IOC consider postponing the scheduled hearing of Dr Barton's case in accordance with Rule 7(1) of the Committee's Rules.

I can confirm that the Chairman of the Committee considered your request and that he did not accede to it.

The Chairman in considering this request considered the nature and purpose of the IOC, which is namely, to determine whether interim action is required to be taken against the registration of a doctor who may pose a risk to the public, the public interest or their own interests and in fulfilling this function it is considered that the Committee should meet as soon as practicable whilst bearing in mind the need to balance the consequences for the practitioner of the imposition of an interim order and to ensure that the doctor is afforded the opportunity to attend any hearing and be represented, although not necessarily by the Counsel of their choice.

The Chairman took account of the Council's letter notifying Dr Barton of the forthcoming hearing and the timetable contained therein and in reaching his decision considered that the date of 7 October 2004.

In reaching his decision the Chairman determined that whilst unfortunate that Dr Barton's chosen Counsel is not available, there was still sufficient time to instruct fresh Counsel to attend and make representations. It is the Council's intention to dispatch a copy of all the papers in the case on 30 September 2004, providing Dr Barton with 7 days in which to prepare a defence. It was the opinion of the Chairman that this was sufficient time in which to fully instruct new Counsel to prepare such a defence. The Chairman further considered that the Council's letter of 24 September 2004 put Dr Barton on notice that the hearing would be taking place on 7October

In all the circumstances, the Chairman having taken into account your letter of 27 September 2004 and balanced the information contained within against the reasons for Dr Barton's referral considered that, it was important in the public interest that Dr Barton's case be heard as soon as possible.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. You are further invited to state in writing whether you propose to attend the meeting, whether Dr Barton will attend and whether she will be represented by Counsel, and if so, by whom.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

With regard to your point regarding Rule 5(1)b it is the opinion of the Council that the letter dated 24 September gave the following brief statement of the matters which appear to raise the relevant question set out in Rule 5(1)b:

> *The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved.*

Further, the Council submits that its letter of 24 September also gives a full explanation as to when Dr Barton can expect to have disclosure of the information to be considered by the Committee, and what information she can expect to be disclosed. The Council is mindful of the provisions of Rule 5(3) but it is not of the view that it's letter contravened those provisions. The letter states that:

The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

The clarification with the Police is in respect of what information the CPS determines can be disclosed to the GMC. The Police are fully aware that any information disclosed to the GMC and subsequently disclosed to any of its Committees must also be disclosed to Dr Barton. The Council will disclose to Dr Barton all information that is to be put before the IOC.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Adam Elliott
Interim Orders Committee Secretariat

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

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Mr Adam Elliott
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178 Great Portland Street
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Also by fax: 0207-915-7406

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Thank you for your letter of 30th September, and I am grateful for the provision of written reasons of the decision not to grant adjournment in this matter.

I am grateful too for the observations concerning Rule 5 (1). It remains my contention, however, that the brief statement required by that Rule has not been provided. The information that you quote within the letter is hardly sufficient. There is no basic summary or indication of what the information provided by Hampshire Constabulary might be. Indeed, as I understood the position yesterday no written statement or evidence had been supplied by Hampshire Constabulary to the GMC at that time.

In any event, I am concerned to make further request for adjournment of Dr Barton's case with the benefit of additional information, and indeed having had the opportunity to consider the written reasons for the Chairman's previous decision.

As you will know, Dr Barton has thus far received no documentation at all in this matter. The statement from the Hampshire Constabulary which it is understood you were to receive yesterday has yet to materialise. Further, I am advised that a significant volume of patient records had been made available to the GMC, which it is felt is not necessary to trouble the Interim Orders Committee but which is nonetheless available. It must be right that Dr Barton has the opportunity to consider those records, which I understand to be some 3 feet deep. It may of course be that there is no information which is necessary to place before the Interim Orders Committee in that regard, on behalf of Dr Barton, but unless and until Dr Barton has had the appropriate opportunity to consider the materials, that cannot properly be determined.

Unfortunately, Dr Barton is not immediately able to consider any such documentation even if it were to be made available forthwith. Sadly, her mother and mother-in-law have both been profoundly ill recently. Indeed, her mother-in-law has only recently been moved from an Intensive Treatment Unit. She will visit them tomorrow and at the weekend. Her first realistic opportunity to look at any amount of documentation would be on Monday of next week.

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30 September 2004

In addition to Dr Barton's ability or lack of it to consider such a significant quantity of material at this stage, sadly Counsel previously instructed for Dr Barton, Mr Alan Jenkins, remains unavailable for the hearing on 7th October. I appreciate at once that the Interim Orders Committee would not ordinarily be concerned to take Counsel's availability into account. However, this matter has previously been considered on three separate occasions by the Interim Orders Committee – and substantively on each occasion, rather than being merely by way of review. There is therefore a long and significant history from which I would submit that it is desirable that there should be continuity of representation, both for Dr Barton herself, and indeed to assist the Committee.

With reference to the limited information given within the letter of the 24th September to Dr Barton about the matter, which you have kindly quoted in your letter to me of 30th September, it is clear that the matter concern the Gosport War Memorial Hospital. Dr Barton ceased to have any involvement with that hospital some long time ago. It must therefore be the case that any matters raised by the Hampshire Constabulary are historical. As best I am aware of it, there has been no expression whatsoever of concern in relation to Dr Barton's recent practice.

I would respectfully submit that this point is highly relevant in terms of the consideration of the public interest in ensuring that a hearing take place very rapidly. It is also relevant in that regard that on each of the three occasions when Interim Orders Committee has met to consider Dr Barton – on each occasion with reference to the Gosport War Memorial Hospital – the Committee concluded that it was not necessary to make an order affecting Dr Barton's registration.

Accordingly, there is as best I am aware of it no indication that Dr Barton's present behaviour gives any obvious cause for concern, and to the extent that her previous activities as a Practitioner have been considered in relation to this very hospital, no action has been taken by the IOC. It must surely be the case in those circumstances that the public interest could not reasonably be adversely affected by an adjournment of a mere week to facilitate both the proper consideration of paperwork and representation by established Counsel.

I would be grateful if my further application for adjournment could be given urgent consideration.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
5 October 2004

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Legal Department of The MDU

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Mr Code A
Assistant Registrar
General Medical Council
350 Regent's Place
London
NW1 3JN
BY HAND

Dear Mr Code A

Dr Jane Barton - Interim Orders Committee

I write with reference to your letter to Dr Barton of 30th September 2004. As you will be aware from our various conversations, I represent Dr Barton.

In your letter of 30th September you indicated that you had voluminous patient records available to you and that if Dr Barton required a copy of those records you would arrange for her to receive a copy expeditiously.

You will recall that you and I spoke on the 30th September, and I indicated that Dr Barton would indeed wish to have sight of the records. I understood that you would endeavour to make those records available the same day, if not the following day.

We spoke again on the 1st October and you indicated that it had not been possible to copy the notes in view of the lack of facilities brought about the GMC move of offices, which I do very much understand. As I understood it, the records were then to be made available yesterday afternoon, but as you will appreciate, these records have still to arrive.

My expectation is that the medical records concern the patients in relation to whom information is given by the Hampshire Constabulary in purported summaries and expert observations. I remain concerned on behalf of Dr Barton to have access to the medical records, but have to point out that Dr Barton cannot realistically assist the Committee now in relation to any points involving specific patients in circumstances in which she will not have had the anticipated and hoped for opportunity to consider medical material.

I look forward to your response.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

RECEIVED
- 5 OCT 2004

In reply please quote PCH/2000/2047

Your ref. ISPB/TOC/0005940/Legal

By Fax and first class post

5 October 2004

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Dear Ian

Dr Jane Barton – Interim Orders Committee

Thank you for your letter of 5 October 2004, a copy of which I will pass on to Adam Elliott in our Committee Section.

I note your comments regarding the medical records and I should inform you that unfortunately, due to the problems experienced by our Reprographics section in the course of our move to our new premises, it is likely that a copy of the records will not be available until tomorrow at the earliest.

I have considered whether it would be prudent to use a commercial reprographics company. However, given the nature of the information, I decided against that course of action.

I will forward a copy of the records to both you and Dr Barton as soon as they are available.

Yours sincerely

Code A

Paul Hylton
Assistant Registrar

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

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Your reference ISPB/TOC/0005940/Legal
In reply please quote ACE/JJC/PCH/2000/2047

By courier and fax – 020 7202 1663

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

6 October 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Further to your letter of 30 September 2004 and our subsequent telephone and e-mail conversations. I can confirm that the Chairman of the Committee did on 1 October 2004 consider your further request to postpone Dr Barton's hearing.

The Chairman considered that whilst the submissions you made may have force in relation to whether or not the Committee should impose an interim order on Dr Barton's registration it was not for the Chairman alone to consider such matters and that in all the circumstances, it was necessary for the reasons given previously and in the public interest that the hearing of Dr Barton's case be expedited notwithstanding that her chosen Counsel is not available.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. I am grateful for your confirmation that Dr Barton will be attending the hearing and that she will be represented by Mr Foster, Counsel.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an

adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Code A

Confidential
Addendum (II)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

551

A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

B

Thursday, 21 June, 2001

C

Chairman: Professor MacKay

D

Case of:

BARTON, Jane Ann

E

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

F

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 13 April 1907. 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

A 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.

B

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.

C 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.

D 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.

E 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.

F 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.

G 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.

H

A

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."

B

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.

C

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.

D

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.

E

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?

F

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.

G

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

MISS GRIFFIN: Yes.

H

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

A 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.

B

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.

C

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.

D

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.

E

F

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.

G

H

I do not mean to criticise the daughters at all. Plainly, they were extremely fond of their mother and they were anxious to do everything that could possibly be done for her. It may well be the case – as I know Dr Barton would say – that they were unable to accept that their mother was terminally ill, and they did not accept it. They believed that their mother would remain alive and continue to live. It would seem that they blamed those around their mother for failing to maintain her and keep her alive.

It is clear from the medical records that this lady was in poor shape and was deteriorating. There has been no conspiracy by medical staff or the nursing staff, the charge nurse, or those others who were responsible. There is no conceivable basis for saying here that there is a *prima facie* case and that those responsible on a day-to-day basis caused this lady's death, or brought it about.

This case may have been brought here prematurely. We suggest that it should not have been brought here at all. There may be, at some stage in the future, if there is an opinion of an expert in palliative care or terminal care, an argument that there were failures in Dr Barton's care of this patient, but on the evidence you have seen there is no basis for such a proposition at all.

Page 266 is Dr Barton's statement, which was provided by her when she was spoken to by the police. She was one of quite a number of people who were spoken to by the police and she was in no different position from the other people responsible for this lady's care. You will see Dr Barton's position, qualifications and experience. She qualified in 1972. She became a partner in her present practice in 1980. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis. She was working at the Gosport War Memorial Hospital. She retired from that position last year. Obviously, this statement dates from 2000.

Her present situation is stated in paragraph 3. She is also the present Chair of the Gosport Primary Care Group.

She was carrying out five clinical assistant sessions at the Gosport Hospital. As you will see from paragraph 4, she would attend the hospital every weekday morning at an early hour and engage in two formal ward rounds with the consultant geriatrician. She would do that before she went to treat her patients in her general practice. She did not have constant attendance at hospital. She was not in a position to review at short notice this lady's condition. It is a misunderstanding on the part of the sisters to the extent that they suggest that Dr Barton was there and able to assist and deal with matters as and when they arose.

As far as the doctor's present position is concerned regarding opiates, she does not continue to work as a clinical assistant at this hospital. She has not prescribed Diamorphine for over a year. The last time she prescribed an opiate of any kind in palliative care was Fentanyl, and that was for a patient who was being nursed intensively. She does prescribe morphine sulphate tablets for her own patients, but obviously only when it is appropriate.

There is no basis here for saying that the prescription of an opiate for this lady was excessive or inappropriate.

A

Page 21 is the statement of the sister who was herself a Registered General Nurse.

> "I have had sight of a report prepared by Dr Lord and dated 22 December 1998, which has attached to it a Hampshire Constabulary exhibit label ... "

B

She goes on to say a few things about the report and, if I can use this phrase, she tries to pooh-pooh it. She says that the report appears to have been prepared by reference some time after the event to information, notes and documents supplied by colleagues with whom she worked on a regular basis. Can I show you this report, because this was the consultant under whose care this lady was admitted? It provides a commentary on two aspects of the case with which you may be concerned: (1) the use of a syringe driver and the prescription of Diamorphine; (2) the provision of

C

fluids for this lady. (Same handed to members of the Committee)

Sir, you and your colleagues will have seen the suggestion that one of the sisters believed the use of Diamorphine was merely to accelerate the death, that Diamorphine was to be used for euthanasia. They raised that proposition, it would seem.

D

> "My sister asked the ward manager: 'Are we talking about euthanasia? It is illegal in this country, you know.' The ward manager replied: 'Goodness, no, of course not.'"

Diamorphine has a perfectly proper use and is used very commonly in terminal care.

The second proposition raised by the daughters is that the use of a syringe driver for

E

Diamorphine was foisted on them and they were unhappy with it. There were discussions. One would hope that there will be discussions between the nursing and medical staff and the relatives, so that agreement can be obtained as to a proper and therapeutic approach. It is clear from the documentation to which you have been referred that there were such discussions. It is regrettable that the daughters were later to say that they did not really agree, but you have been given the references at page 243.

F

The true situation is that, clearly, there were discussions with the daughters and they were perfectly proper discussions. There is no basis for saying that this drug should not have been given or given at that level.

