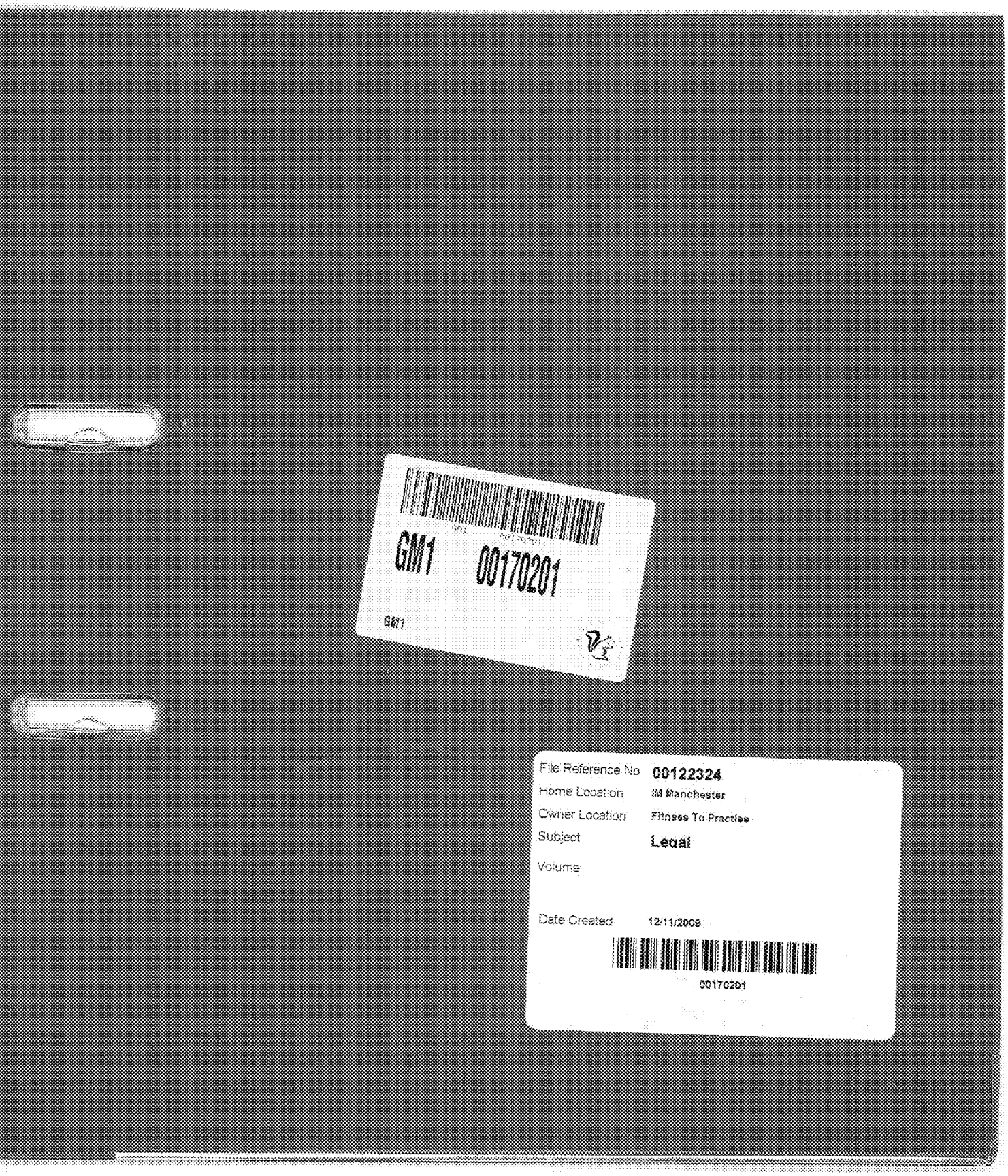
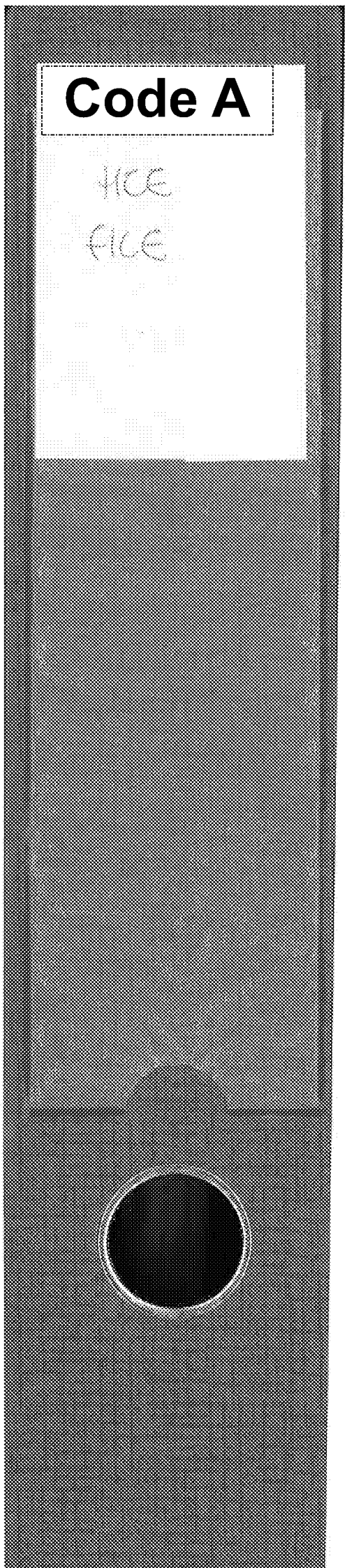

GM1
00170201
GM1
File Reference No 00122324
Home Location IM Manchester
Owner Location Fitness To Practise
Subject Legal
Volume
Date Created 12/11/2008
00170201


Code A
HCE
FCE

Dr Jane Ann BARTON (1587920)
Interim Orders Panel
12 November 2009

Dr Barton: When the Interim Orders Committee first considered your case on 21 June 2001, it determined that it was not necessary for the protection of members of the public, in the public interest or in your own interest to make an order on your registration. Your case was reviewed and no order imposed on a further three occasions. On 11 July 2008, the Interim Orders Panel considered it necessary to impose conditions on your registration. This order was reviewed on 22 December 2008 and 1 June 2009, at which time the conditions were maintained.

The Panel has comprehensively reviewed the order today. In so doing it has considered the information presented to it today, including the submissions made by Code A on behalf of the GMC, and the submissions made by Mr Code A on your behalf. Code A submitted that it is necessary, at the very least, to maintain the current order of conditions on your registration. Ms Code A invited the Panel to consider whether, in light of the substantial adverse findings at the first stage of your Fitness to Practise hearing, an interim order of suspension is warranted in this instance.

Code A submitted that the evidence adduced by your Fitness to Practise Panel, and its subsequent findings, have not added to the gravity of the weight of the allegations against you, but have in fact lessened it. He submitted that there would be no risk to members of the public and no risk of adversely affecting the public interest or your own interests by allowing you to practise with unrestricted registration and that no interim order was therefore necessary. Code A further submitted that it would be wholly and grossly disproportionate to impose an order of suspension on your registration.

In all the circumstances, the Panel is satisfied that it continues to be necessary for the protection of members of the public, in the public interest and in your own interests for your registration to remain subject to the following unvaried conditions:

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

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

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

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

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

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

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

    a. Any organisation or person employing or contracting with you to undertake medical work
    b. Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application)
    c. Any prospective employer (at the time of application)
    d. The PCT in whose Medical Performers List you are included, or seeking inclusion (at the time of application)
    e. Your Regional Director of Public Health.

You were initially referred to the GMC in a letter dated 27 July 2000 from R. Burt, Acting Detective Superintendent, Hampshire Constabulary, concerning your alleged inappropriate prescribing for a number of patients at Gosport War Memorial Hospital and the investigations into their deaths. An overview of the Police investigation was contained in the statement of Detective Superintendent Williams dated 16 January 2007, which stated that the Crown Prosecution Service decided not to proceed with a criminal prosecution.

In October 2002, you voluntarily entered into an agreement with the Fareham and Gosport Healthcare Trust that you would not prescribe diamorphine and would restrict your prescribing of diazepam in line with BNF guidance. In a letter dated 20 October 2009, Neil Hardy, Head of Medicines Management, NHS Hampshire, confirmed that he has continued to monitor your prescribing and is happy that you have complied with the PCT agreement and with condition 5 on your registration.

The Panel noted that your Fitness to Practise hearing was held between 8 June 2009 and 21 August 2009 and that that Panel announced its findings on the facts of the case before adjourning until January 2010 due to a lack of available time.

The Panel noted the positive testimonials from both your colleagues and patients. It further noted the summary of your appraisal dated 11 February 2009 which highlighted your high level of performance in various areas of your medical practice.

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

The Panel has taken account of the issue of proportionality in that it must act in a way which is fair and reasonable. Whilst it notes that its order restricts

your ability to practise medicine, the Panel has determined that, in light of the serious nature of the allegations against you, imposing conditions on your registration is a necessary and proportionate response.

The Panel notes that the order imposed on 11 July 2008 expires on 10 January 2010. It has therefore determined under Rule 27(6) of the General Medical Council (Fitness to Practise) Rules 2004, to notify the Registrar of the General Medical Council that an application should be made to the relevant Court for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

Should the Court extend the interim order, the Panel will again review the order at a further meeting to be held within three months of the Court's determination, unless matters have been concluded before that date.

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

THE MDU

MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

www.the-mdu.com

Code A

Code A
Paralegal
GMC Legal
5th Floor
St James' Buildings
79 Oxford Street
Manchester M1 6FQ

By Fax to: Code A

Telephone:
Fax: Code A

Email: legaldepartment@the-mdu.com
The MDU solicitors do not accept service of documents by e-mail

Please quote our reference in your reply
Our ref:
Your ref:
Date: Code A

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

Further to your letter of 9th December 2009, I have pleasure in returning the Consent Order to you signed on behalf of Dr Barton and indicating her consent to the Order in the terms sought.

I look forward to hearing from you in due course with the Sealed Order.

Yours sincerely,

Code A

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

CO/ /2009

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

UPON READING the Particulars of Claim

AND UPON the agreement of the parties

BY CONSENT it is ordered that:

1. The interim order imposing conditions on the Defendant's registration as a Medical Practitioner, originally made by the Claimant's Interim Orders' Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order which is now due to expire on 10 January 2010, to be extended for a further period of 6 months, to expire on 9 July 2010.

2. There be no order for costs.

3. There be no disclosure to non parties of any documents relating to the present application apart from the Claim Form and the order herein without permission.

4. Any application for disclosure of documents to be made on Notice to the parties.

Dated this day of 2009

Signed.....
(Solicitor to the Claimant)

Code A for the Defendant

REASONS

1. This Order is made under section 41A(6) of the Medical Act 1983, as amended.

2. The reasons for this Order are explained in the Particulars of Claim and in the Witness Statement by Lucy Smith in support.

CO/ /2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

GMC Legal
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

MFS/IOPEXT/BARTON

THE MDU

MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

www.the-mdu.com

Code A

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5th Floor
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79 Oxford Street
Manchester M1 6FQ

By Fax to: 0161 923 6490

Email: legaldepartment@the-mdu.com
The MDU solicitors do not accept service of documents by e-mail

Please quote our reference in your reply

Our ref:
Your ref:
Date:

Code A

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

Further to your letter of 9th December 2009, I have pleasure in returning the Consent Order to you signed on behalf of Dr Barton and indicating her consent to the Order in the terms sought.

I look forward to hearing from you in due course with the Sealed Order.

Yours sincerely,

Code A

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

CO/ 15133 **/2009**

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

UPON READING the Particulars of Claim

AND UPON the agreement of the parties

BY CONSENT it is ordered that:

1. The interim order imposing conditions on the Defendant's registration as a Medical Practitioner, originally made by the Claimant's Interim Orders' Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order which is now due to expire on 10 January 2010, to be extended for a further period of 6 months, to expire on 9 July 2010.

2. There be no order for costs.

3. There be no disclosure to non parties of any documents relating to the present application apart from the Claim Form and the order herein without permission.

4. Any application for disclosure of documents to be made on Notice to the parties.

Dated this 17 day of December 2009

Code A

Code A for the Defendant

REASONS

1. This Order is made under section 41A(6) of the Medical Act 1983, as amended.

2. The reasons for this Order are explained in the Particulars of Claim and in the Witness Statement by Lucy Smith in support.

CO/15133/2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

GMC Legal
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

MFS/IOPEXT/BARTON

General Medical Council

15 December 2009

Our Ref MFS/IOPEXT/BARTON

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

Code A
The MDU Legal Department
230 Blackfriars Road
London
SE1 8PJ

Dear Code A

Re: General Medical Council – v – Dr Jane Barton

Thank you for your letter of 10 December 2009, which was also received by email.

I note your comments regarding the wording used in the statement, however, I should refer you to the determination which was given at the most recent sitting of the IOP in relation to Dr Barton. At the hearing on 12 November 2009, the Panel concluded that it continued '*to be necessary for the protection of members of the public, in the public interest and in the doctor's own interests*' for her registration to remain subject to the relevant unvaried conditions.

The GMC therefore considers that the order is necessary on the above-mentioned grounds. I apologise for any confusion caused by the wording of the previously enclosed statement, and I refer you Section 41A of the Medical Act 1983 (as amended) which provides specifically for the IOP.

Further to my previous correspondence, this matter has now been listed for hearing on 8 January 2010 at Manchester Civil Justice Centre.

As already stated, if you are in a position to deal with this application by consent, please sign and return the enclosed Consent Order to me. I shall then file the Consent Order with the court and ask them to vacate the upcoming hearing.

If a hearing can be avoided, your client will not be at risk of having to pay any costs.

If the matter has to be dealt with by way of a hearing, the GMC will seek to recover from your client the costs incurred by it for the hearing including the instruction of Counsel.

If you require any further information or wish to discuss this please do not hesitate to contact me on the number below.

I look forward to hearing from you and thank you for your assistance in this matter.

Yours sincerely

Code A

Email: Code A
Encl.

General Medical Council

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

15 December 2009

Our Ref MFS/IOPEXT/BARTON

Dr J Barton

Code A

Dear Dr Barton

Re: General Medical Council – v – Dr Jane Barton

Further to my previous correspondence, this matter has now been listed for hearing on 8 January 2010 at Manchester Civil Justice Centre.

As already stated, if you are in a position to deal with this application by consent, please sign and return the enclosed Consent Order to me. I shall then file the Consent Order with the court and ask them to vacate the upcoming hearing.

Clearly, if a hearing can be avoided, you will not be at risk of having to pay any costs.

If the matter has to be dealt with by way of a hearing, the GMC will seek to recover from you the costs incurred by it for the hearing including the instruction of Counsel.

If you require any further information or wish to discuss this please do not hesitate to contact me on the number below.

I look forward to hearing from you and thank you for your assistance in this matter.

Yours sincerely

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Email: Code A
Encl.

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GMC Legal
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By email to: Code A

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: legaldepartment@the-mdu.com
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Please quote our reference in your reply
Our ref:
Your ref: Code A
Date:

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

Thank you for your letter of 9th December with the various documents in relation to the Council's application for an extension of the Interim Order in relation to Dr Barton.

Can I raise one question with you concerning the basis on which the Order is sought. The statement of Lucy Smith sets out the history, and at paragraph 31 she records that the Interim Order on 11th July 2008, which Order it is the Council seeks to have extended, was imposed as it was necessary for the *"protection of members of the public, in the public interest and in Dr Barton's own interests"*.

However, at paragraph 33, Ms Smith sees fit to refer only to the Order being required so that the *"public may remain protected"*.

Can I please ask if it is now conceded by the Council that the Order is no longer necessary as being in the public interest or in Dr Barton's own interests.

Yours sincerely,

Code A

Legal Department
DX No. 149141
Blackfriars 5

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: legaldepartment@the-mdu.com
The MDU solicitors do not accept service of documents by e-mail

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Paralegal
GMC Legal
5th Floor
St James' Buildings
79 Oxford Street
Manchester M1 6FQ

By email to: Code A

Please quote our reference in your reply
Our ref:
Your ref: Code A
Date:

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

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However, at paragraph 33, Ms Smith sees fit to refer only to the Order being required so that the *"public may remain protected"*.

Can I please ask if it is now conceded by the Council that the Order is no longer necessary as being in the public interest or in Dr Barton's own interests.

Yours sincerely,

Code A

General Medical Council

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

9 December 2009

Code A

Code A
The MDU Legal Department
230 Blackfriars Road
London
SE1 8PJ

Dear Code A

Re: General Medical Council – v – Dr Jane Barton

Please find attached, documents relating to the GMC's application for the extension for a period of 6 months, of the Interim Order of Conditions on Dr Barton's registration.

Once the court lists the application for a hearing, I will update you with such information. If you are in a position to deal with this application by consent, please sign and return the enclosed Consent Order to me. I shall then file the Consent Order with the court and ask them to vacate the upcoming hearing.

Clearly, if a hearing can be avoided, your client will not be at risk of having to pay any costs.

If the matter has to be dealt with by way of a hearing, the GMC will seek to recover from your client the costs incurred by it for the hearing including the instruction of Counsel.

If you require any further information or wish to discuss this please do not hesitate to contact me on the number below.

I look forward to hearing from you and thank you for your assistance in this matter.

Yours sincerely

Code A

Email: Code A
Encl.

General
Medical
Council

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

9 December 2009

Code A

Dr J Barton

Code A

Dear Dr Barton

Re: General Medical Council – v – Dr Jane Barton

I have today written to your representatives at the MDU, providing them with the documents relating to the GMC's application for the extension for a period of 6 months, of the Interim Order of Conditions on your registration.

Once the court lists the application for a hearing, I will update you with such information. If you are in a position to deal with this application by consent, please sign and return the enclosed Consent Order to me. I shall then file the Consent Order with the court and ask them to vacate the upcoming hearing.

Clearly, if a hearing can be avoided, you will not be at risk of having to pay any costs.

If the matter has to be dealt with by way of a hearing, the GMC will seek to recover from you the costs incurred by it for the hearing including the instruction of Counsel.

If you require any further information or wish to discuss this please do not hesitate to contact me on the number below.

I look forward to hearing from you and thank you for your assistance in this matter.

Yours sincerely

Code A

Remittance Advice

General Medical Council

HMCS

High Court Application - Dr J Barton

5th Floor, St James's Buildings,
79 Oxford Street, Manchester, M1 6FQ

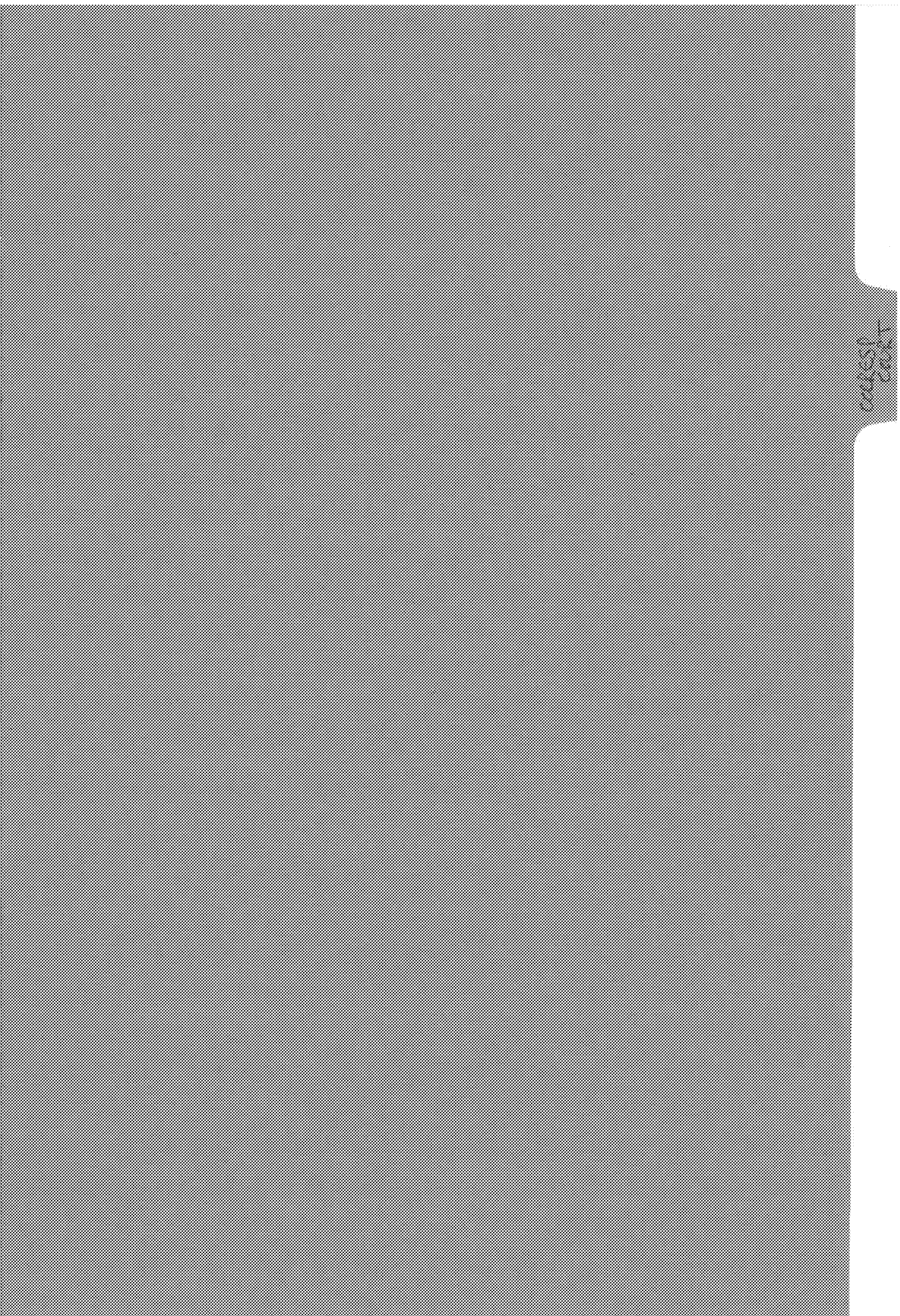
Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

Please address any enquiries in relation to this Remittance quoting your Supplier No. to:
Code A

Supplier no. 999001
Payment date 01/12/2009
Cheque number 116114

Invoice date	Invoice number	Invoice detail	Amount (£)
24/11/2009	Code A	High court application - Code A	400.00

Total **£400.00**


CAUTION

HER MAJESTY'S COURTS SERVICE
hmcs

Administrative Court Office at Manchester
12th Floor
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

DX 724783 Manchester 44

T 0161 240 5313 / 5314
F 0161 240 5315
E administrativecourtoffice.manchester@hmcourts-service.x.gsi.gov.uk

www.hmcourts-service.gov.uk

GENERAL MEDICAL COUNCIL
5TH FLOOR
ST JAMESS BUILDINGS
79 OXFORD STREET
MANCHESTER
M1 6FQ

Our ref: Code A

30 December 2009

Your ref: Code A

Dear Sir / Madam,

Re GENERAL MEDICAL COUNCIL v DR JANE BARTON

I am writing to acknowledge receipt of your Consent Order in the above case, which was received by this office on the 18th December 2009 and referred to His Honour Judge Stewart QC for consideration.

Please find enclosed herewith an approved/sealed copy of the Consent Order and note that the hearing due to take place on the 8th January 2010 will now proceed as a pronouncement hearing without the attendance of any parties.

If you have any queries please contact the Administrative Court General Office on 0161 240 5313 / 5314.

Yours faithfully

Code A

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

CO/ 6133/2009

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

UPON READING the Particulars of Claim

AND UPON the agreement of the parties

BY CONSENT it is ordered that:

1. The interim order imposing conditions on the Defendant's registration as a Medical Practitioner, originally made by the Claimant's Interim Orders' Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order which is now due to expire on 10 January 2010, to be extended for a further period of 6 months, to expire on 9 July 2010.

2. There be no order for costs.

3. There be no disclosure to non parties of any documents relating to the present application apart from the Claim Form and the order herein without permission.

4. Any application for disclosure of documents to be made on Notice to the parties.

Dated this 17 day of December 2009

Code A

the Defendant

REASONS

1. This Order is made under section 41A(6) of the Medical Act 1983, as amended.

2. The reasons for this Order are explained in the Particulars of Claim and in the Witness Statement by Lucy Smith in support.

CO/15133/2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

GMC Legal
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

MFS/IOPEXT/BARTON

THE MDU

MDU Services Limited
230 Blackfriars Road
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Legal Department
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Blackfriars 5

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Code A
Paralegal
GMC Legal
5th Floor
St James' Buildings
79 Oxford Street
Manchester M1 6FQ

By Fax to: 0161 923 6490

Please quote our reference in your reply
Our ref:
Your ref:
Date: Code A

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

Further to your letter of 9th December 2009, I have pleasure in returning the Consent Order to you signed on behalf of Dr Barton and indicating her consent to the Order in the terms sought.

I look forward to hearing from you in due course with the Sealed Order.

Yours sincerely,

Code A

ADMIN COURT

/12/2009 11:34 Code A

HER MAJESTY'S COURTS SERVICE

hmcs

FAX

Administrative Cc
Manchester
12th Floor
Manchester Civil J
1 Bridge Street We
Manchester
M60 9DJ
DX 724783 Manche

Tel: 0161 240 5313

Fax: 0161 240 5315

Minicom VII 0191 478 1478
(Helpline for the deaf and hard of hearing)

Email:
administrativecourtoffice.manchester@hmcourts-service.x.gsi.gov.uk

To:	GMC	From:	Code A
Fax:	Code A	Date:	30/12/09
Phor		Pages:	(including cove
Re:	CO/15133/2009	CC:	

☑ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ As Requested

HARD COPY OF ORDER IN TONIGHTS POST.

Code A

HER MAJESTY'S COURTS SERVICE
hmcs

Administrative Court Office at Manchester
12th Floor
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

DX 724783 Manchester 44

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www.hmcourts-service.gov.uk

GENERAL MEDICAL COUNCIL
5TH FLOOR
ST JAMESS BUILDINGS
79 OXFORD STREET
MANCHESTER
M1 6FQ

Our ref: Code A

Your ref: Code A

30 December 2009

Dear Sir / Madam,

Re GENERAL MEDICAL COUNCIL v DR JANE BARTON

I am writing to acknowledge receipt of your Consent Order in the above case, which was received by this office on the 18th December 2009 and referred to His Honour Judge Stewart QC for consideration.

Please find enclosed herewith an approved/sealed copy of the Consent Order and note that the hearing due to take place on the 8th January 2010 will now proceed as a pronouncement hearing without the attendance of any parties.

If you have any queries please contact the Administrative Court General Office on 0161 240 5313 / 5314.

Yours faithfully

Code A

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

CO/15133/2009

B E T W E E N:

THE GENERAL MEDICAL COUNCIL **Claimant**

-and-

DR JANE BARTON **Defendant**

CONSENT ORDER

UPON READING the Particulars of Claim

AND UPON the agreement of the parties

BY CONSENT it is ordered that:

1. The interim order imposing conditions on the Defendant's registration as a Medical Practitioner, originally made by the Claimant's Interim Orders' Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order which is now due to expire on 10 January 2010, to be extended for a further period of 6 months, to expire on 9 July 2010.

2. There be no order for costs.

3. There be no disclosure to non parties of any documents relating to the present application apart from the Claim Form and the order herein without permission.

4. Any application for disclosure of documents to be made on Notice to the parties.

Dated this 17 day of December 2009

Code A

Code A for the Defendant

REASONS

1. This Order is made under section 41A(6) of the Medical Act 1983, as amended.

2. The reasons for this Order are explained in the Particulars of Claim and in the Witness Statement by Lucy Smith in support.

CO/15133/2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

CONSENT ORDER

GMC Legal
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

MFS/IOPEXT/BARTON

THE MDU

MDU Services Limited
230 Blackfriars Road
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By Fax to: 0161 923 6490

Please quote our reference in your reply
Our ref:
Your ref:
Date: Code A

Dear Code A

GENERAL MEDICAL COUNCIL –v- DR JANE BARTON

Further to your letter of 9th December 2009, I have pleasure in returning the Consent Order to you signed on behalf of Dr Barton and indicating her consent to the Order in the terms sought.

I look forward to hearing from you in due course with the Sealed Order.

Yours sincerely,

Code A

General
Medical
Council

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

17 December 2009

Our Ref **Code A**

The Court Manager
Administrative Court Office
Level 12
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

Dear Sir/Madam

Re: General Medical Council – v – Dr Jane Barton

I refer to the above hearing, listed to take place on **8 January 2010**.

I confirm that Dr Barton and her representatives have now consented to the General Medical Council's application to extend the Interim Order of Conditions in this matter.

I therefore enclose three copies of the Consent Order dated 17 December 2009 signed by the GMC and Dr Barton's representatives, and the relevant cover letter.

I also enclose a cheque in the sum of £40.

Under the circumstances, we would be grateful if you could deal with this matter by way of a pronouncement hearing and excuse the attendance of the parties with a view to saving costs. No discourtesy to the court is intended.

Please do not hesitate to contact me on the number given below if you require any further information.

Yours faithfully

Code A

HER MAJESTY'S COURTS SERVICE
hmcs

Administrative Court Office at Manchester
12th Floor
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

DX 724783 Manchester 44

T 0161 240 5313 / 5314
F 0161 240 5315
E administrativecourtoffice.manchester@hmcourts-service.x.gsi.gov.uk

www.hmcourts-service.gov.uk

GENERAL MEDICAL COUNCIL
5TH FLOOR
ST JAMESS BUILDINGS
79 OXFORD STREET
MANCHESTER
M1 6FQ

14 DEC 2009

Our Ref: Code A

11 December 2009 14:12

Your Ref: Code A

Dear Sir / Madam,

Re GENERAL MEDICAL COUNCIL v DR JANE BARTON

The above matter has been listed for hearing on 08/01/2010 at Manchester Civil Justice Centre, 1 Bridge Street West, Manchester, M60 9DJ. A time estimate of 1 hour having been given. You should therefore instruct counsel to attend.

It is your responsibility to notify the defendant and all interested parties of this date. A copy of this letter should be served by you upon the defendant and any interested party as soon as possible.

Representatives will be required to accept the date fixed for hearing and will not be granted an adjournment save in exceptional circumstances. Should you wish to seek an adjournment, you must make a formal application using Form PF244 – Administrative Court Office. There is a fee payable if the application for adjournment is lodged within 14 days of the hearing date. The fee is currently £75.00, or £40.00 if all parties consent to the application to adjourn.

The court number and hearing time can be found on the Administrative Court Daily List at http://www.hmcourts-service.gov.uk/cms/list_admin.htm after 2.30 on the working day before the hearing.

If you are unable to access the Internet you may telephone the Administrative Court List Office 0161 240 5313 / 5314 after 2.30pm on the last working day before the hearing. Please have your case reference number to hand if you telephone the Court.

Papers for the Court

A paginated bundle prepared for the use of the Court must be lodged with the Administrative Office at least **3 weeks** before the date fixed for hearing.

Advocates for the claimant must lodge, and serve, two copies of their skeleton arguments at least **3 weeks** before the hearing date. Advocates for the defendant or other party wishing to be heard must lodge, and serve, two copies of their skeleton arguments at least **14 days** before the hearing date.

The skeleton argument must quote the Administrative Court reference number and the hearing date and must contain

(a) the time estimate for the complete hearing, including delivery of judgment (whether or not an estimate has been given earlier);

(b) a list of issues;

(c) a list of the legal points to be taken (together with any relevant authorities, with page references to passages relied on);

(d) a chronology of events (with page references to the bundle of documents);

(e) a list of the essential documents for the advance reading of the Court (with page references to passages relied on) (if different from that filed with the claim form) and a time estimate for that reading;

(f) a list of persons referred to.

Bundle of Documents to be filed

The claimant must file a paginated and indexed bundle of all relevant documents required for the hearing when he files his skeleton argument.

The bundle must also include those documents required by the defendant and any other party who is to make representations at the hearing.

The above time limits must be strictly observed. Failure to do so may result in adjournment and may be penalised in costs. Advocates may, however, supplement their skeleton arguments up to one working day before the hearing.

Return of Court Bundles

It is the policy of the Administrative Court Office to return all court bundles to the parties following substantive hearing. All original documents will be retained in the appropriate court file. It will be the responsibility of the lodging party to remove their bundles from the court and arrange for their collection. Any bundles left in court after the hearing will be destroyed.

Destruction of Documents

All copy documents in this case will be destroyed (as confidential waste) two working days after the final decision of the High Court unless a written request for the documents is received by the Administrative Court Office before the expiry of that period.

Withdrawal, Settlement or Discontinuance

Should it be your client's intention not to proceed with this matter, you should obtain the consent of all parties to the matter being withdrawn. Such consent should indicate the terms of any agreed order that the parties would wish the Court to make and in any event should deal with the question of costs. The case will only be taken out of the list when a

notice of withdrawal / discontinuance / consent order with a provision for costs signed by all parties has been received in this office. Please note that if you are lodging a consent order, there is a fee £40.00 payable.

If there is a possibility that the case will settle, but no final agreement has been reached, you should apply forthwith, to the Administrative Court Office to have the case stood out of the Warned List. Please note that there is a fee of £75.00 payable on making such application, or £40.00 if all parties consent to the application.

Yours faithfully

Code A

NB: It is the duty of the parties to notify the Administrative Court Office of any problems which may affect the listing of the above-mentioned case, e.g. whether special facilities for disabled access are required.

Please note the date and time this notification was printed. This supersedes all notifications sent previously. If you have received another notification with the same date please phone to query the position with the List Office (on the telephone number at the head of this letter).

HER MAJESTY'S COURTS SERVICE
hmcs

Administrative Court Office at Manchester
12th Floor
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

DX 724783 Manchester 44

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www.hmcourts-service.gov.uk

GENERAL MEDICAL COUNCIL
5TH FLOOR
ST JAMESS BUILDINGS
79 OXFORD STREET
MANCHESTER
M1 6FQ

Our ref: Code A

11 December 2009

Your ref: In Person

Dear Sir / Madam,

Re: GENERAL MEDICAL COUNCIL v DR JANE BARTON

We received your matter on 11/12/2009 .

Our reference number is Code A . Please quote this reference in all future correspondence.

When serving this matter on the Defendant [and any interested party(ies)], please ensure you enclose a copy of the attached notice.

Code A

The Administrative Court Office will not accept service via email. When using the above email address it should be noted that mail sent after 4.30 p.m. may not be opened until 9.00 a.m. on the following working day. Court users should not send confidential or restricted information over the public Internet.