In relation to fluids, you have the opinion of the consultant. You have Dr Barton's position stated at some length in the statement at the end of the bundle, which I know

G

you will have read. The decision that was taken in this case, I suggest, was an entirely proper one. There is no basis here for suggesting that it was gravely improper or that it departed from proper medical practice. It is perhaps unfortunate that the sisters did not understand, or were later to say that they did not understand or agree with the decision, but it is clear from the records that there were regular discussions between those nursing this lady and the medical staff as to how she should be treated.

H

A As to the decision not to transfer this elderly and demented lady back for a third transfer to the Haslar Hospital in a very few days, there is no basis for saying that that was a wrong decision or one that did not have her best interests at heart – it plainly did. The report of the consultant clearly bears out the approach that Dr Barton took.

B There is no conceivable basis for alleging that any actions by Dr Barton in prescribing or causing to be administered the Diamorphine, caused the death. There is no basis for saying that anything she did reduced the quality of life of this lady or shortened her life. There is no basis for saying in this case that there should be a suspension. I do not deal with the question of conditions. Clearly, conditions have not been asked for. In any event, Dr Barton no longer works in this unit, and I have given you her present situation as far as opiates are concerned.

C DR BHANUMATHI: I notice that Diamorphine was given in the dosage of 40 mg and the patient was on 45 mg of Morphine prior to that. I know that pain control was not too good, but the day the 40 mg of Diamorphine was started it was equivalent to 120 mg of Morphine, which was three times the dosage. What was the dosage that she was on, on the 21st?

MR JENKINS: I think it was the same. There is a record within this bundle.

D

DR BHANUMATHI: There is no mention of dosages anywhere, as to whether it was increased or decreased from 14 August.

MR JENKINS: It was not decreased. There is a record here. There is a prescription sheet, but I do not have a page number. That shows the administration.

E DR SAYEED: Who had the ultimate legal responsibility in Gosport Memorial Hospital? Is there a consultant involved?

MR JENKINS: They are consultant beds.

DR SAYEED: How often does the consultant do a round?

F MR JENKINS: I think the position may have changed since 1998, but Dr Barton's statement says that there were two consultant ward rounds a week.

DR SAYEED: We are talking about 1998. Who carried the ultimate clinical responsibility of those beds?

G DR BARTON: Dr Lord, whose statement you have just read, had responsibility for the patient. She was on study leave for the last three days of Gladys Richards' life but she carried out weekly war rounds prior to that.

DR SAYEED: The clinical assistance sheet shows that it is two sessions weekly.

MR JENKINS: It is page 266. It was five clinical assistant sessions.

H DR SAYEED: Was any junior doctor involved?

A

Dr Barton: There are no junior doctors. It is just me.

DR BHANUMATHI: Going back to what I was saying, now that I have had a chance to read it properly, the Diamorphine was 40 to 200 mg (page 254), which is a very big jump of medication. Who authorised it and how was that done?

B

DR BARTON: The dosage was reviewed every morning, and if an increase was necessary, it would be put up – obviously not straight from 40 to 200 mg but in 20 mg steps until the patient was comfortable. As it turned out, it was not necessary. Gladys needed no increase from the 40 mg initially put.

DR BHANUMATHI: The nurses were not left to increase the dosage; it was by au of the doctor.

C

DR BARTON: Yes.

THE LEGAL ASSESSOR: Sir, the Committee can only act if they are satisfied either that it is necessary for protection of the members of the public, or otherwise in the public interest, or in the interests of the practitioner that an order be made under section 41(A)(i) of the Medical Act 1983. Before you, the Committee, can be so

D

satisfied in any case, it is necessary to find that the evidence before you amounts to a *prima facie* case supporting interim action on one or more of the grounds that I have just referred to. In this particular case, I simply draw to your attention the absence of any independent specialist medical expert opinion indicating fault of any kind on the part of Dr Barton, which is obviously something you will have to take into account in considering the question of whether or not there is a *prima facie* case here suggesting fault. If you find that you are so satisfied in respect of any one or more of those

E

grounds, then you must decide whether to make an order attaching conditions to the registration or suspending that registration in either case for a period not exceeding 18 months.

MR JENKINS: Might I add one point, which I should have raised? Those instructing me did make inquiries of the GMC about this case. I know that the screener, when he or she looked at the papers in this case, did not have Dr Barton's

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statement to look at. It was provided by the police at a date after the screener had looked at these papers, so all the screener saw was the statements of the two sisters and the medical records.

MISS GRIFFIN: My understanding is that the police statement at page 266 came in with the fax header sheet that was received dated 12 June this year (page 265) and that is the date after which the screener screened the matter. My understanding and

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my instructions are that the screener did have the statement of Dr Barton.

THE CHAIRMAN: We are dealing with all the documents before us, which include Dr Barton's statement. We will give due weight to all the documentation we have.

MR JENKINS: We have received a letter from the Fitness to Practise Directorate dated 19 June. Of course, I will check with my learned friend, but we have raised in

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correspondence the question of whether the screener saw Dr Barton's statement, and

we were told that the screener, in reaching his decision, considered the documentation that was supplied to us by the police on 6 June 2001 and which was served on Dr Barton. Dr Barton's statement was received at a later time than that.

THE LEGAL ASSESSOR: In any event, as the Chairman has made clear, this Committee considers all the material matters before it and is not in any way bound by the fact that the screener has decided to refer the case to the Committee.

MR JENKINS: I raise it for the sake of completeness, for no other reason.

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

DECISION

THE CHAIRMAN: Dr Barton, the Committee have carefully considered all the evidence before it today.

The Committee have determined that they are not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under section 41(A) of the Medical Act 1983 should be made in relation to your registration.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: Code A

Date of Death: 27 May 1998

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

Neutral Citation Number: [2002] EWHC 1602 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT

NO: CO/2963/2002

Royal Courts of Justice
Strand
London WC2

Friday, 12th July 2002

Before:

MR JUSTICE CRANE

THE GENERAL MEDICAL COUNCIL

-v-

PEMBREY

Computer-Aided Transcript of the stenograph notes of
Smith Bernal Reporting Limited,
190 Fleet Street, London EC4A 2AG
Code A
(Official Shorthand Writers to the Court)

MS B LANG QC (instructed by Field Fisher Waterhouse) appeared on behalf of the Claimant
MR A MOON (instructed by Radcliffe Le Brasseur) appeared on behalf of the Defendant

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JUDGMENT
(As Approved by the Court)

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1. MR JUSTICE CRANE: Mr Michael Pembrey is a consultant obstetrician and gynaecologist. Pending a hearing of complaints against him by the Professional Conduct Committee (PCC) of the General Medical Council (GMC), the defendant has been made subject to an order for interim conditional registration under the Medical Act 1983, section 41A. In other words, conditions have been imposed upon him if he is to practise. The hearing of the complaints is fixed for 7th October 2002. The GMC is applying to this court under section 41A(6) of the Act for an extension of the order for 12 months from its expiry on 15th July.

2. I deal first with the statutory framework. The GMC is, under the Act, responsible for supervising and regulating the fitness of medical practitioners registered with it to practise. It has a duty to deal with complaints against medical practitioners. The Act provides for various statutory committees. The procedure for dealing with a complaint of serious professional misconduct is set out in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988.

3. Briefly, the normal procedure is as follows. The complaint is first considered by a medical screener. Unless the screener decides that no question of serious professional misconduct arises, the case is then referred to the Preliminary Proceedings Committee (PPC). The PPC may, as one outcome, refer the case to the PCC. At the stage when a screener refers the case to the PPC notification is sent to the medical practitioner, a "Rule 6 Letter", and "as soon as may be after a case has been referred to" the PCC a Notice of Inquiry is sent to the medical practitioner. The charge or charges are specified. In addition, the evidence relied on will be served on him. Various people, including the screener and either of the committees, may refer the case to another statutory committee, the Interim Orders Committee (IOC).

4. I turn to the provisions of the Medical Act 1983, section 41A:

> "(1) Where the Interim Orders Committee are satisfied that it is necessary for the protection of members of public or is otherwise in the public interest, or is in the interests of a fully registered person, for the registration of that person to be suspended or to be made subject to conditions, the Committee may make an order--
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> ...
>
> (b) that his registration shall be conditional on his compliance, during such period not exceeding eighteen months as may be specified in the order, with such requirements so specified as the Committee think fit to impose (an 'order for interim conditional registration').
>
> (2) Subject to subsection (9), where the Interim Orders Committee have made an order under subsection (1), the Committee--
>
> (a) shall review it within the period of six months beginning on the date on which the order was made, and shall thereafter, for so long as the order continues in force, further review it before the end of the period of three months beginning on the date of the decision of the immediately preceding review; and
>
> (b) may review it where new evidence relevant to the order has become available after the making of the order.
>
> ...

(6) The General Council may apply to the court for an order made by the Interim Orders Committee under subsection (1) or (3) to be extended, and may apply again for further extensions.

(7) On such an application the court may extend (or further extend) for up to 12 months the period for which the order has effect."

5. Under subsection (9) the Interim Orders Committee has a duty to continue to review the order if the court orders an extension. It is clear not only that subsection (1) gives guidance to the Interim Orders Committee as to the factors relevant to the making of an order, but that those indications also provide guidance to the court in deciding whether an extension should be granted.

6. I turn to the chronology. From the 1st February 1989 the defendant was employed by the Hastings and Rother NHS Trust. He also had some private practice. On 5th May 1998 information was received by the GMC from the Trust regarding the standard of the defendant's professional conduct, particularly in relation to laparoscopic surgery. I shall refer to that information as Complaint 1. The complaint was referred by the GMC to a screener but ultimately the GMC received a positive report from the Trust about the defendant's progress and on 18th June 1999 the screener decided that no action was necessary. I am not further concerned with Complaint 1.

7. In September 1999 a further decision was made by the Trust: to suspend the defendant from his employment by the Trust and to send further complaints to the General Medical Council, those complaints being received on 23rd September 1999. That group of complaints has been referred to during the hearing as Complaint 2. On 24th September 1999 the defendant's admitting rights to the BUPA hospital at Hastings were withdrawn and hence his private practice effectively came to an end.

8. It is right to note at this stage, not only that the defendant denies these and all other complaints against him, but that he contends, as part of his case before the General Medical Council, that the Trust and certain individuals within it have been guilty of bad faith and have been responsible for a campaign against him. It is not for the court in this hearing to pass judgment on those matters.

9. The matters which led to the defendant's suspension and to Complaint 2 were in fact placed by the Trust before an independent panel, consisting of a member of the Bar and two consultants. There was a hearing before the Panel in the spring and early summer of the year 2000. That panel prepared an initial report, and a final report after seeking comment from the defendant. The final report was dated 14th September 2000.

10. The Panel reported that the defendant was at fault in various respects. In relation to the case of M, it was found that the defendant failed to make a full and proper note of a consultation and counselling of a young woman of 18 with a mental age of six, on whom he had performed an operation. The Panel took the view that, in failing to make such a proper note, the defendant fell well below the standards to be expected of him. They also found that he had failed to consult more widely before deciding to carry out the particular operation.

11. In the second case, that of T, the panel's findings were similar, namely that the defendant failed to make a full and proper note and failed to consult more widely than he did. In the case of A, the findings of fault were that he should have abandoned an operation he was in fact performing and he should not have carried out part of the operation that he did, and that he failed to make a careful note. The Panel concluded that there was a serious lack of

judgment on his part, which fell well below the standard to be expected of a consultanf gynaecologist.

12. In the case of A, the Panel found that the decision to perform an operation was clinically unjustified, as was the taking of biopsies, and that this was an unnecessary intervention on the part of the defendant, which could have had an adverse outcome. In the case of CH, they found that the carrying out of the relevant operation was unnecessary, that the defendant carried out extensive sampling that was not justified and he caused to be inserted a coil without adequate clinical justification. They described him as surgically incompetent in the particular case.

13. In the case of SH they found that the defendant was at fault in treating a burn on the patient without at least first speaking to a plastic surgeon, and he operated outside his area of expertise. In the case of J they found that he failed to make a proper note and reached an erroneous decision as to the capability of the patient of becoming pregnant through her left fallopian tube. He failed, the Panel found, also to advise the patient in certain respects, and overall the Panel found that there was a pattern of inadequate note taking, which justified a specific finding of fault against the defendant.

14. I have deliberately merely outlined the findings without giving specific details as it is not the purpose of this hearing to examine the details of the Panel's findings. It is right, however, to note that the Panel also said this:

> "We are not of the opinion that the findings of fault which we have made are so numerous, or of such severity, that Mr Pembrey's dismissal is inevitable. As was submitted to us by Le Brasseur J Tickle, Mr Pembrey's solicitors, in their response to Part 1 of the Report, our findings need to be set in the context of the many thousands of gynaecological patients whom Mr Pembrey saw and the inevitably larger number of gynaecological treatment episodes with which he dealt over the 10 years that he has worked for the Trust."

15. As I have indicated already, the defendant disagrees strongly with the findings of the Panel.

16. On 29th September 2000 there was a disciplinary hearing, as a result of which the defendant was dismissed from his employment with the Trust. Just before he was dismissed, it so happened that Complaint 2 was referred to the GMC screener. The GMC received a copy of the Panel's report. In October 2000 the medical screener referred the matter to the PPC and the IOC.

17. Pausing at that point, I must bear in mind that the defendant's case emphasises delay on the part of the GMC and of the Trust, but it is clear in my view that there was no delay on the part of any relevant authority up to October 2000.

18. The GMC and the Trust discussed in the same month how the Trust could assist with enquiries and a body of paperwork was forwarded to the GMC. On 1st November 2000 a former patient sent to the GMC direct a separate complaint about the defendant, complaint 3. That complaint was in due course to be dealt with as a separate matter and, although it required some consideration by the GMC, it is common ground that any delay resulting from the receipt of Complaint 3 must have come to an end by April 2001.

19. Meanwhile, on 12th January 2001 the IOC considered Complaint 2 and made the first order for interim conditional registration for 18 months. The conditions imposed were as follows:

"1 You shall restrict your medical practice to positions in obstetrics and gynaecology in NHS hospitals in which your work will be closely supervised by a consultant;

2 You shall not undertake any locum posts;

3You shall notify all current employers and potential employers at the time of application whether for paid or voluntary employment of these conditions and of the matters referred to the GMC;

4You shall notify the Registrar of the GMC of any posts you undertake."

20. Those conditions have to some extent been modified from time to time but essentially are the conditions which remain. It is the condition as to supervision to which particular objection is taken, although the defendant objects to all the conditions.

21. On 17th April 2001 the Trust forwarded to the GMC a further nine complaints: Complaint 4. It is right to note straight away that no final decision has been made about whether to proceed with that complaint and whether it should be heard with Complaint 2 on 7th October.

22. Between April and September 2001 progress was made. Complaint 4 was moved to the special screening team. The GMC then noted that there was insufficient information to screen Complaint 4 properly and there was a request to the Trust for patient records in relation to that complaint. Those records were chased and on 31st July 2001 Complaints 2 and 4 were sent for screening and for approval of draft charges for a Rule 6 Letter. The screener considered the draft charges and revised them more than once. On 4th October 2001 a Rule 6 Letter was sent to the defendant in relation to Complaint 2, as the matter was being referred to the PPC. He was told that Complaint 4 would not be considered by the PPC, at least at that stage, because it was being considered by the screeners. October 2001, for reasons to which I shall return, is said to be an important date. During the period April to September 2001 the IOC reviewed the conditions twice but maintained conditions.

23. Shortly after the sending of the Rule 6 Letter on 4th October the Trust informed the GMC that they would investigate Complaint 4. The reason was that originally the Trust had not been prepared to investigate Complaint 4 as a result of the dismissal of the defendant. An appeal against his dismissal had been allowed in July and the Trust therefore decided that they would investigate.

24. I note in passing that there was a full response on behalf of Mr Pembrey in November 2001 to the Rule 6 Letter.

25. On 14th November 2001 the PPC referred the matter to the PCC. On the following day the Trust wrote to the GMC saying that it would not after all be investigating Complaint 4. The defendant was informed that Complaint 2 was going to the PPC and that a charge was being formulated against him. On 7th December 2001 solicitors were appointed by the GMC to prepare for the PCC hearing. On 17th December the IOC reviewed the conditions for a fourth time. On 24th January 2002 there was a second disciplinary hearing by the Trust. This was an independent panel, which decided on 4th February that the defendant should in fact be dismissed. In January and February 2002, first in a meeting and then by letter, the GMC's solicitors pressed the Trust for documentation, giving full details of what was required. On 6th March 2002 the IOC reviewed the conditions for a fifth time and on

3rd April the GMC offered the defendant a hearing date of 7th October.

26. It is right to note that that hearing date must have been organised as a result of a decision to go ahead with fixing a date, a decision which cannot have been taken later than March. In other words, the solicitors had plainly decided some time prior to 3rd April that, although the documentation was not complete, nevertheless they had to proceed to arrange a date. Shortly after the hearing date was offered, a total of some 15 lever arch files were received from the Trust, although since then further documents have been both requested and received and the documentation is still not regarded as complete.

27. The defendant's solicitors indicated that they could not agree with the time estimate, then of seven days, because they had not yet seen properly formulated allegations but they did not specifically agree or disagree with the proposed date. That date has since been fixed as the hearing date and the GMC wish to maintain that date. The defendant's attitude to the date is that he is only too keen to have as early a hearing as possible but is not prepared to commit himself until the formal charges and the evidence that he has to meet have been served.

28. On 1st May 2002 the IOC reviewed the question of conditions for a sixth time and gave the GMC permission to apply to the High Court. The conditions, as varied on that occasion, were as follows:

> "1. you shall restrict your medical practice to staff grade positions in obstetrics and gynaecology in NHS hospitals under the supervision of a consultant(s);
>
> 2. you shall not accept the offer of any locum post of less than three months' duration;
>
> 3. you shall ensure that a report is provided on your performance by the supervising consultant(s) prior to the review before the IOC;
>
> 4. you shall notify all current employers and potential employers at the time of application, whether for paid or voluntary employment, of these conditions and of the matters referred to the GMC;
>
> 5. you shall notify the Registrar of the GMC of any posts you undertake."

29. On that occasion the continuation of any conditions was firmly opposed by the defendant. The present conditions expire, as I have indicated, on 15th July.

30. I summarise the issues broadly. The claimant's submission is that the imposition of the conditions is justified, both in the public interest and the defendant's interest, until at least the hearing before the PCC has taken place. The defendant's submissions, set out clearly in counsel's skeleton argument and his oral submissions, can conveniently be adopted from the paragraphs at page 3 of his skeleton argument. The defendant submits that, in order to succeed, the GMC must demonstrate a good reason for the delay that has necessitated the application. Secondly, he says that the evidence does not disclose a good reason and the application should be refused. Thirdly, the application should also be refused in the light of the failure by the GMC to inform the defendant of the charges against him and, adds counsel, in all the circumstances. The defendant relies both on Article 6 of the European Convention on Human Rights and on the court's general discretion.

31. I turn first, in relation to the defendant's submissions, to Article 6. Article 6(1) guarantees

a right to a trial "within a reasonable time". I accept first of all on the authorities that this is an independent and free-standing right, the enforcement of which does not depend upon establishing prejudice. The principal authority for that proposition is the decision of the House of Lords in Porter v Magill [2002] 1 All ER 465. These proceedings are civil proceedings. In civil proceedings time runs once proceedings are commenced. On the authority of Konig v Federal Republic of Germany [1980] 2 EHRR 170, although time runs from the commencement of proceedings, one has to look elsewhere for a decision as to when time begins to run. In that connection the authority, as far as this court is concerned, must be the Attorney General's Reference (No 2 of 2001) [2001] WLR 1877. That was of course a criminal case, in which the Court of Appeal Criminal Division, presided over by the Lord Chief Justice, was considering Article 6 in the context of applications to stay proceedings for abuse of process. At paragraph 11 the Lord Chief Justice cited the European Court of Human Rights' decision in Deweer v Belgium [1980] 2 EHRR 439, in which the court had said this:

> "'(a) "Criminal charge" is an "autonomous" concept which must be understood within the meaning of the Convention. (b) The term has a "substantive" rather than a "formal" meaning. (c) On the facts, the court held the proceedings against the applicant had constituted a "criminal charge" which could be defined as "the official notification given to an individual by the competent authority of an allegation that he has committed a criminal offence".'"

32. He further quoted the European Court as saying this at page 459:

> "'There accordingly exists a combination of concordant factors conclusively demonstrating that the case has a criminal character under the Convention. The "charge" could, for the purposes of Article 6(1), be defined as the official notification given to an individual by the competent authority of an allegation that he has committed a criminal offence. In several decisions and opinions the Commission has adopted a test that appears to be fairly closely related, namely, whether "the situation of the [suspect] has been substantially affected".'"

33. The Lord Chief Justice himself went on at paragraph 13 to say this:

> "The approach that we have indicated to the question of when a person is charged is important in relation to what was contended before the judge in this case. It was contended before the judge that there had taken place an interrogation of the defendants and it was said that this constituted the charge. We disagree with that view. In the ordinary way an interrogation or an interview of a suspect by itself does not amount to a charging of that suspect for the purpose of the reasonable time requirement in Article 6(1). We do not consider it would be helpful to seek to try and identify all the circumstances where it would be possible to say that a charging has taken place for the purpose of article 6(1), although there has been no formal charge. We feel that the approach indicated by the authority that we have cited clearly expresses the position and we are content to leave the matter in that way."

34. That was, as I have said, a criminal case. Nevertheless, the authorities indicate that, in proceedings such as the present, the court should take as the starting date the date that would be adopted in a criminal case.

35. In the light of that the claimant argues that the correct date is the date of the Rule 6 Letter, namely 4th October 2001. The defendant argues that the crucial date should be regarded as 12th January 2001, when the IOC first made its order for interim conditional registration. It was submitted by counsel that from that date the defendant was substantially affected by the proceedings. In analogous criminal proceedings an interview, which may be said substantially to affect a defendant, is not to be regarded as the making of a charge, and it seems to me that such preliminary matters as a restraint order or the release on bail with conditions but prior to charge should fall under the same heading. It therefore does not follow in my view that 12th January 2001, although it resulted in an order for interim conditional registration, is the starting date to take. In my view, the submissions on behalf of the claimant are correct, namely that the Rule 6 Letter of 4th October 2001 should be taken as the starting date.

36. It is submitted on behalf of the defendant that any time after October in which there was a delay before attempting to fix the date of the hearing is without justification. He also submits that any delay caused by the Trust is delay which I should consider, bearing in mind that the Trust is a public authority. That submission I accept. My conclusion, however, is that, if one examines the timetable, there is no such delay as to amount to a breach of Article 6. Indeed, if one takes as an alternative the date 12th January 2001, there is no such delay even on that basis. In my view, some of the delays resulting from the receipt of Complaint 4 in April 2001 explain the lapse of time, some six months or so, until the Rule 6 Letter. There is no doubt that the Trust was dilatory in providing records and in due course it was necessary quite plainly for the GMC to grasp the nettle and to decide whether to proceed despite the absence of the record. In fact, in relation to Complaint 2, they did so and wrote the Rule 6 Letter on 4th October 2001, although Complaint 4 had not yet been sufficiently crystallised.

37. If one examines the events immediately after 4th October 2001, there were matters which properly required the attention of the GMC and its solicitors. They plainly needed to consider the Trust's decision, revoked after less than a month, to investigate Complaint 4. They plainly needed to consider the defendant's response to the Rule 6 Letter. In my view the instruction of solicitors on 7th December 2001 was reasonably prompt. Those solicitors, without undue delay, took up the question of the absence of documents and without undue delay decided that the date had to be fixed, as indeed it was, some time after its offer on 3rd April.

38. I agree that, with hindsight, it is perfectly possible to see how nettles should have been grasped somewhat sooner than they were and I accept that months here and there could, with hindsight, have been shaved off the timetable. Looking at it broadly, some three months or so might have been saved. But it does not in my view follow, even if on analysis the delay is open to some criticism, whether with or without hindsight, that a hearing within a reasonable time has been denied and that therefore there is a breach of Article 6. This case as a whole was never allowed to go to sleep, and the impression one gains from the timetable is of the GMC conscientiously pursuing procedures. Those procedures inevitably require some time but are designed to protect medical practitioners.

39. Criticism is made because reference to an expert was not made in 2001, but was only made, it appears, some time much later, in 2002. That criticism, although it has some merit, does not appear actually to have delayed the timetable so far.

40. I have said that I bear in mind the dilatory nature of the Trust's supply of documents. Nevertheless, as I have indicated, the GMC have conscientiously tried to obtain documents and eventually did grasp the nettle, without in my view waiting an unreasonably long time,

to proceed without such documents as they already had.

41. In deciding whether there has been a failure to provide a hearing within a reasonable time, I look at the whole period, I take an overall view, and in my view no breach of Article 6 has been made out. It is therefore not necessary to consider what the conclusion would be if there had been a breach of Article 6, if the hearing on 7th October 2002 had clearly been shown not to be a hearing within a reasonable time. In Porter the question of the effect of a breach of Article 6 was not dealt with and in my view the best authority, as things stand, for the effect of a violation of Article 6 is the holding of Simon Brown LJ in R v Court Martial Administration Officer, ex parte Jordan, decided on 27th July 1999:

> " ... the Strasbourg caselaw is not to be understood as laying down a principle that whenever delay is identified of such a character as to involve a violation of Article 6, that fact of itself necessarily precludes there being a fair trial with the result that any outstanding criminal process must immediately be discontinued."

42. Having decided that there has been no breach of Article 6, I must still examine the question of delay overall. Although under Article 6 the starting point is either January 2001 or October 2001, it seems to me that, under the court's general discretion, the whole period since the matters first arose in 1999 must be considered. If, for example, a complaint were made and the GMC did not properly or rapidly investigate it, that would be something that, although it might not be a violation of Article 6, the court must consider. In my view, if one looks at the whole period, there is no delay which should lead the court to refuse an extension on that ground. The period from September 1999 until October 2000 is explained, as I have indicated, by the fact that the Panel's report was awaited. That was a perfectly rational and sensible decision. Between October 2000 and April 2001 the timetable is explained first of all by necessary and proper processing of the case and then by some delay caused by the receipt of Complaint 3. As to the period after April 2001, I have dealt with that in connection with the Article 6 submissions.

43. Looking at the period overall, I must note that, after the receipt of Complaint 2 on 23rd September 1999, the hearing was first notified to the defendant on 3rd April 2002 for a hearing now fixed for 7th October 2002. I fully understand how such a period must appear to the defendant, who wishes these matters to be cleared up. I accept that the particular allegations individually are not especially complex, but the case has been made somewhat complex by the receipt of further complaints. It is quite plain that there has been no delay by the IOC, nor has the IOC failed in its duty properly to keep the conditions under review. As to delays by the Trust, I have accepted that those are relevant. With maximum cooperation from the Trust, the GMC could no doubt, as I have indicated before, have shaved a few months off the total time taken. It does not follow that it would be wrong for the hearing to take place or for conditions to be extended meanwhile until the 7th October.

44. I bear in mind also the evidence of the GMC that in the year 2000 there was a huge increase in the number of complaints received, a threefold increase. Steps were taken to deal with that increase, but in the short-term that provides some additional reason why matters could not proceed more quickly than they did. I find that delay is not in this case a good reason for refusing an extension.