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www.hmcourts-service.gov.uk

NOTE TO DEFENDANT/RESPONDENT AND

INTERESTED PARTY(IES)

11 December 2009

Our ref: **Code A**

This matter has been commenced and is currently proceeding in the **Administrative Court at Manchester**. Please note that such proceedings may also be administered and determined at one of the following Administrative Court venues:

Birmingham Civil Justice Centre – Priory Courts, 33 Bull Street, Birmingham, B4 6DS;

Cardiff Civil Justice Centre – 2 Park Street, Cardiff, CF10 1ET;

Leeds Combined Court Centre – 1 Oxford Row, Leeds, LS1 3BG;

Royal Courts of Justice – Room C315, Royal Courts of Justice, Strand, London, WC2A 2LL.

Certain matters may only be heard in the Administrative Court in London (see Practice Direction 54D for details of the types of cases excepted from regional hearings). The Court will transfer such cases to London for hearing, where appropriate.

Should this matter not be one that is excepted by PD 54D and you wish to seek a direction that any hearings in this matter be heard at another of the Administrative Court regional venues, you should complete, lodge with the Administrative Court in **Manchester** (address at the top of this letter) and serve on all parties to this claim, a Form N464, Application for Directions as to venue for administration and determination, within 21 days of service of the claim form upon you. There is a fee payable for such application; namely £75.00 or £40.00 if all parties named in the claim form consent to the change of venue and their signed consent is lodged with your Form N464.

Form N464 and Practice Direction 54D can be obtained from any of the Administrative Court Offices or downloaded from Her Majesty's Courts Service website at www.hmcourts-service.gov.uk.

Regional Manager

The Administrative Court Office will not accept service via email. When using the above email address it should be noted that mail sent after 4.30 p.m. may not be opened until 9.00 a.m. on the following working day. Court users should not send confidential or restricted information over the public Internet.

Claim Form
(CPR Part 8)

In the	High Court of Justice – Queens Bench Division – Administrative Court (Sitting in Manchester)
Claim No.	CO/1513/2009

HIGH COURT OF JUSTICE SEAL QUEEN'S BENCH DIVISION ADMINISTRATIVE COURT MANCHESTER

Claimant

The General Medical Council
St James' Building
79 Oxford Street
Manchester
M1 6FQ

Defendant(s)

Dr Jane Barton

Code A

Does your claim include any issues under the Human Rights Act 1998? ☐ Yes ☒ No

Details of claim *(see also overleaf)*

The Claim is made under Section 41A (6) and (7) of the Medical Act 1983 (as amended) for an Order extending for 6 months, from 10 January 2010 to 9 July 2010, an interim order of conditions which was imposed by the Claimant's Interim Orders Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order is now due to expire on 10 January 2010.

Defendant's name and address

Dr Jane Barton

Code A

	£
Court fee	£400
Solicitor's costs	
Issue date	11/12/09

The court office at Manchester Civil Justice Centre, 1 Bridge Street West, Manchester, M60 9DJ is open between 10 am and 4 pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the case number.

Claim No.	CO/ /2009

Details of claim *(continued)*

Please see Particulars of Claim attached.

Please note that, if successful in this application, the Claimant will be claiming its costs in this matter. A separate costs schedule will be prepared and served, together with the substantive bundle, in due course

Statement of Truth

*The Claimant believes that the facts stated in these particulars of claim are true.

* I am duly authorised by the claimant to sign this statement

Full name Lucy Smith

Name of claimant's solicitor's firm GMC Legal

signed **Code A** position or office held Principal Legal Advisor

* (Claimant's solicitor) (if signing on behalf of firm or company)

**delete as appropriate*

Claimant's or claimant's solicitor's address to which documents should be sent if different from overleaf. If you are prepared to accept service by DX, fax or e-mail, please add details.

IN THE HIGH COURT OF JUSTICE **CO/ /2009**
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

and

DR JANE BARTON

Defendant

PARTICULARS OF CLAIM

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1. The Claimant is the regulatory body for the medical profession. It is a body corporate, which performs the functions assigned to it under the Medical Act 1983 (as amended) (hereinafter the "MA 1983"). Pursuant to sections 2 and 30 MA 1983, the Claimant maintains a register of medical practitioners.

2. At all material times, the Defendant was a medical practitioner registered with the Claimant.

Background

3. The Claimant was first made aware of concerns in relation to Dr Barton, a General Practitioner, by way of a letter from Mr R Burt, Acting Detective Superintendent for Hampshire Constabulary (the

'Constabulary'), dated 27 July 2000. Mr Burt advised that an allegation had been made by the family of a woman, GR, to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital ('GWMH') during the period 17 – 21 August 1998. Dr Barton had been the doctor responsible for GR's care at the time.

4. The Claimant was informed that an investigation was currently being conducted into the allegations against Dr Barton, and the investigation was completed on 30 March 2001.

5. The Interim Orders Committee ('IOC', precursor to the Interim Orders Panel 'IOP') first considered Dr Barton's case on 21 June 2001. The Committee heard that a complaint had been made by GR's daughters, who raised concerns regarding the standard of care and attention that had been paid to their mother whilst at the GWMH, in particular by Dr Barton, who they alleged had:

    - Refused to transfer GR to the Haslar Hospital, against their wishes.

    - Shortly before GR's death, suggested that she be given diamorphine after developing a haematoma, in order to provide pain relief.

    - Administered a syringe driver with morphine, advising that this would be the 'kindest way'.

    - Did not ensure that GR was hydrated or nourished, or visit her in the days preceding her death.

6. On that occasion, the Committee determined that it was not satisfied that it was necessary for an order to be made in relation to Dr Barton's registration.

7. On 14 August 2001, the Constabulary informed the Claimant that, based on the papers submitted to the Crown Prosecution Service

('CPS'), there was insufficient evidence to support a viable prosecution against Dr Barton with regard to the death of GR and, consequently, no further action would be taken. The Constabulary did, however, state that it was conducting further preliminary enquiries as several members of the public had expressed concerns regarding the death of their relatives at GWMH, following the publicity generated by the original enquiry.

8. By way of a letter dated 6 February 2002, the Constabulary informed the Claimant that it had commissioned expert reports in respect of four other patient deaths, and had also carried out a further review of the death of GR. Although the reports criticised Dr Barton and raised concerns regarding her professional conduct, it had been decided that no further police investigations were currently appropriate, although this was subject to review should further substantial evidence become available.

9. The IOC reviewed Dr Barton's case on 21 March 2002, when it again made no order.

10. On 11 July 2002 the Claimant wrote to Dr Barton in accordance with Rule 6(3) of the General Medical Council Preliminary Proceedings Committee ('PPC') and Professional Conduct Committee (Procedure) Rules 1988, stating that the allegations against her would be referred to the PPC. It was alleged that Dr Barton had inappropriately prescribed drugs – including diamorphine - to five patients: EP, AW, GR, AC and RW.

11. On 29 August 2002, the PPC determined that a charge should be formulated against Dr Barton on the basis of the information received from the Constabulary, and that an enquiry into the charge should be held by the Professional Conduct Committee ('PCC').

12. On 19 September 2002 and 7 October 2004, the IOC again determined that it was not necessary to make an order in relation to Dr Barton's registration.

13. The expert reports of Professor Black, which were prepared in 2008, in respect of 11 patients, demonstrated the alleged incompetencies of Dr Barton, which appear to form a consistent pattern in all cases, especially with regard to:

    a. over – prescribing, often to the point of overdosing;

    b. prescribing Controlled Drugs ("CDs") without due care;

    c. poor prescribing practices

    d. lack of clinical examinations, especially on admission

    e. no follow up on test results

    f. failure to document patient examinations or treatment plans

    g. no reasoning given for prescribing, especially with regard to syringe pumps

    h. failure to discuss cases or treatments with senior colleagues and consultants

    i. incorrect diagnoses on death certificates

14. The Police are not proceeding further with any of the cases. However, in a letter dated 28 April 2008, the Coroner directed that inquests be held into the deaths of 10 patients at GWMH.

15. The IOP first considered Dr Barton's case on 11 July 2008, when the Panel determined that it was necessary to impose an interim order of conditions on Dr Barton's registration for a period of 18 months. The order was reviewed and maintained by the IOP on 22 December 2008.

16. Dr Barton's substantive case was due to be heard before the Fitness to Practise Panel in September 2008. However, that hearing was postponed pending the outcome of the Coroner's inquest into the deaths of 10 patients at GWMH, eight of which formed the subject of the Fitness to Practise Hearing.

17. The inquest was listed for 18 March 2009, and the inquest verdict in relation to three of the 10 cases was that the medication administered was inappropriate for the condition/symptoms and that its administration had contributed "...more than minimally or negligibly to the death of the deceased".

18. On 1 June 2009, the IOP reviewed and maintained the interim order of conditions upon Dr Barton's registration.

19. Dr Barton's case was considered by the Fitness to Practise Panel on 8 June – 21 August 2009, however, the hearing was adjourned due to insufficient time and will reconvene on 18 – 29 January 2010.

20. The Fitness to Practise Panel did make a determination on findings of fact and made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. The Panel also concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

21. At the IOP review hearing on 12 November 2009, the Panel was satisfied that it continued to be necessary for the doctor's registration to remain subject to the previous unvaried conditions.

22. Given that Dr Barton's Fitness to Practise hearing is due to reconvene on 18 January 2010, the Claimant requires an extension of the interim order of conditions for a period of 6 months to ensure that the order remains in place until the Fitness to Practise matters are resolved.

Relief sought

23. The Claimant seeks an order from the Court to extend the interim order of conditions on Dr Barton's registration, as imposed by the IOP on 11

July 2008, from 10 January 2010 to 9 July 2010. Unless further extended by the court, the interim order will expire on 10 January 2010.

The grounds upon which the Claimant seeks the order

24. On 11 July 2008, the IOP considered that it was necessary to impose an interim order of conditions upon Dr Barton's registration, determining that such an order was necessary for the protection of members of the public, in the public interest and in Dr Barton's own interests. On 22 December 2008, and 1 June 2009 those conditions were maintained.

25. At the IOP review hearing on 12 November 2009, the conditions were once again maintained and the Panel determined that an application should be made for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

26. A period of 6 months is required in order that the public may remain protected during the time that it will take for Dr Barton's Fitness to Practise proceedings to be concluded.

27. The order sought is proportionate to the concerns raised in relation to Dr Barton's professional performance.

AND THE CLAIMANT CLAIMS

An order under Section 41A of the Medical Act 1983 (as amended) extending the interim order of conditions from 10 January 2010 to 9 July 2010.

The Claimant believes that the facts contained in the Particulars of Claim are true.

Signed: Code A

Solicitor to the Claimant

Dated: 9 December 2009

Served this day of 2009

CO/ /2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL
Claimant

-and-

DR JANE BARTON
Defendant

PARTICULARS OF CLAIM

Fitness to Practise
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

Ref: MFS/IOPEXT/BARTON

IN THE HIGH COURT OF JUSTICE **CO/ /2009**
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

WITNESS STATEMENT OF LUCY SMITH

I, Lucy Smith, Solicitor to the General Medical Council, 5th Floor St James' Buildings, 79 Oxford Street, Manchester, M1 6FQ, and a Solicitor of the Supreme Court, will say as follows:

1. I am authorised by the General Medical Council ('the Claimant') to make this statement on behalf of the Claimant in support of its application for an extension of the interim order of conditions imposed by its Interim Orders Panel ('IOP') on 7 June 2007.

2. The Defendant, Dr Jane Barton, is a medical practitioner registered with the Claimant.

Statutory Scheme

3. The Claimant is responsible for, amongst other things, supervising and regulating the fitness to practise of practitioners registered with it under the

Medical Act 1983 (as amended) (hereinafter 'MA 1983'). For this purpose, section 1 MA 1983 provides that the Claimant shall have (amongst other Committees) an Interim Orders Panel ("IOP"). The duties and powers of this Panel are further described in the amended Part V and amended Schedules 1 and 4 MA 1983.

4. The procedure which the IOP follows is set out in the General Medical Council (Fitness to Practise) Rules Order of Council 2004 which came into force on 1 November 2004 and is contained in Statutory Instrument 2004 No. 2608 ('the 2004 Rules').

5. The IOP can, where it considers that it is necessary for the protection of members of the public or is otherwise in the public interest or the medical practitioner's own interest, make an order under the amended section 41A MA 1983 for the medical practitioner's registration to be suspended or restricted by way of conditions pending the outcome of the Claimant's investigation into the doctor's fitness to practise.

6. Under the amended section 41A of the MA 1983, if the IOP is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the interest of the practitioner that an Order be made, the IOP should decide whether to impose specified conditions on, or suspend, the practitioner's registration. The IOP must have in either case specify the period, not exceeding 18 months, during which the Order is to remain in force.

7. Section 41A(2) MA 1983 provides that where the IOP has made an Interim Order, it should be reviewed within 6 months of the date on which the Order was made and thereafter every 6 months.

8. Part 7 of the 2004 rules sets out the procedure for review hearings.

Background

9. The Claimant was first made aware of concerns in relation to Dr Barton, a General Practitioner, by way of a letter from Mr R Burt, Acting Detective Superintendent for Hampshire Constabulary (the 'Constabulary'), dated 27 July 2000. Mr Burt advised that an allegation had been made by the family of a woman, GR, to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital ('GWMH') during the period 17 – 21 August 1998. Dr Barton had been the doctor responsible for GR's care at the time.

10. The Claimant was informed that an investigation was currently being conducted into the allegations against Dr Barton, and the investigation was completed on 30 March 2001.

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- Refused to transfer GR to the Haslar Hospital, against their wishes.
- Shortly before GR's death, suggested that she be given diamorphine after developing a haematoma, in order to provide pain relief.
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- Did not ensure that GR was hydrated or nourished, or visit her in the days preceding her death.

12. On that occasion, the Committee determined that it was not satisfied that it was necessary for an order to be made in relation to Dr Barton's registration.

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15. The IOC reviewed Dr Barton's case on 21 March 2002, when it again made no order.

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18. On 19 September 2002 and 7 October 2004, the IOC again determined that it was not necessary to make an order in relation to Dr Barton's registration.

19. The expert reports of Professor Black, which were prepared in 2008, in respect of 11 patients, demonstrated the alleged incompetencies of Dr Barton, which appear to form a consistent pattern in all cases, especially with regard to:

- over – prescribing, often to the point of overdosing;
- prescribing Controlled Drugs ("CDs") without due care;
- poor prescribing practices
- lack of clinical examinations, especially on admission
- no follow up on test results
- failure to document patient examinations or treatment plans
- no reasoning given for prescribing, especially with regard to syringe pumps
- failure to discuss cases or treatments with senior colleagues and consultants
- incorrect diagnoses on death certificates

20. The Police are not proceeding further with any of the cases. However, in a letter dated 28 April 2008, the Coroner directed that inquests be held into the deaths of 10 patients at GWMH.

21. The IOP first considered Dr Barton's case on 11 July 2008, when the Panel determined that it was necessary to impose an interim order of conditions on Dr Barton's registration for a period of 18 months. The order was reviewed and maintained by the IOP on 22 December 2008.

22. Dr Barton's substantive case was due to be heard before the Fitness to Practise Panel in September 2008. However, that hearing was postponed pending the outcome of the Coroner's inquest into the deaths of 10 patients at GWMH, eight of which formed the subject of the Fitness to Practise Hearing.

23. The inquest was listed for 18 March 2009, and the inquest verdict in relation to three of the 10 cases was that the medication administered was

inappropriate for the condition/symptoms and that its administration had contributed "...more than minimally or negligibly to the death of the deceased".

24. On 1 June 2009, the IOP reviewed and maintained the interim order of conditions upon Dr Barton's registration.

25. Dr Barton's case was considered by the Fitness to Practise Panel on 8 June – 21 August 2009, however, the hearing was adjourned due to insufficient time and will reconvene on 18 – 29 January 2010.

26. The Fitness to Practise Panel did make a determination on findings of fact and made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. The Panel also concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

27. At the IOP review hearing on 12 November 2009, the Panel was satisfied that it continued to be necessary for the doctor's registration to remain subject to the following unvaried conditions:-

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

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

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

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

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

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

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

- Any organisation or person employing or contracting with you to undertake medical work

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

- Any prospective employer (at the time of application)

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

- Your Regional Director of Public Health.

28. Given that Dr Barton's Fitness to Practise hearing is due to reconvene on 18 January 2010, the Claimant requires an extension of the interim order of conditions for a period of 6 months to ensure that the order remains in place until the Fitness to Practise matters are resolved.

29. Conclusion

30. This application to extend the order imposed by the IOP that expires on 10 January 2010 is not one that the Claimant undertakes lightly.

31. On 11 July 2008, the IOP considered that it was necessary to impose an interim order of conditions upon Dr Barton's registration, determining that such an order was necessary for the protection of members of the public, in the public interest and in Dr Barton's own interests. On 22 December 2008, and 1 June 2009 those conditions were maintained.

32. At the IOP review hearing on 12 November 2009, the conditions were once again maintained and the Panel determined that an application should be made for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

33. A period of 6 months is required in order that the public may remain protected during the time that it will take for Dr Barton's Fitness to Practise proceedings to be concluded.

34. The order sought is proportionate to the concerns raised in relation to Dr Barton's professional performance.

I believe the facts stated in this statement are true.

Signed: Code A

Lucy Smith

Dated: 9 December 2009

CO/ /2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

BETWEEN:

GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

WITNESS STATEMENT OF
LUCY SMITH

General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

Ref: MFS/IOPEXT/BARTON

General Medical Council

5th Floor, St James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone 0845 357 8001
Facsimile 0845 357 8011
Email gmc@gmc-uk.org
www.gmc-uk.org

9 December 2009

Our Ref Code A

The Court Manager
Administrative Court Office
Level 12
Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

Dear Sir/Madam

Re: General Medical Council – v – Dr Jane Barton

Please find attached documents relating to our application for the extension for a period of 6 months, of the Interim Order of Conditions on Dr Barton's registration.

We enclose three copies each of:-

(1) The Claim Form (CPR Part 8)
(2) Particulars of Claim
(3) Witness Statement of Code A

We also enclose a cheque in the sum of £400.

Please note that the Order in this case is due to expire on 10 January 2010. In the circumstances, I should be extremely grateful if you could arrange for the matter to be listed **in the period between 6 – 8 January 2010**. Please note that Dr Barton will need a period of at least 7 days in order to afford her the opportunity to seek legal advice.

I look forward to hearing from you and thank you for your assistance in this matter.

Yours faithfully

Code A

Claim Form (CPR Part 8)

In the	High Court of Justice – Queens Bench Division – Administrative Court (Sitting in Manchester)	
Claim No.	CO/ /2009	

Claimant

The General Medical Council
St James' Building
79 Oxford Street
Manchester
M1 6FQ

SEAL

Defendant(s)

Dr Jane Barton

Code A

Does your claim include any issues under the Human Rights Act 1998? ☐ Yes ☒ No

Details of claim *(see also overleaf)*

The Claim is made under Section 41A (6) and (7) of the Medical Act 1983 (as amended) for an Order extending for 6 months, from 10 January 2010 to 9 July 2010, an interim order of conditions which was imposed by the Claimant's Interim Orders Panel on 11 July 2008, which was reviewed and maintained on 22 December 2008, on 1 June 2009 and on 12 November 2009. The order is now due to expire on 10 January 2010.

Defendant's name and address

Dr Jane Barton

Code A

	£
Court fee	£400
Solicitor's costs	
Issue date	

Claim No.	CO/ /2009

Details of claim *(continued)*

Please see Particulars of Claim attached.

Please note that, if successful in this application, the Claimant will be claiming its costs in this matter. A separate costs schedule will be prepared and served, together with the substantive bundle, in due course

Statement of Truth

*The Claimant believes that the facts stated in these particulars of claim are true.

* I am duly authorised by the claimant to sign this statement

Full name Lucy Smith

Name of claimant's solicitor's firm GMC Legal

signed Code A position or office held Principal Legal Advisor

* (Claimant's solicitor) (if signing on behalf of firm or company)

delete as appropriate

Claimant's or claimant's solicitor's address to which documents should be sent if different from overleaf. If you are prepared to accept service by DX, fax or e-mail, please add details.

IN THE HIGH COURT OF JUSTICE **CO/ /2009**
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

and

DR JANE BARTON

Defendant

PARTICULARS OF CLAIM

---

1. The Claimant is the regulatory body for the medical profession. It is a body corporate, which performs the functions assigned to it under the Medical Act 1983 (as amended) (hereinafter the "MA 1983"). Pursuant to sections 2 and 30 MA 1983, the Claimant maintains a register of medical practitioners.

2. At all material times, the Defendant was a medical practitioner registered with the Claimant.

Background

3. The Claimant was first made aware of concerns in relation to Dr Barton, a General Practitioner, by way of a letter from Mr R Burt, Acting Detective Superintendent for Hampshire Constabulary (the

'Constabulary'), dated 27 July 2000. Mr Burt advised that an allegation had been made by the family of a woman, GR, to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital ('GWMH') during the period 17 – 21 August 1998. Dr Barton had been the doctor responsible for GR's care at the time.

4. The Claimant was informed that an investigation was currently being conducted into the allegations against Dr Barton, and the investigation was completed on 30 March 2001.

5. The Interim Orders Committee ('IOC', precursor to the Interim Orders Panel 'IOP') first considered Dr Barton's case on 21 June 2001. The Committee heard that a complaint had been made by GR's daughters, who raised concerns regarding the standard of care and attention that had been paid to their mother whilst at the GWMH, in particular by Dr Barton, who they alleged had:

    - Refused to transfer GR to the Haslar Hospital, against their wishes.

    - Shortly before GR's death, suggested that she be given diamorphine after developing a haematoma, in order to provide pain relief.

    - Administered a syringe driver with morphine, advising that this would be the 'kindest way'.

    - Did not ensure that GR was hydrated or nourished, or visit her in the days preceding her death.

6. On that occasion, the Committee determined that it was not satisfied that it was necessary for an order to be made in relation to Dr Barton's registration.

7. On 14 August 2001, the Constabulary informed the Claimant that, based on the papers submitted to the Crown Prosecution Service

('CPS'), there was insufficient evidence to support a viable prosecution against Dr Barton with regard to the death of GR and, consequently, no further action would be taken. The Constabulary did, however, state that it was conducting further preliminary enquiries as several members of the public had expressed concerns regarding the death of their relatives at GWMH, following the publicity generated by the original enquiry.

8. By way of a letter dated 6 February 2002, the Constabulary informed the Claimant that it had commissioned expert reports in respect of four other patient deaths, and had also carried out a further review of the death of GR. Although the reports criticised Dr Barton and raised concerns regarding her professional conduct, it had been decided that no further police investigations were currently appropriate, although this was subject to review should further substantial evidence become available.

9. The IOC reviewed Dr Barton's case on 21 March 2002, when it again made no order.

10. On 11 July 2002 the Claimant wrote to Dr Barton in accordance with Rule 6(3) of the General Medical Council Preliminary Proceedings Committee ('PPC') and Professional Conduct Committee (Procedure) Rules 1988, stating that the allegations against her would be referred to the PPC. It was alleged that Dr Barton had inappropriately prescribed drugs – including diamorphine - to five patients: EP, AW, GR, AC and RW.

11. On 29 August 2002, the PPC determined that a charge should be formulated against Dr Barton on the basis of the information received from the Constabulary, and that an enquiry into the charge should be held by the Professional Conduct Committee ('PCC').

12. On 19 September 2002 and 7 October 2004, the IOC again determined that it was not necessary to make an order in relation to Dr Barton's registration.

13. The expert reports of Professor Black, which were prepared in 2008, in respect of 11 patients, demonstrated the alleged incompetencies of Dr Barton, which appear to form a consistent pattern in all cases, especially with regard to:

    a. over – prescribing, often to the point of overdosing;

    b. prescribing Controlled Drugs ("CDs") without due care;

    c. poor prescribing practices

    d. lack of clinical examinations, especially on admission

    e. no follow up on test results

    f. failure to document patient examinations or treatment plans

    g. no reasoning given for prescribing, especially with regard to syringe pumps

    h. failure to discuss cases or treatments with senior colleagues and consultants

    i. incorrect diagnoses on death certificates

14. The Police are not proceeding further with any of the cases. However, in a letter dated 28 April 2008, the Coroner directed that inquests be held into the deaths of 10 patients at GWMH.

15. The IOP first considered Dr Barton's case on 11 July 2008, when the Panel determined that it was necessary to impose an interim order of conditions on Dr Barton's registration for a period of 18 months. The order was reviewed and maintained by the IOP on 22 December 2008.

16. Dr Barton's substantive case was due to be heard before the Fitness to Practise Panel in September 2008. However, that hearing was postponed pending the outcome of the Coroner's inquest into the deaths of 10 patients at GWMH, eight of which formed the subject of the Fitness to Practise Hearing.

17. The inquest was listed for 18 March 2009, and the inquest verdict in relation to three of the 10 cases was that the medication administered was inappropriate for the condition/symptoms and that its administration had contributed "...more than minimally or negligibly to the death of the deceased".

18. On 1 June 2009, the IOP reviewed and maintained the interim order of conditions upon Dr Barton's registration.

19. Dr Barton's case was considered by the Fitness to Practise Panel on 8 June – 21 August 2009, however, the hearing was adjourned due to insufficient time and will reconvene on 18 – 29 January 2010.

20. The Fitness to Practise Panel did make a determination on findings of fact and made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. The Panel also concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

21. At the IOP review hearing on 12 November 2009, the Panel was satisfied that it continued to be necessary for the doctor's registration to remain subject to the previous unvaried conditions.

22. Given that Dr Barton's Fitness to Practise hearing is due to reconvene on 18 January 2010, the Claimant requires an extension of the interim order of conditions for a period of 6 months to ensure that the order remains in place until the Fitness to Practise matters are resolved.

Relief sought

23. The Claimant seeks an order from the Court to extend the interim order of conditions on Dr Barton's registration, as imposed by the IOP on 11

July 2008, from 10 January 2010 to 9 July 2010. Unless further extended by the court, the interim order will expire on 10 January 2010.

The grounds upon which the Claimant seeks the order

24. On 11 July 2008, the IOP considered that it was necessary to impose an interim order of conditions upon Dr Barton's registration, determining that such an order was necessary for the protection of members of the public, in the public interest and in Dr Barton's own interests. On 22 December 2008, and 1 June 2009 those conditions were maintained.

25. At the IOP review hearing on 12 November 2009, the conditions were once again maintained and the Panel determined that an application should be made for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

26. A period of 6 months is required in order that the public may remain protected during the time that it will take for Dr Barton's Fitness to Practise proceedings to be concluded.

27. The order sought is proportionate to the concerns raised in relation to Dr Barton's professional performance.

AND THE CLAIMANT CLAIMS

An order under Section 41A of the Medical Act 1983 (as amended) extending the interim order of conditions from 10 January 2010 to 9 July 2010.

The Claimant believes that the facts contained in the Particulars of Claim are true.

Signed: **Code A**

Solicitor to the Claimant

Dated: 9 December 2009

Served this day of 2009

CO/ /2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL
Claimant

-and-

DR JANE BARTON
Defendant

PARTICULARS OF CLAIM

Fitness to Practise
General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

Ref: MFS/IOPEXT/BARTON

IN THE HIGH COURT OF JUSTICE **CO/ /2009**
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

WITNESS STATEMENT OF LUCY SMITH

I, Lucy Smith, Solicitor to the General Medical Council, 5th Floor St James' Buildings, 79 Oxford Street, Manchester, M1 6FQ, and a Solicitor of the Supreme Court, will say as follows:

1. I am authorised by the General Medical Council ('the Claimant') to make this statement on behalf of the Claimant in support of its application for an extension of the interim order of conditions imposed by its Interim Orders Panel ('IOP') on 7 June 2007.

2. The Defendant, Dr Jane Barton, is a medical practitioner registered with the Claimant.

Statutory Scheme

3. The Claimant is responsible for, amongst other things, supervising and regulating the fitness to practise of practitioners registered with it under the

Medical Act 1983 (as amended) (hereinafter 'MA 1983'). For this purpose, section 1 MA 1983 provides that the Claimant shall have (amongst other Committees) an Interim Orders Panel ("IOP"). The duties and powers of this Panel are further described in the amended Part V and amended Schedules 1 and 4 MA 1983.

4. The procedure which the IOP follows is set out in the General Medical Council (Fitness to Practise) Rules Order of Council 2004 which came into force on 1 November 2004 and is contained in Statutory Instrument 2004 No. 2608 ('the 2004 Rules').

5. The IOP can, where it considers that it is necessary for the protection of members of the public or is otherwise in the public interest or the medical practitioner's own interest, make an order under the amended section 41A MA 1983 for the medical practitioner's registration to be suspended or restricted by way of conditions pending the outcome of the Claimant's investigation into the doctor's fitness to practise.

6. Under the amended section 41A of the MA 1983, if the IOP is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the interest of the practitioner that an Order be made, the IOP should decide whether to impose specified conditions on, or suspend, the practitioner's registration. The IOP must have in either case specify the period, not exceeding 18 months, during which the Order is to remain in force.

7. Section 41A(2) MA 1983 provides that where the IOP has made an Interim Order, it should be reviewed within 6 months of the date on which the Order was made and thereafter every 6 months.

8. Part 7 of the 2004 rules sets out the procedure for review hearings.

Background

9. The Claimant was first made aware of concerns in relation to Dr Barton, a General Practitioner, by way of a letter from Mr R Burt, Acting Detective Superintendent for Hampshire Constabulary (the 'Constabulary'), dated 27 July 2000. Mr Burt advised that an allegation had been made by the family of a woman, GR, to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital ('GWMH') during the period 17 – 21 August 1998. Dr Barton had been the doctor responsible for GR's care at the time.

10. The Claimant was informed that an investigation was currently being conducted into the allegations against Dr Barton, and the investigation was completed on 30 March 2001.

11. The Interim Orders Committee ('IOC', precursor to the Interim Orders Panel 'IOP') first considered Dr Barton's case on 21 June 2001. The Committee heard that a complaint had been made by GR's daughters, who raised concerns regarding the standard of care and attention that had been paid to their mother whilst at the GWMH, in particular by Dr Barton, who they alleged had:

- Refused to transfer GR to the Haslar Hospital, against their wishes.
- Shortly before GR's death, suggested that she be given diamorphine after developing a haematoma, in order to provide pain relief.
- Administered a syringe driver with morphine, advising that this would be the 'kindest way'.
- Did not ensure that GR was hydrated or nourished, or visit her in the days preceding her death.

12. On that occasion, the Committee determined that it was not satisfied that it was necessary for an order to be made in relation to Dr Barton's registration.

13. On 14 August 2001, the Constabulary informed the Claimant that, based on the papers submitted to the Crown Prosecution Service ('CPS'), there was insufficient evidence to support a viable prosecution against Dr Barton with regard to the death of GR and, consequently, no further action would be taken. The Constabulary did, however, state that it was conducting further preliminary enquiries as several members of the public had expressed concerns regarding the death of their relatives at GWMH, following the publicity generated by the original enquiry.

14. By way of a letter dated 6 February 2002, the Constabulary informed the Claimant that it had commissioned expert reports in respect of four other patient deaths, and had also carried out a further review of the death of GR. Although the reports criticised Dr Barton and raised concerns regarding her professional conduct, it had been decided that no further police investigations were currently appropriate, although this was subject to review should further substantial evidence become available.

15. The IOC reviewed Dr Barton's case on 21 March 2002, when it again made no order.

16. On 11 July 2002 the Claimant wrote to Dr Barton in accordance with Rule 6(3) of the General Medical Council Preliminary Proceedings Committee ('PPC') and Professional Conduct Committee (Procedure) Rules 1988, stating that the allegations against her would be referred to the PPC. It was alleged that Dr Barton had inappropriately prescribed drugs – including diamorphine - to five patients: EP, AW, GR, AC and RW.

17. On 29 August 2002, the PPC determined that a charge should be formulated against Dr Barton on the basis of the information received from the Constabulary, and that an enquiry into the charge should be held by the Professional Conduct Committee ('PCC').

18. On 19 September 2002 and 7 October 2004, the IOC again determined that it was not necessary to make an order in relation to Dr Barton's registration.

19. The expert reports of Professor Black, which were prepared in 2008, in respect of 11 patients, demonstrated the alleged incompetencies of Dr Barton, which appear to form a consistent pattern in all cases, especially with regard to:

- over – prescribing, often to the point of overdosing;
- prescribing Controlled Drugs ("CDs") without due care;
- poor prescribing practices
- lack of clinical examinations, especially on admission
- no follow up on test results
- failure to document patient examinations or treatment plans
- no reasoning given for prescribing, especially with regard to syringe pumps
- failure to discuss cases or treatments with senior colleagues and consultants
- incorrect diagnoses on death certificates

20. The Police are not proceeding further with any of the cases. However, in a letter dated 28 April 2008, the Coroner directed that inquests be held into the deaths of 10 patients at GWMH.

21. The IOP first considered Dr Barton's case on 11 July 2008, when the Panel determined that it was necessary to impose an interim order of conditions on Dr Barton's registration for a period of 18 months. The order was reviewed and maintained by the IOP on 22 December 2008.

22. Dr Barton's substantive case was due to be heard before the Fitness to Practise Panel in September 2008. However, that hearing was postponed pending the outcome of the Coroner's inquest into the deaths of 10 patients at GWMH, eight of which formed the subject of the Fitness to Practise Hearing.

23. The inquest was listed for 18 March 2009, and the inquest verdict in relation to three of the 10 cases was that the medication administered was

inappropriate for the condition/symptoms and that its administration had contributed "...more than minimally or negligibly to the death of the deceased".

24. On 1 June 2009, the IOP reviewed and maintained the interim order of conditions upon Dr Barton's registration.

25. Dr Barton's case was considered by the Fitness to Practise Panel on 8 June – 21 August 2009, however, the hearing was adjourned due to insufficient time and will reconvene on 18 – 29 January 2010.

26. The Fitness to Practise Panel did make a determination on findings of fact and made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. The Panel also concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

27. At the IOP review hearing on 12 November 2009, the Panel was satisfied that it continued to be necessary for the doctor's registration to remain subject to the following unvaried conditions:-

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

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

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

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

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

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

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

- Any organisation or person employing or contracting with you to undertake medical work

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

- Any prospective employer (at the time of application)

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

- Your Regional Director of Public Health.

28. Given that Dr Barton's Fitness to Practise hearing is due to reconvene on 18 January 2010, the Claimant requires an extension of the interim order of conditions for a period of 6 months to ensure that the order remains in place until the Fitness to Practise matters are resolved.

29. Conclusion

30. This application to extend the order imposed by the IOP that expires on 10 January 2010 is not one that the Claimant undertakes lightly.

31. On 11 July 2008, the IOP considered that it was necessary to impose an interim order of conditions upon Dr Barton's registration, determining that such an order was necessary for the protection of members of the public, in the public interest and in Dr Barton's own interests. On 22 December 2008, and 1 June 2009 those conditions were maintained.

32. At the IOP review hearing on 12 November 2009, the conditions were once again maintained and the Panel determined that an application should be made for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

33. A period of 6 months is required in order that the public may remain protected during the time that it will take for Dr Barton's Fitness to Practise proceedings to be concluded.