45. I look at other matters. There is complaint about the lack of a formal Notice of Inquiry and the lack therefore of formal charges. It is proposed by the GMC that there will be service of evidence and formal charges some six to eight weeks before the hearing date, longer than the minimum required but, it is said, usual in a case of the present kind. I am of course

proceeding on the assumption that the timetable will be maintained and that the defendant will then receive what he is entitled to. There is no reason in my view to suppose that he will be taken by surprise as to the nature of the allegations against him. If he were to be, then he would have remedies, such as an application for a stay or an application for an adjournment. But today I must proceed on the basis that that will not occur. I bear in mind the submission on the defendant's behalf that of course, not only has he had the matter hanging over his head, but there remains uncertainty in particular as to whether Complaint 4 will form part of the proceedings in October.

46. If I look at section 41A, the public interest plainly has to be considered. The other side of the coin, however, is the effect of the conditions upon the defendant and I accept that such orders may have serious consequences for medical practitioners. I have the benefit of a statement made by the defendant, and his evidence is that he has been prevented from obtaining work, in particular by the condition as to supervision. The only work he has obtained has been unpaid work. It is submitted on behalf of the defendant, although he does not mention this in his statement, that he would, if that condition in particular was removed, be able to obtain private work. He points out rightly that if he does not carry out his work as a gynaecologist and obstetrician, he will become, as he says, increasingly deskilled. I fully accept that that is a real consideration. On the other hand, the GMC points out that the defendant has been receiving his salary and continues to do so. Although the second appeal against his dismissal has been rejected, he is appealing to the Secretary of State and his dismissal has therefore not become final. I accept of course that he must have lost the income from his private practice, although I do not know any figures. The GMC also submits that his dismissal from the Trust (now upheld by an independent panel, although subject to the appeal to the Secretary of State), plus the original Panel findings, plus the process of the GMC itself, would have made it extremely difficult for him to obtain a post, even unpaid, for more than a short period. In my judgment, his prospects, even in the absence of conditions, of obtaining a post within the next few months are poor, but I do accept that the conditions, added to those other matters that I have referred to, make obtaining work virtually impossible.

47. My conclusions then are these. It is plainly in the public interest that these conditions be imposed: the defendant has been found to be at fault in the way I have described by an independent panel in relation to Complaint 2; in addition, he has been dismissed by his employer as a result, on the second occasion, of an independent recommendation. I bear in mind that it is in the defendant's interests as well that he should not practise without supervision if those criticisms of him are valid. I bear in mind the lapse of time and the conclusions I have reached in relation to delay. I bear in mind the adverse effect of the conditions in practice on the defendant. I also bear in mind that the hearing is now three months ahead, in October. I have ignored in what I have said that on 5th July 2002 yet another set of complaints, Complaint 5, has been received from the Trust and that those matters appear to be old matters which have not previously been brought to the attention of the GMC. It is quite clear that I should ignore Complaint 5 and assume that such a complaint will not hold up any hearing in October.

48. In all the circumstances, I conclude that there must be an extension of the conditional registration. No specific changes in the conditions are submitted and I should therefore adopt the conditions as most recently set out by the IOC.

49. There remains the question of the period of conditions. I assume a hearing in October. At the end of that hearing, presently estimated as a precaution at 15 days, either the conditions will fall away or be superseded by an adverse finding against the defendant. I am not prepared to

order an extension on the assumption that there could be any postponement of the whole hearing. If for any reason 7th October cannot be maintained as a date on which the defendant can fairly be heard by the PPC, then there would be, in my view, a completely new situation, which would require, if necessary, a consideration of a further application. However, I am prepared to allow for some adjournment of part of the hearing. It is not unknown for hearings not to be completed and for there to be difficulties in reconvening such a hearing of the committee, bearing in mind its composition. It is always possible that there will be some meritorious reason for the adjournment of part of the hearing and a consequent failure to complete it in October. It seems to me that if there was unfortunately to be such an adjournment, it would be wrong to impose on the parties the need to come back to the court and I therefore shall order the extension until 31st January 2003. Subject to any submissions, the order will then be that the order for interim conditional registration should be extended from 15th July 2002 until 31st January 2003.

MS LANG: I am obliged. I make an application for costs. Could I hand up a few documents that I would like to refer to in the course of that application. (Handed)

The first point I make is that Mr Pembrey is supported by the Medical Defence Union and therefore any order for costs will be met by them. Secondly, Mr Pembrey was warned in correspondence from the GMC that an application for costs would be made if he resisted the application for an extension and if the GMC was successful. That is the letter of 3rd April. It is the penultimate paragraph on the second page.

MR JUSTICE CRANE: Yes.

MS LANG: Then again on 13th May, the second paragraph. My Lord, although the C applied for the maximum period of 12 months and your Lordship has granted a period of less than that, my submission is that that should not affect the order for costs because the parties could have reached agreement for an extension for a lesser period than 12 months.

MR JUSTICE CRANE: Was that ever canvassed on either side?

MS LANG: It was canvassed by me to Mr Moon and he said he would take instructions on the matter, but his instructions were to oppose any extension. I had in mind to agree something around the October date. My Lord, I invite you to make a summary assessment of costs, and there is a schedule which has been served and been handed up to your Lordship.

MR JUSTICE CRANE: Yes, I think I have seen it before actually, but perhaps I did not look at it in detail then.

MS LANG: There is now an updated statement on the last page of the bundle which just takes account of the additional costs incurred as a result of today's hearing and also -- the time estimate was originally three hours and so there has been some increase in solicitors' costs to reflect that.

MR JUSTICE CRANE: So what you are applying for is the total of the two?

MS LANG: Yes, which is £10,742.79, which is not written down anywhere.

MR JUSTICE CRANE: I will hear Mr Moon in a moment on principle. I was somewhat concerned, I must say -- these are matters of detail -- at the bulk of the documentation that was submitted for a hearing of this kind. In fact, quite apart from my comments, it was all done in triplicate for reasons that I will now hear about.

MS LANG: Because on the last two occasions when applications have been listed by the Administrative Court they have directed that it should be heard by two judges and so we had to put in one for each judge and then always one extra for the court office. The Administrative Court must presumably have now changed its mind to the view that these applications are fit to be heard by one judge. This is a relatively new procedure and so everyone is feeling their way, but that is why.

MR JUSTICE CRANE: Yes, I see. What about the bulk of the documentation?

MS LANG: There are always difficult judgments to be made here. The really big document is part 1 of the Inquiry Report, and we agonised about whether to put that in or not, and in the end I felt that, if all your Lordship had was my summary of what that report said and the original document was not before you, then, if there was any issue about the accuracy of what I had put, there was nothing to refer to, and of course in fact Mr Pembrey was not very happy with my summary.

MR JUSTICE CRANE: I suppose the other major documentation is the IOC hearings.

MS LANG: Yes.

MR JUSTICE CRANE: Again, I see why on reflection they might have needed to be --

MS LANG: Yes, the letters that are sent out from the IOC giving a decision are fairly bald and one really gets much more a sense of what the issues were before the IOC, particularly in relation to the wording of conditions, when one looks at the transcript.

MR JUSTICE CRANE: I think on reflection --

MS LANG: So it was a difficult judgment call but I would say that preparing the photocopied bundles is not the bulk of the costs.

MR JUSTICE CRANE: I said those were matters of detail. Let me hear what Mr Moon says.

MR MOON: First, the GMC would have had to have made this application anyway because of course it is required do so under the Act and so it would inevitably incur some costs in making the application. The second point, which is really related to that, is that of course the court, under section 6 of the Human Rights Act, would have had to have considered the human rights' implications anyway. Of course, the bulk of the argument is really related to Article 6. So, on any view substantial costs would have been incurred, whether or not Mr Pembrey had resisted.

The third point is that, of course, the GMC has not been successful and I must say there may have been some misunderstanding between my learned friend and I, but I understood my friend to say earlier this week that she did not have instructions to pursue anything other than 12 months. It is quite right that I did not have instructions to offer less, but I did understand my friend to tell me that she was pursuing the 12 months, and she has been unsuccessful in that.

MR JUSTICE CRANE: It does not sound the sort of discussion between counsel which we need to analyse in detail. It sounds as if there may have been sensible words, but it is quite plain there was no firm proposal on either side to compromise the length of time.

MR MOON: My Lord, the first time it was put forward as being possible by the GMC was when Ms Lang was on her feet yesterday.

MR JUSTICE CRANE: So what do you say? I see the point that an application would be needed anyway and that the defendant was in no way responsible for that. What do you say I should order?

MR MOON: My primary position is no order as to costs. My fallback position is that a proportion of these costs would have been incurred anyway.

My Lord, I do have a fourth point, which I have not made, which is this. As I understand my Lord's judgment, there is a period of about three months where, with hindsight, some of the delay could have been shaved off, and that is a matter that my Lord may wish to take into account.

MR JUSTICE CRANE: I do not regard that as a serious criticism. In almost any case with hindsight you can shave the timetable. Looking back, that is the point I was making.

MR MOON: Coming back to my broader submission, it is primarily no order as to costs. If you are against me on that, half the costs that have been put forward in the schedule.

MR JUSTICE CRANE: Thank you. (Inaudible)

MS LANG: Yes, the position is that in the 12 applications that there have been so far, ten have been resolved with the consent of the doctor.

MR MOON: My Lord, I am so sorry. I am not in a position to gainsay these matters. Ms Lang has not told me that until this moment and I am afraid I just cannot accept that sort of --

MR JUSTICE CRANE: Let us see what conclusions she draws from it. Why is it relevant?

MS LANG: What happens when a doctor consents is that, yes, the GMC through Field Fisher Waterhouse have to make an application to the court, but it is dealt with on the papers, and therefore particulars of claim and the claim form and the witness statement in fairly short form are lodged and the consent order is signed by both parties.

MR JUSTICE CRANE: That is if there is actually a consent order.

MS LANG: Yes, drafted by Field Fisher Waterhouse. It is sent to the --

MR JUSTICE CRANE: I can see that.

MS LANG: -- doctor and it is signed, and then presumably a judge is asked to look at the matter and the order is made.

MR JUSTICE CRANE: I am not sure that is really relevant.

MS LANG: Can I just develop the point? It is about the costs incurred. Mr Moon was kind enough to mention yesterday that he wanted to take this point and so overnight we have considered, well, what costs would we have incurred had this been dealt with by consent? So, yes, we would have had to make the application, but we would not have had to prepare for a court hearing and instruct counsel and come to court. So that is essentially the difference that is caused by it being contested. Obviously, that is quite a detailed exercise, which I am happy to go through now if your Lordship wishes, or your Lordship might wish to refer it to a costs judge for a detailed assessment. But the principle is that it is very different: they would not have needed to instruct counsel; obviously, no one would have needed to attend a court hearing; and the degree of preparation, particularly in this case where delay was raised and therefore we had to do a very detailed chronology and a second witness statement dealing with, point by point, the history of the case -- the costs are very different, if I can give you the figures. The total costs figure, as I have said to your Lordship, is £10,742.79. These figures include that. The costs of the contested hearing are £8,972.15. The costs of proceeding with Mr Pembrey's consent would have been £1,770.64. So we say it is nearly £9,000 that has been incurred as a result of this contested hearing. So at the very least those are the costs

that we seek.

MR JUSTICE CRANE: There you are drawing a distinction between a consent order on paper, rather than an unopposed order in court.

MS LANG: That is just not obviously the way it has proceeded in the past, an unopposed application --

MR JUSTICE CRANE: Can I tell you what I am inclined to do? I follow the costs would have been a great deal less -- but for the moment doubt your figures -- than if it had been a consent order. They would plainly have been more than that if there had been an application in court without consent but simply unopposed (inaudible).

MS LANG: You mean with the defendant not attending?

MR JUSTICE CRANE: Not attending or just indicating that he did not oppose the application, an attitude I can understand in the circumstances, and in addition it seems to me relevant to note that, although ultimately I have decided that you can justify the delay -- if one puts hindsight aside, you can justify it -- nevertheless, many of the reasons for that will not have been apparent to the defendant until they were set out and thus required justification. So, although they ultimately have been unsuccessful, I am not sure I would regard his opposition as being, as it were, totally unreasonable or capricious. I am rather inclined for that reason to order him to pay half the costs on the basis that you have put forward.

MS LANG: My Lord, if that is your Lordship's ruling, I will say no more. I am not sure if your Lordship is inviting me to comment?

MR JUSTICE CRANE: I am, yes.

MS LANG: I simply say this, that, given the past history of this case, which your Lordship has found not to involve unreasonable delay, the fact that the hearing is listed for October and that we are now in July meant that the prospects of any court refusing to grant the extension were slim. If the GMC were coming to court and saying, "We have not fixed the PCC hearing," or the PCC hearing was going to be in a year's time, it would be a different story, but ultimately my best point was that the hearing was so soon and really that extending the conditions from now until October would make a marginal impact on Mr Pembrey's personal position, and it is really for that reason at the end of the day that, in my view, Mr Pembrey was doomed to fail, and his lawyers should have advised him of that. Maybe they did. But it was not a strong application and we submit a great deal of time and money has been taken up unnecessarily.

MR JUSTICE CRANE: A great deal of time and money has been taken up but -- yes, I think in all the circumstances there should be an order that he pays half the costs.

MR MOON: My Lord, can I with great diffidence ask for permission to appeal? With the greatest of diffidence I possibly can muster.

MR JUSTICE CRANE: You can certainly ask. In my view these are matters of detail eminently suitable for a first instance judge to decide and I do not regard there as being in the ultimate analysis any point of principle arising.

under s.96(2) of the 1999 Act to treat T and S as an exceptional case and to provide them with support, by way of the provision of free milk, under s.95 of the Act.