34. The order sought is proportionate to the concerns raised in relation to Dr Barton's professional performance.

I believe the facts stated in this statement are true.

Signed: Code A

Lucy Smith

Dated: 9 December 2009

CO/ /2009

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

BETWEEN:

GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

WITNESS STATEMENT OF
LUCY SMITH

General Medical Council
5th Floor St James' Building
79 Oxford Street
Manchester
M1 6FQ

Ref: MFS/IOPEXT/BARTON

VOLBOLT

IOP Item template
Confidential

General Medical Council

Interim Orders Panel

Review case

12 November 2009

Dr Jane Ann BARTON

BM BCh 1972 Oxford University

Code A

Current Employer: Code A **Hampshire Primary Care Trust, Omega House, 112 Southampton Road, Eastleigh, Hampshire, SO50 5PB**

d.o.b: unknown

FPD reference and Name of investigation officer: Code A
Code A

GMC registration number: 1587920

Nature of case: Misconduct

Reason for referral to IOP: Concerns about inappropriate prescribing in respect of 12 patients

Previous history: This case has previously been considered by the IOC on four occasions and no order was made. See Case Overview

Case overview

July 2000	Information received from the Hampshire Constabulary concerning the alleged unlawful killing of a patient at the Gosport War Memorial Hospital **(GWMH)**
21 June 2001	**Interim Orders Committee (IOC)** No order
14 August 2001	Hampshire Constabulary informs the GMC that there is insufficient evidence to prosecute Dr Barton concerning the death of the patient. However, they are conducting preliminary enquiries into the circumstances of the deaths of other patients at the GWMH.
6 February 2002	Hampshire Constabulary informs the GMC that they investigated five cases (including the one that was originally referred) and that no further police action is appropriate. However, criticism has been made concerning Dr Barton.
21 March 2002	**IOC** No order
11 July 2002	Rule 4 letter sent to Dr Barton informing her that allegations concerning five patients have been referred to the PPC for consideration
27 August 2002	Rule 4 reply from Dr Barton's representatives
29 August 2002	PPC refers five cases to the PCC for consideration
19 September 2002	**IOC** No order
23 September 2002	Hampshire Constabulary re-open their investigation into deaths at the GWMH
30 September	Update from Hampshire Constabulary concerning their

2004	investigation into the circumstances surrounding the deaths of 88 patients at GWMH
7 October 2004	**IOC** No order
16 January 2007	Operation Rochester - Investigation Overview CPS concluded that it could not be proved that doctors were negligent to a criminal standard. Police investigation complete
6 September 2007	Cases listed for consideration before a FTP to commence on 8 September 2008
3 March 2008	Draft Notice of Hearing sent to the MDU in respect of 11 patients
28 April 2008	Coroner's Office inform the GMC that there will be Inquests into the deaths of ten people who died at the GWMH
6 May 2008	Draft Notice of Hearing sent to the MDU in respect of another patient
30 May 2008	Confirmation to the MDU that 12 cases will be considered by the FTPP, five of which were referred by the PPC.
20 June 2008	MDU provided with the GMC reasons for postponing the FTP hearing.

Position – December 2008 IOP hearing

The Inquest into the deaths of ten patients at the Gosport War Memorial Hospital, eight of which are due to be considered by a Fitness to Practise Panel has been listed for 18 March 2009. The Fitness Panel hearing has been re-listed for 8 June 2009 and is expected to last 55 days.

Position – June 2009 IOP hearing

The Inquest concluded on 20 April 2009 and the transcript of this day can be found at pages 358-361.

A separate Inquest is due to take place into the death of Gladys Richards but a date has not yet been fixed for it. This is one of the cases which is due to be considered by a Fitness to Practise Panel on 8 June 2009 and the Notice of Hearing will be issued shortly.

We have instructed a new expert Professor Ford, as our prior expert Professor Black is not available for the June hearing. Professor Ford's reports can be found at pages 364-455. A report in respect of another patient will follow.

Current Position – November 2009 – IOP hearing

The Fitness to Practise Panel commenced consideration of this case on 8 June 2009. The Panel's determination in respect of the matters found proved and not proved can be found at pages 517-564. The hearing was adjourned due to insufficient time and the Panel will reconvene on 18-29 January 2010.

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Dr Barton

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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. Code A

Your Ref

Tel. 0845 045 45 45
Extn.
Fax. Code A

Code A

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
W1N 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 (born: 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.

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
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Hampshire
PO2 8BU

Our Ref. Code A

Your Ref.

Tel. 0845 045 45 45
Ext. Code A
Fax.
20/09/00

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Code A

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.

Code A

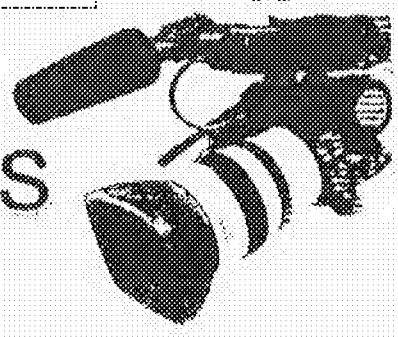
R J BURT
Detective Chief Inspector

Code A

Code A

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 Code A Code A

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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

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

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

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

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

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

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

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

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

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

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

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 C reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

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

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 H ongoing and no charge is preferred. The letter at page 5, dated 20 September, says

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

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

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

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

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

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

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

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.

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 ... "

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 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.

> "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 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.

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 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.

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?

D MR JENKINS: I think it was the same. There is a record within this bundle.

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?

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?

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 all of the doctors.

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 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 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 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 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 29 June. Of course, I will check with my learned friend, but we have raised in 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.

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. :

Your Ref. : **Code A**

Tel. : 0845 045 45 45
Direct Dial
Fax. : 023 9289 1504

14 August 2001

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 7JJ

Dear **Code A**

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

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06 February 2002

Code A
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Code A

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

Dr Barton

IOC 21 March 2002

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.

In reply please quote 2000/2047

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

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 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.

AGENDA ITEM: 17
Confidential
(2000/2047) Barton, J
(continued from page 403)
'Explanation'

dealing with us about this matter

THE MDU

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27th August 2002

FAO: Lorna Johnston
General Medical Council
178 Great Portland Street
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Also by fax: Code A

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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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 opinids 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

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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 flat. 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, Code A Code A 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

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 1998, 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.

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 looking after and doing with the patients and what the private sector was going to take from us.

B 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.

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

D 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] 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.

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

F 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.

G 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.

H

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Perhaps I can ask this. Was it apparent that the Trust were seeking to raise the level of experience and qualification of the nursing staff in the War Memorial Hospital? And the answer should go on the transcript.
A Does it?
B
Q Was it apparent?
A It was not apparent that they were making any great attempts to improve the cover, the experience and the training of some of the nurses.

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

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

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

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

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

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

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.

C 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".

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.

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.

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.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who became [redacted] who commenced her annual leave on 27 April 1998 and followed on with [redacted] 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 compleints 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 Code A

Please address your reply to Conduct Case Presentation Section, FPD
Fax Code A

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.

Yours sincerely

Code A

c.c. 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.

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

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

(Introductions made)

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

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

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

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

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

THE CHAIRMAN: Sorry? They referred to the PCC?

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

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

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

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

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

> "Generally unwell, off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking; needs hoisting; Barthel – 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death."

The nursing notes confirm that she had been admitted for palliative care.

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

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

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

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

THE CHAIRMAN: Is there a page number?

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

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

He comments:

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

In his conclusion is:

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

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

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

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

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

THE CHAIRMAN: Can we have a page, please?

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

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

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

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

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

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

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

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

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

> "[She] is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated a meantime she want the toilet. Occasionally incontinent at night, but usually wakes."

The following day, 11 August, she was transferred to the Daedalus ward. On that date, Dr Barton had written in the medical notes.

> "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death."

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

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

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

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

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

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

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

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

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

She recorded as her overall condition deteriorated.

> "Medication keeping her comfortable."

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

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

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

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

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

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

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

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

He said:

> "I do not consider it appropriate to administer intermittent doses of Oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. … Dr Barton's statement that diamorphine and Oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians."

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

The prescription of oral paracetamol and my Lady opiates would have been appropriate and would have had a better risk/benefit ratio. The prescription of

subcutaneous diamorphine, haloperidol, and Midazolam infusions "to be taken if required" was inappropriate even if she was experiencing pain. It goes on to explain why. He says:

> "The prescription by Dr Barton on 11 August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effect on conscious level and respiration to frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry is high risk of producing respiratory depression or coma"

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

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

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

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

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

At paragraph 39, she says similarly:

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

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

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

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

THE CHAIRMAN: Is this page 72?

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

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

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

> "... to prescribe and administer diamorphine and Midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent"

– apparently underlined –

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

and he gives the amounts –

> "to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and Midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing Midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I am looking at paragraph 5.12. He says:

> "I am unable to establish when Dr Barton wrote the prescription …. as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous frusemide or another loop diuretic."

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

In the following 48 hours, the increase of diamorphine was from 40 mg/24 hours and then 60 mg/24 hours. At paragraph 5.13, Professor Ford says that that increase was not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time.

> "This was poor practice and potentially very hazardous. Similarly the addition of Midazolam and subsequent increase in dose to 40 mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive."

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

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

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

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

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

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

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

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

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

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

MISS DOIG: It is surely Dr Mundy?

MS HORLICK: Dr Mundy, yes.

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

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

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

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

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

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

THE CHAIRMAN: Do you have any recommendations?

MS HORLICK: No, madam.

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

MS HORLICK: Yes.

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

MS HORLICK: That is right, yes.

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

MS HORLICK: Yes, it did.

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

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

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

MS HORLICK: No, madam.

THE CHAIRMAN: It came from the President?

MS HORLICK: That is right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR JENKINS: Indeed.

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

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

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

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

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

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

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

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

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

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

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

MS HORLICK: Madam, no.

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

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

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

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

PARTIES HAVING BEEN READMITTED

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

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

DETERMINATION

THE CHAIRMAN:

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

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

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

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

MG11T

HAMPSHIRE CONSTABULARY

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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

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 : .....

MG11T

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URN //

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 URN //

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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Statement of : STEVEN ALEC WATTS

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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Statement of : STEVEN ALEC WATTS

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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Statement of : STEVEN ALEC WATTS

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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Statement of : STEVEN ALEC WATTS

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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Statement of : STEVEN ALEC WATTS

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.'

I 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 : .....

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

THURSDAY 7TH OCTOBER 2004-10-30

CHAIRMAN: DR MACKAY

CASE OF

JANE ANN BARTON

MR R HENDERSON QC instructed by Messrs Field Fisher Waterhouse, solicitors to the Council, appeared for the Council.

MR FOSTER instructed by the Medical Defence Unit appeared on behalf of Dr Barton who was present.

T A REED & CO

THE CHAIRMAN: Good morning. I would just check that everybody has the addendum to the papers, there is addendum 1 which is paginated from 510 to 551 and addendum 2 which seems to be paginated from 533 to 563. Dr Barton this is not the first time you have appeared before the Interim Orders Committee, the location is different, but the principles remain the same. The Panel is at this end of the table. Mrs Atma is to my far right, she is the lay member, Dr McCuggage is the medical member, Mr Swann is the legal assessor, and Ms Varsani is the secretary, Mrs MacPherson is the lay member and Dr Stewart is the medical member of the Panel and my name is Professor Mackay, I am the medical member as well, and also act as chairman. Mr Henderson appears for the council and Mr Foster appears for you. We will start with Mr Henderson.

MR HENDERSON: This matter has a long history but it is not a review hearing because in the previous three hearings no order has been made, nor is it an adjourned hearing, there have been no adjournments. It comes before you because the General Medical Council has just received a statement from Detective Chief Superintendent Watts an officer of the Hampshire Constabulary who is in charge of the investigation comprehending acts and omissions of Dr Barton. The statement shows the scale of the police concern on top of the reference which has already been made by the Preliminary Proceedings Committee to the Professional Conduct Committee of the Council for enquiry into certain matters concerning Dr Barton. There is no application for an adjournment although one has been requested in correspondence which you will have seen and is in one of the addendum bundles.

Because the matter has such a long history it seems to me it would be helpful to you and I provided this morning to my learned friend a chronology. It has already been partly over taken by events in that various things which I saw were missing have been produced but I hope you will find it is helpful and where I know there is some page references I will give them to you.

THE CHAIRMAN: We will refer to this as C1.

MR HENDERSON: The order that I would seek today is that there should be conditional registration of Dr Barton. I do not seek and in my submission it would not be appropriate to seek suspension of Dr Barton. So the primary reason why I seek conditional registration is to protect patients and to protect public interest and it would be my submission that in all the circumstances such conditions would be proportionate and that Dr Barton would be able to continue in medical practice as a general practitioner.

I will come to suggested draft conditions in a few minutes if that will be convenient. If you have the chronology in front of you you will see that it begins on the first page with the period, which was the originally alleged period of inappropriate prescribing to five patients, aged between 75 and 91 at Gosport War Memorial Hospital and concerns two wards Dryad Ward and Daedalus Ward, as you will have seen from the papers, all of whom died at the hospital where Dr Barton was a part-time clinical assistant, that is to say that patients Page, Wilkie, Richards, Cunningham and Wilson.

Before going to those matters and going on may I begin by considering what it is I on behalf of the Council would need to establish and what it is what I would seek from you today. The

primary condition which we would ask for is that otherwise than in a medical emergency Dr Barton should neither issue nor write any prescriptions for nor administer benzodiazepines or opiates. Other fairly standard forms of conditions about notification of employers and prospective employers and not undertaking positions elsewhere where registration is required without informing the IOC secretariat we would also obviously ask for.

The points that I would make apropos such an order for conditional registration are these. I would accept straight away that such conditions limit a general practitioner in his or her practice, but such a condition has not hitherto prevented Dr Barton from such practice. I am not entirely clear whether or not such an undertaking originally lapsed or whether some such undertaking has been in place at all times, but I have been shown today by my learned friend Mr Foster a document of October 2002, headed on AFareham and Gosport Primary Care Trust@ paper which contains a form of undertaking; it is a voluntary undertaking and it may be convenient if at this stage you had that document available to you. (Handed.)

THE CHAIRMAN: D1.

MR HENDERSON: That you have in front of you a file note of a meeting held on the 9th October 2002 a meeting at which Dr Barton was present when Dr Sommerville in the second paragraph confirmed that Dr Barton=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.@ It goes into monitoring arrangements with which I do not think is pertinent at the moment unless my friend wants me to read them out. So it would appear that there is in place some form of voluntary undertaking on the part of Dr Barton. The obvious point I will take on behalf of the Council is that it is of course an unwritten undertaking of no particular duration and capable of being withdrawn at any time and incapable of enforcement by the General Medical Council. It is not something which would come to the notice of anybody making enquiries in relation to Dr Barton whereas conditional registration has that important and significant effect. That is a matter which I am conscious you will be perfectly familiar with as being of importance,. Now that the Council for Regulation of Health Care Professionals has appealed a number of cases concerning doctors in the course of the past 12 months or so, we can see the importance that is attached to the public availability of information so that the public can be confident that those things that ought to be able to be known by the public are known by the public, whether they be prospective employers or prospective patients. This sort of undertaking is unfortunately not in any way known to any such persons.

I accept therefore that there are limitations on Dr Barton=s practice, but they are not presently enforceable. I accept, secondly, that the draft condition which I would submit is appropriate in this case can potentially disadvantage patients of the general practitioner, particularly a patient in need of such medication who will come under the aegis of another registered

A medical practitioner, but it is clear in this case from what we have seen in the papers that Dr Code A is supported by other medical practitioners in the partnership and that has been obviously important to the patients.
Can I say as a footnote that I am not suggesting that there should be any arrangement in relation to prescription or administration under an appropriate supervising medical practitioner. You will understand from the way I put it that it would be envisaged by the Council that this is a lady who should be able to continue in practice and that I do not rule out
B some such possibility. What I am concerned about is that there must appropriate protection in all the circumstances of the case.

The third point that I would make is that I would accept that a condition such as I would propose adversely but temporarily affect a doctor=s reputation.

C Fourthly, the duty of the GMC is to guide and regulate doctors while protecting the patients and the public interest. Therefore what you are concerned with today as in all these cases is to achieve a proper balance between the competing interests of patient protection, protection of the maintenance of the reputation of doctors in the profession and good practice, and, of course, the interests of the doctor herself.

D These, as you will know only too well, are spelt out in section 41A of the 1983 Act as amended and I hope I will be forgiven if I simply go to those opening words of section 41A. I do it in part also because my submission to you today B I endeavoured to forewarn my friend Code A by making sure that he had a copy of the case which I was going to refer to and refer him to B is that a test which has been propounded in past cases and I believe has probably been propounded in this case, at least once, is not in truth the proper test to be applied by an interim orders committee. Section 41A provides

E AWhere the Interim Orders Committee are satisfied that it is necessary for the protection 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 ....@

either suspension or registration being conditional with such requirements for a period not exceeding 18 months as the Committee thinks fit to impose. So you have a very very wide
F discretion in terms of conditions that you think fit to impose. Going back to the opening words it is plain that nothing is said in the Act as to what is the test to be applied. The verb Ayou must be satisfied@ is plain, you must be satisfied in relation to three alternatives which are not exclusive, they can overlap and be accumulative.

What then is the test? The test which has been applied in the past by many interim orders committees was one which I understand was propounded by a legal assessor on an inaugural
G training day when matters came to be considered in the light of the problems which had been thrown up by the fact that there had been inadequate powers to deal with interim protection of patients and doctors when the PPC could only impose interim conditions if there was a reference to the PCC. So in came the amendment rules and the test which I understand has been consistently applied has been this that there should be cogent and credible prima facie evidence which if proved could amount to seriously deficient performance of serious

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professional misconduct or impaired fitness to practice by reason of a physical or mental condition such that the doctor=s registration could be restricted by interim suspension or conditions until matters are resolved.

The difficulty about that test is that, as you will know from experience, as many of your colleagues will know, in many cases a doctor who has been arrested and charged B I use that by way of example, this is a lady who has neither been arrested nor charged at an earlier stage despite some three years of police investigation C with a very serious criminal offence, perhaps relating to patients, perhaps not, the police will probably have made no evidence available to the General Medical Council apropos that document or the evidence which is the subject of the charge. Therefore there would like as not be no evidence, not prima facie evidence, but no evidence in relation to that doctor and yet of course if it be a very serious matter which potentially affects the capacity of that doctor=s safety to behave as a doctor then the problem is that the statute requires that you consider whether it is necessary for the protection of members of the public or patients and others which was otherwise in the public interest that that doctor be suspended or made the subject of conditions. That test I do not understand has been substantially considered in the case law, but in the case of Dr X which I would ask for that to be made available to you if possible, and I know it was made available to your legal assessor yesterday at my request, the Court consisting of Pill LJ and Silber J C(Handed)

THE CHAIRMAN: This will be C2.

MR HENDERSON: The court had to consider the case of Dr X who was applying to quash and I am looking at paragraph 1 now an order of this Committee made on the 2nd March 2001 following an oral hearing on that day. A

"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.

The claimant is a general practitioner of 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 the 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.@

I have already read you section 41A so I do not need to read it again and subsection 10 we do not need to be concerned. Then paragraph 5:

A The IOC has its 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.@

From paragraphs 6 - 10 is concerned with the court and I can pass over the courts position and we come to paragraph 11:

A The determination complained of was:

A... 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.@

I hope I will not need to read all of those. In paragraph 14 five of the charges related to one girl and the sixth related to the younger girl.

We come to paragraph 15:

AMr 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: AThey 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 Aenough evidence to provide a realistic prospect of conviction@.@.

Can I interpolate that. It is plain that the court was giving weight to the fact that Dr X had been charged. They would clearly have given less weight, as you clearly must give less weight, to the fact that here Dr Barton has not been charged. They proceeded however on the basis that the police would not be proceeding to charge unless there was evidence and therefore although there was no evidence in front of the IOC none the less the fact that there was a charge was a relevant matter which should be taken into account and could properly form the basis of the IOC,

Can I pass over paragraph 16. Paragraph 17 is informative but not relevant, so I move to paragraph 17:

A 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.

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 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.

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.@

Just interpolating there on paragraphs 18 and 19 Dr Barton can go further than even Dr X. She can rightly say AI have given evidence before an earlier IOC@ and I will draw your attention to that evidence. She can say AI have not been charged.@. She can even say AI have not been interviewed, therefore we are concerned only with the possibility of allegations being made against me of a criminal character.@ That is also entirely true. That is why I say she can say it. She can no doubt through Mr Foster will say it. The question is what is the test? Before I come to what I suggest a proper test should be can I just continue on at paragraph 20. AThe third submission is as to lack of reasons.@ That is formative but not relevant to my point and I pass over that paragraph and paragraph 21, and can I come to paragraph 22:

A 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.@

B I would parethenthally if I may underline that sentence. Dr Barton=s case is to be considered in its special and you may think unusually prolonged and difficult circumstances, its own particular circumstances.

A 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 C 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 D 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 E untested in 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.@

F That is another way in which one can test the matter, ,is what is being put before you something which plainly and obviously lacks substance?

AThey 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 G 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.@

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What do I submit is the appropriate test if it be not cogent and credible evidence etc> The formulation which I would respectfully submit would be this that if you are satisfied B I use the same verb - (a) in all the circumstances of this particular case that there may be impairment of Dr Barton=s fitness to practice which poses a real risk to members of the public, or may adversely affect the public interest or her interests (b) after balancing her interests and the interests of the public that an interim order is necessary to guard against such a risk then the appropriate interim order should be made. Such a test is not confined to evidence; it plainly permits consideration of a reliance on materials such as third party reports. In my submission it is implicit in the reasoning of the court in Dr X=s case that that is a more appropriate test if not the test which the court applied.

In terms of the application of that test to this case my submission is that the circumstances should satisfy you that there may be such impairment and that it does pose a real risk potentially to her patients, members of the public and I also submit as a separate consideration that if no conditions are made and the doctor in her circumstances is permitted to practice with no more than a voluntary undertaking that also may adversely affect the public interest by which I refer to the reputation of the profession, and the need of the public to have complete trust and confidence in registered medical practitioners.

I will add this in relation to public interest that confidence would be undermined if upon due enquiry, whether on our website or by telephone or otherwise, nothing was shown which in any way restricted Dr Barton to practice in all the circumstances of this case.

Clearly I have tried to build into that test the proportionately which is essential in respect of Dr Barton=s interests, namely, balancing the interests of practitioners with the interests of the public. That is the test.

As I understand it the difference between us, it being agreed suspension is plainly not appropriate, which I noticed was what was originally asked for on the first hearing, is some condition on the registration in the public interest, but it will permit Dr Barton to continue in practice.

Those are the preliminary submissions which I wish to make before going to the chronology, so can I go to the chronology. If I leave anything out because I am conscious that my learned friend may have access to a few more documents than do I please will he say so so they can go in chronological and present a better picture. Can I add a footnote to the first block in this matter, February to October. That is the period of the five patients. The period of the police investigation has been said as you will see by Detective Chief Superintendent Watts to be between January 1996 and November 1999, but actually that seems to me to be wrong berceuse it is plain from the document which they have just produced to us, which I have not yet seen, or my friend has seen or Dr Barton has seen, the notes that come with it, the case of a patient called Batty, which is at page 490 in the bundle, covers the end of the year 1993 and the beginning of the year 1994. SO we are concerned with a long period in which Dr Barton was a part-time clinical assistant at those particular wards in Gosport.

A She resigned from part-time employment and continued in general practice. I have given the page references where I have noted them and they were obviously available; in some instances I have simply taken it straight from what she has said and that comes from her own evidence to an earlier Committee. I am not going to turn up the pages unless anyone wants me to do so.

B On the 27th July 2000 at page 9 you have the letter which as I understand it first informs, though I have seen in an earlier transcript it seems to have been said to be later, but this is a letter of the 27th July 2000 where Hampshire Constabulary informed the GMC fitness to practice directory of concerns relating to Dr Barton and a patient called Gladys Richards. She was the subject of an allegation that she had been unlawfully killed as a result of Dr Barton=s medication at one of the wards, so it was put as a very serious allegation back in 2000. Unsurprisingly, it led to a reference

C to this Committee on the 21st June 2001. That you will see in my note of the chronology said ANo transcript available@. You of course have that available to you and I will give you the reference to pages 553 to 562. It would be helpful just to have a quick look at one or two matters there. It only concerned the patient Gladys Richards, it was not concerned with any other patients. You will see if you turn to page 554 at the top of the page Ms Griffin on behalf of the Council opened it in her second sentence that the nature of the case as set out in summary was one of unlawful

D killing and talks about the police investigation continuing. I am going to pass over to page 4 at letter E and you will note there that Ms Griffin submitted on behalf of the Council that although Dr Barton had not been charged or interviewed or arrested that it was her submission that in her view it would not be appropriate to consider conditions on the doctor=s registration, in other words it had to be suspension, and you will see contrary submissions being advanced by Mr Jenkins who appeared all the time although he is not available today and at page 555 at letter C you will note he

E says AThis case may have been brought prematurely@ and he suggested it should not have been brought at all and so on and he goes into the details and says AAs far as the doctor=s present position is concerned she does not continue to work with the hospital.@ Can I go onto the test which seems to have been applied at page 561 the legal assessor gave advice and you will see at D

F AIt is necessary to find the evidence before it amounts to a prima facie case supporting interim action on one or more of the grounds that I have just referred to.@

The determination of the Committee on page 562 AThe Committee have determined that they are not satisfied that it is necessary for the protection of members of the public ...@ and so on. We can put that document away and perhaps not come back to it, can I say the last page there was the expert review which was missing which you may have noted in going through the extra pages which went with Chief

G Superintendent Watts statement had not been provided until yesterday for which we apologise , but it has been found and now provided.

So much for the first Interim Orders Committee hearing.

There was therefore as you can see at that stage no independent expert opinion. At pages 19 to 52 by a report of the 20th July 2001 you will see Professor Livesleys

H report. Can I interpolate before looking at this and the next two reports, I would

accept straight away that you would only in the most exceptional circumstances make an order on material which had been decided not to justify making an order in the past by earlier interim orders committees, whether you had been a member of it or not, it would only be in the most exceptional circumstances. Clearly a relevant circumstance was the test which was applied in the other cases and if I persuade you that in fact the prima facie evidence test was not the right test then it would be right I would suggest that you should revisit the totality of the evidence and apply if you are so satisfied in the light of your legal assessors advice is the appropriate test. I do suggest here that it is right that you must look at the totality, you must look at all the circumstances, that is what Pill LJ indicated was appropriate and we need now to consider in the interests of Dr Barton, the interest of all the patients, her patients and other patients of the practice and other members of the public for whom she might prescribe or administer, and equally we must consider the interests of the medical profession and public confidence in it, looking at the totality. I am not going to go through everything at the same pedestrian pace which might be appropriate if you have not seen much of it before, but I understand one member of the committee has not been involved in any of the previous hearings otherwise everybody has had some involvement with this case at some earlier stage, not including the legal assessor. I come freshly entirely as well. If I take matters either too fast or too slow I would ask you to indicate that to me and I will change the pace accordingly.

Professor Liversley=s report begins at page 19 and you will see in the synoposis on page 19, he was considering the case of Gladys Richards, says this at paragraph 1:

A At the age of 91 years Mrs Gladys Richards was an inpatient in Daedalus ward at Gosport War Memorial Hospital. A registered medical Practitioner prescribed the drugs diamorphine, haloperidol, madazolan and hypascine for Mrs Richard. These drugs were to be administered Subcutaneously by a syringe driver over an undetermined number of days. They were given continuously until Mrs Richards became unconscious and died. During this period there is no evidence that Mrs Richards was given life sustaining fluids or food. 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.@

There is his synopsis to be seen in the context of the earlier IOC hearing which in the second hearing has made no order having seen that material. I will bring you to that in due course.
Paragraph 2.5 on page 21:

A 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.@

I will pass much of the material here and can I draw your attention in paragraph 4.9 page 25 to some standard which is to be found in the majority of the patients with which we are concerned that Dr Barton said in the notes AI am happy for nursing staff to confirm death.@

A

Then on paragraph 5 page 29,

A Dr Barton wrote the following drug prescriptions for Mrs Richards ....@
And you have the detail there, we have Oramorph 11th August four hourly and then diamorphine at a dose range of 20 - 200mb to be given subcutaneously in 24 hours. A number of people have drawn attention to that rate, it is a very large range, and it has been subjected to some criticism as being undue, you may think when you see the evidence, which I will draw to your attention of Dr Barton circumstances there is very really little consultant supervision and with precious little and sometimes know medical support at all= so that effectively the circumstances in which she was working was most undesirable by any standard and she was incredibly hard pressed and much will have turned on the circumstances which she has described in her oral evidence as to what was necessary in order to try and provide proper attention to those patients. I am trying to present what I understand to be the picture which may be true, it may be false, but it is one that one can see in the papers. Then hyacine, midazonlan, then haloperidol. On the 12th August oramorph in 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly.

Then on the 18th August, moving on, diamorphine with a dose range of 40- 200 mg and haloperidol. Then on the 18th, 19th, 20th and 2lst August Mrs Richards was given simultaneously and continuously subcutaneously diamorphine 40mgs and haloperidol 5mgs and midazolam20 mgs during each 24 hours.

If I can go to the conclusion on page 32

A Mrs Gladys Mabel Richards died on 2lst August 1998, while receiving treatment on Daedulus ward at Gosport War Memorial Hospital

Some four years earlier on 3rd August 1994 Mrs Richard had become resident at the Glen Heathers Nursing Home.

Mrs Richards 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.

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.

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.

At that time Dr Barton recorded that Mrs Richards was not obviously in pain but despite this Dr Barton prescribed Oramorph to be administered orally four hourly

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.

Also on 11th August 1998 at the end of a short case note Dr Barton wrote AI am happy for nursing staff to confirm death.@

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 midazolan, were not administered at that time.@
It then goes through the sequence and I have taken you through the prescriptions so far. At paragraph 7.10 he said:

A 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.

Despite this and on 18th August 1998 Dr Barton while knowing of Mrs Richards= sensitivity to oral morphine and midazolam prescribed diamorphine, midazolam, haloperidol and hyoscine to be given continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

Neither midazolam nor haloperidol is licensed for subcutaneous administration.

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.

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

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

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

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

Then we come to his opinion. I would invite you to read all of this to yourselves. Can I say you find the conclusions at 8.10 and 8.11 perhaps deserving of particular attention. (Pause to read)

You will see that it was his opinion that mrs Gladys Richards, and I am looking particularly at paragraph 8.11 death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine and other drugs. That was our starting point in relation to the medical evidence none of

which was available at the first hearing. It was part of the material which was put before the second hearing on the 21st March and led to the making of no order.

The next report was that from Dr Mundy, but before we see Dr Mundy=s report you will note at page 13 of the bundle a letter from the Hampshire Constabulary that there was insufficient evidence to support a viable prosecution against Dr Barton concerning Gladys Richard. That was in relation to the unlawfully killing of Gladys Richards based upon the allegation of her two daughters. I am not going to take you through those statements. My learned friend can call your attention to any part of it which he feels is of assistance to you, but clearly those two ladies have made allegations against a lot of people including Dr Barton in relation to the allegedly untimely death of their mother.

I pass on therefore to Dr Mundy=s report beginning at page 53. He considers the case not just of Gladys Richards, but also those of other patients. He describes the use of opioid analgesics which I will not read to you. He then turns to Mr Cunningham at page 54:

A Mr Cunningham was known to suffer with depression, Parkinsons disease and cogitive impairment with poor short term memory.@

Then can I go to Comments:
A All the prescriptions for opioid analgesics 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 does 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 20mg to 200mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Mr 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 40mg 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.@

Mr Cunningham you will see is a patient who has been categorised when you come to Police Chief Superintendent Watts statement as a category 3 case which is to say B and I refer to page 460 and 461 B a case where patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice.@ That is the definition. The reference of mr Cunningham being so categorised is at page 465. So what we do not have to day is a statement from the doctor or doctors who have made that categorisation, it is undoubtedly new information which was not available to any earlier committee. What we do not have today is the notes of papers or documents from which that categorisation has been made, but none the less it has been thought appropriate to bring this matter back to an interim orders committee, clearly matters have moved on, but they are still on going.

A Alice Wilkie is considered on page 55. He notes in the latter part of the first paragraph that the dose of 30mgs was given on the 20th August of Midazilam apparently by Dr Barton and the patient was given another 30mg of Diamorphine on the 21st August and died later that day. The Comment was:

B A 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 30mg 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 20mg to 200mg in 24 hours.@
Alice Wilkie is a case where it is said by the police in their statement at page 465
C ANo further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.@

Robert Wilson, page 55, was none to suffer alcohol abuse with gastritis hypothyroidism and heart failure. Like many he had fractured bones, a fractured humerus in his case. Turning to page 56:

D A A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16th October 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 16th October and the nurses commented later that the Apatient appears comfortable.@ The dose was increased to 40mg the next day when copious secretions were suctioned from Mr Wilson=s chest.@

The patient in this case died on the 18th October. Comments:

E A Mr Wilson was clearly in pain .from his fractured arm at the time of transfer to Dryad ward. Simple analgesics was prescribed but never given there was an entry earlier in the episode of care that Mr Wilson had refused paracetomol. 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 against the diamorphine
F 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 29th September.@

G Now that needs to be contrasted with this that that assessment was in effectively an exonerated assessment you may think in relation to Mr Wilson, but if you turn to page 465 you will see that it has been categorised as category 3.

The next patient was Eva Page and 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. The comments page 57:
H

A 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 and 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 clear that her physical condition deteriorated rapidly and I suspect that 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 charge is in my view unacceptable. In my view the dose of diamorphine should be prescribed on a regular basis and reviewed regularly my 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 practice. 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 requires further consideration by the Hospital Trust.@

That was the view of Dr Mundy a consultant physician and geriatrician.

Then we have the opinion of Dr Ford concerning the five patients, not four, pages 59 to 97, he is a Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology in the University of Newcastle and a consultant physician in Clinical Pharmacology at Freeman Hospital. He then reviews the case of Gladys Richards, from pages 62 through until 71. I am only going to draw your attention to paragraph 2.29 on page 70 under the heading Appropriateness and justification of the decisions that were made@.

A A There were 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.@

B The under Summary:

AGladys 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 Daedoalus 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.@

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Arthur Cunningham he considers from page 72 and following. At paragraph 3.10 at page 74 second sentence:

A 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 Barton of subcutaneous diamorphine 20-200 mg/24 hr prn, hyoscine 200-800 microg/24 hr and midazolam :20-80 mg/24hur to be poor practice and potentially very hazardous. A

D

E He at paragraph 3.14 was concerned by the note which we have seen in relation to a number of the patients that Dr Barton was happy for nursing staff to confirm death. Then at paragraph 3.16 he considered it very poor practice that midazolam was increased from 20 to 60 mg every 24 hours on the 23rd September. Then under duty of care issues at page 77 under 3.23 the last sentence:

A In my opinion this duty of care was not adequately met and the denial of fluid and diet and prescription of high dosage of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham=s death.