HELD: (1) This court was quite satisfied that Parliament and the executive had intended the exclusionary result brought about by s.115 of the 1999 Act. In the circumstances, there was nothing that required D1 to exercise his powers of amendment. (2) D2's decision proceeded on the basis of two flaws: (a) it took account of certain cash payments of benefit which had been made to T but which were irrelevant for the purposes of the exercise under s.96(2); and (b) it failed to take account of the risk that, as a result of poverty, an HIV positive mother might breastfeed her child. In those circumstances, D2's decision fell to be quashed.

Judgment accordingly.

LTL 8/8/2002 (Unreported elsewhere)

Judgment Draft - 55 pages

Document No: C0103622

CASE LAW

GENERAL MEDICAL COUNCIL v PEMBREY (2002)

QBD Administrative Court (Crane J) 12/7/2002

MEDICAL - ADMINISTRATIVE - HUMAN RIGHTS
INTERIM CONDITIONAL REGISTRATION ORDERS : EXTENSIONS : DOCTORS : SURGEONS : CONSULTANTS : OBSTETRICIANS : GYNAECOLOGISTS : DISCIPLINARY PROCEEDINGS : PROFESSIONAL MISCONDUCT : RESTRICTIONS ON PRACTISING : SUPERVISION BY CONSULTANTS : REVIEWS OF CONDITIONS : PRELIMINARY PROCEDURES COMMITTEE : PPC : PROFESSIONAL CONDUCT COMMITTEE : PCC : INTERIM ORDERS COMMITTEE : IOC : NHS TRUSTS : DISMISSAL : DELAY : BAD FAITH : JUDICIAL DISCRETION : PUBLIC INTEREST : INTEREST OF DEFENDANTS : RULE 6 LETTERS : STARTING DATES : S.41A MEDICAL ACT 1983 : HUMAN RIGHTS ACT 1998 : EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS 1950 : EUROPEAN CONVENTION ON HUMAN RIGHTS : ECHR : ART.6 : RIGHT TO A FAIR TRIAL : ART.6(1) : REASONABLE TIME : GENERAL MEDICAL COUNCIL PRELIMINARY PROCEEDINGS COMMITTEE AND PROFESSIONAL CONDUCT COMMITTEE (PROCEDURE) RULES 1988 SI 1988/2255

The General Medical Council was entitled to an extension of an interim conditional registration order against a consultant pending a hearing of complaints by the Professional Conduct Committee where the delay in progressing the matter did not breach Art.6 European Convention on Human Rights and did not justify the exercise of the court's general discretion to refuse the extension.

Application to extend an order for interim conditional registration under s.41A Medical Act 1983. The defendant ('P'), a consultant obstetrician and gynaecologist, had been made subject to conditions in the event that he practised pending a hearing of complaints against him by the professional conduct committee ('PCC') of the claimant ('GMC'). In September

1999 P was suspended from employment and his employer NHS Trust sent complaints about him to the GMC. In September 2000 P was dismissed after a disciplinary hearing. In October 2000 the GMC's medical screener referred the matter to the interim orders committee ('IOC'), which ordered that P be subject to interim conditional registration for a period of 18 months, and P was sent draft charges against him in the form of a "rule 6 letter" on 4 October 2001. The GMC submitted that the imposition of conditions was justified in both the public and P's interest until at least the hearing before the PCC. P submitted as follows: (i) the GMC had to show a good reason for the delay that had necessitated this application; (ii) the evidence did not disclose a good reason and this application should be refused; (iii) relying on Art.6 European Convention on Human Rights and the court's general discretion this application should also be refused in the light of the GMC's failure to inform P of the charges against him.

HELD: (1) P had an independent and free-standing right to a trial within a reasonable time. The starting date in these proceedings was the date that would be adopted in a criminal case, which was the date of the rule 6 letter. (2) There had been no delay in this case sufficient to amount to a breach of Art.6. (3) Examining the question of delay overall under the court's general discretion, there had been no delay sufficient for this court to refuse an extension on that ground. Further, there was no reason to suppose that P would be taken by surprise concerning the nature of the allegations against him. (4) It was plainly in the public interest for the conditions to P's registration to be imposed given that he had been found to be at fault and had been dismissed by his employer as a result of an independent recommendation. It was also in P's interests that he should not practice without supervision if the criticisms of him were valid. In all the circumstances, the conditional registration had to be extended.

Application allowed.

Ms B Lang QC instructed by Field Fisher Waterhouse for the GMC. Mr A Moon instructed by Radcliffe Le Brasseur for P.

LTL 8/8/2002 (Unreported elsewhere)

Judgment Official

Document No: C0103661

Neutral Citation Number: [2002] EWHC 1602 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT

NO: CO/2963/2002

Royal Courts of Justice
Strand
London WC2

Friday, 12th July 2002

Before:

MR JUSTICE CRANE

THE GENERAL MEDICAL COUNCIL

-v-

PEMBREY

Computer-Aided Transcript of the stenograph notes of
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Code A
(Official Shorthand Writers to the Court)

MS B LANG QC(instructed by Field Fisher Waterhouse) appeared on behalf of the Claimant
MR A MOON(instructed by Radcliffe Le Brasseur) appeared on behalf of the Defendant

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J U D G M E N T
(As Approved by the Court)

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1. MR JUSTICE CRANE: Mr Michael Pembrey is a consultant obstetrician and gynaecologist. Pending a hearing of complaints against him by the Professional Conduct Committee (PCC) of the General Medical Council (GMC), the defendant has been made subject to an order for interim conditional registration under the Medical Act 1983, section 41A. In other words, conditions have been imposed upon him if he is to practise. The hearing of the complaints is fixed for 7th October 2002. The GMC is applying to this court under section 41A(6) of the Act for an extension of the order for 12 months from its expiry on 15th July.

2. I deal first with the statutory framework. The GMC is, under the Act, responsible for supervising and regulating the fitness of medical practitioners registered with it to practise. It has a duty to deal with complaints against medical practitioners. The Act provides for various statutory committees. The procedure for dealing with a complaint of serious professional misconduct is set out in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988.

3. Briefly, the normal procedure is as follows. The complaint is first considered by a medical screener. Unless the screener decides that no question of serious professional misconduct arises, the case is then referred to the Preliminary Proceedings Committee (PPC). The PPC may, as one outcome, refer the case to the PCC. At the stage when a screener refers the case to the PPC notification is sent to the medical practitioner, a "Rule 6 Letter", and "as soon as may be after a case has been referred to" the PCC a Notice of Inquiry is sent to the medical practitioner. The charge or charges are specified. In addition, the evidence relied on will be served on him. Various people, including the screener and either of the committees, may refer the case to another statutory committee, the Interim Orders Committee (IOC).

4. I turn to the provisions of the Medical Act 1983, section 41A:

> "(1) Where the Interim Orders Committee are satisfied that it is necessary for the protection of members of public or is otherwise in the public interest, or is in the interests of a fully registered person, for the registration of that person to be suspended or to be made subject to conditions, the Committee may make an order--
>
> ...
>
> (b) that his registration shall be conditional on his compliance, during such period not exceeding eighteen months as may be specified in the order, with such requirements so specified as the Committee think fit to impose (an 'order for interim conditional registration').
>
> (2) Subject to subsection (9), where the Interim Orders Committee have made an order under subsection (1), the Committee--
>
> (a) shall review it within the period of six months beginning on the date on which the order was made, and shall thereafter, for so long as the order continues in force, further review it before the end of the period of three months beginning on the date of the decision of the immediately preceding review; and
>
> (b) may review it where new evidence relevant to the order has become available after the making of the order.
>
> ...

> (6) The General Council may apply to the court for an order made by the Interim Orders Committee under subsection (1) or (3) to be extended, and may apply again for further extensions.
>
> (7) On such an application the court may extend (or further extend) for up to 12 months the period for which the order has effect."

5. Under subsection (9) the Interim Orders Committee has a duty to continue to review the order if the court orders an extension. It is clear not only that subsection (1) gives guidance to the Interim Orders Committee as to the factors relevant to the making of an order, but that those indications also provide guidance to the court in deciding whether an extension should be granted.

6. I turn to the chronology. From the 1st February 1989 the defendant was employed by the Hastings and Rother NHS Trust. He also had some private practice. On 5th May 1998 information was received by the GMC from the Trust regarding the standard of the defendant's professional conduct, particularly in relation to laparoscopic surgery. I shall refer to that information as Complaint 1. The complaint was referred by the GMC to a screener but ultimately the GMC received a positive report from the Trust about the defendant's progress and on 18th June 1999 the screener decided that no action was necessary. I am not further concerned with Complaint 1.

7. In September 1999 a further decision was made by the Trust: to suspend the defendant from his employment by the Trust and to send further complaints to the General Medical Council, those complaints being received on 23rd September 1999. That group of complaints has been referred to during the hearing as Complaint 2. On 24th September 1999 the defendant's admitting rights to the BUPA hospital at Hastings were withdrawn and hence his private practice effectively came to an end.

8. It is right to note at this stage, not only that the defendant denies these and all other complaints against him, but that he contends, as part of his case before the General Medical Council, that the Trust and certain individuals within it have been guilty of bad faith and have been responsible for a campaign against him. It is not for the court in this hearing to pass judgment on those matters.

9. The matters which led to the defendant's suspension and to Complaint 2 were in fact placed by the Trust before an independent panel, consisting of a member of the Bar and two consultants. There was a hearing before the Panel in the spring and early summer of the year 2000. That panel prepared an initial report, and a final report after seeking comment from the defendant. The final report was dated 14th September 2000.

10. The Panel reported that the defendant was at fault in various respects. In relation to the case of M, it was found that the defendant failed to make a full and proper note of a consultation and counselling of a young woman of 18 with a mental age of six, on whom he had performed an operation. The Panel took the view that, in failing to make such a proper note, the defendant fell well below the standards to be expected of him. They also found that he had failed to consult more widely before deciding to carry out the particular operation.

11. In the second case, that of T, the panel's findings were similar, namely that the defendant failed to make a full and proper note and failed to consult more widely than he did. In the case of A, the findings of fault were that he should have abandoned an operation he was in fact performing and he should not have carried out part of the operation that he did, and that he failed to make a careful note. The Panel concluded that there was a serious lack of

judgment on his part, which fell well below the standard to be expected of a consultant gynaecologist.

12. In the case of A, the Panel found that the decision to perform an operation was clinically unjustified, as was the taking of biopsies, and that this was an unnecessary intervention on the part of the defendant, which could have had an adverse outcome. In the case of CH, they found that the carrying out of the relevant operation was unnecessary, that the defendant carried out extensive sampling that was not justified and he caused to be inserted a coil without adequate clinical justification. They described him as surgically incompetent in the particular case.

13. In the case of SH they found that the defendant was at fault in treating a burn on the patient without at least first speaking to a plastic surgeon, and he operated outside his area of expertise. In the case of J they found that he failed to make a proper note and reached an erroneous decision as to the capability of the patient of becoming pregnant through her left fallopian tube. He failed, the Panel found, also to advise the patient in certain respects, and overall the Panel found that there was a pattern of inadequate note taking, which justified a specific finding of fault against the defendant.

14. I have deliberately merely outlined the findings without giving specific details as it is not the purpose of this hearing to examine the details of the Panel's findings. It is right, however, to note that the Panel also said this:

> "We are not of the opinion that the findings of fault which we have made are so numerous, or of such severity, that Mr Pembrey's dismissal is inevitable. As was submitted to us by Le Brasseur J Tickle, Mr Pembrey's solicitors, in their response to Part 1 of the Report, our findings need to be set in the context of the many thousands of gynaecological patients whom Mr Pembrey saw and the inevitably larger number of gynaecological treatment episodes with which he dealt over the 10 years that he has worked for the Trust."

15. As I have indicated already, the defendant disagrees strongly with the findings of the Panel.

16. On 29th September 2000 there was a disciplinary hearing, as a result of which the defendant was dismissed from his employment with the Trust. Just before he was dismissed, it so happened that Complaint 2 was referred to the GMC screener. The GMC received a copy of the Panel's report. In October 2000 the medical screener referred the matter to the PPC and the IOC.

17. Pausing at that point, I must bear in mind that the defendant's case emphasises delay on the part of the GMC and of the Trust, but it is clear in my view that there was no delay on the part of any relevant authority up to October 2000.

18. The GMC and the Trust discussed in the same month how the Trust could assist with enquiries and a body of paperwork was forwarded to the GMC. On 1st November 2000 a former patient sent to the GMC direct a separate complaint about the defendant, complaint 3. That complaint was in due course to be dealt with as a separate matter and, although it required some consideration by the GMC, it is common ground that any delay resulting from the receipt of Complaint 3 must have come to an end by April 2001.

19. Meanwhile, on 12th January 2001 the IOC considered Complaint 2 and made the first order for interim conditional registration for 18 months. The conditions imposed were as follows:

> "1 You shall restrict your medical practice to positions in obstetrics and gynaecology in NHS hospitals in which your work will be closely supervised by a consultant;
>
> 2 You shall not undertake any locum posts;
>
> 3You shall notify all current employers and potential employers at the time of application whether for paid or voluntary employment of these conditions and of the matters referred to the GMC;
>
> 4You shall notify the Registrar of the GMC of any posts you undertake."

20. Those conditions have to some extent been modified from time to time but essentially are the conditions which remain. It is the condition as to supervision to which particular objection is taken, although the defendant objects to all the conditions.

21. On 17th April 2001 the Trust forwarded to the GMC a further nine complaints: Complaint 4. It is right to note straight away that no final decision has been made about whether to proceed with that complaint and whether it should be heard with Complaint 2 on 7th October.