F

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 hoscine by Dr Barton was in my view reckless. The dose increases undertaking 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

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drugs most likely contributed to the death through pneumonia and/respiratory depression.@

Alice Wilkie is considered at pages 70 to 82. Can I go to the summary at page 82:

AIn 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 sand opiate drugs.@

Then Mr Wilson is considered and the conclusion is at page 87

A 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 does 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.@

Then Eva Page the summary at page 92:

A 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.@

Then he concludes at pages 93 and 94. And at 7.3:

A 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 old 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 obstructions or where the patient does not wish to take regular medication. 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 does 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 ay have been routinely written up for many older frail patients admitted to Daedalas 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 concluder 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.@

There are then the appendices which I do not need to turn to.

On the 6th February 2002 the Crown Prosecution Service decided not to institute criminal proceedings concerning Richards and they disclosed their papers to the GMC, that is on page 15 and 16.

On the 21st March 2003 we had the second interim orders committee hearing. You have the partial transcript in your earlier papers and you now have the full transcript available.. The submission was that Dr Barton should not be suspended but that her registration should not remain unrestricted and that the voluntary arrangements should be formalised so that was to be found on page 4 of the transcript. I will take you to the full transcript if that was thought helpful. I do not know whether you have had a

proper chance to consider it. I was presently minded not to take you to it, and I have taken you thought what much would have then been said.

THE CHAIRMAN: We have all read it.

MR HENDERSON: Can I move on from the 2lst March emphasising that what I have just been drawing your attention to has been considered query with the appropriate test by an earlier interim orders committee and which resulted in no order being made.

You see at the top of the second page of my chronology I say at the end of March 2002 Dr Barton=s undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased., see pages 453 and 454. That was taken from the submissions made on her behalf by Mr Jenkins her counsel and perhaps we ought to look at it because I anticipate one of the matters you will want to know what is the true state of affairs and what has been the position in the recent past. At H Mr Jenkins said

A The condition to which she agreed with the Health Authority B 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 far as the circumstances changing since the last hearing before the IOC 21 March 2002, I think that is the only change, I am sorry condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.@

It seems there was a slight change in instruction of the understanding. I am not in a position to assist you further with that. I have no document to assist further all I have is the document produced at D1 today, but clearly there was in October of that year an informal undertaking in the respects you have seen. So on the 11th July 2002 the rule 6(3) notice was provided to Dr Barton. If we could look at that briefly. You will see there were a number of headings to the allegations that in relation to Eva Page, item 2, Alice Wilkie item 3, Gladys Richards item 4, Arthur Cunningham item 5, Mr Wilson item 6, there were respectively effectively inappropriate prescription, particular diamorphine, hyoscine and midazolam, inappropriate administration of the treatment of those patients should be the subject of a proper inquiry by the PCC for the reasons there set out. I am not going to go into the detail because it is repetitious. That rule 6(3) notice duly led to a reference. But there was a detailed reply from the medical defence union on behalf of Dr Barton at pages 404 to 412. You will see that in essence what was said on her behalf was the substance of what she then gave by way of oral evidence to the third committee hearing. Since I am going to take you to that in some detail I will not take you through this, but clearly I will put it this way that what was being advanced on her behalf was that there was seriously deficient support, that she was seriously pressed to cope, she was doing everything she could to cope and that the treatment of these patients was appropriate. In addition to that she was saying that such were the pressures it meant that she could not keep proper note and that therefore what was the true condition of those patients is not adequately described in those notes, and therefore the problems were acute. I hope that is a fair summary.

THE CHAIRMAN: There was a second IOC hearing in March 2002?

MR HENDERSON: What I have failed to do is to go to what she said in the earlier hearing, could I go to that, it is at page 413. Rather than read it out to you can I invite you even if you have read it before to reread pages 413 through to 429 so that what she has said on oath is in your minds when you come to make your decision. If you could do that now.

THE CHAIRMAN: Yes, we can do that, I am sure we already have that.

MR HENDERSON: Yes, I am sure you have, I just wanted to make sure that her side had been put fairly and squarely before you not just by my learned but by me.

THE CHAIRMAN: Very well, if you give us a moment to read it. (Pause to read) Yes, we have read it.

MR HENDERSON: To continue the chronology the matter came before the preliminary proceedings committee on the 29th August 2002 and it was decided that Dr Barton=s case should be referred to the Professional Conduct Committee; unsurprisingly the police investigations were still continuing some two years later. That hearing is still awaiting. There was notice given on the 13th September of a third hearing and you have a transcript of the third hearing at pages 437 to 455. You will see that Ms Horlick on behalf of the Council said at page 439: AIn 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.@ That was the way it was put, in other words not new medical evidence, but the referral on to the PCC and the continued police investigation. The view of the committee was at page 455

A There is no new material in this case .since the previous hearing of the Interim Orders Committee on 2lst March 2002. The Committee has reached this determination in the light of this and the legal assessor=s advice.@

The legal assessor's advice is at page 454 in relation to what he said in camera namely

AIn the light of the fact that there was no new evidence it would be unfair to the doctor for the Committee to consider the matter any further.@

The earlier advice I pass over at page 453.

THE CHAIRMAN: This might be a convenient moment to have a break.

(Adjourned for a short time)

MR HENDERSON: The next entry in the chronology is September 2002 to date, the police investigation continues, pages 458 to 460 AThe first papers of selected cases are likely to go to the CPS in December of this year or early 2005.@ I should add straight away if there is a sufficiency of evidence and you can see immediately that that is bringing in the police new evidence. You might like for your own assistance

just to have the complete chronology in this sense that D1 seemed to me to go in immediately after that block of September 2002, that is to say the file note evidencing the undertaking of Dr Barton with the Gosport NHT 9th October2002.

Can I go to page 456 and following and to the statement of Chief Superintendent Watts of the Hampshire Constabulary Criminal Investigation Department, senior investigating officer in respect of this operation, given a code name.

A An investigation surrounding the death of 88 patients occurring principally during the late 1990s at Gosport War Memorial Hospital. This investigation followed allegations that during the 1990s elderly patients at Gosport War Memorial Hospital received sub optimal or substandard 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 circumstance surrounding the deaths of these patients to gather evidence and with the Crown Prosecution Service 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.@.

Dr Livesley reported on the death of Mrs Richards in 2000 and you have seen Professor Ford statement and you have seen that statement of Professor Mundy.

AThe Aforementioned reports has all been made available to the GMC. Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths and concluded that A 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 toxically, general medicine, palliative care, geriatrics and nursing. All the cases examined were elderly patients (79 to 99 years of age) their deaths occurring at Gosport War Memorial hospital between January 1996 and November 19999. A common denominator in respect of the patient care is that many were administered opiates authorised 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 patient4s 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.@

It is not before you, I have not seen it.

A The team of experts has scored the cases as follows.@ Just interpolating if I may the Detective Chief Superintendent says that these are against agreed criteria. We do

not have an appendix showing what the agreed criteria were or are, therefore the quality of our knowledge is imperfect.

Category 1 there were no concerns in respect of these cases upon the basis that optimal care had been delivered to patients prior to their death.@

Interpolating again you have behind this statement a number of summaries relating to patients, 40 in number, and you will see that 19 are referred to in category 2. Mr Hilton on seeing the 19, looked at them, some of them did not appear to come into category 2, they appeared to come in to category 1, and that is why you only have 14.

A These cases are currently undergoing a separate quality assurance process by a medico-legal expert to confirm their rating. 19 of these cases that have been confirmed have been formally released from police investigation and handed to the General Medical Council for their consideration.@
So it is those of which you have a number behind the statement,

AA number of cases 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 3 patient care in respect of these cases has been assessed as Anegligent, 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. That is my next block in the chronology. AAs part of the ongoing investigative strategy, since May 2004, a further tier of medical experts,in geriatrics and palitiative 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 investigation AHolmes@ system a national police IT application used to record and analyse information relating to serious/complex police investigations. To date 330 witness statements have been taken and 349 officers 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 .Hampshire Constabulary. A

Stopping there for the moment, what weight and what relevance does that have? If you are concerned with the test of prima facie evidence the answer is none at all. If we are concerned with the test which I have propounded them it is of some relevance. In exactly the same way, I would suggest, as a charge on Dr Barton would be of some relevance, in exactly the same way it is reference from the PPC to the PCC is of some relevance. The question is what weight is attached to it. Plainly if it is of this scale

you give it the weight that you think that it deserves. It clearly falls less than and lower than an arrest or a charge, none the less I submit it should be given appropriate weight or suitable weight and in that context one needs not to look at the interests of Dr Barton one must also look at the context that there is out there a large number of members of the public who are well aware of this investigation which is taking place, who are therefore very well aware that a doctor or doctors and nurse or nurses are under the scrutiny of the police, and that there have been allegations made of unnatural and untimely death brought about by lack of care.

How then do you balance this matter in that context? That must be for you to say. If my learned friend advances the old test as being appropriately then effectively I would say that is wrong as a matter of law. When we look at the section 41A test effectively you need to give it such weight as you think is right considering what is the public entitled to think in the present circumstances of what it knows in the context of what we know we know and what we do not know.

Back to the statement if I may.

A Whilst investigations will be fully completed in respect of all 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.@

It does seem as though in that sentence he is saying in terms there is a number of category 3 cases which will be referred to the Crown Prosecution Service.

A Timescales for this action are clearly dependent 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 sufficient 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.@

That sentence or those sentences appear to somewhat undermine the first sentence of the preceding paragraph

Al understand the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Orders 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. 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 .....@

I am not going to read out aloud the next matter. Effectively it summarises why it is that they conceive it to be their public duty not to divulge to the General Medical Council the information which is available to them at this stage. There is clearly tension is there not between the protection of patients which the GMC provides and the protection of the patients which might derive from prosecutions. It is not

concerned with the protection of patients, it is concerned with conviction of criminals and that tension does not seem to be very happily met when we have a three plus year investigation as we have here, which is still continuing, and plainly will be continuing into 2005. Again that is a reason I would submit why the test which I say should apply is likely to be right, rather than the earlier test.

Turning over from the explanations providing an effective investigation he acknowledges on page 464 in the sixth line:

A 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....@

I assume he is referring to this document at D1, and he quotes from that. My learned friend has shown to me today another document which I will not try and anticipate which relates to the prescription of drugs by Dr Barton. It does not come to quite that number but it matters not, but he doubtless be in a better position to explain the true state of affairs.

AI 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 orders committee during September 2000.
Arthur Cunningham - this has been assessed as a category three case and is being investigated.
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.@

That concluding sentence is obviously important. What does it mean? In a sense I would suggest to you that it may be presumptuous for me to try and say what it means, but you may think one thing for certain is assured and that is this that a Detective Chief Superintendent in charge of the investigation amongst others of Dr Barton considers with the benefit of expert medical advice that the investigation should continue at a very high level. What relevance is that if you were to accept the test I have propounded its relevance is this is it not? It falls short of saying this lady is ever going to be charged, materially short of that, but it does say that there is a very real cause for concern and which this Committee and any member of the public, and of course you contain two quite specific members of the public as well as being

members of the public in your medical capacity, would if they knew that be entitled to say to themselves AWell, are we being properly protected against a person whose qualitive medical care is under such serious criminal investigation by either suspension or conditions?@ At the moment there are none, there is no suspension, no conditions. There have been voluntary undertakings. Are they sufficient? In my submission the answer is No and that in all the circumstances the test I have propounded brings in this matter. I recognise straight away it falls short of and is not an allegation in relation to a charge, a lady who has ever been arrested, or anything of the kind.

That brings me to the final documents as to how I approach this. For a reason which I will show you in a moment I am going to give them no great weight. Firstly, the documents which go with them, which I assume are in those piles over there and this pile here, a foot high, they are unseen by me appearing for the Counsel, they have only just been reproduced, they have not been seen by my learned friend Mr Foster or Dr Barton, and I do not know the extent to which these documents are a reasonable analysis of those documents when done by counsel or solicitors with experience in this sort of field. Secondly, I do not know who has done this analysis; I do not know their qualifications, I do not know their expertise, and therefore it is a matter which is only to be approached with considerable reservations, very considerable reservations.

The third concern, it seemed to me on looking at the first of these cases Harry Hadley if you look over the page at 468 you will find that the prescriptions are normally done by persons other than Dr Barton. Say, for example, the 5th October, Dr Pennells is involved and he discontinues the diazepam. Dr Shawcross is to rewrite MST. Dr Pennells on the 7th October commences the syringe driver of 16 mls of diamorphine. On the 8th October Dr Shenton commences the second, on the 9th October we have a Dr Yale and a Dr Chilvers involved. Therefore to have assumed that where Dr Barton is not mentioned that she was involved would seem to me to be an assumption which should not properly be made by you and I am not going to invite you to do it. Therefore I am only going to invite you to do it, and therefore I am only going to invite you to even look at five of these cases and they are Taylor, page 403, Abbott page 406, Batty 490, Lee 499 and Carby 502.

I am going to take this simply because you may think the appropriate thing to do is to draw your attention to the matter and highlight any matter which seems to be potentially relevant with all the reservations which I have already expressed. At page 483, Daphne Taylor, Dr Barton is identified at the foot page on the 7th October, seen by Dr Barton and Daphne Barton appeared to be in pain, she was a lady of some 70 years of age, one of the examples of the age group not being as we have been told.; also seen by Dr.Lloyd. 9th August the nursing staff may confirm death. 17th October summary left arm elbow still very painful on movement. Dr Barton seen X-ray from Haslar has requested.repeat x-ray. 18th October summary AAM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs, diamorphine and midazolam 20 mgs over 24 hours. Fentanyl patch removed appears more comfortable. PM appears more peaceful and relaxed no pain on turning. Family seen by Dr Barton and informed of poor prognosis. 19th October condition deteriorating chesty very bubbly. 20th October died peacefully, verified by the nurses.

A

Daphne Taylor=s expert view by the doctor who I cannot identify, perhaps I had better read all of it A

Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a cerebrovascular acciden4t. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

B

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 18th 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 20 mgs of midazolam over twenty four hours.

C

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 does of opioids without there appearing to be a comprehensive assessment made for her pain.

D

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.@
You may think that that is a criticism, it is a criticism which potentially affects Dr Barton and her care in particular the pharmalogical care of these elderly ladies by an anonymous expert or experts.

Victor Abbat is the next one and the summary is at page 486. He was a 77 year old. We are dealing with one of the latest ones, May 1990, he was admitted to Gosport Hospital on the 29th May as an emergency requested by Dr Barton. His wife could no longer cope with him at home. Mr Abbatt died .at five minutes past midnight 30th May and son and daughter informed. Death certified. by ....@ The expert review

E

A He was diagnosed with 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 10 mgs temazepam apparently which had been written up for him. The experts criticised the use of a small dose of temazepam in a patient who is cyanosed. They note though that Mr A bbatt was already very.unwell.@

F

.Unfortunately when you look back at the cyanosis in the summary it is not there but it is referred twice in the expert review.

G

The next one is Charles Batty and he is at page 490 and you see on the 28th December1993 Mr Batty a gentleman of 80 was seen by Dr Barton and oramorph 10mg 6 hourly prescribed was prescribed. On the 30th December the oramorph was increased and syringe driver commenced diamorphine 40mgs.... 31st December general condition deteriorates. On the 2nd January he died at 10-05. The summary in relation to him page 492

H

A In December.1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesis 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 does especially B midazolam. Cause of death was felt to be unclear by the expert team.@

Working with the material available to us that you may think does not subtract but adds to potential criticism of Dr Barton but I do not think I can add any useful submission in relation to that.

C THE CHAIRMAN: Dealing with Mr Batty=s case the summary does indicate on the 28th December he was seen by Dr Barton and then we go to the entry of the 30th December, but it does not specifically say that Dr Barton made these prescriptions.

MR HENDERSON: You are absolutely right.

THE CHAIRMAN: I think also with Mr Taylor.

D

MR HENDERSON: You are absolutely right. I hope I am deliberately minimising which I concede to be relevant and readable for your proper consideration. The reason why I thought it right to draw it to your attention was, one, she was obviously involved in the orothorm, I cannot say for certain whether or not she was involved in the driver. It may be that Dr Barton can say and remember, it may well she cannot and we may need to look at the notes, but what one does know is this that she has E certainly said before a constitution of this committee on earlier occasions that she was generally the only person there, yes there were others involved which is why I drew your attention to the notes in the first case. I would leave it as an entirely open question and whether it is right to draw an inference against her in relation to that diamorphine and the syringe driver you may think is not enough material to do so, but none the less right to draw it to your attention.

F THE CHAIRMAN: The other case I had in mind was the Victor Abbatt case where DrBarton arranged the admission but there is no specific mention in the summary as to who it was who prescribed the diazepam. It does not specify it.

MR HENDERSON: You are quite right about that . The next one was Catherine Lee at page 499. She went to the Dryad Ward, this is the top of page 500, where Dr Barton was pretty well in daily contact. On the 14th April 1988 the normal entry A G happy for nursing staff to confirm death.@ Turning down to the 15th May 1998 summary seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly. 21st May clinical notes further deterioration uncomfortable ad restless . Happy for nursing staff to confirm death. Summary - restless, agitated. Seen by Dr Barton. Syringe driver commended diamorphine 20mg at 09.40.. Then she deteriorated further. There is no further reference to Dr Barton and I drew your attention earlier on in the summary in relation to Catherine Lee.

H

Lastly Stanley Carby. He was admitted to the Daedulus Ward on the 26th April 1999,again one of Dr Barton=s two wards and on the 27th April he was seen by her that is shown in the fourth line, ASeen by Dr Barton and family spoken to. Cyanosed and clammy. Wife thinks he will not survive. Dr said AI will make him comfortable.@@ In terms f his then state of health he had left hemiplegia secondary to CVA, angina, obese, hypertension, cardiac failure, non insulin dependent diabetic, prostatic hypertropy depression.
In terms of commentary by the expert, third paragraph

A 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 ay 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.@

That is the supplementary evidence.

My submission is that if you apply the test which I have propounded as to how you balance the public interest in doctors reputation, patient interest, both patient interest of the patients of Dr Barton and the patient interest in having trust in doctors, with Dr Barton=s position that she is able subject to conditions still to practice as a general practitioner, it would be disproportionate for her to be suspended, but it would be proportionate and necessary that you should be satisfied that it is necessary that she be the subject of conditions either in the terms which I have suggested or in similar terms,otherwise than in an medical emergency she should neither issue nor write prescriptions or administer denzolbiate or opiates is of course limited to those where problems appear to have arisen. Look at the totality, look at all the circumstances of this case, it is clearly going to be a continuing enduring one for months still to come and you have three consultants who have criticised her in respects of which the condition is designed to deal with. You have a PCC reference, PPC has concluded in the past that there was a reasonable prospect that she would be found to be guilty of serious professional misconduct, you have police categorisation on expert advice that a number of cases in which she has been concerned are cases where there has been negligence in the sense of being beyond acceptable clinical practice and you have the scale of the police investigation. It is a different state of affairs from that which came before the first, second and third committee. Some of the evidence, much of it, has been before different committees and you must obviously bear that in mind to be fair. At the same time if the test that they have applied has been a conditional test I question whether or not it has been the right test. Those are my submissions.

THE CHAIRMAN: I will see if we have got any questions.

MRS MACPHERSON: It is really just a query on the documentation. I notice that the GMC=s notice of the hearing of Dr Barton is dated 24th September which is at page537. It refers in the first paragraph to the President deciding on the referral. AAfter considering the information provided by the Hampshire Constabulary@ and then we have the report or summary from the Hampshire Constabulary which you have gone through in detail for us which was dated 30th September which is obviously after the date of this notice of the hearing. I wonder whether you have any comment on that?

MR HENDERSON: Clearly it was anticipated that there would be a statement forthcoming and that it was going to be forthcoming earlier than it was. We may have had anticipation of somewhat different from what came into the state in which it was produced, I do not know. One way or the other at the time that the letter of the 24th September was written the limit of what could be said was said in paragraph 3 and it gave the earliest possible notice of a hearing. There is nothing in the rules which says it has to be seven days. As a convention one goes for seven days. In truth we are exactly on seven days, it came in on the 30th September and was electronically forwarded on the same day. In effect it was early notice of the 7th October hearing with sufficient supporting material at that stage, about which reasonable concerns were expressed on behalf of Dr Barton but there has been no application for an adjournment and we are here on both sides to go ahead today.

MRS MACPHERSON: There is no further information available to us which would indicate why the President made his decision?

MR HENDERSON: That is correct.

THE CHAIRMAN: We do not have any further questions. Mr Foster?

MR FOSTER: I should begin by saying that I am very grateful to my learned friend for his thoroughness and for his even-handedness. Both of those things mean that I can be a lot briefer than I originally thought that I would have to be. I have to say a little bit about the background and could I begin by inviting you to look again at the letter which is at page 404 of the bundle MDU written on Mrs Barton=s behalf in August 2002. My learned friend has referred to this and I know you have read it before and I k now you will read it again but there are some matters which I wish to highlight. It is Dr Barton=s position that she was forced because of the conditions in which she had to work to choose between optimal note keeping and proper patient care and notekeeping was a casualty, patient care was not. If you look at pages 404 and 405 you will see that she compressed her clinical sessions at the hospital into three and a half sessions each week. In the two wards over which she had responsibility there were a total of 48 beds for her patients care which were extremely high, and he points out in paragraphs 3 and 4 on page 405 which indicates that Dr Barton lacked effective consultant support and indeed during the time in which the formal allegations took place the second consultant Dr Tandy was on leave, so already he inadequate consultant support if there was any was cut in half.

The penultimate paragraph on page 405 tells the story of Dr Barton=s frantic life. She arrived at the hospital at 7-30 and she would visit both wards, reviewing patients and

liaising with staff before she commenced he general practitioner duties at 9 am. She visited the wards, she would do her general practitioner appointments between nine and lunch time and would often go back at lunch time to review patients and then after doing her afternoon session as a general practitioner she would frequently go back to the hospital about seven and stay there for sometime.

That is a picture of an extremely concerned and diligent doctor doing her best under horrific circumstances. Those circumstances were made clear by Dr Barton to the management on a number of occasions APlease help, we need more funds, we need more staff@ but unfortunately those tries went unheeded. With the benefit of hindsight it might very well be the case that the wisest thing to have done would be to have resigned and of course Dr Barton facing the problems that she has faced over the last few years regrets very much that she did not do that. That would have been the only way in which the management would have taken any notice, but unfortunately she did not want to let the patients down, she did not want to let down the nurses with whom she had a very close relationship and so she battled on. In battling on she did not make the notes that she should have made therefore it is not clear, it is accepted in relation to many patients, just what the clinical indication was for the prescription which is recorded.

This is a case of poor documentation, it is not case of poor patient care. My learned friend has taken you to the transcript of Dr Barton=s evidence on page 413 and when you are making your deliberations today I would invite you to look at that again. There is some useful cross-referencing which deals with the position of the hospital which is to be found in the Commission about Health Improvement Report which was published in July 2002. I do not propose to burden you with what is a bulky document, there are quite enough pages in this case. There are a few passages I wish to highlight.

THE CHAIRMAN: Has Mr Henderson seen this?

MR FOSTER: No, I do not imagine there will be huge surprises. Does Mr Henderson want to see it?

Mr HENDERSON: The answer is yes I want to, what I suggest when we have the break I suggest my learned friend goes ahead and if he could make it available to me during the lunch hour adjournment and anything I ought to say I will let you know, would that be a convenient way of dealing with it?

THE CHAIRMAN: Yes.

MR FOSTER: There are three paragraphs I wish to refer. The first is paragraph 6. 8, this relates to the appraisal of supervision of clinical assistance. (Paragraph read) There the commission concluded that the work place was intolerable and the sessions that were allocated to Dr Barton were inadequate to deal with the work she was required to do. The next paragraph is 7.9 (Paragraph read) Finally in this report there is a heading at 7.11 headed AOther trust lessons@. (Paragraph read)

That is a long boring list which indicates what had to be done in order to do properly the job which Dr Barton was required to do. The conclusion I would invite you to draw from that is that Dr Barton was operating in circumstances which made full notekeeping quite impossible.

The other important bit of background which has been referred to repeatedly this morning of course is that there have been three successive IOCs hearing which have not found any order is necessary. In the transcript at page 438 of the bundle, which relates to the IOC hearing on the 19th September 2002 there was a good deal of discussion between the Committee and the legal assessor and counsel about whether it was proper to make any order no new evidence having been adduced. It was decided there that no new order should be made because there was no significant new evidence. That in my submission is the proper way to deal with it in my submission. The question therefore arises what has changed since the last IOC hearing? The important point which my friend makes is that the test which was applied on previous occasions is wrong and accordingly you have to reconsider all the material which was before previous Committees and apply the proper test, that was part of the reason for detailed consideration of all the previous evidence. He invited your attention to the case of Dr X and he invited you to adopt an alternative test which said if you are satisfied (a) in all the circumstances of this particular case that there may be impairment of Dr Barton's fitness to practice which poses a real risk to members of the public or may adversely affect the public interest or her interests and (b) on balancing her interests and the interests of the public an interim order is necessary to guard against the risk then the order should be made. I do not have a lot of dissent to that formulation save I suggest it should read if you are satisfied (a) in all the circumstances of this particular case a sufficiently robust case has been made that there may be impairment of Dr Barton=s fitness to practice; that caveat is necessary to avoid a potentially ludicrous result. If one adopts that formulation then I would respectfully submit that for all intents and purposes the right test has been applied by previous committees. Both Mr Henderson=s formulation of the test and the test which I have formulated today begs the really important question which is the question begged by section 41A itself, how are you satisfied? Mr Henderson=s test does not answer that question. It cannot be the case having regard to basic principles of fairness described if you like in terms of Article 6, that a malicious allegation by a patient of a serious offence can have the effect of causing the interim orders committee to apply a draconian order affecting a doctor in practice.

There must be implicit in the statutory requirement "to be satisfied" a basic requirement that you look for some evidence. What therefore amounts to satisfactory evidence, evidence sufficiently cogent for you to be satisfied? My learned friend says that the additional evidence which you have in this case is the fact of an ongoing police inquiry. That with respect does not add anything to the position which had obtained previously, the police inquiry had been going on for an awfully long time, yes it is right that we have now been told that the police inquiry will look at among other things the patients whose summarises are contained in the back of the IOC bundle. But we have known for a very long time that patients including these patients had previously been looked at, and there is not the slightest reason to suppose that those patients were not among the patients who were being looked at and in any event my learned friend I would say very fairly down played the weight which you should

attach to those summaries for all the reasons which he has identified; we do not know anything about their authorship, but without wanting to be flippant those summaries could have been compiled by a secretary with medical knowledge in the police department.

The neutral stance I would take is that it is simply more of what we have seen before. If we believe everything which is said in those summaries there is evidence of hurried and in some cases incomplete medical records. There is no indication there has been any inappropriate prescribing. There is sometimes inadequate documentation of the implication of prescribing but again I do not want to be flippant but it is important to understand the context in which this police investigation has happened. This has been an absolutely massive police investigation. When those instructing me spoke to the police in September 2003 my solicitors were told that a team of six detectives had been working full time on the case and as you have heard already that a number of experts have been called in, including experts from nursing, from forensic psychology, general practice, care and so on. I respectfully and rhetorically say that after all that expenditure, money time and manpower is that the best that there can be? They have been unable to put any firm allegations against Dr Barton in the sense of new charges. In relation to the weight which my learned friend says he should attach to the fact that the preliminary proceedings committee have referred to the professional conduct committee, point 1 that is a matter which has already been considered by the committee and, two, a test in which the police are deciding whether to bring charges. We know what the police=s view of the present situation is because Chief Superintendent Watts has been very candid about it and a portion of his evidence has been read out ANo evidence of any criminal charges and we really do not know where we are going to go from here". Again I rhetorically ask should that be sufficient for you to say that there has been new material upon which you could be satisfied that the position has changed from previous IOC hearings and that statutory criteria in section 41A has been met?

Chief Superintendent Watts obviously thought that he had a very cogent point to bring before the committee, that was the issue of the undertaking about the opiates and benzodiazepines prescriptions; he thought as his statement makes clear that he had caught Dr Barton out in breaching her undertaking. That quite plainly is not the case. You have seen the document in D1 Which is the formalised second undertaking which was given. You will see the terms where Dr Barton prescribed diazepam where there was a clinical indication for doing so which was endorsed by the British National Formula. Dr Barton has undertaken the exercise of looking at her prescribing over the period which is dealt with by Chief Superintendent Watts in his statement.A computer print out has been generated and if copies could be handed up. This is D2. My learned friend has seen this. It requires some explanation. It relates to diazepam prescriptions by other partners in the practice where Dr Barton works during the material period. The names of the national health service numbers of the patients have been deleted so confidentiality is secure. You will see at the bottom of the first page Dr Barton=s name and she is described there as the usual doctor, so all the entries under her name relate to prescritpions of diazepam which were given to patients for whom Dr Barton was the usual doctor. That does not mean, as the medical people will know, that all the prescriptions were written out by Dr Barton herself. The prescriptions which were written out by Dr Barton herself are indicated on the right

hand side of the page by the initial JAB. You will see four occasions on which Dr Barton has herself written out prescriptions for diazepam. The other prescriptions were written out by other doctors whose initials appear on the right hand side of the page on behalf of patients who were the usual patients of Dr Barton. In relation to each of the four prescriptions and Dr Barton has gone back and checked all this and they were all for muscular type pain which is a legitimate prescription for that. That indicates Superintendent Watts killer point before you, namely this is a doctor who breaks her undertakings and incontinently prescribes diazepam is a wrong point.

You are left solely with the question whether there is new evidence which justifies the departure from the IOC previous findings that there is need for an order in Dr Barton=s case.

There is no evidence at all that Dr Barton is unable to prescribe safely in the GP context. That is the only context in which she now prescribes. There is every reason to suppose that all the concerns arose solely because of the pressures which arose in an appalling environment which a long time ago now she prescribed, it is a long time now since she was working on these wards and she has no intention of going back.

That being the case no proper public confidence issues arise. In her general practice she has an acceptable work load, the work load is divided between several partners and accordingly record keeping is simply not an issue either. Is it therefore necessary again for there to secure public safety that she has an order in the terms suggested by my learned friend? Absolutely not. The necessary protection was given by the undertakings which she has made and manifestly by this evidence has complied with. The Committee I know will be keen to guard against the tendency which arises in many high profile public cases of complying with what can amount to mob rule of a doctors inability to practice being interfered with simply because people make unsubstantiated allegations.
For all those reasons I suggest that there is no material on which you can properly conclude that the earlier committees were wrong in deciding that no order be made. Those are my submissions.

THE CHAIRMAN: I will just see if we have any questions.

DR STEWART: It is just to clarify a matter to do with the D2, the diazepam. Under the usual doctors, Dr Barton=s list it is quite clear that other doctors whose names appear on this document have prescribed for her patients. Dr Beasley has prescribed morphine on a couple of occasion on Dr Barton=s list and Dr Peters has. What you have not indicated to us is how many of these prescriptions under the names of Dr Knapman Dr Peters, Dr Brigg or Dr Beasley and Dr Brooke were actually written by Dr Barton rather than by the doctors whose names appear at the top of the list. That is information that I think would be useful for the Committee to have if you are asking it to consider that this is an indication of the number of frequency that diazepam prescriptions are prescribed by Dr Barton?

MR FOSTER: I can tell you, sir that none of the other prescriptions under other doctors names were written out by Dr Barton.

DR McCUGGAGE: Just on that point that Dr Stewart made. Perhaps when we look at the prescription under A J Barton under JAB it appears twice. Were there two prescriptions written by Dr Barton.

MR FOSTER: I understand it was an error.

DR BARTON: It was an error, I think what it was when it was pressed down the computer generated two prescriptions.

MS RAZI: I just wanted to check when this report is dated.

MR FOSTER: July 2002.

THE CHAIRMAN: We have in our bundle doctors arrested on suspicion of an offence and we have others who are formally charged and clearly we are aware of the police investigations which have been going on for some time. Has there ever been any stage where Dr Barton has been arrested on suspicion?

MR FOSTER: No, sir. She has been interviewed under caution in relation to the case of Gladys Richards and the police decided there would be no proceedings. The police interviewed her and the papers were sent to the Crown Prosecution Service and the answer came back that was the end of the case.

THE CHAIRMAN: So it was the CPS who decided in that case?

MR FOSTER: Yes.

THECHAIRMAN: At this stage we would normally ask the legal assessor for advice, but since Mr Henderson is going to look at this document at the lunch break it might be better if we break now and reconvene later.

MR HENDERSON: Could I just respond in relation to the legal matter and on the matter of a correction. The first is this my learned friend=s submission seeks to add some words to my test and he is trying to say effectively what does satisfy mean and the test he applied that it must be sufficient robust and goes on to say the basic requirement is that this committee must look at some evidence. This in my submission is obviously more important in this case essentially but I would suggest to you that that reason is wrong. The reason we can see it is wrong is Dr X. We know in Dr X there was no evidence, there was a charge, they did not look at the evidence underlying the charge, therefore in my submission the additional words which he implies do not add anything when he says what he means by it, they actually go further than they properly should.

In relation just to a correction he says we do not know anything about the authorship but in fact we know something. We know what Chief Superintendent Watts has said about it. In addition if one looks at page 507 we know one of the experts, Dr Macey, is expressly identified,therefore it cannot have been, to use my learned friend=s

forensic flourish simply a medical secretary. It may be a medical secretary who typed it but the substance of the matter cannot be limited to that.

In relation to other matters I would like to see the document and I will come back to you.

MR FOSTER: I wonder if I can respond very briefly to that. I would accept that if a police investigation resulted in a charge then that charge is evidence within the ambit of the test proposed, but in the case of Dr Barton we are a million miles from that; not only do we not have any charges, you have it indicated by the police on several occasions to take no action, so to suggest it is parallel with the case of Dr X where there were charges simply do not stand up.

THE CHAIRMAN: Right we will adjourn to 2pm

(Adjourned for a short time)

MR HENDERSON: I mentioned to my learned friend that I wanted to draw attention to one or two passages in this report. It is the only copy with have here. He has highlighted certain passages and when you retire you can look at the report. I could not hear clearly what Dr Barton said but I understood it to be the case that the pressing down twice explained duplication of prescriptions in relation to the 15 items where they are duplicated. I think along side you will see some dates. While obviously that may well be the case, I am not questioning one way or the other, that in relation to the first entry, the third shown, nor the one April 9th, the one after that three from the end, the patient 1959 No 111496, you have got two different dates, one of which was the 7th November and the other 28th October and that would not marry with that explanation. The last is the penultimate one, that is dated 28th May but I merely draw that to your attention.
Can I respond to the report. The function of CHI which produces this report is not to investigate particular doctors and therefore the point my learned friend makes, there is no criticism of individual doctors, with respect is clearly limited, the absence of criticism is not a basis for the answer that none is to be found. This came into existence particularly to deal with systematic or systemic organisational problems in the provision of health care.Its remit is at paragraph 1.4 and I mention this in this context because you will find the passages to which I am going to draw your attention show that one would not generally expect to find individual criticisms and the terms of reference which were agreed on the 9th October 2001 are as follows.