22. Between April and September 2001 progress was made. Complaint 4 was moved to the special screening team. The GMC then noted that there was insufficient information to screen Complaint 4 properly and there was a request to the Trust for patient records in relation to that complaint. Those records were chased and on 31st July 2001 Complaints 2 and 4 were sent for screening and for approval of draft charges for a Rule 6 Letter. The screener considered the draft charges and revised them more than once. On 4th October 2001 a Rule 6 Letter was sent to the defendant in relation to Complaint 2, as the matter was being referred to the PPC. He was told that Complaint 4 would not be considered by the PPC, at least at that stage, because it was being considered by the screeners. October 2001, for reasons to which I shall return, is said to be an important date. During the period April to September 2001 the IOC reviewed the conditions twice but maintained conditions.

23. Shortly after the sending of the Rule 6 Letter on 4th October the Trust informed the GMC that they would investigate Complaint 4. The reason was that originally the Trust had not been prepared to investigate Complaint 4 as a result of the dismissal of the defendant. An appeal against his dismissal had been allowed in July and the Trust therefore decided that they would investigate.

24. I note in passing that there was a full response on behalf of Mr Pembrey in November 2001 to the Rule 6 Letter.

25. On 14th November 2001 the PPC referred the matter to the PCC. On the following day the Trust wrote to the GMC saying that it would not after all be investigating Complaint 4. The defendant was informed that Complaint 2 was going to the PPC and that a charge was being formulated against him. On 7th December 2001 solicitors were appointed by the GMC to prepare for the PCC hearing. On 17th December the IOC reviewed the conditions for a fourth time. On 24th January 2002 there was a second disciplinary hearing by the Trust. This was an independent panel, which decided on 4th February that the defendant should in fact be dismissed. In January and February 2002, first in a meeting and then by letter, the GMC's solicitors pressed the Trust for documentation, giving full details of what was required. On 6th March 2002 the IOC reviewed the conditions for a fifth time and on

3rd April the GMC offered the defendant a hearing date of 7th October.

26. It is right to note that that hearing date must have been organised as a result of a decision to go ahead with fixing a date, a decision which cannot have been taken later than March. In other words, the solicitors had plainly decided some time prior to 3rd April that, although the documentation was not complete, nevertheless they had to proceed to arrange a date. Shortly after the hearing date was offered, a total of some 15 lever arch files were received from the Trust, although since then further documents have been both requested and received and the documentation is still not regarded as complete.

27. The defendant's solicitors indicated that they could not agree with the time estimate, then of seven days, because they had not yet seen properly formulated allegations but they did not specifically agree or disagree with the proposed date. That date has since been fixed as the hearing date and the GMC wish to maintain that date. The defendant's attitude to the date is that he is only too keen to have as early a hearing as possible but is not prepared to commit himself until the formal charges and the evidence that he has to meet have been served.

28. On 1st May 2002 the IOC reviewed the question of conditions for a sixth time and gave the GMC permission to apply to the High Court. The conditions, as varied on that occasion, were as follows:

> "1. you shall restrict your medical practice to staff grade positions in obstetrics and gynaecology in NHS hospitals under the supervision of a consultant(s);
>
> 2. you shall not accept the offer of any locum post of less than three months' duration;
>
> 3. you shall ensure that a report is provided on your performance by the supervising consultant(s) prior to the review before the IOC;
>
> 4. you shall notify all current employers and potential employers at the time of application, whether for paid or voluntary employment, of these conditions and of the matters referred to the GMC;
>
> 5. you shall notify the Registrar of the GMC of any posts you undertake."

29. On that occasion the continuation of any conditions was firmly opposed by the defendant. The present conditions expire, as I have indicated, on 15th July.

30. I summarise the issues broadly. The claimant's submission is that the imposition of the conditions is justified, both in the public interest and the defendant's interest, until at least the hearing before the PCC has taken place. The defendant's submissions, set out clearly in counsel's skeleton argument and his oral submissions, can conveniently be adopted from the paragraphs at page 3 of his skeleton argument. The defendant submits that, in order to succeed, the GMC must demonstrate a good reason for the delay that has necessitated the application. Secondly, he says that the evidence does not disclose a good reason and the application should be refused. Thirdly, the application should also be refused in the light of the failure by the GMC to inform the defendant of the charges against him and, adds counsel, in all the circumstances. The defendant relies both on Article 6 of the European Convention on Human Rights and on the court's general discretion.

31. I turn first, in relation to the defendant's submissions, to Article 6. Article 6(1) guarantees

a right to a trial "within a reasonable time". I accept first of all on the authorities that this is an independent and free-standing right, the enforcement of which does not depend upon establishing prejudice. The principal authority for that proposition is the decision of the House of Lords in Porter v Magill [2002] 1 All ER 465. These proceedings are civil proceedings. In civil proceedings time runs once proceedings are commenced. On the authority of Konig v Federal Republic of Germany [1980] 2 EHRR 170, although time runs from the commencement of proceedings, one has to look elsewhere for a decision as to when time begins to run. In that connection the authority, as far as this court is concerned, must be the Attorney General's Reference (No 2 of 2001) [2001] WLR 1877. That was of course a criminal case, in which the Court of Appeal Criminal Division, presided over by the Lord Chief Justice, was considering Article 6 in the context of applications to stay proceedings for abuse of process. At paragraph 11 the Lord Chief Justice cited the European Court of Human Rights' decision in Deweer v Belgium [1980] 2 EHRR 439, in which the court had said this:

> "'(a) "Criminal charge" is an "autonomous" concept which must be understood within the meaning of the Convention. (b) The term has a "substantive" rather than a "formal" meaning. (c) On the facts, the court held the proceedings against the applicant had constituted a "criminal charge" which could be defined as "the official notification given to an individual by the competent authority of an allegation that he has committed a criminal offence".'"

32. He further quoted the European Court as saying this at page 459:

> "'There accordingly exists a combination of concordant factors conclusively demonstrating that the case has a criminal character under the Convention. The "charge" could, for the purposes of Article 6(1), be defined as the official notification given to an individual by the competent authority of an allegation that he has committed a criminal offence. In several decisions and opinions the Commission has adopted a test that appears to be fairly closely related, namely, whether "the situation of the [suspect] has been substantially affected".'"

33. The Lord Chief Justice himself went on at paragraph 13 to say this:

> "The approach that we have indicated to the question of when a person is charged is important in relation to what was contended before the judge in this case. It was contended before the judge that there had taken place an interrogation of the defendants and it was said that this constituted the charge. We disagree with that view. In the ordinary way an interrogation or an interview of a suspect by itself does not amount to a charging of that suspect for the purpose of the reasonable time requirement in Article 6(1). We do not consider it would be helpful to seek to try and identify all the circumstances where it would be possible to say that a charging has taken place for the purpose of article 6(1), although there has been no formal charge. We feel that the approach indicated by the authority that we have cited clearly expresses the position and we are content to leave the matter in that way."

34. That was, as I have said, a criminal case. Nevertheless, the authorities indicate that, in proceedings such as the present, the court should take as the starting date the date that would be adopted in a criminal case.

35. In the light of that the claimant argues that the correct date is the date of the Rule 6 Letter, namely 4th October 2001. The defendant argues that the crucial date should be regarded as 12th January 2001, when the IOC first made its order for interim conditional registration. It was submitted by counsel that from that date the defendant was substantially affected by the proceedings. In analogous criminal proceedings an interview, which may be said substantially to affect a defendant, is not to be regarded as the making of a charge, and it seems to me that such preliminary matters as a restraint order or the release on bail with conditions but prior to charge should fall under the same heading. It therefore does not follow in my view that 12th January 2001, although it resulted in an order for interim conditional registration, is the starting date to take. In my view, the submissions on behalf of the claimant are correct, namely that the Rule 6 Letter of 4th October 2001 should be taken as the starting date.

36. It is submitted on behalf of the defendant that any time after October in which there was a delay before attempting to fix the date of the hearing is without justification. He also submits that any delay caused by the Trust is delay which I should consider, bearing in mind that the Trust is a public authority. That submission I accept. My conclusion, however, is that, if one examines the timetable, there is no such delay as to amount to a breach of Article 6. Indeed, if one takes as an alternative the date 12th January 2001, there is no such delay even on that basis. In my view, some of the delays resulting from the receipt of Complaint 4 in April 2001 explain the lapse of time, some six months or so, until the Rule 6 Letter. There is no doubt that the Trust was dilatory in providing records and in due course it was necessary quite plainly for the GMC to grasp the nettle and to decide whether to proceed despite the absence of the record. In fact, in relation to Complaint 2, they did so and wrote the Rule 6 Letter on 4th October 2001, although Complaint 4 had not yet been sufficiently crystallised.

37. If one examines the events immediately after 4th October 2001, there were matters which properly required the attention of the GMC and its solicitors. They plainly needed to consider the Trust's decision, revoked after less than a month, to investigate Complaint 4. They plainly needed to consider the defendant's response to the Rule 6 Letter. In my view the instruction of solicitors on 7th December 2001 was reasonably prompt. Those solicitors, without undue delay, took up the question of the absence of documents and without undue delay decided that the date had to be fixed, as indeed it was, some time after its offer on 3rd April.

38. I agree that, with hindsight, it is perfectly possible to see how nettles should have been grasped somewhat sooner than they were and I accept that months here and there could, with hindsight, have been shaved off the timetable. Looking at it broadly, some three months or so might have been saved. But it does not in my view follow, even if on analysis the delay is open to some criticism, whether with or without hindsight, that a hearing within a reasonable time has been denied and that therefore there is a breach of Article 6. This case as a whole was never allowed to go to sleep, and the impression one gains from the timetable is of the GMC conscientiously pursuing procedures. Those procedures inevitably require some time but are designed to protect medical practitioners.

39. Criticism is made because reference to an expert was not made in 2001, but was only made, it appears, some time much later, in 2002. That criticism, although it has some merit, does not appear actually to have delayed the timetable so far.

40. I have said that I bear in mind the dilatory nature of the Trust's supply of documents. Nevertheless, as I have indicated, the GMC have conscientiously tried to obtain documents and eventually did grasp the nettle, without in my view waiting an unreasonably long time,

to proceed without such documents as they already had.

41. In deciding whether there has been a failure to provide a hearing within a reasonable time, I look at the whole period, I take an overall view, and in my view no breach of Article 6 has been made out. It is therefore not necessary to consider what the conclusion would be if there had been a breach of Article 6, if the hearing on 7th October 2002 had clearly been shown not to be a hearing within a reasonable time. In Porter the question of the effect of a breach of Article 6 was not dealt with and in my view the best authority, as things stand, for the effect of a violation of Article 6 is the holding of Simon Brown LJ in R v Court Martial Administration Officer, ex parte Jordan, decided on 27th July 1999:

> " ... the Strasbourg caselaw is not to be understood as laying down a principle that whenever delay is identified of such a character as to involve a violation of Article 6, that fact of itself necessarily precludes there being a fair trial with the result that any outstanding criminal process must immediately be discontinued."

42. Having decided that there has been no breach of Article 6, I must still examine the question of delay overall. Although under Article 6 the starting point is either January 2001 or October 2001, it seems to me that, under the court's general discretion, the whole period since the matters first arose in 1999 must be considered. If, for example, a complaint were made and the GMC did not properly or rapidly investigate it, that would be something that, although it might not be a violation of Article 6, the court must consider. In my view, if one looks at the whole period, there is no delay which should lead the court to refuse an extension on that ground. The period from September 1999 until October 2000 is explained, as I have indicated, by the fact that the Panel's report was awaited. That was a perfectly rational and sensible decision. Between October 2000 and April 2001 the timetable is explained first of all by necessary and proper processing of the case and then by some delay caused by the receipt of Complaint 3. As to the period after April 2001, I have dealt with that in connection with the Article 6 submissions.

43. Looking at the period overall, I must note that, after the receipt of Complaint 2 on 23rd September 1999, the hearing was first notified to the defendant on 3rd April 2002 for a hearing now fixed for 7th October 2002. I fully understand how such a period must appear to the defendant, who wishes these matters to be cleared up. I accept that the particular allegations individually are not especially complex, but the case has been made somewhat complex by the receipt of further complaints. It is quite plain that there has been no delay by the IOC, nor has the IOC failed in its duty properly to keep the conditions under review. As to delays by the Trust, I have accepted that those are relevant. With maximum cooperation from the Trust, the GMC could no doubt, as I have indicated before, have shaved a few months off the total time taken. It does not follow that it would be wrong for the hearing to take place or for conditions to be extended meanwhile until the 7th October.

44. I bear in mind also the evidence of the GMC that in the year 2000 there was a huge increase in the number of complaints received, a threefold increase. Steps were taken to deal with that increase, but in the short-term that provides some additional reason why matters could not proceed more quickly than they did. I find that delay is not in this case a good reason for refusing an extension.

45. I look at other matters. There is complaint about the lack of a formal Notice of Inquiry and the lack therefore of formal charges. It is proposed by the GMC that there will be service of evidence and formal charges some six to eight weeks before the hearing date, longer than the minimum required but, it is said, usual in a case of the present kind. I am of course

proceeding on the assumption that the timetable will be maintained and that the defendant will then receive what he is entitled to. There is no reason in my view to suppose that he will be taken by surprise as to the nature of the allegations against him. If he were to be, then he would have remedies, such as an application for a stay or an application for an adjournment. But today I must proceed on the basis that that will not occur. I bear in mind the submission on the defendant's behalf that of course, not only has he had the matter hanging over his head, but there remains uncertainty in particular as to whether Complaint 4 will form part of the proceedings in October.