AThe investigation will look at whether since 1998 there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within the services of older people inpatient and continuing and rehabilitative care at Gosport War Memorial Hospital. ...(reading to the words) .....care for older people.@

In the context of that remit none the less there are certain key conclusions and at page vii in the key conclusions I will alert you to this:

ACHI concludes that a number of ..... reading to .....were not identified.@

Those are amongst the key findings, the first one under Chapter 4, under the heading

AArrangements for the prescription administration and review@ ACHI have serious concerns ..... reading to ..... Would have been questioned.@

Then in relation to Chapter 5 under the heading of AQuality of care and patient experience.@
A Relatives speaking to CHI had some ..... ward now.@

Then in chapter 4 at paragraph 4.2, a chapter headed AArrangement for the prescription, administration and review of the calling of medicines, police enquiry and expert witness reports@

A Police expert witnesses .....reading to ..... to reach the conclusions in this chapter.@

I have already given you the conclusions in the chapter at the beginning.

Then in relation to paragraph 4.4 on page 13 under the heading AMedicine usage@

A Experts commissioned by the police ..... number of patients treated.@

On the next page you have graphs.

Then paragraph 4.5

A The Trust=s own data ..... 2000 and 2001.@

Then there is the graph. Finally paragraph 7.9, my learned friend read the first sentence and could I read to the end

A Gosport Health Care NHS .....reading to ..... April 2001.@

Sir, are the paragraphs which I thought I would draw your attention to, there is nothing else I wish to say. Thank you very much.

MR FOSTER: Could I just say this there is no new evidence which my friend read out which should alter your approach to this case. You may feel that the simple question for this committee to decide is whether it is proper for the IOC committee to impose conditions on Dr Barton's fitness to practice on evidence primarily of a police officer's assertions that an enquiry is continuing without being able to give a coherent indication as to the nature of the enquiry or the evidence that the enquiry has. In my submission the answer to that question must be No.

THE CHAIRMAN: I will now ask our legal assessor for his advice?

THE LEGAL ASSESSOR: This is an application under section 41A of the Medical Act 1983 for an interim order that conditions should be placed on the registration of Dr Barton. It is not suggested that her registration should be suspended.

I advise that the approach the Committee should now take is to consider all the particular circumstances of Dr Barton=s case as they prevail today. This must include the circumstances as at the time of the three previous hearings when no order was made and to consider it in the light of the new material which is before them today.

I advise that before any order may be made the Committee must be satisfied that by reason of Dr Barton=s intending to practice it is necessary for the protection of the public, or is otherwise in the public interest, for example, to maintain public confidence in the medical profession, or in the doctor=s own interest that conditions should be imposed on her registration. The Committee must consider proportionality. The protection of the public, particularly patients, and the maintenance of confidence in the medical profession, must be balanced against the consequences of an order for the doctor, such as interfering with her ability freely to practice her professional and the staining of her reputation.

Mr Henderson, for the General Medical Council, has suggested a new test should be applied as to when the Committee should make an order. The advice which I have just given is in the same or similar terms to the advice which has always been given to this Committee since its inception with the omission of the words Aby cogent and credible prima evidence@ after Athe Committee must be satisfied@. With that omission my advice is in broad terms identical to Mr Henderson=s new formulation, although perhaps not so elegantly expressed.

Mr Foster, for the doctor, does not criticise Mr Henderson=s new formulation save he speaks to add Athat the committee must be satisfied that a sufficiently robust case has been madeMy advice is this: the Committee must act on the material which the General Medical Council and the defendant sees fit to call before it and that is a quotation from paragraph 18 of the case of Dr X to which reference has been made. This often includes material such as the mere fact of the doctor being charged or arrested for an offence or third party report, which would not possibly be evidence admissible in the criminal court or before the Professional Conduct Committee. That follows necessarily from the nature of the interim Order Committee function and the point in the proceedings at which that function is performed.

However, I advise the Committee that they are not required to act upon any material put before them. They must first consider its weight and quality; put another way, as was done by Pill LJ at paragraph 25 of Dr X they should consider whether the material put before them in support of the application Aplainly and obviously lack substance.@ That may be no more than another way of saying AIs the material credible and cogent?@ If the Committee is satisfied that the material relied upon by the General Medical Council plainly and obviously lacked substance or is not credible and cogent they will not be satisfied that it is necessary to make an order.

That is my advice.

THE CHAIRMAN: Right if you could withdraw while we consider the matter.

(The Committee conferred in private)

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the information before it today, including the statement dated 30th 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 noet as yet been arrested or charged with any offence. The Committee has taken into account the new material 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.

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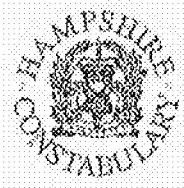

OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

The First Police investigation.

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

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

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

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

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and Code A hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist

  Geoffrey Packman – general physician, gastroenterologist

  Helena Service – general physician, cardiologist

  Elsie Lavender – haematologist

  Sheila Gregory – psychogeriatrician

  Leslie Piltock – general physician/palliative care physician

  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

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

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.
Detective Superintendent 7227
Senior Investigating Officer.
16th January 2007.

FILE COPY

Ian Barker
MDU Legal Department
230 Blackfriars Road
London
SE1 8PJ

Our ref: Code A
Your ref:

3 March 2008

Dear Sirs

General Medical Council - Dr J Barton

Please find enclosed, by way of service, Draft Notice of Hearing in relation to Dr Barton.

Please telephone Tamsin Hall on Code A if you have any queries.

We also enclose, by way of service, the expert reports of Professor Black with regard to Patients Eva Page and Alice Wilkie.

Please note that we have also e-mailed you copies of these reports and do not enclose them with the faxed version of this letter.

Yours faithfully

Field Fisher Waterhouse LLP

FILE COPY

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR JANE BARTON

DRAFT NOTICE OF HEARING

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

Patient A (Leslie Pittock)

2. a) i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

ii) Between 5 and 10 January 1996 you prescribed Oramorphine as well as Diamorphine with a dose range of 40 – 80 mg over a twenty-four hour period to be administered subcutaneously ("SC") on a continuing daily basis,

iii) On 11 January you prescribed Diamorphine with a dose range of 80 – 120 mg and Midazolam with a range of 40 – 80 mg to be administered SC over a twenty-four hour period,

iv) On 15 January a syringe driver was commenced at your direction containing 80 mg Diamorphine and 60 mg Midazolam as well as Hyoscine Hydrobromide,

v) On 17 January the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg,

vi) On 18 January you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

vii) On 20 January you increased the prescription of Nozinan to 100 mg.

b) In relation to your prescriptions described in paragraphs 2a (ii) and 2a (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs.

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

d) Your prescriptions described at paragraphs 2a) vi) and/or vii) in combination with the other drugs already prescribed were excessive to the patient's needs.

e) Your actions in prescribing the drugs as described in paragraphs 2a) ii), iii), iv), v), vi) and/or vii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient A.

Patient B (Elsie Lavender)

3. a) i) Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996,

ii) On 24 February you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day,

iii) On 26 February you increased the prescription for MST and prescribed Diamorphine with a dose range of 80 mg - 160 mgs and Midazolam with a dose range of 40 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

iv) On 5 March you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg – 80 mg over a twenty-four hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg.

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

i) the dose range for Diamorphine on 26 February and on 5 March for Diamorphine and Midazolam was too wide,

ii) the lowest commencing dose on 5 March of 100 mgs Diamorphine was excessive to Patient B's needs,

iii) the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs.

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient B.

d) In relation to your management of Patient B you:

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

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

iii) did not provide a plan of treatment,

iv) did not obtain the advice of a specialist when Patient B's condition deteriorated.

e) Your actions and omissions in relation to your management of patient B were:

i) inadequate,

ii) not in the best interests of Patient B.

Patient C (Eva Page)

4. a) i) On 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

ii) On 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 4a) ii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

c) Your actions in prescribing the drugs described in paragraph 4a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Patient D (Alice Wilkie)

5. a) i) On 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation,

ii) On or before 20 August you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20mg - 80mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs as described in paragraph 5a (ii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

c) Your actions in prescribing the drugs as described in paragraph 5a (ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient D.

Patient E (Gladys Richards)

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

ii) On 11 August you prescribed 10 mg Oramorphine 'prn' (as required),

iii) On 11 August you also prescribed Diamorphine with a dose range of 20 mg - 200 mg and Midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 6a) (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraph 6a) ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

Patient F (Ruby Lake)

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

ii) On 18 August you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required),

iii) On 19 August you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80

mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 7a) (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs.

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

Patient G (Arthur Cunningham)

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

ii) On 21 September 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

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

b) In relation to your prescriptions for drugs described in paragraphs 8a) (ii) and/or (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 8a) (ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient G.

Patient H (Robert Wilson)

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

ii) On 14 October you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

iii) On or before 16 October you prescribed Diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

iv) On or before 17 October you prescribed Midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis.

b) You did not properly assess Patient H upon admission. This was:

i) inadequate,

ii) not in the best interests of Patient H.

c) In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9a (ii) was:

i) inappropriate,

ii) potentially hazardous,

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

iv) not in the best interests of Patient H.

d) In relation to your prescription described in paragraph 9a) iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs.

e) Your actions in prescribing the drugs described in paragraphs 9 ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient H.

Patient I (Enid Spurgin)

10 a) i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii) On 12 April you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

iii) On 12 April a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Reid.

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

i) inadequate,

ii) not in the best interests of Patient I.

c) In relation to your prescription for drugs described in paragraph 10a) ii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs.

d) Your actions in prescribing the drugs described in paragraph 10a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

Patient J (Geoffrey Packman)

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

ii) On 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J,

iii) You saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

iv) You did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

v) On 26 August you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

vi) On 26 August you also prescribed Oramorphine 20 mg at night.

b) In relation to your prescription for drugs described in paragraph 11a) v):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 11a) ii) and/or v) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient J.

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

i) inappropriate,

ii) not in the best interests of Patient J.

Patient K (Elsie Devine)

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

ii) On admission you prescribed Morphine solution 10mg in 5 ml as required,

iii) On 18 and 19 November there was a deterioration in the Patient K's condition and on 16 November you prescribed Fentanyl 25 µg by patch,

iv) On 19 November you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis.

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

c) In relation to your prescription for drugs described in paragraph 12a) iv):

i) the dose range was too wide,

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

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient K.

Records

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

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed and/or directed by you,

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

i) inappropriate,

ii) not in the best interests of your patients.

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

SUMMARY OF CONCLUSIONS

Leslie PITTOCK
DOB: Code A
DOD: 24/01/1997

Mr Leslie Pittock was an 83 year old gentleman with a long recurrent history of severe depression resistant to treatment. This was complicated by drug induced parkinsonism and subsequent mental and physical frailty and dependency. His admission to the Gosport War Memorial Hospital Mental health beds on the 29th November and subsequent transfer to a medical bed on the 5th January 1997 was the end point of these chronic disease process. He continues to deteriorate and dies on the 24th January 1997.

However there were significant failings in the medical care provided to Mr Pittock and also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, M = microfilm notes)

3.1 Mr Leslie Pittock had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In 1979 he had agitation and in 1988 agitated depression.

3.2 He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

3.3 In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam,

Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which looks similar to Parkinson's disease but is actually as a result of long-term anti-psychotic medication).

3.4 On 29th November 1995 he was admitted under the psychiatrist Dr Banks (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

3.5 On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Dr Banks stating "everything is horrible", he was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

3.6 On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin, (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

3.7 On 2nd January 1996 Dr Lord, consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

3.8 On 4th January 1996 Mr Pittock is seen by Dr Lord, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores and hypoproteinaemia. (67). He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Dr Lord also states (5M) "Mrs Pittock is aware of the poor prognosis".

3.9 Medical notes after transfer (13M and 15M). On 5th January a basic summary of the transfer is recorded, no clinical examination is either undertaken or recorded.

On the 9th January increasing anxiety and agitation is noted and the possibility of needing opioids is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with the wife also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Mrs Pittock is

aware of the poor outcome (25M).

3.10 On 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated, (27M) the nursing cardex states that Dr Barton attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

3.11 The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut analgesia continues .... try Nozinan. On 20th January the nursing notes state that Dr Briggs was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M). The medical notes on 21st January state "much more settled", respiratory rate of 6 per minute, not distressed and on 24th January the date of death is verified by Staff Nurse Martin in the medical notes (15M).

Note: Nozinan is a major tranquilliser similar to Chlorpromazine but more sedating. It is usually used for patients with schizophrenia and because of its sedation is not usually used in the elderly, though it is not completely contraindicated. Used subcutaneously in palliative care for nausea and vomiting at a dose of 25 - 200 mgs for 24 hours although British National Formulary states that 5 - 25 mgs for 24 hours can be effective for nausea and vomiting with less sedation.

3.12 Drug Chart Analysis:

On 5th January at transfer (16M), Mr Pittock is written up for the standard drugs that he was on in the mental health ward including his Sertraline and Lithium (for his depression) Diazepam (for his agitation) Thyroxine for his hypothyroidism. The drug chart also had Diamorphine 40 - 80 mgs subcut in 24 hours, Hyoscine 200 - 400 micrograms subcut in 24 hours and Midazolam 20 - 40 mgs subcut in 24 hours. Midazolam 80 mg subcut in 24 hours written up but not dated and never prescribed. (18M)

3.13 On 10th January, Oramorph 10 mgs per 5 mls is written up for 2.5 mls four hourly and prescribed on the evening of 10th and the morning of the 11th. On the 11th Oramorph 10 mgs per 5 mls is written up to be given 2.5 mls 4 hourly 4 times a day with 5 mls to be given last thing at night. This is then given regularly between 11th and up to early morning on 15th January. This is a total daily dose of 30 mgs of Morphine (19M). The Lithium and Sertraline are crossed off after the 10th January.

3.14 Diamorphine 80 - 120 mgs subcut in 24 hours is written up on 11th January "as required" as is Hyoscine 200 - 400 micrograms in 24 hours, Midazolam 40 - 60 mgs in 24 hours. 80 mgs of Diamorphine together with 60 mgs of Midazolam are then started by syringe driver on the morning of the 15th January and re-started on both the mornings of the 16th and 17th January. (18M). On 16th January Haloperidol 5 mgs - 10 mgs subcutaneous for 24 hours is written up, prescribed over 24 hours on both 16th and 17th, I am not clear if this was mixed in the other syringe driver or was the "second pump" referred to in the nursing cardex. (20M and 27M)

Diamorphine 120 mgs subcut in 24 hours is then prescribed on 18th January, together with Hyoscine 600 mgs subcut in 24 hours. The drug charts (20M) show this starting on the morning of 17th January and at 08.30 hours. If this correct there may have been up to three syringe drivers running, one with Diamorphine 80 mgs, one with Diamorphine 120 mgs in and one with the Haloperidol. The reason for this confusion needs clarification, but is possibly a nursing error with the drug chart.

The subsequent drug charts all appear to be missing for the final 6 days, however the nursing notes (27M, 28M and 29) suggest that there was a fairly constant prescription of 120 mgs of Diamorphine 24 hours, Midazolam 80 mgs 24 hours, Hyoscine 1200 mgs, Haloperidol 20 mgs and Nozinan 50 mgs. On the 20th there was no Haloperidol and the Nozinan was increased 100 mgs a day. This is still the prescription on 23rd January (27M).

Drug	Date prescribed	Prescribed as	Prescriber	Given
Oramorphine	10/01	10 mgs in 5 mls 2.5 mls, 4hrly oral Regular	Barton	10/01 2200 11/01 0800 (never crossed out)
Diamorphine	?	40 mgs S/C in 24 hours Regular	Barton	Never given or crossed off
NEW DRUG CHART				
Midazolam	?	20 - 40 mgs S/C in 24 hours Regular	Barton	Never given or crossed off
Diamorphine	11/01	80 – 120 mgs S/C in 24 hours PRN	Barton	15/01 ? 80 mgs 16/01 0815 80 mgs 17/01 ? 80 mgs
Midazolam	11/01	40 – 60 mgs S/C in 24 hours PRN	Barton	15/01 ? 60 mgs 16/01 ? 60 mgs 17/01 ? 60 mgs
Midazolam	? 16/01	80 mgs S/C in 24 hours PRN	Barton	Never given
Oramorphine	11/01	10 mgs in 5 mls Oral 2.5 mls 4 hourly Regular	Barton	Regular doses 4 times a day until 0600 on 15/01 No further doses Not crossed off
Oramorphine	11/01	10 mgs in 5 mls Oral 5 mls nocte	Barton	11/01 – 15/01 2200 No further doses Not crossed off
Diamorphine	18/01	120 mgs S/C in 24 hours	Barton	"17/01" 0830 120 mgs (probably 18/01)

4. TECHNICAL BACKGROUND AND EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Mr Leslie Pittock. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mr Pittock, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 In particular I will discuss a) whether Mr Pittock had become terminally ill and if so whether symptomatic treatment was appropriate and b) whether the treatment provided was then appropriate.

4.3 Mr Pittock has an unfortunate long history of depression, which had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his depressive symptomatology.

4.4 He had many treatments including high levels of drug treatment over many years and many episodes of electro convulsive treatment (ECT).

4.5 The complex and unresolved psychiatric problem led to a requirement to move to a residential accommodation in 1993. However he had further relapses and problems in 1995. A change occurred by September 1995 where the residential home was now noticing weight loss, increasing frailty and falls. Although a subsequent admission only came to the conclusion that he was depressed I have no doubt that his terminal decline was starting from that time.

4.6 By October 1995 he had extremely poor mobility and a shuffling gate. When re-admitted in December is aggressive, essentially immobile and extremely mentally distressed alongside his increasing physical frailty.

4.7 It is impossible in retrospect to be absolutely certain what was causing his physical as well as his mental decline. It may be that he was now developing cerebrovascular disease on top of his long standing drug induced Parkinsonism together with his persistent and profound depression agitation. It is not an uncommon situation for people with long standing mental and attendant physical problems, to enter a period of rapid decline without a single new diagnosis becoming apparent.

4.8 His deterioration is complicated by a probable chest infection (64, 81), which does not respond particularly well to appropriate antibiotic and physiotherapy treatment. He also has bowel complications attendant on all his other medical and drug treatment (116).

4.9 Dr Banks, psychiatric service asked Dr Lord, Consultant Geriatrician, to see the patient on 2nd January and he is actually seen on 4th January 1996. Dr Lord describes a very seriously ill gentleman. His comments that a long-stay bed will be found at the Gosport War Memorial and that he is unlike to return to his residential bed, reflect the fact that it was probably in his mind that this gentleman was probably terminally ill.

4.10 Mr Pittock is then transferred to Dryad Ward and is apparently seen by Dr Barton. A short summary of his problems is written in the notes but no physical examination, if undertaken, is documented. The lack of an examination, or record of an examination, if undertaken, would be poor clinical practice.

4.11 It remains clear from the nursing record that he remains extremely frail with very little oral intake on 7th January (25M). When seen again by Dr Barton on 9th, there is the first note suggesting that Opiates may be an appropriate response to his physical and mental condition.

4.12 It is my view that this gentleman by this stage had come to the end point of a series of mental and physical conditions and that his problems were now irreversible. The decision that he was now terminally ill and for

symptomatic relief seems to have been made appropriately with both the family and the ward staff and there was no disagreement with this decision.

This is indicated in the medical notes by the comment "for TLC" (13M) together with the statement that it was discussed with the wife "for TLC" (note TLC. tender loving care). Beyond the statement in the medical notes that the patient was "for TLC" there is no specific justification given for the Oramorph, in particular, to be started. The notes are at best very sparse making a full assessment of Mr Pittock's mental and physical state extremely difficult. In particular, there is a failure to offer any detailed assessment of the pain, agitation or distress he was in that would allow an objective view on his symptoms and prognosis. The lack of documentation is likely to mean that these detailed assessments did not take place.

4.13 On the 10th Oramorphine was started. Oramorphine and Diamorphine are particularly used for pain in terminal care. The nursing notes document that he had some pain; but most of his problems appeared to be restlessness, agitation and mental distress. However, despite the evidence of serious pain, morphine like drugs are widely used and believed to be useful drugs in supporting patients in the terminal phase of the restlessness and distress that surrounds dying. I would not particularly criticise the use of Oramorphine in conjunction with his other psychiatric medication at this stage. The decision is to stop non-palliative drugs like Sertraline was reasonable.

4.14

In my previous report for the police (31st Jan 2005) I wrote in paragraph 6.14:

"The Drug Chart analysis (para. 5.12) described Diamorphine, Hyoscine and Midazolam all written up to be prescribed with a dosage range. This is quite common clinical practice, the aim of which is to allow the nursing team to have some flexibility in the management of a patient needing symptom control at the end of their life without having to call a doctor to change the drug charts every time a change in dosage is needed to maintain adequate palliation."

As this could be misunderstood I wish to make it clear that this refers to the practice of allowing on the PRN side of the drug chart a small dosage range of a drug to be available for breakthrough pain or distress, as is normal in palliative care practice. It is not to support either (a) writing up large dosage ranges of drugs, or (b) the use of PRN side of the drug chart for prescription for syringe driver, both of which are poor medical practice.

4.15 The dose of Oramorph given from the early morning of 15th January was 30 mgs of morphine a day (see paragraph 3.13) (19M). On the 15th a syringe driver is started containing 80 mgs Diamorphine and 60 mgs of Midazolam. If a straight conversion is being given from Morphine to Diamorphine then you normally as a maximum halve the dose i.e. 30 mgs of Oramorphine might be replaced by 15 mgs of Diamorphine (Wessex protocol). If you are increasing the dose because of breakthrough agitation or pain then it would be normal to increase by 50% each day, some clinicians might increase by 100%. This would suggest that the maximum dose of Diamorphine to replace the stopped Oramorphine would be 30 mgs of Diamorphine in 24 hours. Starting 80 mgs of Diamorphine is approximately three times the usual expected dose. No justification is

provided in the notes for starting at approximately 3 times the dose.

I believe the dose of Oramorph originally prescribed between 11th and 15th January was appropriate if Mr Pittock was terminally ill by that stage. However, no justification is given within the notes for originally writing up the higher than usual doses of Diamorphine and Midazolam on 11th January, the same time as the Oramorph was started, nor indeed is any rationale made in the medical or nursing notes on the decision to commence the syringe driver on the 15th January. This lack of medical documentation is poor clinical practice, and without justification of the dosage used is likely to have been negligent clinical practice. Although the nursing cardex suggests it was Dr Barton's decision to start the syringe driver on the 15th (25M), nothing is recorded in the medical notes.

4.16 Midazolam was also started at a dose of 60 mgs per 24 hours. The main reason for using this is terminal restlessness and it is widely used subcutaneously in doses from 5 - 80 mgs per 24 hours for this purpose. Although 60 mgs is within current guidance, many believe that elderly patients need a lower dose of 5 - 20 mgs per 24 hours. This would again suggest that the patient was being given a higher starting dose of Midazolam then would usually be required for symptom relief. Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly.

The nursing notes documented anxiety, agitation and generalised pain for which the Midazolam and the strong opioids (Oramorph and Diamorphine) were started. Midazolam is often used for the restlessness of terminal care and although Oramorphine and Diamorphine are usually used for severe pain, in clinical practice it is often used as well for the severe restlessness of terminal care. One study of patients on a long stay ward (Wilson J.A et.al. Palliative Medicine 1987;149-153) found that 56% of terminally ill patients on a long-stay ward receive opioid analgesia. Hyoscine is also prescribed in terminal care to deal with excess secretions which can be distressing for both patient and carers. I believe this was appropriately prescribed and given.

4.17 Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Based on the evidence suggesting unusually high dosage of these medications being used I have considered whether there was evidence in the notes of any drug complications, in particular whether giving three times the normal starting dose for both Diamorphine and Midazolam together caused excessive sedation or other side effects that might be considered negligent. I was only able to find two pieces of evidence. The first was a statement in the nursing notes (26M) that by the evening that the syringe driver was started, the patient was unresponsive. The aim of palliative care is to provide symptom relief not possible over sedation leading to unconsciousness. However, this did not continue and Mr Pittock was noted to be more alert and agitated again on the 16th.

Secondly on the 21st January (15M) a respiratory rate of 6 per minute is noted suggesting some possible respiratory depression.

4.18 A further drug, Nozinan, a sedating major tranquilliser is added to the drug regime, 50 mgs a day on the 18th January and increased to 100 mgs a day on the 20th January. Though this is within the therapeutic range in

palliative care, 25 - 200 mgs a day when it is used for nausea and vomiting, the BNF advises 5 - 20 mgs a day and that the drug should be used with care in the elderly because of sedation.

The rationale for starting Nozinan appears to be the fact that the patient had become unsettled on Haloperidol (a different sort of major tranquilizer) and Nozinan is more sedating that Haloperidol. A verbal order to increase the dose of Nozinan from 50 to 100 mgs is documented in the medical notes (M15). This suggests that the 100 mgs was not actually written up within the Drug Charts, which if true, would be poor clinical practice. The absence of the drug charts makes this harder to determine.

4.19 The prediction of how long a terminally ill patient would live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Constantini M. Accuracy of Prognosis Estimates by 4 Palliative Care Teams: A prospective cohort study. BMC Palliative Care 2002 1:21). The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation beyond the need the symptom control in this dying man. In my view the medication is likely, but not beyond reasonable doubt, to have shortened life. However, I would have expected this to have been by no more than hours to a few days had a lower dose of all, or indeed any, of the drugs been used instead.

5. OPINION

5.1 Mr Leslie Pittock was an 83 year old gentleman with a long recurrent history of severe depression resistant to treatment. This was complicated by drug induced parkinsonism and subsequent mental and physical frailty and dependency. His admission to the Gosport War Memorial Hospital Mental health beds on the 29th November and subsequent transfer to a medical bed on the 5th January 1997 was the end point of these chronic disease process. He continues to deteriorate and dies on the 24th January 1997.

5.2 However there were significant failings in the medical care provided to Mr Pittock, in particular:

- The failure to undertake a physical examination of the patient on admission to the medical ward at the Gosport War Memorial Hospital, or if it was undertaken, the failure to record in the notes.

- The prescription of a high dose of Diamorphine (40 – 80 mgs) on the PRN part of the drug char ton admission, without explanation.

- The failure to document a detailed assessment of his pain and distress in the notes prior to starting regular opioid treatment.

- The use of approximately 3 times the usual expected daily dose of Diamorphine when starting the syringe driver, together with a dose of 60 mgs of Midazolam, without any explanation in the notes, in my view negligent clinical practice.

5.3 There were also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The failure to cross off the regular prescription of Oramorphine and Diamorphine when rewritten on the 11th January and on the 15th January.

- The use of the PRN side of the drug chart to write up regular syringe driver medication for PRN use.

- The failure to date several prescriptions.

- Inaccurate information on the drug chart for the prescription of the Diamorphine on the 18th January.

- The failure to write dosages of controlled drugs in words and figures as well as total dosages given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which 1 have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, 1 have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. 1 will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. 1 understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:, _____, Date: _____

SUMMARY OF CONCLUSIONS

Elsie LAVENDER
DOB: Code A
Died: 06/03/96

Mrs Elsie Lavender was an 83 year-old lady admitted to the Haslar Hospital on 5th February 1996 following a fall and then transferred to Gosport War Memorial Hospital on 26th February 1996. She had long-standing problems with diabetes, a peripheral neuropathy, poor eyesight and registered blind. After admission she is found to be doubly incontinent, totally dependent with a probable quadriplegia, constant pains down her shoulders and arms and is found to have serious and unexplained abnormalities in various blood tests.

In the Gosport War Memorial Hospital, she fails to make any improvement, deteriorates with a bed sore that eventually becomes black and blistered. She receives pain relief and palliation for her deteriorating physical condition including subcutaneous Diamorphine and Midazolam and dies on 6th March 1996.

The expert opinion is:

> Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.
>
> There are particular significant concerns about the medical management in the Gosport War Memorial Hospital, and significant failings in the use of the drug charts at Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

3.1 The Gosport notes record that Mrs Lavender was an insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73). Her weight in 1988 is 85 kgs (73) and in 1987 her weight is 89 kgs (77). By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

3.2 Elsie Lavender was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H23). She apparently goes out once a week with her son and is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Tandy actually sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain, brain stem or spinal cord somewhere above the thoracic spine.

Dr Tandy records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167). I was unable to find any x-ray request recorded in the notes for a cervical spine, nor any reports of an x-ray of a cervical spine or indeed reports on the x-rays that were recorded as being requested (i.e. the skull and shoulder x-rays).

Dr Tandy notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that he will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or other problems with the raised alkaline phosphatase potentially coming from a fracture.

Dr Tandy's letter says Mrs Lavender will be transferred for rehabilitation as soon as possible although his written notes say that "I'm not sure she will be able to get back home, but we'll try." She is transferred on the 22nd February 1996 to the Gosport War Memorial Hospital.

On the 20th February Mrs Lavender is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

3.3 Mrs Lavender is transferred on the 22nd February 1996 to the GWMH. The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no apparent examination of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to

hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on assessment, then continually leaks faeces throughout her admission (119).

3.4 Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

3.5 Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

3.6 An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

3.7 Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, Dr Barton records that the patient is not so well, also that Mrs Lavender's "bottom was very sore needs Pegasus mattress institute, S/C analgesia if necessary". The family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

3.8 The medical notes on 5th March say "deteriorated over the last few days..., in some pain, therefore start subcutaneous analgesia." On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

3.9 The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97). On 6th March pain is controlled.

3.10 **Drug management in Gosport.** I shall concentrate on the use of analgesia. Throughout the patient received appropriate doses of insulin, Co-amilofruse (a diuretic), Digoxin, Iron and steroid inhalers up unto the last twelve hours. She also received a course of Trimethoprim (an antibiotic) between 23rd and 27th February.

3.11 Morphine slow release (MST) (67M)was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145)is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

3.12 When admitted into hospital Dihydrocodeine PRN for pain had been written up together Hyoscine. Diamorphine 80 – 160 mgs subcut in 24 hours was written up on 26th February together with Midazolam 40 – 80 mgs in 24 hours subcut, but these drugs were never prescribed (141).

3.13 The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

Drug	Date prescribed	Prescribed as	Prescriber	Given	
Dihydrocodeine	22/02	TT oral Qds, PRN	Barton	22/02 – 24/02 03/03	
Diamorphine	26/02	80 – 160 mgs S/C in 24 hours PRN	Barton	-	
Midazolam	26/02	40 – 80 mgs S/C in 24 hours PRN	Barton	-	
MST	24/02	10 mgs oral b.d Regular	Barton	24/02 25/02 26/02	2 doses 2 doses am only
MST	Probably 26/02	20 mgs oral b.d Regular	Barton	26/02 27/02 28/02 29/02 01/03 02/03 03/03	pm dose 2 doses 2 doses 1 dose 2 doses 2 doses 2 doses
NEW PRESCRIPTION CHART					
Oramorphine SR Tablets and MST (in	04/03	30 mgs oral b.d Regular	Barton	04/03 05/03	2 doses not given but prescription not

same prescription box)				crossed out.		
Diamorphine	05/03	100 – 200 mgs S/C in 24 hours Regular	Barton	05/03 06/03	0830 0845	100 mgs 100 mgs
Midazolam	05/03	40 – 80 mgs S/C in 24 hours Regular	Barton	05/03 06/03	0830 0845	40 mgs 40 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Elsie Lavender. Also whether there were any actions or admissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Lavender, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 In particular I have discussed:
a) Her medical conditions
b) Whether she had become terminally ill during her admission
c) Whether the treatment that was then provided was appropriate.

4.3 Mrs Lavender had a number of serious underlying medical conditions. The most serious of which was her insulin dependent diabetes mellitus going back to the 1940's complicated by hypoglycaemia's, which had led, to falls on previous occasions, peripheral neuropathy which may also contribute to falls and with a combination of diabetes and other processes she had become registered blind. She also had documented frailty prior to admission, for example, already having moved her bed downstairs with an exercise tolerance of 10 yards with a stick. Her son was documented to do her shopping (11). However, she was still living alone, was only documented to have stress incontinence (11) and was cognitively intact (MTS 10/10) (165).

4.4 She was then admitted to Haslar Hospital having had a fall, which was from the top to the bottom of the stairs. No explanation is given as to how she was at the top of the stairs, if she was already set up with her bed downstairs at home. Following this she is documented both at the assessment at Haslar Hospital and then on admission to Gosport Hospital as being severely dependent. She cannot use her arms properly, her hands and wrists are noted to be weak and she cannot stand and walk, she is so incontinent she needs a catheter and she has continual faecal leakage. Barthel is 4/10. I believe this lady was misdiagnosed and had quadriplegia from a high cervical Spinal cord injury secondary to her fall. This diagnosis appears to have been missed by all the doctors who saw her. Although the A&E notes in Haslar state

"cervical spine normal" (H18), presumably on clinical, not x-ray, grounds. Also Dr Tandy mistakenly believes she had her neck x-rayed and it was normal (H163). No-one checks this statement is correct.

4.5 Other on-going serious medical problems have also not been explained. She has a documented low platelet count on admission to Gosport, which on repeat is extremely low and at a level that makes life threatening bleeding at any time quite probable. The blood film is also highly abnormal which suggests that there is now some systemic illness going on, probably involving this lady's bone marrow. In the absence of infection or a likely drug culprit, then cancer involving the bone marrow would be a possibility. She also has a very rapidly rising alkaline phosphatase, which suggests either liver, or bone pathology. No other information is now available that would help me clarify this further.

I would have expected that these very abnormal blood tests would have been reviewed and commented on by the doctor in charge of the case. There is no point in undertaking investigations if the results are ignored. The blood results appear to be complex to interpret and I would have expected a clinical assistant or General Practitioner to have taken advice from the consultant in charge of the case as to their relevance and whether further action was required. If further discussion did take place or the results were properly looked at, this is simply not recorded in the notes.

4.6 Other evidence that this lady was frail and ill is provided by the pressure sore which appears to deteriorate during admission and a low albumin documented on admission.

4.7 In my view this lady received a negligent medical assessment in both Haslar and Gosport. In particular the cervical spine xrays, if undertaken, were not checked or reported in Haslar, she was not examined on admission to Gosport, or if she was it was not documented in the notes. Thus no medical explanation beyond the "possible brain stem CVA" is made. This would not explain all her physical symptoms, or her profound neurological deficit. Also no medical diagnosis was made for pain that she continually complained of down her arms, which again would fit with a high cervical Spinal cord fracture or similar injury. Also, no attempt was made to determine why this lady had a very low platelet count and rising alkaline phosphatase. Without making an adequate medical assessment it is impossible to plan appropriate management. The lack of an adequate medical assessment and adequate documentation make it very difficult to be certain as to what treatment should normally have been given.

4.8 There can be no doubt though that the family, Dr Barton and the nursing staff all recognised this lady was seriously ill. Although the doctors fail to come to a diagnosis and therefore could not determine whether there was any treatable underlying problem. Evidence for this is that there was already discussion, within 2 days of admission, with the family about prognosis for recovery and how best to manage her illness. A syringe driver was already being discussed with the family on 24th February. Indeed all the markers of illness I have found, suggest this lady was very seriously ill.

4.9 Even if a high cervical Spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in an elderly lady with diabetes is low and treatment with prolonged immobilisation has a very high mortality rate in itself. The unexplained low platelet count also suggests other significant serious pathology, which was never diagnosed, more complex in a patient who needing all care with leg ulcers and pressure sores. In my view, there were only two options by 24th February, **a)** to get a further specialist opinion or **b)** treat symptomatically and provide palliative care.

4.10 In view of the complexity of the medical problems, it would have been wise and appropriate to have obtained a further specialist opinion, probably from the consultant in charge of the case before deciding this lady was definitely terminally ill. I can see no evidence in the notes that this was considered.

It was appropriate though to provide pain relief for someone who was both in pain and distressed with loss of totally bodily function. To start MST at a normal low dose on the 24th February was appropriate.

4.11 If the pain was not resolved, increasing the dose to 20 mgs bd on both the 26th February adding the Oramorph 30 mgs bd on 4th March were all appropriate symptomatic responses.

4.12 An unusually large dose of Diamorphine (80 – 160 mgs subcut in 24 hours) is written up on the 26th February on the PRN section of the drug chart. Midazolam 40 - 80 mgs subcut is also written up PRN. Although never given, there is no justification in the notes for why such an apparently large dose of Diamorphine was written to be given if needed.

4.13 I have little doubt this lady was moving to a terminal phase of her illness by the 5th March. There had been no improvement in her quadriplegia, she remained faecally incontinent, the nursing cardex documents increasing pain, her platelet count has fallen further and her urea has doubled to 14.6 (187). At this stage a decision to start Diamorphine 100 mgs once a day subcutaneously and 40 mgs once a day Midazolam is

made.

4.14 Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 40 mgs for 24 hours, which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours. (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th Edition 2003).

4.15 The Diamorphine was specifically prescribed for pain and is commonly used for pain in terminal care, Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. The dose of Diamorphine actually prescribed was 100 mgs in 24 hours. At that time Mrs Lavender was receiving 60 mgs a day of Oramorphine. Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. up to 30 mgs of Diamorphine in 24 hours for 60 mgs of Oramorphine). (Wessex Guidelines). However if her pain was not controlled and it would be appropriate to give a higher dose of the Diamorphine. Conventionally this would be 50% greater than the previous days; (Wessex Guidelines) some clinicians might give up to 100%. Thus a starting dose of Diamorphine of 45 – 60 mgs in 24 hours would seem appropriate. Mrs Lavender actually was prescribed a dose of 100 mgs of Diamorphine, in my view excessive.

4.16 Diamorphine is compatible with Midazolam and can be used in the same syringe driver. It is documented above though that she received a significant dose of Midazolam and an excessive, and in my view, inappropriately large dose of Diamorphine. Together these drugs are likely to have caused excessive sedation and respiratory depression. However there is no evidence in the notes to prove these complications occurred.

4.17 Mrs Lavender is documented to be comfortable on the 6th and dies approximately 36 hours after the Midazolam and Diamorphine pumps were started.

The prediction of how long a terminally ill patient will live is virtually impossible and even Palliative Care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

4.18 The doses of Diamorphine used, in conjunction with a significant dose of Midazolam, was in my opinion excessively high. However, I can not find evidence to satisfy myself the standard of "beyond reasonable doubt", they had the definite effect of shortening her life in more than a minor

fashion of a few hours to a few days.

5. OPINION

5.1 Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

5.2 There are significant concerns about the medical management of Mrs Lavender, in particular:

- The failure of doctors in both Haslar and Gosport to consider other possible neurological causes for her problems or to obtain expert neurological advice.
- The failure of doctors in Haslar to follow up the reports on the Cervical Spine xrays, if they were actually undertaken.
- The failure to examine or record the examinations of Mrs Lavender on admission to the Gosport War Memorial Hospital, and therefore missing the opportunities to review her diagnoses.
- The failure to consider the implications of abnormal blood tests requested in the Gosport War Memorial Hospital.
- The failure of Dr Barton to get further advice from her consultant on the 24th February.
- The prescription of a large range and a very large minimum dose of Diamorphine (80 mgs) on the PRN side of the drug chart on the 26th February.
- The lack of a through recorded assessment of pain before starting regular strong opioid analgesia or the syringe driver (see generic report).
- The use of Diamorphine at a dose of 100 mgs in 24 hours on the 5th March , in my view an excessive dose.

5.3 There are also significant failings in the use of the drug chart at Gosport War Memorial Hospital, in particular:

- The failure to cross out the regular prescription of MST when replaced by other medication.
- The prescription of a large range of controlled drugs on both the PRN and regular sides of the drug chart (see generic report).
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

Eva PAGE
DOB: Code A
Died: 03/03/1998

SUMMARY OF CONCLUSIONS

Mrs Eva Page, an elderly lady who was admitted to Queen Alexander Hospital in February 1998. She was subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

The use of the drug chart in the Gosport War Memorial Hospital was seriously deficient.

There is inadequate documentation of clinical review of the patient in particular on 3rd March and inadequate documentation regarding decision making to start the syringe driver. This represents poor medical practice.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

3.1. Eva Page was an 88 year old lady at the time of her final admission to hospital on 6th February 1988.

3.2. She lived in a residential home for a number of years and was reported as being independent in 1995 (32). During 1995 she had been admitted to hospital with chest pain (28) left ventricular failure in atrial fibrillation (22) and Digixon toxicity (14). At the time of her

admission with Digixon toxicity she had also been noted to have a transient impairment of renal function (14).

3.3. Eva Page was admitted to hospital on the 30th March 1997 (10) with confusion, right sided weakness and a probable dysphasia caused by a probable stroke (90) (112), however she improved rapidly and her comprehension was good and she was much less confused by the time of her discharge back to her residential home on 6th May 1997 (116).

3.4. The next documented hospital admission was 6th February 1998 when she was admitted to Victory Ward from home (157) (medical notes 246). The notes document that she had several days of rapid deterioration but she had been depressed for the last few weeks, increasingly withdrawn and had been started on Sertraline, an anti-depressant (246). Investigations showed a modestly raised urea of 8.4 (247), a low albumin of 30 (247) and a white cell count of 13.

3.5. Further investigations showed an abnormal chest x-ray that was thought to be a very suspicion of a carcinoma of bronchus (248) confirmed by an x-ray report (240). A decision is made not to bronchoscope her (249) and on 15th February there is a discussion with the son about the diagnosis (249). She has a documented fall on the ward (250) and the medical notes confirm her continued confusion. There is a good summary in the notes on 19th February (252) confirming that she is sleepy but responsive, incontinent of urine and faeces and has a low MTS (252-3).

3.6. On 25th February she is confused with some agitation (254) and the medical notes document that she has started on Thioridazine because of her anxiety and distress.

3.7. The nursing notes confirm her rapid physical decline during her time after admission. Her Barthel falls from 13 on admission to only 4 on 23rd February (162). Her Waterlow score also rises from 11 to 20 on 21st February (164). She has very little food intake during her admission (204-217). There is continual evidence from the nursing notes of anxiety, fear and variable confusion (180, 183, 184). She is catheterised, leaking faeces, frightened and agitated on 23rd February (189).

3.8. On 27th February she is transferred to Dryad Ward (254). The notes document her diagnosis of Ca Bronchus made on a chest x-ray on admission; she is generally unwell and off legs; and needs help with eating and drinking, and has a Barthel of 0. The notes also state that the family have been seen and are aware of prognosis and that Dr

Barton is happy for the nursing staff to confirm death (255). Needs hoisting and opiates commenced.

3.9. On 28th February (255), Mrs Page is confused, agitated particularly at night but not in pain. Medical notes say for regular Thioridazine (412). The next medical notes are 2nd March: there has been "no improvement on the major tranquilisers. I suggest adequate opiates to control fear and pain". A further note on 2nd March by a different doctor says "spitting out Thioridazine, quieter – now on sub-cut Oramorphine". "Fentanyl patch started today. Agitated and calling out even when staff present". "Diagnosed carcinoma bronchus ?Cerebral metastases". Continue Fentanyl patches. The son is seen. The next note in the medical section is on 3rd March and states the patient continues to deteriorate and died peacefully at 2130 hours. Death verified and signed by the staff nurse.

3.10. Drug Cardex. The drug chart before transfer to the Gosport War Memorial Hospital (234) shows that Thioridazine 10mgs was given 3 times a day on 25th and 26th February.

3.11. The drug chart at Dryad (222-224) demonstrates that on the once only prescription side that Diamorphine 5mgs was given at 0800 and 1500 mgs – date not visible on photocopies. On the PRN part of the drug chart Thioridazine 25mgs sub-cut is written up on 27th February and prescribed on 28th February at 1300. Oramorphine 10 mgs of 10ml is written up on 27th February and a single dose of 5mgs given on 28th February. Fentanyl patch 25 mgs is written up on 2nd March and prescribed once on 2nd March at 0800. There is no documentation if this ever removed.

3.12. On the regular side of the drug chart, Digoxin, Frusemide, Ramipril, Sotalol and Sertraline are written up and then crossed off and never given. Thioridazine is written up on 28th February and prescribed twice a day on 1st and 2nd March. Heminevrin is written up on 28th February and given once in the evening on 28 February and once on 1st March. Diamorphine 20-200 mgs sub-cut in 24 hours is prescribed on the regular prescription part of the drug chart which has been crossed out and PRN written. Hyoscine 200-800 mcgs in 24 hours and Midazolam 20-80 mgs sub-cut in 24 hours are also written up in the same way. I could not identify which day these prescriptions were written but 20 mgs of Diamorphine with 20mgs of Midazolam were both started in a syringe driver at 1050 am on 3rd March.

3.13. All the prescribing of opiates on Dryad Ward appear to be in Dr Barton's handwriting.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 5mg	? Date	Once only	BARTON	0800 am ? date 1520 am ? date
Thioridazine 25mg	27th February	PRN	BARTON	1300 am 28th Feb
Oramorphine 10 mgs in 10 mls	27th February	PRN	BARTON	5mg 28th Feb
Fentanyl 25mgs x 5 days	2nd March	PRN	BARTON	0800 am 2nd March
Diamorphine 20 – 200 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March
Midazolam 20 – 80 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Eva Page, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Page was an elderly frail lady with multiple pathology having documented evidence of cardiac and cerebro vascular disease with intermittent confusion diagnosed previously.

4.3. The final admission seems to have been preceded by fairly rapid physical decline. The diagnosis of probable carcinoma of the lung was made on radiological grounds on her admission to the Victory Ward. This was an appropriate diagnosis and would explain her rapid physical decline. A decision was made not to bronchoscope which would have been extremely difficult and an unlikely to have changed management in any way. This was also appropriate.

4.4. The nursing cardex and medical notes confirm her rapid physical and mental deterioration after admission. The objective evidence from both her decreasing Barthel, increasing Waterlow dependency and her rapidly falling albumin are all signs of a rapidly deteriorating condition, and compatible with a diagnosis of carcinoma of lung.

4.5. Although it is not specifically mentioned in the medical notes it is clearly documented in the nurses' notes that before transfer the she is for palliative care (at 157).

4.6. It was decided to transfer to the Gosport War Memorial Hospital to be nearer her son. There is a good summary of her problems written in the notes shortly prior to transfer (252).

4.7. On admission to Dryad Ward there is a very basic summary of the condition and dependency of Mrs Page but in view of the clear understanding that she was for palliative care and the good summary in the notes just prior to transfer I do not think that this was an unreasonable summary.

4.8. During her stay in the Queen Alexander Hospital and the Gosport War Memorial Hospital she continues to be frightened, agitated and confused. She is started on a major tranquiliser (Thioridazine) before transfer and this continued after transfer. The continued notes on 2nd March suggests that this drug management regime which then included Heminevrin was not being successful. All these symptoms are compatible with someone rapidly deteriating with carcinoma of lung, and probably also indicate mild delirium. A psycogeriatric opinion would not be needed in these circumstances.

4.9. The medical notes on the 27th February (254) state that opiates have been commenced but it is not clear though from the drug chart what this is referring to unless she received two doses of Diamorphine on the 27th, however, the photocopy is inadequate (222) to determine if this was the case. She receives a single dose of 5mg Oramorphine on 28th February and the next opiate

documented in the drug chart is the Fentanyl patch on 2nd March (222).

4.10. There is no doubt in my mind that this lady was rapidly deteriorating and dying and that in view of her failure to get adequate palliation from a regular major tranquiliser for her continued distress and agitation that it was appropriate to start a regular opiate by a syringe driver. It was also evident that she was not able to take her tablets orally (255).

4.11. Clinically it is slightly surprising that she was started with Fentanyl as this is likely to take 24 hours to have a maximal affect and that it might have been more clinically appropriate to start a syringe driver on 2nd March.

4.12. Diamorphine 20mgs in 24 hours and Midazolam 20mg in 24 hours was then started on 3rd March. It is not clear if the patient was seen by a doctor on 3rd March. It is not clear when the prescription was written up and if the decision to start Diamorphine and Midazolam on 3rd March was a medical or nursing decision. It is also not clear from the notes whether the Fentanyl patch was removed. 20mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 10mgs every 4 hours. In my opinion this would be high but not an unreasonable dose in somebody where there was a good reason to start an opiate and there had been an inadequate response to the Fentanyl in the previous 24 hours. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 – 80 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people but particularly the most frail.

4.13. In my view a dose of Diamorphine and Midazolam was on the high side but within written clinical guidelines such as the British National Formulary. However, if the Fentanyl patch was continued there would have been a risk of over sedation for example causing unnecessary respiratory depression. The medical notes are inadequate to make an assessment as to whether the doses that were given were appropriate to her condition or excessive.

5. OPINION

5.1. Mrs Eva Page, an an 88 year old lady was admitted to Queen Alexander Hospital in February 1998 subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost

certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

5.2. Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

5.3. The use of drug charts in The Gosport War Memorial Hospital is seriously deficient. In particular:

- The use of the regular side of the drug chart for a PRN prescription.
- The prescription of a large range of controlled drugs (in particular diamorphine) on a PRN basis.
- The failure to write dosages in words and figures as well as total dosages to be given.

5.4. There is inadequate documentation of medical review of the patient. In particular:

- The failure to record who made the final decision to start the syringe driver on the 3rd of March.
- The failure to record the clinical condition of the patient that led to that decision.
- The failure to document how the final starting dose of the drugs in the syringe driver was made, in particular why the dose used was chosen.
- The failure to record in the medical or nursing notes if the Fentanyl patch was removed or the reason for not removing it.
- The failure to document relevant medical or nursing assessments to check on possible side effects (for example oversedation) with the high starting dose of both Diamorphine and Midazolam used.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

Alice WILKIE
DOB: Code A
Died: 21/08/1998

SUMMARY OF CONCLUSIONS

Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence except for two unnumbered pages which are referred to as UN).

3.1. Alice Wilkie was a 92 year old lady at the time of her death in the Gosport War Memorial Hospital on 21st August 1998.

3.2. Alice Wilkie's main problem was progressive dementia presumably of the Alzheimer's type. In 1992 her dementia was already known (243) and she was having problems with wandering (164). She started to

have respite care for her dementing illness in 1994 (189). Depixol was already started in 1995 (186). By 1996 she was having problems with aggressive behaviour (201) and was subsequently started on Carbamezepine as well as her major tranquilisers to help try and manage her behavioural problems (207). Eventually she ended up in a specialist psychiatric residential home by the summer of 1997. As she continued to have regular Depixol injections through 1998 although on 21st July the dose was reduced because of reported sleepiness (221). This appeared to be her last dose of Depixol, which was subsequently withdrawn by the psycho-geriatric team on 6th August (222). This was as a result of a visit by the community psychiatric nurse, part of the psycho-geriatric team, who saw the patient on Daedalus Ward. The psycho-geriatric team also either saw the patient or contacted the ward on 12th August (222).

3.3. From a medical as opposed to psychiatric perspective there had been a number of problems including rectal bleeding in 1993 and 1994 and known diabetes, controlled by diet since at least 1995 (381). She had a previous pneumonectomy many years before for possible tuberculosis. In 1995 she had problems with an oesophageal stricture (201) and was put on long term Omeperazole.

3.4. On 31st July 1998 she was admitted as an emergency to the Queen Alexander Hospital. The letter from the admitting GP (69) states that she had had a urinary tract infection and had fallen the night before and was now refusing fluids. Medical clerking (85-86) notes that Mrs Wilkie was pyrexial but there were no other specific abnormalities apart from conjunctivitis noted on examination. The diagnosis was of a urinary tract infection which had not responded to oral antibiotics.

3.5. Various investigations are undertaken but her blood tests are normal (87) and a sample of urine from her catheter grows nothing (101). Her blood glucose is appropriately requested, she is thought to be diabetic but was never measured or reported (91). She is known to have a long term catheter (24, 86). There is no biochemical evidence of dehydration with a normal sodium urea and creatinine (91).

3.6. The nursing notes also document her admission pyrexia and undertake a nutritional assessment which show that she is at high risk (33, 34). She is also noted to be almost completely dependent with a Barthel score of 1 on 31st July and a 2 on 5th August (22). The temperature chart shows that she becomes apyrexial by 1st August (39).

3.7. On the 3rd August she is apyrexial and is on subcutaneous fluids but had 500 mls of oral intake the previous day. The plan was to stop the subcutaneous fluids (88).

3.8. The nursing notes demonstrate that she has settled by 1st August (24) and also comments that she is sleeping well on 3rd August (23).

3.9. The next medical notes are on the unnumbered sheets where Alice Wilkie is seen by a consultant, Dr Lord on 4th August. However, this history sheet is marked GWM. It is difficult to be certain but I assume this was added when the patient was transferred to the Gosport War Memorial Hospital on 6th August because Mrs Wilkie must have been seen on 4th August in the Queen Alexander Hospital.

3.10. Dr Lord refers as diagnosis – see problem sheet, I believe this is the sheet (83) which summarises the problems as dementia, urinary tract infection, dehydration and catheterised. Dr Lord's notes summarise the very severe dementia and dependency and the current functional status. The plan is then made to continue the oral antibiotic, to continue the subcutaneous fluids (although it had already been decided the day before to stop these) (88) and states the overall prognosis as poor and that Mrs Wilkie is now too dependent to return to her residential home. She is therefore to be transferred to Deadalus Ward for continuing care, observation and possible placement, although she does ask that her bed is kept at the residential home for a further period. Dr Lord confirms the do not resuscitate status of Mrs Wilkie (UN) previously made by the medical team in the Queen Alexander Hospital (88).

3.11. Mrs Wilkie is transferred on 6th August. There is a very brief note in the medical notes that she is to continue the Augmentin. There is no evidence that she is on subcutaneous fluids at that time or that any subcutaneous fluids are given at the Gosport War Memorial Hospital.

3.12. On 10th August, the consultant, Dr Lord reviews Mrs Wilkie and notes that she has improved a little and that she is now eating and drinking better but remains very confused and highly dependent. The request is that the residential place is given up, and a plan is made to review in a month's time the possibility of a long term nursing home placement.

3.13. The next medical note is on 21st August in Dr Barton's handwriting which states marked deterioration over the last few days. Subcutaneous analgesia commenced yesterday, family aware and happy. Someone has written in a different handwriting "syringe driver" on the photocopied page.

3.14. The final note is on 21st August at 1830 where charge nurse confirms death. The family were present.

3.15. Nursing notes at the Gosport War Memorial state that on admission that she is for assessment and observation (115) and document that she has a Waterlow score of 15 on admission which is high risk (123) and "does have pain at times" (117). Although the signature is unreadable in the medical notes, the nursing contact record (125) confirms that it was a Dr Peter who admitted Mrs Wilkie into the Gosport War Memorial Hospital on 6th August. The contact record also states that on 17th August that her condition has generally deteriorated over the weekend, the daughter seen and aware that mum's condition is worsening, agrees active treatment not appropriate and to use syringe driver. Mrs Wilkie is in pain. The notes also comment that there is some food and fluid intake up until 18th August (129).

3.16. There is a single drug chart (57-64) that goes from her admission on 31st July to 21st August.

3.17. The PRN side, a Promazine syrup 25mgs orally is prescribed as is magnesium hydroxide neither of which are given. Haloperidol 2.5 – 10 mgs subcutaneously is also prescribed and single dose of 2.5 mgs is given at 2045 on 1st August in the Queen Alexander Hospital.

3.18. Regular prescriptions of Prozac, Co-danthramer, Zopiclone, Lactulose and Augmentin are written up. Zopiclone and Co-danthramer certainly continue until 15th August and the Augmentin until 9th August.

3.19. Diamorphine 20 – 200 mgs subcut in 24 hours is written up on the daily review prescriptions part of the drug chart together with Hyoscine 20 – 80 micrograms subcut in 24 hours and Midazolam 20 – 80 mgs subcut in 24 hours although there is nothing to say which days the prescriptions was written up. However, Diamorphine 30 mgs and Midazolam 20 mgs appear to have both been started at 1350 in a syringe driver on 20th August and the same does re-prescribed on 21st August.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 20 – 200 mgs	No date	Daily review prescriptions	BARTON	30 mgs 20/08 30 mgs 21/08
Midazolam 20 – 80 mg	No date	Daily review prescriptions	BARTON	20 mgs 20/08 20 mgs 21/08

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Alice Wilkie, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Wilkie was a very elderly lady with severe end-stage Alzheimer's disease. This disease is documented in the notes for at least 6 years with increasing behavioural problems requiring both pharmacological intervention and specialist residential care.

4.3. She also had a number of medical problems in particular her oesophageal stricture and diabetes although this diagnosis was completely ignored in her final admission. Although her admission to Queen Alexander is presented as an acute UTI there had probably been a longer period of deterioration. The GP's letter documents weight loss and her dose of Depixol had been reduced 10 days earlier because of sleepiness. However, there is no doubt she was pyrexial on admission and her condition had significantly deteriorated to the point where she could not be managed in the residential home.

4.4. She was appropriately investigated and treated with antibiotics and subcutaneous fluids in the Queen Alexander Hospital and becomes apyrexial. She is seen by a consultant Geriatrician who makes an adequate assessment and arranges for Mrs Wilkie to be transferred to the Gosport War Memorial Hospital for a period of observation to determine a final outcome.

4.5. The consultant states the prognosis is poor, this usually means that the expected outcome is the patient is not going to leave

hospital and really is in the terminal phase of their illness. Although it is quite appropriate to have a plan that should that not be the case a long term nursing placement might be needed as she was not far too dependent to return to her residential home. I believe this was all appropriate management.

4.6. The patient is transferred to Gosport War Memorial on 6th August and the admission clerking is unacceptably brief. Indeed it is not clear the admitting doctor, a Dr Peter saw the patient although the nursing cardex does refer to "clerked in". It is impossible from the notes to make a judgement of the clinical status of Mrs Wilkie on arrival.

4.7. However, she is reviewed by Dr Lord on 10th August who does an assessment and this would suggest that she is now clinically stable as Dr Lord remarks "eating and drinking better". The plan is to review progress in a month's time.

4.8. There is nothing further in the medical notes until the day of her death, the 21st August which states a marked deterioration over the last few days. Her syringe driver had been started the day before.

4.9. There are clues in the nursing records that deterioration must have started several days before, for example in the contact record on 17th August (125) states her condition has generally deteriorated over the weekend, however, there is no evidence at all that this lady was seen by the medical staff, or if they did, no record has been written in the notes. However, it is also impossible to tell from the notes whether the nursing staff informed the medical staff that there had been any change in condition.

4.10. A syringe driver is started on 20th August. There is absolutely no documentation as to the clinical reason to do this. There is one comment in the nursing notes about pain at times (117) but no evidence from the drug chart of any other analgesia apart from the syringe driver is needed or used. In my view the failure to document any medical reasons for her deterioration or why she was started on a syringe driver is unacceptable medical practice. I cannot exclude the possibility that she needed symptom palliation during her last few days but there is no evidence that I can find in the medical or nursing notes to justify use of the syringe driver.

4.11. Diamorphine 30 mgs in 24 hours and Midazolam 20 mgs in 24 hours were started on 20th August. The prescriptions are not dated so it is impossible to tell when they were originally written, it is also impossible to tell who made the final decision to start the Diamorphine on 20th August or indeed who chose the starting dose of 30 mgs when 20 mgs was the lowest dosed prescribed.

4.12. 30 mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 15 mgs every 4 hours. In my view this is an unnecessarily high dose for someone who has received no previous opiate analgesia or indeed any other analgesia. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5-20 mgs in older people, in particularly the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and a high dose of Diamorphine were required in this patient. In my view the doses of Diamorphine and Midazolam were unacceptably high as a starting dose from the evidence available in the notes. There would have been a very significant risk of over sedation, for example causing respiratory depression, impaired conciousness and a possibility of shortening her life by some hours or days.

5. OPINION

5.1. Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

5.2. Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

5.3. The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical assessment on admission.
- The lack of any medical records after 10th August until the day of her death.
- The lack of any description of why she was deteriorating sometime after 10th August.
- The failure to explain why a syringe driver was required for symptom control.

- The lack of any written justification of the doses of Diamorphine and Midazolam actually used in the syringe driver.
- Any observations to look for possible side effects of the high doses of Diamorphine and Midazolam used.
- Inability to tell from the notes who made the final decision to start the syringe driver and the dose to be used.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient. In particular:

- The prescription of a large range of a controlled drug (in particular, Diamorphine) in the "daily review prescriptions" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.
- The failure to date the prescriptions of Diamorphine, Hyoscine and Midazolam.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS

Gladys RICHARDS
DOB: Code A
DOD: 21/08/1998

Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

However there were significant failings in the medical care provided to Gladys Richards as well as deficiencies in the use of the drug chart at the Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes).

3.1 Gladys Richards was a 91 year old lady and in 1998 was admitted as an emergency on 29th July 1988 to the Haslar Hospital (H39).

3.2 She had had a progressive dementing illness documented as short term memory loss in 1988 (435), a mental test score of 4/10 in 1994 (443) and a mental test score of 0/10 in 1996 (451). She was admitted to the Glen Heathers Nursing Home in 1994 (202) and was moderately dependent with a Barthel of 11/20 at that time (200). She was seen by a psycho-geriatrician, Dr Banks, who in 1998 found that she had end stage dementia (473). The nursing home noticed that she was wandering and very frail in July 1998 (563). The nursing home notes document multiple falls.

3.3 On admission to the Haslar Hospital, a fractured neck of femur is diagnosed and she is treated with a right hemi-arthroplasty (H50). Recovery is complicated by agitation. She is seen by Dr Reid on 3rd August (23) who notes her long standing dementia. He finds her pleasant, co-operative, with little discomfort on passive movement and she should be transferred to the Gosport War Memorial hospital to see if it was possible to remobilise her (466,467).

3.4 Her drug charts in Haslar Hospital show that no regular pain killer is given during her first admission (H110), although Diclofenac was prescribed but not given. She does receive intravenous morphine 2.5. mgs on 31st July, then single doses on the 1st and 2nd August (H114). She then receives regular Co-codamol orally, although it is written up Prn, until 7th August. After this date there appears to be no further painkillers given.

3.5 The nursing cardex in Haslar (H152, H167) does not mention any pain during her recovery.

3.6 She is transferred to Gosport War Memorial Hospital on 11th August and seen by Dr Barton (29) who notices her previous hysterectomy in 1953, her cataract operations, her is deafness and that she has "Alzheimer's Disease". She records that her impression is of a frail demented lady who is not obviously in pain. Despite the statement in the notes, there is no other evidence of a clinical examination, or any record, if it was undertaken. There is also no mention of pain in the medical notes until after her hip dislocation. She mentions that her Barthel score is 2 (heavily dependent), she transfers with a hoist. She also states "I am happy for nursing staff to confirm death".

3.7 The next medical note on 14th August and states that sedation/pain relief has been a problem, screaming not controlled by Haloperidol and very sensitive to Oramorphine (29). Fell out of chair last night, right hip shortened and internally rotated, daughter aware and not happy. Is this lady well enough for another surgical procedure? She has an x-ray that notes the hip is dislocated and is transferred back to the Haslar Hospital.

3.8 The nursing notes for this first admission to Gosport War Memorial Hospital state that she had a Barthel of 3/20 on admission (40). Is highly dependent with a Waterlow score of 27 (41). The nursing care plan for the 12th (49) mentions that Haloperidol was given because she woke from sleep very agitated. It mentions that on the 13th August Oramorphine is given at 21.00 (50). It mentions an x-ray needed the following morning. On 14th August pain is mentioned in the right leg in the nursing cardex (50). I find no other mention of pain in the nursing cardex.

3.9 Oramorphine 10 mgs in 5mls (62) is written up prn on admission to Gosport Hospital, two doses are given on 11th August, one dose 12th August, one dose 13th August in the evening (as confirmed in the nursing cardex) and

one dose on 11th August in the morning (as confirmed in the nursing cardex). Also on the prn side of the drug cardex on admission to Gosport on the 11th August, Diamorphine 20 – 200 mgs is prescribed subcutaneously but never given. Hyoscine 200 – 800 mgs and Midazolam 20 – 80 mgs in 24 hours subcutaneously are both written up on 11th August. Neither of these two drugs are given until her subsequent return from Haslar.

3.10 On 14th August she is transferred back to Haslar where a dislocation of a hip is confirmed by x-ray (H67) and is reduced under sedation (H67). She has an uneventful recovery and is transferred back to Gosport War Memorial on 17th August. Discharge summary mentioning Haloperidol, Lactulose, Co-codamol and Oramorphine 2.5 – 5mgs for pain (H79), although the Oramorphine was never given in Haslar.

3.11 Dr Barton writes in the notes on the 17th August after her re-admission to the Gosport War Memorial Hospital to continue Haloperidol and only give Oramorphine if in severe pain (30), and that she wishes to see the daughter again. There is no record of any assessment of Mrs Richard's mental or physical state on transfer except a statement 'now appears peaceful'. Yet the nursing cardex 17th August says patient distressed and appears to be in pain (45). In the afternoon of 17th August, states, "in pain and distress, agree with daughter to give her mother Oramorphine 2.5 mgs in 5 mls". It is possible Dr Barton only saw the patient after she had been given Oramorphine. Due to the pain, a further x-ray is ordered and no dislocation is seen (46) (75).

3.12 On 18th August, Dr Barton notes the patient is still in great pain, nursing is a problem, she suggests subcutaneous Diamorphine, Haloperidol and Midazolam and that she will see the daughters. The nursing cardex records the decision to pain control by syringe driver (46). She then receives Diamorphine 40 mgs daily in a syringe driver, with Haloperidol 5 mgs and 20 mgs Midazolam until her death on 21st August 1998.

3.13 An unusual feature of the original Gosport War Memorial Drug Chart (64) is that Oramorphine 2.5 mgs 4 hourly was written up on the regular prescription side on the 11th August, together with 5 mgs at night regularly. It then has the letters prn against both of these prescriptions which make no sense(62).

Drug	Date prescribed	Prescribed as	Prescriber	Given		
Oramorphine	11/08	10 mgs in 5 mls 2.5 – 5 mls 4 hourly Oral PRN	Dr Barton	11/08 11/08 12/08 12/08 14/08 17/08 17/08 17/08 17/08	? 1145 0815 2050 1150 1300 ? ? 2030	10 mgs 10 mgs 10 mgs 10 mgs 10 mgs 5 mgs 5 mgs 5 mgs 10 mgs

				18/08 ? 10 mgs 18/08 0400 10 mgs
Diamorphine	11/08	20 – 200 mgs S/C in 24 hours PRN	Dr Barton	Never given
Midazolam	11/08	20 – 80 mgs S/C in 24 hours PRN	Dr Barton	18/08 1145 20 mgs 19/08 1120 20 mgs 20/08 1045 20 mgs 21/08 1105 20 mgs
"PRN" Oramorphine	12/08	10 mgs in 5 mls 2.5 mgs oral 4 hourly Regular	Dr Barton	Never given or crossed off
"PRN" Oramorphine	12/08	10 mgs in 5 mls 5 mgs oral nocte Regular	Dr Barton	Never given or crossed off
Diamorphine	18/08	40 – 200 mgs S/C in 24 hours Regular	Dr Barton	18/08 1145 40 mgs 19/08 1145 40 mgs 20/08 1045 40 mgs 21/08 1105 40 mgs
Haloperidol	18/08	5 -10 mgs S/C in 24 hours Regular	Barton	18/08 1145 5 mgs 19/08 1145 5 mgs 20/08 1045 5 mgs 21/08 1105 5 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Gladys Richards. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Gladys Richards, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 Mrs Richards was suffering from the terminal stage of a dementing process, probably Alzheimer's disease. This is reflected in the comments earlier in 1998 by a consultant psycho-geriatrician that she had end stage disease and the well-documented progression of this over many years. Despite this though, she was still able to get around in the nursing home and as is often the case, even with the best forms of monitoring, having multiple falls.

4.3 As a result of one of these, she suffers a fractured neck of femur. Sadly this is very common, it is also common for the original fall to lead to a partial fracture which is not diagnosed and then only subsequently sometimes hours, sometimes days later, does it become a clinically

obvious fractured neck of femur. Patients with dementia and fractured neck of femur are often missed in hospitals as well as in nursing homes, even by the most astute of staff.

4.4 She has a successful hemi-arthroplasty in Haslar, receives pain relief but does not need any pain relief for the 3 days on 7th – 10th August. She remains highly dependent though with a Barthel of 3/20. Although she is described as weight bearing in Haslar, the Barthel describes no mobility at all as does the fact that a hoist is needed for transfer at Gosport War Memorial. Many patients with severe dementia, never walk again after a fractured neck of femur and indeed the mortality rate in the months after a fractured neck of femur is extremely high, particularly in the very elderly and those with mental impairment.

4.5 However, she survives the first operation and is seen by Dr Reed, Consultant Geriatrician who believes that she should be transferred to Gosport War Memorial to see if any mobility can be regained. This is not unreasonable; it may make her new placement in a nursing home easier if she is able to have some increase in independence.