46. If I look at section 41A, the public interest plainly has to be considered. The other side of the coin, however, is the effect of the conditions upon the defendant and I accept that such orders may have serious consequences for medical practitioners. I have the benefit of a statement made by the defendant, and his evidence is that he has been prevented from obtaining work, in particular by the condition as to supervision. The only work he has obtained has been unpaid work. It is submitted on behalf of the defendant, although he does not mention this in his statement, that he would, if that condition in particular was removed, be able to obtain private work. He points out rightly that if he does not carry out his work as a gynaecologist and obstetrician, he will become, as he says, increasingly deskilled. I fully accept that that is a real consideration. On the other hand, the GMC points out that the defendant has been receiving his salary and continues to do so. Although the second appeal against his dismissal has been rejected, he is appealing to the Secretary of State and his dismissal has therefore not become final. I accept of course that he must have lost the income from his private practice, although I do not know any figures. The GMC also submits that his dismissal from the Trust (now upheld by an independent panel, although subject to the appeal to the Secretary of State), plus the original Panel findings, plus the process of the GMC itself, would have made it extremely difficult for him to obtain a post, even unpaid, for more than a short period. In my judgment, his prospects, even in the absence of conditions, of obtaining a post within the next few months are poor, but I do accept that the conditions, added to those other matters that I have referred to, make obtaining work virtually impossible.

47. My conclusions then are these. It is plainly in the public interest that these conditions be imposed: the defendant has been found to be at fault in the way I have described by an independent panel in relation to Complaint 2; in addition, he has been dismissed by his employer as a result, on the second occasion, of an independent recommendation. I bear in mind that it is in the defendant's interests as well that he should not practise without supervision if those criticisms of him are valid. I bear in mind the lapse of time and the conclusions I have reached in relation to delay. I bear in mind the adverse effect of the conditions in practice on the defendant. I also bear in mind that the hearing is now three months ahead, in October. I have ignored in what I have said that on 5th July 2002 yet another set of complaints, Complaint 5, has been received from the Trust and that those matters appear to be old matters which have not previously been brought to the attention of the GMC. It is quite clear that I should ignore Complaint 5 and assume that such a complaint will not hold up any hearing in October.

48. In all the circumstances, I conclude that there must be an extension of the conditional registration. No specific changes in the conditions are submitted and I should therefore adopt the conditions as most recently set out by the IOC.

49. There remains the question of the period of conditions. I assume a hearing in October. At the end of that hearing, presently estimated as a precaution at 15 days, either the conditions will fall away or be superseded by an adverse finding against the defendant. I am not prepared to

order an extension on the assumption that there could be any postponement of the whole hearing. If for any reason 7th October cannot be maintained as a date on which the defendant can fairly be heard by the PPC, then there would be, in my view, a completely new situation, which would require, if necessary, a consideration of a further application. However, I am prepared to allow for some adjournment of part of the hearing. It is not unknown for hearings not to be completed and for there to be difficulties in reconvening such a hearing of the committee, bearing in mind its composition. It is always possible that there will be some meritorious reason for the adjournment of part of the hearing and a consequent failure to complete it in October. It seems to me that if there was unfortunately to be such an adjournment, it would be wrong to impose on the parties the need to come back to the court and I therefore shall order the extension until 31st January 2003. Subject to any submissions, the order will then be that the order for interim conditional registration should be extended from 15th July 2002 until 31st January 2003.

MS LANG: I am obliged. I make an application for costs. Could I hand up a few documents that I would like to refer to in the course of that application. (Handed)

The first point I make is that Mr Pembrey is supported by the Medical Defence Union and therefore any order for costs will be met by them. Secondly, Mr Pembrey was warned in correspondence from the GMC that an application for costs would be made if he resisted the application for an extension and if the GMC was successful. That is the letter of 3rd April. It is the penultimate paragraph on the second page.

MR JUSTICE CRANE: Yes.

MS LANG: Then again on 13th May, the second paragraph. My Lord, although the C applied for the maximum period of 12 months and your Lordship has granted a period of less than that, my submission is that that should not affect the order for costs because the parties could have reached agreement for an extension for a lesser period than 12 months.

MR JUSTICE CRANE: Was that ever canvassed on either side?

MS LANG: It was canvassed by me to Mr Moon and he said he would take instructions on the matter, but his instructions were to oppose any extension. I had in mind to agree something around the October date. My Lord, I invite you to make a summary assessment of costs, and there is a schedule which has been served and been handed up to your Lordship.

MR JUSTICE CRANE: Yes, I think I have seen it before actually, but perhaps I did not look at it in detail then.

MS LANG: There is now an updated statement on the last page of the bundle which just takes account of the additional costs incurred as a result of today's hearing and also -- the time estimate was originally three hours and so there has been some increase in solicitors' costs to reflect that.

MR JUSTICE CRANE: So what you are applying for is the total of the two?

MS LANG: Yes, which is £10,742.79, which is not written down anywhere.

MR JUSTICE CRANE: I will hear Mr Moon in a moment on principle. I was somewhat concerned, I must say -- these are matters of detail -- at the bulk of the documentation that was submitted for a hearing of this kind. In fact, quite apart from my comments, it was all done in triplicate for reasons that I will now hear about.

MS LANG: Because on the last two occasions when applications have been listed by the Administrative Court they have directed that it should be heard by two judges and so we had to put in one for each judge and then always one extra for the court office. The Administrative Court must presumably have now changed its mind to the view that these applications are fit to be heard by one judge. This is a relatively new procedure and so everyone is feeling their way, but that is why.

MR JUSTICE CRANE: Yes, I see. What about the bulk of the documentation?

MS LANG: There are always difficult judgments to be made here. The really big document is part 1 of the Inquiry Report, and we agonised about whether to put that in or not, and in the end I felt that, if all your Lordship had was my summary of what that report said and the original document was not before you, then, if there was any issue about the accuracy of what I had put, there was nothing to refer to, and of course in fact Mr Pembrey was not very happy with my summary.

MR JUSTICE CRANE: I suppose the other major documentation is the IOC hearings.

MS LANG: Yes.

MR JUSTICE CRANE: Again, I see why on reflection they might have needed to be --

MS LANG: Yes, the letters that are sent out from the IOC giving a decision are fairly bald and one really gets much more a sense of what the issues were before the IOC, particularly in relation to the wording of conditions, when one looks at the transcript.

MR JUSTICE CRANE: I think on reflection --

MS LANG: So it was a difficult judgment call but I would say that preparing the photocopied bundles is not the bulk of the costs.

MR JUSTICE CRANE: I said those were matters of detail. Let me hear what Mr Moon says.

MR MOON: First, the GMC would have had to have made this application anyway because of course it is required do so under the Act and so it would inevitably incur some costs in making the application. The second point, which is really related to that, is that of course the court, under section 6 of the Human Rights Act, would have had to have considered the human rights' implications anyway. Of course, the bulk of the argument is really related to Article 6. So, on any view substantial costs would have been incurred, whether or not Mr Pembrey had resisted.

The third point is that, of course, the GMC has not been successful and I must say there may have been some misunderstanding between my learned friend and I, but I understood my friend to say earlier this week that she did not have instructions to pursue anything other than 12 months. It is quite right that I did not have instructions to offer less, but I did understand my friend to tell me that she was pursuing the 12 months, and she has been unsuccessful in that.

MR JUSTICE CRANE: It does not sound the sort of discussion between counsel which we need to analyse in detail. It sounds as if there may have been sensible words, but it is quite plain there was no firm proposal on either side to compromise the length of time.

MR MOON: My Lord, the first time it was put forward as being possible by the GMC was when Ms Lang was on her feet yesterday.

MR JUSTICE CRANE: So what do you say? I see the point that an application would be needed anyway and that the defendant was in no way responsible for that. What do you say I should order?

MR MOON: My primary position is no order as to costs. My fallback position is that a proportion of these costs would have been incurred anyway.

My Lord, I do have a fourth point, which I have not made, which is this. As I understand my Lord's judgment, there is a period of about three months where, with hindsight, some of the delay could have been shaved off, and that is a matter that my Lord may wish to take into account.

MR JUSTICE CRANE: I do not regard that as a serious criticism. In almost any case with hindsight you can shave the timetable. Looking back, that is the point I was making.

MR MOON: Coming back to my broader submission, it is primarily no order as to costs. If you are against me on that, half the costs that have been put forward in the schedule.

MR JUSTICE CRANE: Thank you. (Inaudible)

MS LANG: Yes, the position is that in the 12 applications that there have been so far, ten have been resolved with the consent of the doctor.

MR MOON: My Lord, I am so sorry. I am not in a position to gainsay these matters. Ms Lang has not told me that until this moment and I am afraid I just cannot accept that sort of --

MR JUSTICE CRANE: Let us see what conclusions she draws from it. Why is it relevant?

MS LANG: What happens when a doctor consents is that, yes, the GMC through Field Fisher Waterhouse have to make an application to the court, but it is dealt with on the papers, and therefore particulars of claim and the claim form and the witness statement in fairly short form are lodged and the consent order is signed by both parties.

MR JUSTICE CRANE: That is if there is actually a consent order.

MS LANG: Yes, drafted by Field Fisher Waterhouse. It is sent to the --

MR JUSTICE CRANE: I can see that.

MS LANG: -- doctor and it is signed, and then presumably a judge is asked to look at the matter and the order is made.

MR JUSTICE CRANE: I am not sure that is really relevant.

MS LANG: Can I just develop the point? It is about the costs incurred. Mr Moon was kind enough to mention yesterday that he wanted to take this point and so overnight we have considered, well, what costs would we have incurred had this been dealt with by consent? So, yes, we would have had to make the application, but we would not have had to prepare for a court hearing and instruct counsel and come to court. So that is essentially the difference that is caused by it being contested. Obviously, that is quite a detailed exercise, which I am happy to go through now if your Lordship wishes, or your Lordship might wish to refer it to a costs judge for a detailed assessment. But the principle is that it is very different: they would not have needed to instruct counsel; obviously, no one would have needed to attend a court hearing; and the degree of preparation, particularly in this case where delay was raised and therefore we had to do a very detailed chronology and a second witness statement dealing with, point by point, the history of the case -- the costs are very different, if I can give you the figures. The total costs figure, as I have said to your Lordship, is £10,742.79. These figures include that. The costs of the contested hearing are £8,972.15. The costs of proceeding with Mr Pembrey's consent would have been £1,770.64. So we say it is nearly £9,000 that has been incurred as a result of this contested hearing. So at the very least those are the costs

that we seek.

MR JUSTICE CRANE: There you are drawing a distinction between a consent order on paper, rather than an unopposed order in court.

MS LANG: That is just not obviously the way it has proceeded in the past, an unopposed application --

MR JUSTICE CRANE: Can I tell you what I am inclined to do? I follow the costs would have been a great deal less -- but for the moment doubt your figures -- than if it had been a consent order. They would plainly have been more than that if there had been an application in court without consent but simply unopposed (inaudible).

MS LANG: You mean with the defendant not attending?

MR JUSTICE CRANE: Not attending or just indicating that he did not oppose the application, an attitude I can understand in the circumstances, and in addition it seems to me relevant to note that, although ultimately I have decided that you can justify the delay -- if one puts hindsight aside, you can justify it -- nevertheless, many of the reasons for that will not have been apparent to the defendant until they were set out and thus required justification. So, although they ultimately have been unsuccessful, I am not sure I would regard his opposition as being, as it were, totally unreasonable or capricious. I am rather inclined for that reason to order him to pay half the costs on the basis that you have put forward.

MS LANG: My Lord, if that is your Lordship's ruling, I will say no more. I am not sure if your Lordship is inviting me to comment?

MR JUSTICE CRANE: I am, yes.

MS LANG: I simply say this, that, given the past history of this case, which your Lordship has found not to involve unreasonable delay, the fact that the hearing is listed for October and that we are now in July meant that the prospects of any court refusing to grant the extension were slim. If the GMC were coming to court and saying, "We have not fixed the PCC hearing," or the PCC hearing was going to be in a year's time, it would be a different story, but ultimately my best point was that the hearing was so soon and really that extending the conditions from now until October would make a marginal impact on Mr Pembrey's personal position, and it is really for that reason at the end of the day that, in my view, Mr Pembrey was doomed to fail, and his lawyers should have advised him of that. Maybe they did. But it was not a strong application and we submit a great deal of time and money has been taken up unnecessarily.

MR JUSTICE CRANE: A great deal of time and money has been taken up but -- yes, I think in all the circumstances there should be an order that he pays half the costs.

MR MOON: My Lord, can I with great diffidence ask for permission to appeal? With the greatest of diffidence I possibly can muster.

MR JUSTICE CRANE: You can certainly ask. In my view these are matters of detail eminently suitable for a first instance judge to decide and I do not regard there as being in the ultimate analysis any point of principle arising.

E:\c\ioc\followup\barton

Your reference

In reply please quote NV/PH/2000/2047

Registered Charity No. 1089278
Please address your reply to the Committee Section FPD

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

8 October 2004

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

Notification of decision of the Interim Orders Committee

On 7 October 2004 the Interim Order Committee of the GMC considered whether it was necessary for the protection of members of the public or was otherwise in the public interest or in your own interests to make an Order under Section 41A(1) of the Medical Act 1983 as amended (the Act).

You were present at the meeting and were represented by Mr Charles Foster, Counsel, instructed by the Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Committee in your case on 7 October 2004 the Chairman announced the Committee's determination as follows:

> "Dr Barton: The Committee has carefully considered all the information before it today, including the statement dated 30 September 2004 made by Detective Chief Superintendent Watts of the Hampshire Constabulary, the submissions made by Mr Henderson, QC on behalf of the General Medical Council and the submissions made by Mr Foster on your behalf.
>
> The Committee has determined 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 to make an order in accordance with Section 41A of the Medical Act 1983, as amended.
>
> In reaching its decision the Committee has noted that the police investigation is at present ongoing and that you have not as yet, been arrested or charged with any offence. The Committee has taken into account the new material

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No.

before it today but it is of the opinion that this taken with the information before the IOC at previous hearings is insufficient to justify the imposition of an interim order. The statement provided by Hampshire Constabulary provides little substantive information and the Committee is unable to place sufficient weight on the supporting documentation.