4.6 When she is transferred to Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination apart from a general statement she is a frail and demented lady. However, she does state she is not obviously in pain. Despite this, she has written up her drug charts for both low dose of Oramorphine and a high dose of Diamorphine. I can find no clinical justification for these decisions in the notes. If she was worried about pain and feared that it would be hard for the nursing staff to get hold of the doctor, then it would be reasonable to write up a prn of a mild pain killer such as Paracetamol and possibly doses of weak Opioid if simple analgesia did not work. Dr Barton also writes up on the regular prescription side a significant dose of Oramorphine, although this has prn put next to it. I believe all this prescribing to be very poor, and in my view negligent, medical practice.

4.7 In paragraph 15 of Dr Barton's police statement (12 June 2001) she states "Given my assessment that she was in pain I wrote a prescription for a number of drugs on the 11th August, including Oramorph and Diamorhine". I can find nothing in the notes to support this statement.

In the same report (paragraph 22) Dr Barton states referring to her readmission on the 17th August that "I was not aware that she had been having intravenous Morphine at the RHH until shortly before her transfer". I can find no evidence to support this statement in the Hasler notes. The only intravenous Morphine she received in Hasler was around the time of the first operation, the last dose given on 2nd August.

4.8 Oramorph is actually given by the nursing staff on 11th, 12th and 13th, certainly prior to the definite diagnosis of the dislocation. I can find no justification for giving the drugs in the medical or nursing notes. The comment on the 14th August that pain relief has been a problem, probably relates to the dislocation after the fall on the 13th. If no reason can be documented or proven, then this is certainly very poor drug prescribing and management. Indeed to prescribe a controlled drug without a clinical indication must be considered negligent in my view.

4.9 She is identified as having had dislocation of hip by the 14th August. This probably resulted from the documented fall and is not uncommon in frail older people after a fractured neck of femur repair. The Oramorphine that had been given might have contributed in part to this, though she was also on major tranquillisers and suffering from severe dementia. All of which makes such an outcome more likely.

4.10 She then returns to Haslar Hospital. The dislocation is reduced under intravenous sedation, and she is then returned back to Gosport War Memorial. She is never right from the moment she returns. She is now documented to be in significant pain. No cause for this pain is suggested in the notes. In my view it would have been appropriate for Dr Barton to discuss Mrs Richards with the surgical team at Haslar Hospital, or with her consultant, to decide if anything further should be done at this stage. Unfortunately, not only is the mortality high after a single operation in a patient with end stage dementia but having a further operation is often an agonal event. The cause of her pain remains unexplained and when seen on the 17th by Dr Barton is "now appears peaceful". It is possible Dr Barton only saw her after she had been given Oramorphine, if this is the case it would be poor medical practice, as she would not have been reassessed as to the medical cause of her pain and distress.

However it seems to me that it would be not unreasonable at this stage if nothing more can be done medically, to provide palliative care and pain relief. Diamorphine is specifically prescribed for pain and is commonly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morphine, is usually given at a maximum ratio of 1 – 2 (i.e. up to 10 mgs Diamorphine in 20 mgs of Oramorphine). The maximum amount of Oramorphine she had received in 24 hours was 45 mgs prior to starting the syringe driver pump. Thus if her pain was not controlled, it would be appropriate to give a higher dose of Diamorphine and by convention this would be 50% greater than the previous days (Wessex Guideline) but some people might give up to 100%. A starting dose of Diamorphine of 20 – 40 mgs in 24 hours would seem appropriate. Mrs Richards was prescribed 40 mgs, which in my view is just within prescribing guidelines yet seem high for someone who had been identified as "sensitive to Oramorph" by Dr Barton on the 14th

August (29).

4.11 Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for 24 hours which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

4.12 It was documented that Mrs Richards is peaceful on this dose in the syringe driver and a rattly chest is documented in the medical notes on 21st prior to her death (30).

4.13 I understand the post mortem and the cause of death said:
1a Bronchopneumonia.
In my view the correct Death Certificate would have said:
1a Fractured Neck of Femur
2 Severe dementia.
There is no doubt that after people have been dying over a number of days, if a post mortem is performed, then secretions and changes of Bronchopneumonia are often found in the lungs as the very final agonal event. This allows clinicians to put the phrase "Bronchopneumonia" on the death certificate.

5. OPINION

5.1 Gladys Richards presents an example of a common, complex problem in geriatric medicine. A patient with one major progressive and end stage pathology (a dementing illness) develops a second pathology, has surgery, has a complication after that surgery, has more surgery and gradually deteriorates and dies.

5.2 However there were significant failings in the medical care provided to Gladys Richards, in particular:

- The failure to undertake a clinical examination, or to record it if it was undertaken on admission to the Gosport War Memorial Hospital.
- The PRN prescription of strong opioid analgesic on admission to the Gosport War Memorial Hospital without any explanation.
- The use of strong opioid analgesia on the 11th, 12th and 13th of August without any explanation. A decision that might have contributed to her hip dislocation.
- The failure to write up milder analgesic PRN on first admission to the Gosport War Memorial Hospital.
- The possible evidence that Mrs Richards was only reviewed medically after receiving further doses on Oramorphine on her readmission to the Gosport War Memorial Hospital on the 17th August.

- The failure to ask for specialist advice as to the cause of the continuing pain after the re-operation and second admission to the Gosport War Memorial Hospital.

5.3 There were deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The prescription of a large range of PRN Diamorphine on the PRN side of the drug chart.
- The "PRN" Oramorphine on the 'Regular' side of the drug chart, which is never given or crossed off.
- The prescription of a large range of a controlled drug (Diamorphine) on the regular side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

Ruby LAKE
DOB: Code A
Died: 21/08/98

SUMMARY OF CONCLUSIONS

Ruby Lake an 84-year-old lady with a number of chronic diseases, suffers a fall and a fractured neck of femur in August 1998. She is admitted to hospital and has operative treatment but develops post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorates and dies in the Gosport War Memorial Hospital.

In my view a major problem in assessing this case is the poor documentation in the Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. However, I believe the overall standard of medical care is the Gosport War Memorial Hospital to be negligent. The use of the drug chart was also significantly deficient.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes).

3.1 Ruby Lake an 84-year-old lady in 1998, was admitted as an emergency on 5th August 1998 to the Haslar Hospital (H52).

3.2 In 1982 she had been diagnosed with osteoarthritis (211). In 1989 she was noted to have varicose leg ulcers (73) and in 1990 was documented as having gross lipodermatus sclerosis (239). In 1993 she had problems with left ventricular failure, atrial fibrillation, aortic sclerosis and during that admission had a bout of acute renal failure

with her urea rising to 25.7 (60). Her Barthel was 18 in 1993 (179).

3.3 In 1995 she was admitted with an acute arthritis and was noted to have a positive rheumatoid factor (30) and a positive ANF. She had mild chronic renal failure, which was noted to be worse when using non-steroidal anti-inflammatory drugs (31) her creatinine rose to 178 when Brufen was introduced (69). Her mental test score was 10/10 (70) but she did have some mobility problems and was seen by an Occupational Therapist and a Physiotherapist (93) (164).

3.4 In 1997 she was under the care of the Dermatologist with considerable problems from her leg ulcers and she was now having pain at night and was using regular Co proxamol (239). In 1998 she was seen by a Rheumatologist who thought she had CREST syndrome including leg ulcers, calcinosis, telangiectasia, and osteoarthritis, (353).

3.5 On 29th June 1998 she was admitted to the Gosport War Memorial Hospital under the care of her GP Dr North (300). The medical clerking is virtually non-existent (75), simply saying that she was admitted for her leg ulcer treatment and her pulse, blood pressure and temperature being recorded. It was noted that she was having continual pain and Tramadol 50 mgs at night was added to her regular 3 times a day Co proxamol. (197) She was seen by a Consultant Dermatologist during this admission (76).

3.6 The nursing cardex showed that she was continent with no confusion (298) however; she was sleeping downstairs (299). Her Barthel was 12 (314) and her Waterlow pressure score was 16 (high risk). She appears to have been discharged home.

3.7 She was admitted to the Haslar Hospital on 5th August having fallen and sustained a fractured neck of femur. This is operated upon successfully. By the 8th she is noted to be short of breath and probably in left ventricular failure with fluid overload (H63). Her renal function has deteriorated from a urea of 16 and a creatinine of 119 on admission (H9) to a urea of 25 and a creatinine of 127 (H68) by the 10th. Certainly on the 10th she appear unwell (H17) and it was not clear if this was a possible myocardial infarction or a chest infection (H17). However a chest x-ray is thought to show a chest infection and she is treated with regular Augmentin, an antibiotic (H69). On 11th her white count is significantly raised at 18.8 (H96). She has a

mild anaemia post operatively of 10.5 (H92) her haemoglobin was normal on admission at 13.1 (H16).

3.8 On 13th August she is found to be brighter and sitting out and walking short distances with frame (H18) and this functional improvement continues, documented in the notes up to 17th August (H18). However, she is noted to have had an episode of chest pain on 15th August (H75). Initial cardiac enzymes were normal (H103) on the 16th August and non-diagnostic on the 10th August (H109). But there is no doubt that her ECG changes between her admission ECG (H86) and the ECG(s) on 13th August and 15th August (H80 and H78). This is not commented on in the notes.

3.9 The nursing cardex shows that she is unsettled most nights, for example, 10/8 (H166), 13/8 (H168), 16/8 (H170) and on the night before discharge from Haslar on 17th August she "settled late after frequent calling out". The nursing notes also show that she had a continuing niggling pyrexial and was still significantly pyrexial the day before discharge (H137). It also documents that on the day of transfer to the Gosport War Memorial Hospital, she has increased shortness of breath and oxygen is restarted (H171).

3.10 Her drug chart shows that she receives low molecular weight Heparin as a prophylaxis against deep venous thrombosis (Calciparine) from admission until discharge. Diamorphine 2.5 mgs IV is giving as a single dose on 5th August (H128). Co-proxamol is given from 5th – 8th August (H128) and then replaced by Paracetamol written up on the 'as required' part of the drug chart, which she receives almost every day, until the 16th August (H175). The discharge letter mentions her regular drugs of Allopurinol, Bumetanide, Digoxin and Slow K, but does not mention any analgesia (H44).

3.11 She is seen by Dr Lord on 14th August (25-26). She notes that Mrs Lake's appetite is poor, is in atrial fibrillation and may have Sick Sinus Syndrome (an irregularity of cardiac rhythm). She has been dehydrated, hypokalaemic, and has a normochromic anaemia. She notes her leg ulcers and her pressure sores. She agrees to transfer her to the Gosport War Memorial Hospital and is uncertain as to whether there will be significant improvement.

3.12 She is admitted to Dryad Ward on 18th August (77) and the medical notes states that she had a fractured neck of femur and a past

medical history of angina and congestive cardiac failure. The rest of the medical notes, note that she is continent, transfers with two, needs help with ADL's, a Barthel of 6. The management plan is "get to know, gentle rehabilitation". The next line states "I am happy for the nursing staff to confirm death". The next and final line in the medical notes (77) is a nursing note from 21st August that Mrs Lake had died peacefully at 18.25 hrs.

3.13 The nursing care plan, on admission, noted her pressure sores (375), her leg ulcer care (377) and notes that she communicates well (387) but does have some pain (387).

3.14 On 18th August the nursing continuation notes state that she awoke distressed and anxious and was given Oramorphine (388), it states that she was very anxious and confused at times. On 19th August it said that she was comfortable at night, settled well, drowsy but rousable. Syringe driver satisfactory. On 20th August it stated continued to deteriorate. The nursing summary (394) states on 18th August, pleasant lady, happy to be here. On 19th August at 11.50 am she complains of chest pain and looks "grey around mouth". Oramorphine is given. She is noted to be very anxious and the doctor is notified. The pain is apparently only relieved for short period and she is commenced on a syringe drive.

On 20th August she continued to deteriorate overnight, the family have been informed and "very bubbly". On 21st August she deteriorates slowly.

3.15 Drug Chart Review: Admission on 18th August, Digoxin, Slow K, Bumetanide and Allopurinol are written up as per the discharge note from Haslar (369). On the 'as required' part of the drug chart (369) Oramorphine 10 mgs in 5 mls, 2.5 – 5 mgs is written up together with Temazepam. No Temazepam is given but 3 doses of Oramorph are given, one on the 18th August and two doses on 19th August.

3.16 On 19th August (368) Diamorphine 20 – 200 mgs sub cut in 24 hours is written up 20 mgs is started on 19th August, 20 mgs is started on 20th August, then discarded, and 40 mgs started, on 21st August 60 mgs is started. Hyoscine 200-800 micrograms subcut in 24 hours is also prescribed on 19th August. 400 micrograms is started on 20th August and replaced later in the day by 800 micrograms, which is continued on 21st August. Midazolam 20 – 80 mgs subcut in 24 hours is written up and 20 mgs prescribed on 20th August, replaced later in

the day by 40 mgs and finally by 60 mgs on 21st August.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Diamorphine	05/08	2.5 – 5.0 mgs IV/I/M PRN	? (at Hasler)	05/08 1300 2.5 mgs
Co-proxamol	06/08	T – TT oral hourly PRN	? (at Hasler)	06/08 2 doses 07/08 3 doses
Paracetamol	08/08	1 gram oral PRN	? (at Hasler)	1 or 2 doses most days 08/08 – 16/08
Oramorphine	18/08	10 mg in 5 mls oral 2.5 – 5 mls 4 hourly PRN	Barton (GWMH)	18/08 1415 5 mgs 19/08 0015 10 mgs 19/08 1150 10 mgs
Diamorphine	?	20 - 200 mgs SC in 24 hours Regular	Barton (GWMH)	19/08 1600 20 mgs 20/08 0915 20 mgs stopped and restarted 20/08 1630 40 mgs stopped and restarted 21/08 0735 60 mgs
Midazolam	?	20-80 mgs S/C in 24 hours PRN Regular	Barton (GWMH)	19/08 1600 20 mgs 20/08 0915 20 mgs stopped and restarted 20/08 1630 40 mgs stopped and restarted 21/08 0735 60 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Ruby Lake. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Ruby Lake, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 Mrs Lake had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many

years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

4.3 She is admitted by her GP into a GP bed consultant ward in June 1998. Beyond measuring her blood pressure, there is no medical clerking and the medical notes are rudimentary at best. Significant information is available from the nursing cardex, which confirms that she is continent and there is no confusion. However, she does have some dependency with a Barthel of 12. Her pain relief is increased by adding Tramadol (an oral opiate like drug) to her Co proxamol and she is able to be discharged home, having been seen by the Dermatologist.

4.4 She subsequently has a fall and suffers a fractured neck of femur. She is admitted to the Haslar Hospital for operative repair. There is always a very significant mortality and morbidity after fractured neck of femurs in old people, particularly in those who have previous cardiac and other chronic diseases.

4.5 She is clearly unwell on 10th August, this is thought to have probably have been a chest infection and she is treated appropriately with antibiotics. However, her pyrexia never actually settles prior to discharge. She also suffers from at least one other episode of chest pain, again no diagnosis is come to in the medical notes, although her ECGs do appear to have changed during her admission, suggesting that this was either coronary event, including a possible heart attack or even a possible pulmonary embolus, despite her prophylactic anti-DVT therapy.

4.6 She is documented to be confused on many evenings, including the evening before transfer from Haslar to Gosport War Memorial Hospital. There may be multiple reasons for this, simply having an operation after a fractured neck of femur can cause acute confusion which is more obvious in the evenings. Chest infections and cardiac events can also cause acute confusion. She was on regular oral Co proxamol and Tramadol prior to her admission. The Tramadol was not continued and the Co proxamol was replaced after a few days with Paracetamol which she does receive on a regular basis for pain, although it is not clear whether this is pain from her leg ulcers or her chest. It is therefore possible that she is also getting drug withdrawal symptoms and this is a further contributing factor to cause her restlessness and confusion at night.

4.7 She is seen by Dr Lord who does a thorough assessment and arranges for an appropriate transfer to Gosport War Memorial Hospital. Dr Lord does not mention pain management as an issue. It is clear though from the notes that on the day of transfer she is still not right. She had been pyrexial the day before, she had been confused the night before transfer and she is more breathless needing oxygen on the day of transfer. It might have been wiser not to transfer her in this unstable clinical state.

4.8 When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination, apart from a statement regarding her functional status, that she is catheterised, needs two to transfer and needs help with ADL and documents a Barthel of 6. An opportunity to assess her apparent unstable clinical state appears to have been missed. The nursing cardex states the Bartel is 9 (373) and that in the nursing cardex, she can wash with the aid of one and is independent in feeding.

4.9 The continuation notes of Dr Barton (77) then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all and in view of the subsequent changing clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor (394) this is a poor standard of care. It also makes it very difficult to assess whether appropriate medical management was given to Mrs. Lake.

4.10 On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia. On her first night she is documented as anxious and confused. This is then treated by giving her two doses of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her evenings in Haslar which did not need any specific medication management. She also had Temazepam available on the drug chart to be used as a night time sedative if needed. In

my view this is poor nursing and medical care in the management of confusion in the evening.

4.11 On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

4.12 Later on 19th August s syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes (394) where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure while the patient continues to have pain.

4.13 The syringe driver is continued the next day and Hyoscine is added and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Mrs Lake dies peacefully on 21st August.

4.14 Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Diamorphine subcutaneously after oral morphine is usually given at a maximum ratio of 1 to 2 (up to 10 mgs of Diamorphine for 20 mgs or Oramorphine). She had received 20 mgs of Oramorphine on 19th and appears to have been in continuing pain so I think it is probably reasonable to have started with 20 mgs of Diamorphine in the syringe driver over the first 24 hours.

4.15 Midazolam is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance, although many believe that elderly patients need a lower dose of 5 – 20 mgs per

24 hours (palliative care). (Chapter 23 in the Brocklehurst's Text Book of Geriatric Medicines 6th Edition 2003). The original dose of Diamorphine appeared to be for continued chest pain. It is unusual to use continuous Diamorphine for chest pain without making a specific diagnosis. It is possible the patient had had a myocardial infarction and was now in cardiogenic shock. In that case it would be very reasonable to use a syringe driver and indeed to add Midazolam and Hyoscine over the subsequent 48 hours. This can only be supposition without adequate documentation.

4.16 In my view it is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held.

5. OPINION

5.1 Ruby Lake an 84-year-old lady with a number of chronic diseases, suffers a fall and a fractured neck of femur in August 1998. She is admitted to hospital and has operative treatment but develops post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorates and dies in the Gosport War Memorial Hospital.

5.2 In my view a major problem in assessing this case is the poor documentation in Gosport Hospital in both the medical and nursing notes, making a retrospective assessment of her progress difficult. However, I believe the overall standard of medical care in the Gosport War Memorial Hospital to be negligent, in particular:

- The lack of any documented medical examination on admission, in a patient that appeared to be clinical unstable.
- The failure to prescribe milder oral analgesia on admission to the Gosport War Memorial Hospital.
- The use of Oramorphine for 'anxiety and confusion' on the first night in the Gosport War Memorial Hospital.
- The apparent failure to attend the patient when she developed chest pain and became unwell on the 19th August.
- The failure to attempt to make any diagnosis or assessment of the change in condition on 19th August.
- The decision to start a syringe driver on the 19th August without any record of the medical justification.
- The failure to record any justification for the decision to increase the doses of Diamorphine and Midazolam on the 20th and 21st August.

5.3 The use of the drug chart was also significantly deficient, in particular:

- The prescription of a large range of a controlled drug (see my generic report).
- The failure to date prescriptions on the regular side of the drug chart.
- The failure to cross out and rewrite prescriptions on the regular side of the drug chart when changing controlled drug dosages.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

5.4 Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However, I am unable to satisfy myself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS:

Arthur CUNNINGHAM
DOB: Code A
Died: 26/09/98

Mr Arthur Cunningham a 79 year-old gentleman, suffers from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

Arthur Cunningham is an example of a complex and challenging problem in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance the patient is dying and that symptom control is appropriate.

However there are a number of areas of poor medical practice and also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

3.1 During the 1980's Mr Cunningham noted a tremor in his left hand and by 1987 a clinical diagnosis of Parkinson's disease had been made and he had been started on Sinemet a drug specifically for the treatment of Parkinson's disease (445). He then remains on Sinemet in one form or another for the rest of his life. In 1992 another drug called Selegiline is added to his Sinemet (445). His only previous problem had been a lumbar spinal fusion

following a war accident (375) that left him with chronic back pain and foot drop.

3.2 In 1992 he had a percutaneous nephrolithotomy for kidney stones. (9). During that admission he was written up for Omnopon 10 – 20 mgs and received a dose of 20 mgs (12). There were no ill effects.

3.3 He was assessed in December 1994 (439 and 441) for declining mobility. He was noted to have a weight of 102 kgs, a mental test score of 10 out of 10, and a Waterlow score of 13 (391) suggesting some dependency. His wife had died in 1989 (439). His Barthel was 17 (433) some help needed was with dressing. The problems were assessed to be due to be Parkinson's disease, a weak leg from his war injury and obesity.

3.4 He was followed up in 1995 with a diet and change to his Sinemet regime in the Day Hospital. He was also treated with Ranitidine and Gaviscon, presumably for acid reflux (425) and was on regular Co-proxamol for pain (425). Subsequently Enalapril was started for hypertension (399 and 417). In March 1995 his weight was 99.4 kgs (407) and he was discharged shortly after from the Day Hospital (400).

3.5 In September 1997 the GP requests a domiciliary visit (379). He notes that he has been diagnosed with diabetes and was now losing weight (379). His Parkinson's disease has deteriorated and he is now getting dystonic movements. Dystonic movements are writhing and jumpy movement that occur as a side effect of drug therapy in people who have had Parkinson's disease for many years. These movements often occurs at times of peak drug levels and may alternate with periods of severe stiffness and immobility at times of low drug levels. It was also noted that he had lost some lower body strength (379). He was now spending most of his time in his chair (379). His drugs included the regular analgesia, Solpadol (381).

3.6 An assessment in September 1997 (375, 377) finds he has weak lower limbs and has difficulty in transfers. He can walk indoors slowly with sticks. He has a poor appetite and daily home care. He is documented to have very weak flexion and extension of the left hip, wasting of the left quadriceps and left foot drop (377). It is suggested that he comes to the Day Hospital for physiotherapy. His weight in October 1987 (629) is 84 kgs. However in November 1987 he cancels further appointments (355). In September 1997 his white cell count is 4.0 and his platelet count is 112. It is likely that his haematological abnormalities date from this time.

3.7 In March 1998 he is seen again in outpatients with new episodes of shortness of breath (139 – 141). The diagnosis is not clear but was thought possibly to be cardiac in nature. However a chest x-ray (519) was normal. There is no further investigation of this problem. One note suggests that he

had just moved to a nursing home (141).

3.8 In June 1998 he is seen at the Merlin Park Residential Home by Dr Lord, following a GP request (345). He is noted to have significant weight loss, is transferring very unsteadily, is occasionally breathless and has had two falls in the home. He remains on a five times a day dose of his Sinemet and is also on Amlodipine, Diazepam and drugs for constipation. Examination (349) finds that he has markedly dystonic movements and records that the home had noticed visual hallucinations after he moved in. Dr Lord feels that he is on too much Levodopa (the main drug in Sinemet). She feels the Sinemet is causing his dystonic movements, too low a blood pressure on standing leading to falls, and his hallucinations. The notes state that Mr Cunningham never agreed with this diagnosis. Dr Lord also feels that he is depressed (349).

3.9 On 22nd June 1998 he is brought to the Gosport War Memorial Hospital by Social Services as he was refusing to stay at Merlin Park (343). He is described as a difficult and unhappy man (59). No acute health problems are found (343). Social Services place him in the Alvestoke Nursing Home (341).

3.10 On 6th July 1998 he is seen again at the Gosport War Memorial Hospital (339) and is noted to have decreased mobility and his weight has now decreased to 68.7 kgs. He is not happy with his new nursing home placement. His functional status has declined and his Barthel is 9/20 (334). His blood count that day shows a normal haemoglobin but a white cell count of 2.7, platelets of 103 (650). The reduced white count particularly his neutrophil count and reduced platelets count is thought to be due to "likely myelodysplasia known since February 1997" (68). This was never confirmed with specialist haematologist investigation.

3.11 On 8th July he is seen by Dr Scott Brown a psychiatrist and is thought to be depressed (117). Other problems including his Parkinson's disease and his myeloproliferative disorder are noted (115).

3.12 On 20th July his care is discussed with Dr Lord in the Day Hospital (111 and 113). It is thought his Parkinson's disease is stable but because of concern about his weight loss, he is referred for a speech and language assessment, which subsequently occurs on 27th July (101). This finds he has difficulty in initiating swallow but there is no aspiration. This likely to be a complication of his Parkinson's disease.

3.13 On 21st July he is admitted to Mulberry Ward with depression (323) his weight is 65.5 kgs (303) a bed sore is now noted (293) he is thought to have dementia (67) and there is a documented mental test score in June of 23 out of 29 on the Folstein Mini Mental State Examination (343). He is found to be

constipated (289) is restless and demanding at night (271) (269), nursing notes comment that he can be awkward and difficult (242). Waterlow scores are recorded on a number of occasions, all between 19 and 20 suggesting very high risk of further pressure sore development (309 and 310). He is documented to have various urinary tract infections including proteus (207) and enterococcus on two occasions (211) (205). On admission his white cell count is 2.9 neutrophil count 1.4 and platelet count of 97 (201). On 12th August his white count is 3.5 his neutrophil count 1.8 and platelets 135. The blood form states "known myelodysplasia" (193). On admission his albumin is 26 (185) his urea is 6 and his creatinine 59, his prostatic-specific antigen is 6.4 (179) normal is less than 4. This raised level is not investigated any further, it might represent either benign prostate disease or early prostatic cancer.

3.14 During his admission to Mulberry ward he has a fall on the 24th July (70). He is described as quite demanding, wanting staff to come and see him every few minutes (70), he is depressed and tearful on 24th July (71), he is rude and abusive to a member of staff on 26th July (72) and apologises later in the day (73). Dr Lord sees him on 27th July (74) and finds that there were no particular new problems. He is still low in mood on 3rd August (79) calling out for assistance quite a lot (80). He needs a lot more assistance on 10th August (83). On 17th August he became noisy, shouting for help and very abusive, refusing medication (85). He is assessed for a further move to the Thalassa Nursing Home on 17th August (86). He is again confused in the middle of the night on 18th August (87). On 25th August it is noted that he has not passed much urine (90). Blood tests carried out on 26th August (175) find a Sodium 134, Potassium 5.1, Urea 28 and Creatinine 301. He has gone into acute renal failure and is examined and found to have a large palpable bladder (90). He is catheterised. On 28th August there is a significant improvement in his renal function, Sodium 140, Potassium 4.1, Urea 15.6, Creatinine 144 (173). By the time of his discharge to his current usual medication of Sinemet, pain killers and anti-hypertensive drugs; Mirtazapine (an anti-depressant), Carbamazepine 100 mgs nocte, Triclofos 20 mls nocte and Risperidone 0.5 mgs early evening, have all been started as psychotropic medication to help control his mood and agitation (161 and 163).

3.15 He is seen by Dr Lord on Mulberry Ward on 27th August the day before his discharge, the day after he has had a catheter put in. She finds him much better in mood and eating better with a weight of 69.7 kgs (327). There were 2 litres of urine passed after he was catheterised (91). He cannot wheel himself but Dr Lord is happy for him to be discharged to the Thalassa Nursing home with a follow up in the Day Hospital on 14th September. He is then discharged to the Thalassa Nursing Home on 28th August.

3.16 On 11th September (99) he is seen by the Community Psychiatric Nurse who says that he has settled well into the Thalassa Nursing Home and his mood seems good.

3.17 On 14th September he is seen in the Gosport War Memorial Day Hospital his weight is 68.6 kgs (323), brighter and says he is eating not too badly (459). His blood pressure is a little low at 108/58 and his pulse is 90 (323). There is no comment on his pressure sore although, he is subsequently given a prescription for Metronidazole from "a swab to the sores on your bottom" (317). He is presumably still catheterised.

3.18 He appears to have a routine appointment at the Day Hospital on 17th September (908) for therapist assessment. It is noticed that the pressure sore is exudating markedly. During this session it is recorded that he would not comply with dressings and then would not wake up after bed rest. He was refusing to eat or drink and expressing a wish to die. The nursing notes state that he is seen by Dr Lord (909) who thinks he may need admission on Monday when reviewed again. I have not found any medical notes relating to this.

3.19 On 21st September (642) he is again seen in the Day Hospital by Dr Lord (909). He is recorded to be very frail with his tablets not swallowed and in his mouth. He has a very offensive large necrotic sacral ulcer. His weight is 69 kgs (642). A care plan is made by Dr Lord (643) to stop unneeded drugs, to admit to hospital for treatment of the sacral ulcer, to nurse on the side, for a high protein diet and for Oramorph prn for pain. The notes state the nursing home should keep the bed open for the next three weeks at least and the prognosis is poor (643).

3.20 He is taken to Dryad Ward (645) and seen by Dr Barton who says to make comfortable, give adequate analgesia and that "I am happy for the nursing staff to confirm death". The next medical note (which is out of sequence (644)) on 24th September, states, "remains very poorly, Son has visited again today and is aware of how unwell he is. Analgesia is controlling pain just. I am happy for the nursing staff to confirm death".

3.21 25th September (Dr ?) Brook writes, "remains very poorly on syringe driver for TLC". There is then a nursing note on 26th September, the patient died at 23.25 on 26th September and the final medical note is on 28th September saying "death certificate discussed with Dr Lord, 1 – Bronchopneumonia, 2 – Parkinson's Disease, Sacral Ulcer".

3.22 The nursing notes are more detailed on 21st September. He is admitted (867) but at 20.30pm is noted to have remained agitated and was pulling off his dressing (880). Syringe driver is commenced "as requested" and he is peaceful. On 22nd September the Son is told that the Diamorphine pump

has been "started for pain relief and to allay his anxiety". His Barthel is 0/20 (873) and Waterlow 20, suggesting high risk. The patient is recorded as "stating he had HIV disease" and trying to remove his catheter.

3.23 23rd September (868) it is recorded that he is chesty overnight and Hyoscine is added. The Son and wife are angry that a syringe driver was commenced and the nurses "explain it was to control pain". He is agitated at night that evening (876).

3.24 On 24th September the night staff and the day staff report pain and in the notes his Midazolam is increased to 80 mgs a day and his Diamorphine to 40 mgs. The nursing notes record that Dr Barton saw the Son, confirming the medical notes (643).

3.25 On 25th September Midazolam is continued at 80, he is on Diamorphine 60 mgs and is recorded as being peaceful (876). Finally on 26th September the notes record his Diamorphine is increased to 80 mgs and Midazolam to 100 mgs.

3.26 Drug Chart Analysis:

His original drug chart on admission to the ward on 21st September (752) prescribes Oramorphine 2.5 – 10 mgs orally 4 hourly, he receives 5 mgs at 14.50pm on 21st and 10 mgs at 20.15pm. He is also written up (753) for all his current anti-Parkinsonian and anti-psychotic medication but the notes demonstrate that on some dates the drugs are missing and on almost all occasions he is too ill to be able to take the medication on 21st – 24th September.

3.27 Diamorphine is 20 –200 mgs subcutaneously in 24 hours is written up on (presumably) the 21st September (756) and on the 21st at 23.10pm, 20 mgs is started. On 22nd September 20.29pm, 20 mgs is started and on 23rd September at 9.25am, 20 mgs is started. On 24th 40 mgs is started in the syringe driver at 10.55am, on 25th 60mgs is in the syringe driver (837) and on 26th 80 mgs.

3.28 Midazolam 20 – 80 mgs is written up on 21st September (756) and 20 mgs is given on 21st, 22nd and 23rd. On the 23rd though, this is increased to 60 mgs then 80 mgs on the 24th. He receives another 80 mgs on 25th and 100 mgs written up in 24 hours on 26th (second drug chart 837).

3.29 Hyoscine 200 – 800 micrograms sub cut in 24 hours is written up 400 micrograms are given on 22nd and 23rd September and 800 micrograms on 24th. This is then re-prescribed. Hyoscine 80 – 2 grams sub cut in 24 hours (837) and he receives 1,200 micrograms on 25th and 26th.

Drug	Date prescribed	Prescribed as	Prescriber	Given

Oramorphine	21/09	2-5 – 10 mgs Oral 4 hourly PRN	? ? Dr Lord	21/09 21/09	1450 2015	5 mgs 10 mgs
Co-proxamol	14/09	2 tabs 6 hourly Regular	?	14/09 17/09 21/09 Other doses missed	1200 1200 1800	(? in day hospital)
Diamorphine	? ?21/09	20 – 200 mgs S/C in 24 hours Regular crossed out and PRN written	Barton	21/09 22/09 23/09 23/09 24/09	2310 2029 0925 2000 1055	20 mgs 20 mgs 20 mgs "discarded" 20 mgs 40 mgs then 60 mgs
Midazolam	?21/09	20 – 80 mgs S/C in 24 hours Regular crossed out and PRN written	Barton	21/09 22/09 23/09 23/09 24/09	2310 2020 0925 2000 1055	20 mgs 20 mgs 20 mgs "discarded" 60 mgs 80 mgs
Diamorphine	25/09	40 - 200 mgs S/C in 24 hours Regular	Barton	25/09 26/09	1015 1150	60 mgs 80 mgs
Midazolam	25/09	20 - 200 mgs S/C in 24 hours Regular	Barton	25/09 26/09	1015 1150	80 mgs 100 mgs

4 TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts or deliberate unlawful killing in the care of Mr Arthur Cunningham. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mr Cunningham, in particular, whether beyond reasonable doubt, actions or admissions more than minimally, negligently or trivially contributed to death.

4.2 Mr Cunningham's two main problems were lumbar spinal fusion as a result of a war injury, which left him his weakness in his lower legs and his progressive neurological disease, Parkinson's disease. Parkinson's disease is a degenerative disease of the central nervous system, which causes tremor, body rigidity and akinesia (stiffness in movement). It was first noted in 1980 presenting with a tremor, he was certainly on treatment by 1987. The natural history is often a good response to treatment over 5 years and then gradual increasing problems. Late Parkinson's disease becomes increasingly difficult to control with drugs; the patients get difficulty in swallowing, severe constipation, and often in later stages a dementing illness.

4.3 There are complications with the drugs as the disease progresses, as the drugs are harder to keep in an effective therapeutic range. Too much and the patients get marked writhing or shaking movements call dystonias, too little and the patient may cease up completely. The longer-term side effects of the drugs also include postural hypotension (loss of blood pressure when standing, leading to falls) and mental state deterioration, including hallucinations. To try and combat this, complex regimes are used with multiple doses at different times of days, sometimes combined with other drugs. There is no cure for the condition.

4.4 In 1992 he is troubled with kidney stones but has an uneventful operation.

4.5 In 1994 he has a decline in his conditions with reduced mobility. This is a multiple factorial problem caused by his Parkinson's disease, weak legs as a result of his war injury and his obesity of 102 kgs. He is now living alone as his wife had died in 1989. He uses an electric wheelchair effectively and his Barthel is 17 but most of the help he currently needs is with dressing.