The Committee has taken into account that no concerns have been revealed about your work in General Practice. The Committee has also noted that you have made a voluntary undertaking to Fareham and Gosport Primary Care Trust regarding the prescribing of opiates and benzodiazepines.

Notification of this decision will be served upon you, in accordance with the Committee's Procedure Rules."

Yours sincerely

Code A

cc: Ian Barker, Medical Defence Union

E:\COMMITTEE\IOC\FOLLOWUP\BARTON-FAREHAM&GOSPORT PCT

Your reference

In reply please quote NV/PH/2000/2047

Registered Charity No. 1089278
Please address your reply to the Committee Section FPD

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

8 October 2004

Mr Ian Piper
Chief Executive
Fareham & Gosport PCT
Unit 180 Fareham Reach
166 Fareham Road
Gosport
Hampshire
PO13 0FH

Dear Mr Piper

Dr Jane Ann BARTON
GMC Registration No: Code A

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting on 7 October 2004.

Dr Barton attended the meeting and was legally represented.

After considering submissions from the GMC's legal representatives and also from Dr Barton's legal representatives, the IOC considered that it was not necessary for the protection of the members of the public, in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Committee Section
Code A

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

E:\COMMITTEE\IOC\FOLLOWUP\BARTON-FAREHAM&GOSPORT PCT

Your reference

In reply please quote NV/PH/2000/2047

Registered Charity No. 1089278
Please address your reply to the Committee Section FPD

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

8 October 2004

Detective Chief Inspector D Williams
Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Dear DCI Williams

Dr Jane Ann BARTON
GMC Registration No: Code A

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting on 7 October 2004.

Dr Barton attended the meeting and was legally represented.

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Yours sincerely

Code A

Committee Section
Code A

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

In reply please quote NV/IOC/7 October 2004

Please address your reply to the Committee Section FPD
Fax Code A

7 October 2004

By E-mail to gmc-info@doh.gsi.gov.uk

Barbara Carter
NHS Executive
HRD-EIB
Room 2N 35A
Quarry House
Leeds LS2 7UE

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mrs Carter

I am writing to confirm the decisions taken by the GMC's Interim Orders Committee at its meeting on 7 October 2004. The decisions were as follows:

Name of respondent doctor: BARTON, Jane
Registration Number: Code A
Registered qualifications:
Registered address: Code A

Decision: The Committee considered the case of Dr Barton and directed that no order should be made in relation to his registration.

Yours sincerely

Code A

Committee Section

Direct Dial : Code A
E-mail :

E:\Committee\ioc\PHC\2004\Barton\Barker(MDU)290904

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – 020 7202 1663

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to the Committee Section FPD
Fax **Code A**

30 September 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Thank you for your letter of 27 September 2004 in which you request that the Chairman of the IOC consider postponing the scheduled hearing of Dr Barton's case in accordance with Rule 7(1) of the Committee's Rules.

I can confirm that the Chairman of the Committee considered your request and that he did not accede to it.

The Chairman in considering this request considered the nature and purpose of the IOC, which is namely, to determine whether interim action is required to be taken against the registration of a doctor who may pose a risk to the public, the public interest or their own interests and in fulfilling this function it is considered that the Committee should meet as soon as practicable whilst bearing in mind the need to balance the consequences for the practitioner of the imposition of an interim order and to ensure that the doctor is afforded the opportunity to attend any hearing and be represented, although not necessarily by the Counsel of their choice.

The Chairman took account of the Council's letter notifying Dr Barton of the forthcoming hearing and the timetable contained therein and in reaching his decision considered that the date of 7 October 2004.

In reaching his decision the Chairman determined that whilst unfortunate that Dr Barton's chosen Counsel is not available, there was still sufficient time to instruct fresh Counsel to attend and make representations. It is the Council's intention to dispatch a copy of all the papers in the case on 30 September 2004, providing Dr Barton with 7 days in which to prepare a defence. It was the opinion of the Chairman that this was sufficient time in which to fully instruct new Counsel to prepare such a defence. The Chairman further considered that the Council's letter of 24 September 2004 put Dr Barton on notice that the hearing would be taking place on 7October

In all the circumstances, the Chairman having taken into account your letter of 27 September 2004 and balanced the information contained within against the reasons for Dr Barton's referral considered that, it was important in the public interest that Dr Barton's case be heard as soon as possible.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC **at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. You are further invited to state in writing whether you propose to attend the meeting, whether Dr Barton will attend and whether she will be represented by Counsel, and if so, by whom.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

With regard to your point regarding Rule 5(1)b it is the opinion of the Council that the letter dated 24 September gave the following brief statement of the matters which appear to raise the relevant question set out in Rule 5(1)b:

> *The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved.*

Further, the Council submits that its letter of 24 September also gives a full explanation as to when Dr Barton can expect to have disclosure of the information to be considered by the Committee, and what information she can expect to be disclosed. The Council is mindful of the provisions of Rule 5(3) but it is not of the view that it's letter contravened those provisions. The letter states that:

The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

The clarification with the Police is in respect of what information the CPS determines can be disclosed to the GMC. The Police are fully aware that any information disclosed to the GMC and subsequently disclosed to any of its Committees must also be disclosed to Dr Barton. The Council will disclose to Dr Barton all information that is to be put before the IOC.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Interim Orders Committee Secretariat

E:\Committee\ioc\PHC\2004\Barton\Barker(MDU)290904

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to the Committee Section FPD
Fax Code A

30 September 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

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I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Interim Orders Committee Secretariat

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Code A

Email: mdu@the-mdu.com
Website www.the-mdu.com

Mr Code A
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

Dear Mr Code A

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Thank you for your letter of 30th September, and I am grateful for the provision of written reasons of the decision not to grant adjournment in this matter.

I am grateful too for the observations concerning Rule 5 (1). It remains my contention, however, that the brief statement required by that Rule has not been provided. The information that you quote within the letter is hardly sufficient. There is no basic summary or indication of what the information provided by Hampshire Constabulary might be. Indeed, as I understood the position yesterday no written statement or evidence had been supplied by Hampshire Constabulary to the GMC at that time.

In any event, I am concerned to make further request for adjournment of Dr Barton's case with the benefit of additional information, and indeed having had the opportunity to consider the written reasons for the Chairman's previous decision.

As you will know, Dr Barton has thus far received no documentation at all in this matter. The statement from the Hampshire Constabulary which it is understood you were to receive yesterday has yet to materialise. Further, I am advised that a significant volume of patient records had been made available to the GMC, which it is felt is not necessary to trouble the Interim Orders Committee but which is nonetheless available. It must be right that Dr Barton has the opportunity to consider those records, which I understand to be some 3 feet deep. It may of course be that there is no information which is necessary to place before the Interim Orders Committee in that regard, on behalf of Dr Barton, but unless and until Dr Barton has had the appropriate opportunity to consider the materials, that cannot properly be determined.

Unfortunately, Dr Barton is not immediately able to consider any such documentation even if it were to be made available forthwith. Sadly, her mother and mother-in-law have both been profoundly ill recently. Indeed, her mother-in-law has only recently been moved from an Intensive Treatment Unit. She will visit them tomorrow and at the weekend. Her first realistic opportunity to look at any amount of documentation would be on Monday of next week.

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

In addition to Dr Barton's ability or lack of it to consider such a significant quantity of material at this stage, sadly Counsel previously instructed for Dr Barton, Mr Alan Jenkins, remains unavailable for the hearing on 7th October. I appreciate at once that the Interim Orders Committee would not ordinarily be concerned to take Counsel's availability into account. However, this matter has previously been considered on three separate occasions by the Interim Orders Committee – and substantively on each occasion, rather than being merely by way of review. There is therefore a long and significant history from which I would submit that it is desirable that there should be continuity of representation, both for Dr Barton herself, and indeed to assist the Committee.

With reference to the limited information given within the letter of the 24th September to Dr Barton about the matter, which you have kindly quoted in your letter to me of 30th September, it is clear that the matter concern the Gosport War Memorial Hospital. Dr Barton ceased to have any involvement with that hospital some long time ago. It must therefore be the case that any matters raised by the Hampshire Constabulary are historical. As best I am aware of it, there has been no expression whatsoever of concern in relation to Dr Barton's recent practice.

I would respectfully submit that this point is highly relevant in terms of the consideration of the public interest in ensuring that a hearing take place very rapidly. It is also relevant in that regard that on each of the three occasions when Interim Orders Committee has met to consider Dr Barton – on each occasion with reference to the Gosport War Memorial Hospital – the Committee concluded that it was not necessary to make an order affecting Dr Barton's registration.

Accordingly, there is as best I am aware of it no indication that Dr Barton's present behaviour gives any obvious cause for concern, and to the extent that her previous activities as a Practitioner habr been considered in relation to this very hospital, no action has been taken by the IOC. It must surely be the case in those circumstances that the public interest could not reasonably be adversely affected by an adjournment of a mere week to facilitate both the proper consideration of paperwork and representation by established Counsel.

I would be grateful if my further application for adjournment could be given urgent consideration.

Yours sincerely

Code A

Code A

Ian S.P. Barker
Solicitor

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Committee
29 SEP 2004

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Mr Code A
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

Code A

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Further to the letter from Mr Hylton to Dr Barton of the 24th September, and indeed our telephone conversation today, can I confirm that I continue to act for Dr Barton.

As you know, Dr Barton has previously appeared before the Interim Orders Committee on three occasions. On each occasion the matters raised have been essentially of the same origin and nature.

On each occasion Dr Barton has been represented by Mr Alan Jenkins of Counsel. The matter is necessarily a little complex and continuity of representation, somewhat unusually for the purposes of such hearings, in this instance is of clear importance. Indeed I would respectfully submit that it would only be reasonable and fair for Dr Barton to have that continuity of representation.

I very much regret to advise you that Mr Jenkins is unavailable on 7th October. I have made enquiries to see if it might be possible for his existing commitment to be dealt with on another occasion, but understand this is simply not possible.

In these circumstances I would be most grateful if consideration could be given to the provision of an alternative date for the hearing of this matter. I appreciate that the General Medical Council would not seek to delay the matter for any significant period of time, but it may be relevant to observe that at none of the previous three hearings, in June 2001, March 2002 and September 2002 was considered necessary by the Committee to make an Order affecting Dr Barton's registration.

Can I also take the opportunity to point out that the letter to Dr Barton of 24th September, advising her of the forthcoming hearing does not appear to comply with Rule 5 (1) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000. The letter does not contain a brief statement of the matters which appear to raise the relevant question set out sub sub rule (b).

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Further, Dr Barton has not yet been provided with any documentation. Curiously, it seems to be suggested that the issue of what documentation will be disclosed has still to be determined. Specifically, in paragraph 3 of the letter from Mr Hylton it is said that the GMC is in the process of clarifying with the Police the level of disclosure that can take place. As you will appreciate, Rule 5 (3) of the procedure rules requires that the Registrar shall send a Practitioner copies of any documents received in connection with a case. It is therefore not open to the GMC to be selective – any document received should be disclosed.

I make the points in relation to compliance with Rule 5 (1) and Rule 5 (3) as clearly there are issues to resolve before the matter can reasonably proceed and in those circumstances too brief adjournment might be sensible for all concerned.

I would be most grateful if this application could be given urgent consideration and if I can assist with the provision of any further information, including further details of Mr Jenkins' availability, I will be pleased to do so immediately.

It may assist if I mention now that Mr Jenkins would be available both on the 13th and 15th October, when I understand the IOC will be sitting to consider cases generally.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

26 August 2004

Detective Chief Inspector David Williams
Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Dear DCI Williams

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I write further to our exchange of e-mails and, in particular, your e-mail of 17 August 2004. Thank you for your continued assistance in this matter. I am very pleased to note that, subject to certain conditions, you are in a position to provide us with the information you have relating to 19 of the category two cases.

I confirm that we will review the information you supply and, if appropriate, make an application to the Interim Orders Committee. If an application is made to that Committee, the doctor and her representatives will be supplied with information upon which we intend to rely. The Interim Orders Committee usually sits in private but the doctor has a right to insist on a public hearing. It is rare that a doctor insists on a public hearing. There is no indication that the doctor in this case will insist on a public hearing, she has not done so at previous hearings and we have no reason to believe that her representatives would advise her to do so.

Publicity about the case is generally outside our control but the GMC shall not instigate publicity before or during any criminal trial.

I acknowledge that statements the GMC takes from witnesses who subsequently take part in any trial are discloseable to the defence. I confirm that the GMC will liaise with the police and inform you of the identity of proposed witnesses before we take statements.

In general terms, we are willing to confirm that we will not proceed to a public inquiry at the Professional Conduct Committee in relation to matters which are the subject of your investigation until the conclusion of that investigation or any criminal trial. However, as you are aware, the GMC also has statutory duties and any agreement to delay our dealing with this matter is subject to the police keeping us informed about the progress of the investigation and pursuing the investigation and prosecution within a reasonable time. We may proceed to the Professional Conduct Committee if, for example, the police investigation is in abeyance for an indefinite

period or is subject to unreasonable delay. If other matters concerning this doctor come to our attention (for example matters relating to health, performance or conduct) which do not form part of your investigation we may proceed to investigate and adjudicate in relation to those matters.

As we have not yet seen the material, I do not wish to raise an expectation that we shall definitely proceed to the Interim Orders Committee. Therefore, I would ask that you exercise caution in this regard in your communication with the families, their representatives, the Strategic Health Authority, the Primary Care Trust or any other interested party.

I note that you will seek the consent of witnesses to release statements to us. I look forward to receiving the material during the week commencing 30 August 2004.

Thank you again for your helpful approach in this case.

Yours sincerely

Code A
Manager, Special Projects
Code A