4.6 Further problems occur include hypertension, which is treated in 1995, and diabetes mellitus (high blood sugar), which is diagnosed later in the year.

4.7 By September 1987 he is getting considerable problems in managing his mobility as well as his Parkinsonian drug regime with significant dystonic movements. He is now on multiple drugs to treat his various medical conditions. He is referred to the Day Hospital for more physiotherapy to try and support him and to change his drug regime but he cancels further appointments in November 1997 (355).

4.8 By March 1998 (141) when he is seen in the Day Hospital within the Outpatients it mentions that he was now in Solent Cliff Nursing Home, though when seen in June 1998 (345) he has moved to the Merlin Park Residential Home. Throughout this gentleman's last illness there is a pattern of him being persistently dissatisfied with the care he receives, either in hospital or in the various homes he is cared for in, leading to multiple moves. This often complicates assessment as one institution never gets entirely used to him, his management and his behaviour.

4.9 By June 1998 there is now a very marked change in his health. There has been massive weight loss from 102 kgs in 1994 (441), 84 kgs in October 1997 (629) to 68.7 kgs documented by July 1998 (339). He is walking very unsteadily, is having falls in the home, having hallucinations at night, he is depressed and has marked dystonic movements. He is

not happy with the suggestion that he actually needs less medication rather than more to help manage his condition.

4.10 Whether the result of genuine unhappiness with the home or depression on top of what is now probably becoming an early dementing illness (his mental test score on 22nd June (343) was 23/29), he refuses to stay at Merlin Park. Social Services become involved and he is seen in the Day Hospital when no new acute problems on top of his known chronic problems are detected. Social Services manage to place him in the Alvestoke Nursing Home (341).

4.11 However, he is not happy at all with this placement when he is seen in the Day Hospital on 6th July 1998 (339). The plan is to investigate his weight loss and to reduce his Sinemet treatment. His Barthel is now 9/20. A further medical complication that has developed, probably since early 1997 (68), is that he has an abnormality of his full blood count with a reduced white cell count and a reduced platelet count. This suggests a problem with his bone marrow. Although the blood film say this is likely to be myelodysplagia (a pre-malignant condition of the bone marrow where there is partial bone marrow failure, but it has not progressed to Leukaemia) no definitive haematological investigations appear to have been undertaken. The main effect of this condition is he is likely to be much more susceptible to infections.

4.12 He is seen by the psychiatric team on 8th July (117) and then is admitted to hospital on 21st July to Mulberry Ward with a primary diagnosis of depression, probably on top of an underlying mild dementing illness (67). For the first time a bed-sore is noted in the nursing notes (293) although this is not commented on in the medical clerking that was undertaken on admission (66).

4.13 There is no doubt that there has been a very significant decline in this gentleman's general health. He has now lost over 40 kgs of weight, including 25% of his body weight in the last year. He had rapidly declining mobility, an early bedsore, he has started to develop mental impairment and his Parkinson's disease has become increasingly difficult to manage.

4.14 Admission is characterised by descriptions of restless and demanding behaviour and occasionally aggression. I suspect he has a low-grade delirium (delirium is acute confusion on top of, in this case, an early underlying dementing illness). Probably being caused by a combination of his drugs and the urinary tract infections that are documented on serial urine samples. He is started on drugs for his (understandable) depressive illness, which in themselves may complicate his drug regime. Finally he is treated with major tranquillisers to try and control his moods

and behaviours.

4.15 The outcome of this admission is that he is now on multiple medications to try and control multiple symptoms. Yet there is very little improvement or change in his behaviour, as noted in the nursing cardex.

4.16 He is planned to the Thalassa Nursing home on 28th August as his 4th residential move of the year. However, on the 25th August he is noted to be passing less urine and a blood test on 26th August shows that he has gone into quite significant acute renal failure. On examination he is found to be in retention of urine and is catheterised and two litres of urine is passed (91).

4.17 The retention of urine in itself is likely to have had multi-factorial causes, including the drugs he was on, his proven urinary tract infections and he may also have had an undiagnosed prostatic problems based on a raised PSA (179). However, he responds well to catheterisation and his renal function is dramatically improved by 28th when he is discharged, with a Urea of 15.6 and a Creatinine of 144 (173).

4.18 Following discharge things appear to go not too badly, the CPN seeing him on 11th September (99) states that his mood seems good and he is settled well. On 14th September when he is seen in the Day Hospital, his weight remains unchanged on 68.6 kgs (323) "he is brighter and says eating not too badly" (459). However, his blood pressure is rather low on 14th September at 108/58 (323) and the pressure sore must be causing concern as a swab is sent (317).

4.19 He then has a routine review, for a therapist assessment on 17th September. The nursing notes give a clue that he is quite unwell that day (908 and 909), they refer to the pressure sore now exudating markedly, he would not comply with his dressings, he would not wake up after bed rest and was refusing to eat or drink. He was apparently expressing a wish to die. This suggests to me he was acutely delirious again and the underlying aetiology could well be sepsis from pressure sore or sepsis (which is very common) from his urinary tract after a recent catheterisation. The nursing notes say that he is seen by the consultant but I was not able to find any medical notes. The nursing notes suggest that Dr Lord considered that she needed to review him on 21st and might need admission at this stage. It is below normal acceptable good medical practice to not make a record when seeing a patient, particularly if there has been a significant change in their condition.

4.20 Mr Cunningham is reviewed again on 21st September (642) when he has rapidly deteriorated, is very ill and very frail. He has an offensive large

necrotic sacral ulcer and is not able to swallow with tablets in his mouth. He is admitted to hospital appropriately. Dr Lord asked for a management plan, including nursing him on his side, a high protein diet, Oramorph PRN for pain and writes to the nursing home to keep the bed open for three weeks at least, the prognosis is poor.

4.21 This gentleman is very seriously ill, with multiple problems and has been in decline for at least three months. The consultant has to make a judgement whether these are easily reversible problems, which would need intensive therapy, including drips and surgery to the pressure sore in an acute hospital environment or whether this is likely to be the terminal event of a progressive physical decline.

4.22 In my view the combination of acute problems on top of his known progressive chronic problems, including the large necrotic pressure ulcer would mean that active treatment in an acute DGH was very likely to be futile and therefore inappropriate. It was appropriate to admit him into a caring environment for pain relief and to observe and provide symptomatic support. In my experience it is unusual for a consultant to write "poor prognosis" in the notes unless they believe the patient is terminally ill and death is likely to be imminent.

4.23 He is admitted to the ward, Dr Barton sees him and writes, "make comfortable" in the notes (645). As the patient has just been seen and examined by a consultant who has made a care plan, I think it is reasonable for no further clerking or examination to have been carried out, although most doctors would automatically do that, if briefly, so that they know the baseline of the patient. As suggested Oramorphine is written up and Mr Cunningham receives two doses on 21st.

4.24 However, a syringe driver has also been written up on admission (756) for Diamorphine and Midazolam. There is nothing in the medical notes that specifically explain why was it written up, when the drugs should be started or what dose. It was not part of Dr Lord's management plan. It would be normal medical practice to write a comment on such management plan in the notes.

4.25 The nursing notes state that he remains agitated, pulling off his dressings later in the day (880). A decision is made late on the 21st , with the drugs written up (who decides?) to start him on Diamorphine 20 mgs with 20 mgs of Midazolam in a syringe driver. No justification for starting the syringe driver is made in the medical notes, which are inadequate with no entries on the 22nd and 23rd.

4.26 The dose of Diamorphine is within an acceptable starting range for patients in pain. Midazolam is also widely used for terminal restlessness;

the dose prescribed is from 5 – 80 mgs per 24 hours. The starting dose is within the range of 5 – 20 mgs per 24 hours that is acceptable for older patients (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003). Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver.

4.27 By 22nd he is clearly delirious (867) and is now totally dependent with a Barthel of 0/20. There does not appear to have been very good communication with the Son as anxieties are raised about his management (868). The dose of Diamorphine and Midazolam remain unchanged on 22nd and 23rd, although he is a little agitated at night on 23rd (876) and both day and night staff report pain on 24th (869). At this stage Diamorphine is increased to 40m mgs and the Midazolam to 80 mgs. In my view, the increased dose of Diamorphine prescribed was appropriate, however the four-fold increase in Midazolam 20 mgs on the 23rd to 80 mgs on the 24th appears excessive without explanation in the medical notes.

4.28 After the pain on 24th there is no further distress noted in either the medical notes (645) or the nursing notes (869). However, the drug chart is rewritten and now allows a possible dose of Midazolam up to 200 mgs a day, outside of a normal prescription range..

4.29 The dose of Diamorphine is then increased on both the 25th and 26th. to 60 then 80 mgs (837) and Midazolam is increased again on 26th September to 100 mgs. There is no justification given for either these changes in the nursing or the medical notes, nor at any stage is it possible to tell from the notes whether the decision to change the drug dosages was a medical or a nursing decision or which doctor or nurse made that decision.

4.30 In my view from the information available in the notes, the dose of Midazolam was excessive on 25th and 26th and the medication may have slightly shortened life. However, I cannot find evidence to satisfy myself to the standard of "beyond reasonable doubt". I would have expected a difference of at most, no more than a few hours to days if a lower dose of either or both of the drugs had been used instead during the last few days.

5. OPINION

5.1 Arthur Cunningham is an example of a complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point to stop trying to deal with each individual problem or crisis, to an acceptance the patient is now dying and that symptom control is appropriate.

5.2 In my view many aspects of Mr Cunningham's medical care were managed appropriately. The use of a syringe driver as part of his terminal care was appropriate.

5.3 However, there are a number of areas of poor medical practice, in particular:

- The failure to make a medical note when seen by Dr Lord on the 17th September.
- The failure to record in the medical notes the reason for the decision to start the syringe driver, and whether that was a medical decision.
- The failure to record reassessments on the 22nd and 23rd September.
- The failure to record in the medical notes the reason for a 4 fold increase in Midazolam to 80 mgs on the 24th September from 20 mgs on the 23rd September.
- The failure to record in the medical notes the justification for the increased dose of Diamorphine and Midazolam on the 25th and 26th September.
- The failure to record if doses changes were a medical or nursing decision.
- The prescription of a dose range up to 200 mgs a day of Midazolam.

5.4 There are also deficiencies in the use of the drug chart at the Gosport Warm Memorial Hospital, in particular:

- The failure to date prescription of Diamorphine and Midazolam on the first drug.
- The use of the regular side of the drug chart for 'PRN' prescription, when actually they should have been regular prescription anyway.
- The prescription of a large range of a controlled drug (see my generic report).
- The failure to cross out drugs on the regular side of the drug chart when no longer required.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

Robert WILSON
DOB: Code A
Died: 19 October 1998

SUMMARY OF CONCLUSIONS

Mr Robert Wilson a 74 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is evidence of both poor, and in my view negligent, medical practice at the Gosport War Memorial Hospital. The use of the drug chart is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence in the police files).

3.1 Robert Wilson a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 (125-127) with a fracture of the left femoral head and tuberosity (169).

3.2 Mr Wilson had suffered many years before with Malaria and Diphtheria (143) but was first noticed to be abusing alcohol at the time of an endoscopy in 1994 (313). In 1997 he was admitted to

hospital with a fall, epigastric pain and was found to have evidence of severe alcoholic liver disease (129). During the 1997 admission, an ultra sound showed a small bright liver compatible with cirrhosis and moderate ascites (129). His Albumin was very low at 19 (150) and a bilirubin was 48 (129). All these are markers of serious alcoholic liver disease with a poor long term prognosis. His weight was 100 kgs (152). There is no record of follow up attendance.

3.3 When he attends A&E it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation (161-2). It becomes apparent by the next day that he is not well, is vomiting (163) and he is needing Morphine for pain (11). His wife is on holiday (11) and it is not thought possible for him to go home so he is transferred on 22nd September to the Care of the Elderly team at the Queen Alexandra Hospital (163).

3.4 The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have been an extremely heavy drinker with considerable oedema and abdominal distension on admission (167). He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133 (239). Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123 (237). There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997 (241).

3.5 He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission (209) and on 25th September Urea of 17.8 and a Creatinine of 246 (203). He is started on intravenous fluids on 27th September (12) and his renal function then continues to improve so that by the 7th October both his Urea and Creatinine are normal at 6.1 and 101 (199).

3.6 His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundice) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82 (199). His AST is 66 (171).

3.7 His vomiting within 24 hours of admission may have been due to alcohol withdrawal but he had also been given Morphine for pain (11). He is started on a Chlordiazepoxide regime (11) as standard

management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

3.8 His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home (12). His renal function deteriorates as documented above. He is communicating poorly with the nursing staff (28) and is restless at night on 30th September (30). His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October (69), his continued nutritional problems are documented by the dietician on 2nd October (16). In the nursing cardex he is vomiting, he has variable communication problems, he is irritable and cross on 1st October (30). On 4th October (16) his arm is noted to be markedly swollen and very painful and it is suggested he needs Morphine for pain (31). The following day he knocks his arm and gets a laceration (16).

3.9 There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5 (16) (69). However on the 5th the nursing cardex note that he is starting to improve (32) although, he remains catheterised and has been faecally incontinent on occasion.

3.10 On 7th October is now more alert and is now telling the staff that he wishes to return home (17). The nursing staff notes that he is now much more adamant in his opinions (33). However on 8th he had refused to wash for 2 days (18). He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related and depression. He is noted to be difficult to understand with a dysarthria (117-118). He is started on Trazodone as an antidepressant and as a night sedative, he is still asking for stronger analgesics on 8th October (35). The letter also mentions (429) "rather sleepy and withdrawn..... his nights had also been disturbed."

3.11 On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home (19). By the 12th October (21) his Barthel has improved to 7 (69) so Social Services say that he no longer fits their criteria for a nursing home and he should now be considered for further rehabilitation (21). The nursing cardex notes that his catheter is out (35) he is eating better but he

still gets bad pain in his left arm (36). His arms, hands and feet are noted to be significantly more swollen on 12th October (36). His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October (61,63). However his Waterlow score remains at "high risk" for all his admission (71). A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect and injury if he starts to take alcohol again. He currently needs 24 hour hospital care (21).

3.12 On 14th October he is transferred to Draed Ward and the notes (179) say "for continuing care". The notes document the history of fractured humerus, his alcohol problem, current oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation. I am unable to read four words. The single word on the line above incontinence, two words after lives with wife (this may be a street address) and the word in front of gentle mobilisation.

3.13 The next medical notes (179) are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr Barton, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes (265) state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. The evidence from Mr Wilson's wife (Gillian Kimbley) is that he looked dreadful and was incomprehensible at lunchtime on the 15th October, a very significant change from the morning of the 14th.

On 16th in the nursing cardex he is "seen by Dr Knapman am as deteriorated overnight, increased Frusemide". The nursing care plan (278), states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30 hours. From the analysis of the drug chart, Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours 10 mgs

Oramorph on 16th.

3.14 The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration (179) and death is later recorded at 23.40 hours and certified by Staff Nurse Collins. The nursing cardex mentions a bubbly chest late pm on 16th October (265). On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions (265). Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction (266). The higher dose of Diamorphine on the 18th and Midazolam is recorded in the nursing cardex (266).

3.15 Two Drug Charts: (see table). The first is the Queen Alexandra drug chart (106-116). This records the regular laxatives, vitamins and diuretics given for his liver disease. The reducing dose of Chlordiazepoxide stops on 30th September for his alcohol withdrawal and the Trazodone started for his mild depression and night sedation. In terms of pain management Morphine, slow IV or subcutaneous 2.5 – 5 mgs written up on the prn side and 5 mgs given on 23rd September and 2.5 mgs twice on 24th September. Morphine is also written up IM 2 – 5 mgs on 3rd October and he receives 2.5 mgs on 3rd and 2.5 mgs on 5th. He is also written up for prn Codeine Phosphate and receives single doses often at night up until 13th October but never needing more than 1 dose a day after 25th September. Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

3.16 The second drug chart is the drug chart of the Gosport War Memorial Hospital (258-263). His diuretics, anti-depressant, vitamins and laxatives are all prescribed regularily. The regular Paracetamol is not prescribed but is written up on the as required (prn) part of the drug chart. This is never given. Regular prescriptions also contains Oramorphine 10 mgs in 5 mls to be given 10 mgs 4 hourly, starting on 15th October (261). 10 mgs is given at 10 am, 2pm and 6 pm on 15th, 6am, 10 am and 2 pm on 16th. A further dose of 20 mgs at night given at 10 pm is given at 10 pm on 15th October. Although these prescriptions are dated as given on the 15th October it is not clear if they were written up on the 14th or 15th.

3.17 On a further sheet of this drug chart (262) regular prescription has been crossed out and prn written instead. Oramorphine, 10 mgs in 5 mls, 2.5 – 5 mls 4 hourly is then prescribed on this sheet. It is not dated but it would appear 10 mgs is given at 2.45 on 14th October and 10 mgs at midnight on 14th October. Further down this page Diamorphine 20 – 200 mgs subcut in 24 hours from Hyoscine 200 – 800 micrograms subcut in 24 hours, Midazolam 20 – 80 mgs subcut in 24 hours are all prescribed. It is not clear what date these were written up. The first prescription is 16th October and the 20mls of Diamorphine with 400 micrograms of Hyoscine are started at 16.10. On 17th October, 20 mgs of Diamorphine, 600 micrograms of Hyoscine are started at 5.15 and the notes suggest that what was left in the syringe driver at that stage was destroyed (262). At 15.50 hours on 17th October, 40 mgs, 800 mgs of Hyoscine and 20 mgs of Midazolam are started and on 18th 60 mgs of Diamorphine, 1200 micrograms of Hyoscine (a new prescription has been written for the Hyoscine) and 40 mgs of Midazolam are started in the syringe driver at 14.50 and again the notes suggest the remainder that was previously in the syringe driver is destroyed.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Morphine	22/09	2-5 mgs IV/SC PRN 4 hourly	? (at QAH)	23/09 1540 5 mgs 24/09 0615 2.5mgs 24/09 0645 2.5mgs
Morphine	03/10	2-5 mgs I/M PRN 4 hourly	? (at QAH)	03/10 2319 2.5 mgs 05/10 0200 2.5 mgs
Codeine Phosphate	23/09	30mgs 6 hourly PRN	? (at QAH)	23/09 2 doses 30 mgs 24/09 3 doses 30 mgs 25/09 1 dose 30 mgs
CoDydramol	25/09	2 tabs 6 hourly Regular	? (at QAH)	25/09 3 doses 26/09 – 29/09 4 doses each day then stopped
Codeine Phosphate	8/10	15-30 mgs 4 hourly PRN	? (at QAH)	08/10 09/10 1 dose 12/10 each day 13/10
Paracetamol	30/09	TT 6 hourly Regular	? (at QAH)	30/09 – 06/10 Many missed doses until the 07/10 – 14/10. 4 doses a day
Paracetamol	14/10	1 gram 4 hourly, PRN	Barton (at GWMH)	Never given
Oramorphine	Undated but probably 14/10	2.5-5mls of 10 mgs in 5mls 4 hourly, PRN (regular crossed out)	Barton (at GWMH)	14/10 1445 10 mgs 14/10 2345 10 mgs

Oramorphine	15/10	10mgs 4 hourly regular	Barton	15/10 1000 10 mgs 15/10 1400 10 mgs 15/10 1800 10 mgs 16/10 0600 10 mgs 16/10 1000 10 mgs 16/10 1400 10 mgs No further prescription recorded by drug chart. But prescription not crossed off or stopped
Oramorphine	15/10	20mgs nocte Regular	Barton	15/10 2200 20 mgs
Diamorphine	Undated, possibly 16/10 but might well have been 14/10	20 – 200mgs S/C in 24 hours PRN (Regular crossed out)	Barton	16/10 1610 20 mgs 17/10 0515 20 mgs 17/10 1550 40 mgs 18/10 1450 60 mgs
Midazolam	Undated, possibly 14/10; or 16/10 or 17/10	20-80 mgs S/C in 24 hours PRN (Regular crossed out)	Barton	17/10 1550 20 mgs 18/10 1450 40 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Robert Wilson. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Robert Wilson, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 The principle underlying medical problem in Mr Wilson is his **Code A** liver disease. There is no doubt that he had hepatocellular failure based on long-standing alcohol abuse, with evidence at least back to his admission in 1997 where he has evidence of portal hypertension giving him a significant ascites. He also at that stage had a low albumin and a persistently raised bilirubin, hall-markers of a poor medium to long-term prognosis.

4.3 The presenting problem on admission was his complex fracture of his left upper arm, which ideally would have had an operative repair. First he refuses this, and then by the time he agrees it his physical status has significantly deteriorated to a point that he was not fit for an anaesthetic. He gets continual pain from this arm throughout his admission. His admission treatment is strong opiate analgesia; this is then replaced by regular oral mild opiate

analgesia and finally by regular Paracetamol supplemented by mild oral opiate analgesia (Codeine Phosphate) at night. There is no doubt though that he does have continuing pain from this arm.

4.4 His health deteriorates for at least the first 7 – 8 days after his admission. He develops impaired renal function; there is evidence of change in mental state with comments on poor communication, sleepiness, irritability and restlessness, and "dysarthria". There are a number of possibilities for this. The first possibility is that he is having alcohol withdrawal, combined with the sedative effect of Chlordiazepoxide to prevent marked symptoms of alcohol withdrawal delirium. The psycho-geriatrician wonders if he has alcohol related dementia plus some depression. I believe it is very likely that he has early hepatic encephalopathy, a change in mental state that goes with hepatic failure. This includes disturbed consciousness with sleep disorder, personality change and intellectual deterioration. It is often precipitated by acute events including gastro-intestinal blood loss and drugs, in particular opiates. There is other evidence of major impairment to his liver function including a reduced platelet count, (suggesting an enlarged spleen due to portal hypertension), his bilirubin which is significantly higher than his previous admission and his persistent very low albumin. His haemoglobin does fall during admission. It is possible that he has had a small gastro-intestinal bleed at some stage but this is not pursued.

4.5 Despite all of this, there is a an improvement in his condition recorded in both his better functioning on the ward with the nursing staff, his greater alertness and communication improvement. The fact that his catheter can be removed and he becomes continent and that his overall measured functional status through the Barthel score improves to a point that Social Services will no longer place him in a nursing home, although he clearly needs nursing care. However, his weight dramatically increases by 11 kgs during his admission and this will be almost entirely fluid retention going to his abdomen, legs and potentially his chest. This is not adequately managed medically.

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

4.7 The only management that is really needed at this stage is to continue the management that was ongoing from the Queen

Alexandra Hospital while carefully addressing the fluid balance problems. However the regular oral analgesics that he was on are not written up regularly, no explanation is given for this. Strong opioid analgesia is written up and two doses of 10 mgs Oramorphine are given on the day of transfer, the 14th October. At the Queen Alexandra Hospital the single doses on the 3rd and 5th October had been at 2.5 mgs. Regular Oramorphine to a total dose of 50 mgs is then given on the 15th October. It is now being given regularly and it is not clear whether the original intention to give it regularly was from the admission on the 14th, though the prescription is clearly written and starts at 10 am on 15th. There is no documentation in the nursing or medical notes to suggest the patient was seen by a doctor on 15th when the decision to start the regular dose of Morphine appears to be made.

4.8 The decision to give Morphine on the 14th and then the regular Morphine, at this dose, on 15th October is crucial to the understanding of this case. "*.....the effects of hepatitis or cirrhosis on drug deposition range from impaired to increased drug clearance in an unpredictable fashion..... the oral availability for high first class drugs such as Morphine.....is almost double in patients with cirrhosis compared to those with normal liver function. Therefore the size of the oral dose of such drugs should be reduced in this setting" (Harrison).* In my view the decision to give the significant doses of Morphine on the 14th then the regular oral doses of high oral doses of strong opiates on 15th was negligent. The appropriate use of weaker analgesics had not been used, though these had apparently controlled his symptoms the previous week in the Queen Alexandra Hospital as he had not received strong opioid analgesia after the 5th October. The dose of Morphine used, particularly in the presence of severe liver disease, was very likely to have serious implications (see para 4.4).

4.9 By the 16th October there has been a very significant clinical deterioration overnight and Mr Wilson is examined by Dr Knapman. He is noted to be unwell and unresponsive to spoken orders. While it is possible that Mr Wilson has gone into heart failure due to his salt and water retention documented previously, his unresponsiveness is almost certainly, in my view, to be because of a direct cerebral effect of the Morphine or that he is being precipitated again into Hepatic Encephalopathy (see para 4.4). The situation may or may not have been still reversible on 16th October but he was probably now entering a period of irreversible terminal decline. However, it would still have been appropriate to have obtained senior medical opinion as to whether

other management should be considered. In my view, the failure to obtain senior medical opinion was poor clinical practice. This criticism could be made of Dr Knapman on the 16th October and certainly of Dr Barton on the 15th, as the patient was seen by Dr Barton on the 15th October (as suggested by her statement to the police). The situation was unrecoverable by the 17th October.

4.10 On the afternoon of the 16th he is started on a syringe driver. Although prescribed by Dr Barton there is nothing in the notes to document the decision to start is a medical or nursing decision. He is started on a syringe driver containing Diamorphine and Hyoscine. Diamorphine, Hyoscine (and Midazolam) are all compatible in the same syringe driver. Hyoscine is particularly useful for patients with a large amount of secretion as is documented in this case. The increase in dose of Hyoscine on the 17th was an appropriate decision. When starting Diamorphine in a syringe driver it is conventional to do it at a dose of 2 or 3 to 1 i.e. at most half the dose of Diamorphine in the syringe driver than was being given orally. On 15th October 50 mgs in total of Oramorphine was prescribed, it was reasonable to start 20 mgs in the syringe driver on 16th October. The dose of Diamorphine is increased on both 17th and 18th and Midazolam is started on 17th. Apart from comments about secretions in the nursing cardex, there is no rationale for the increase in dose of Diamorphine or the addition of Midazolam provided in either the medical or nursing notes. It is not clear whether the decision to increase the dose is a medical or nursing decision. I have indicated in section 3 that there are significant problems with the use of the drug chart in Gosport which seems to have been used in an irregular fashion.

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

5. OPINION

5.1 Mr Robert Wilson is a 71 year old gentleman with known severe alcoholic liver disease who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further

assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

5.2 There is evidence of poor medical practice at the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission to the Gosport War Memorial Hospital.
- The failure to continue his oral analgesic regime on admission.
- The decision to use strong opiate based analgesic on the 14th October and at a dose higher than previously needed in the Queen Alexander Hospital. In my view a negligent decision that formed a major contribution to the clinical documentation that occurred over 15th-16th October.
- The failure to realise the potential risks of using strong opiate analgesia in the presence of liver failure.
- The failure to document any reason for starting regular Oramorphine on the 15th October.
- The failure to investigate the possible causes of his deterioration on 15th and 16th October, or to consider that they might be reversible.
- The failure to ask for a senior medical opinion certainly on the 15th October and possibly on the 16th October (also see my generic report).
- The failure to document in either the medical or nursing notes the reasons for the decision to start the syringe driver on the 16th October.
- The failure to document any reason for the increased dose of Diamorphine and Midazolam in the syringe driver on the 17th and 18th, and whether that was a medical or nursing decision.

5.3 The use of the drug chart in the Gosport War Memorial is significantly deficient. In particular:

- The prescription of a large range of a controlled drug (see my generic report).
- The misuse of both the "PRN" and regular sides of the drug chart.
- The failure to cross out drugs on the regular side of the drug chart when no longer required.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS

Enid SPURGIN
DOB: Code A
DOD: 13/04/1999

Mrs Enid Spurgin was a 92-year-old lady admitted to the Haslar Hospital on 19th March 1999 following a fall. She undergoes an operation for a proximal femoral fracture and then transferred to the Gosport War Memorial Hospital on 26th March 1999. She is known to have become increasingly frail with poor eyesight, depression and mild memory impairment.

In the Gosport War Memorial Hospital she is in continual pain for which no definite diagnosis is made. She develops a wound infection and then deteriorates rapidly and receives pain relief and palliation for her terminal decline, including subcutaneous Diamorphine and Midazolam and dies on 13th April 1999.

However there were failings in the medical care provide to Enid Spurgin also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence; 'M' in front are the microfilm notes).

3.1 At the time of her death in 1999 Edith Spurgin was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. (M38). She was also noted to have Paget's disease in her pelvis in 1988 (M39). She had a probably myocardial infarction in 1989 (M6). In 1997 she had been seen by a Dr Mears, a Consultant Psycho-Geriatrician, for depression (144). He also noted poor eyesight (145). At that time she was on an anti-depressant and was noted

to have a normal mini-mental test score of 27/30 (148). She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment (152) (158).

3.2 Enid Spurgin was admitted to the Haslar Hospital on the 19th March1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999 (20). The notes for Haslar are not currently available to me, the only information is the hand written one page summary that says post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn. The only nursing information from Haslar is an admission assessment and pressure sore assessment on 19th March (64 & 66).

3.3 The next medical notes we have until her death, are written on a single page from Gosport Hospital (24). This states that the patient was transferred to Dryad Ward on 26th March, with a history of a fractured neck of femur and no significant past medical history. The medical notes state she was not weight bearing, she was not continent, tissue paper skin. The medical plan was "sort out analgesia".

3.4 The next medical note is on the 7th April, "still in a lot of pain and very apprehensive. MST increased to 20 mgs bd yesterday, try adding Flupenthixol. For x-ray of right hip as movement still quite painful – also about 2" shortening right leg."

3.5 The next medical note is 12th April, "now very drowsy (since Diamorphine infusion established) reduced to 40 mgs per 24 hours, if pain recurs increase to 60mgs". Able to move hips ? (illegible) pain, patient not rousable. Final note is dated 1.15 am 13th April. Died peacefully.

3.6 Nursing notes from Mrs Spurgin's admission on 26th March continually refer to pain. The first night she has difficulty in moving, Oramorphine is given (80). The admission care plan mentions she was experiencing a lot of pain and movements (84). The desired outcome is "to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation". 27th March, "is having regular Oramorphine but still in pain" (84). 28th March (84) "has been vomiting with Oramorph, advised by Dr Barton to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

3.7 On 29th (85) pain needed to be reviewed and on 31st March 10 mgs bd of MST (Morphine slow release tablets) is documented. "Mrs Spurgin walked with the Physiotherapist but was in a lot of pain". She was still having pain

on 1st and 3rd April (85).

3.8 On 4th April (86) it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr Reid who thought the wound site was infected and started Mrs Spurgin on Metronidazole and Ciprofloxacin (both antibiotics) (107). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr Reid had reviewed the x-ray of the hip.

3.9 Mrs Spurgin clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink (107). The wound looks red and inflamed and feels hot (107). As recorded in the nursing notes Mrs Spurgin is seen by Dr Barton (107), and a decision is made to commence a syringe driver. There is no record in the medical notes.

3.10 The patient is seen by Dr Reid on the afternoon of the 12th (108) the Diamorphine dosage is reduced. Early morning of 13th April, death is confirmed (108).

3.11 Dependency is also confirmed by a Waterlow score of 32 on the 26th March (i.e. very high risk for pressure sores) (92) and a Barthel of 6/20 on 29th March (94) and 5/20 on 10th April (94).

3.12 Drug management in Gosport concentrating on the use of analgesia:

3.13 At the point of admission Oramorphine 10 mgs in 5 mls (2.5 – 5 mgs 4 hourly prn) is written up on the "as required" part of the drug chart. Two doses in total are documented to have been given on 31st March and the 11th April.

3.14 On the regular prescription Oramorphine 2.5 mgs 4 hourly and 5 mgs at night is written up, first dose given by 10 am on 26th March (125). This is then changed to 5 mgs four hourly with 10 mgs at night up until 28th March, then the Oramorphine is then discontinued and Co-dydramol 2 tablets 6 hourly written and prescribed from 28th March – 1st April (125).

3.15 Metoclopramide 10 mgs three times a day is written up continuously from 28th March to 11th April, but is only actually given to the patient intermittently. Morphine slow release tablets 10 mgs bd (MST) are written up on 31st March and given to 6th April. MST 20 mgs bd is written up on 6th April and given to 11th April. A double dose of MST (one 10 mgs and one 20 mgs) is given on the morning of the 6th April.

3.16 Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given

to 11th April. (134)

3.17 Finally, Diamorphine 20 – 100 mgs is written up on 12th April. 80 mgs in a syringe driver started at 8 am and according to the drug chart "dose is discarded at 16.40 hours and reduced the dosage to 40 mgs in 24 hours". The pump is discontinued at 1.30 am on the patient's death on 13th March. Midazolam 20 – 80 mgs is written and is prescribed. 20 mgs put in the syringe driver at 8 am. It appears this was increased to 40 mgs at 16.40 hours and discontinued at 1.30 am on 13th April.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Oramorphine	26/03	10 mgs in 5 mls 2.5 – 5 mls oral PRN	Dr Barton	31/03 1320 5 mgs 11/04 0715 5 mgs
Oramorphine	26/03	10 mgs in 5 mls 2.5 oral 4 hourly Regular	Dr Barton	27/03 1515 5 mgs 27/03 1800 5 mgs Then crossed off
Oramorphine	26/03	10 mgs in 5 mls 5 mgs oral nocte Regular	Dr Barton	27/03 2200 10 mgs Then crossed off
Oramorphine	27/03	10 mgs in 5 mls 5 mgs oral 4 hourly Regular	Dr Barton	27/03 0600 10 mgs 27/03 1000 10 mgs 27/03 1400 10 mgs 28/03 0600 10 mgs 28/03 1000 10 mgs 3 doses missed with no explanation. Crossed off.
Oramorphine	27/03	10 mgs in 5 mls 10 mls oral nocte Regular	Dr Barton	27/03 2200 20 mgs Crossed off
Co-dydromol	27/03 or 28/03 (?)	TT 6 hourly oral Regular	Dr Barton	Regular doses 4 x a day until 1200, 31/08 when no further doses given. Crossed off
NEW CHART				
Morphine MST	31/03	10 mgs bd Oral Regular	Barton	Started 31/03, 0930 and given regularly until last dose 06/04, 0800 crossed off
Morphine MST	06/04	20 mgs bd Oral Regular	Barton	Started 06/04, 0800 given regularly until last dose 11/04, 2000. Never crossed off
NEW CHART				
Diamorphine	12/04	20 – 200 mgs SC in 24 hours Regular	Barton	12/04 0800 80 mgs 12/04 1640 changed to 40 mgs
Midazolam	12/04	20 – 80 mgs SC in 24 hours Regular	Barton	12/04 0800 20 mgs 12/04 1640 changed to 40 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Enid Spurgin. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Spurgin, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 It is difficult to provide a comprehensive opinion in the absence of the Haslar notes and the very sparse nature of the Gosport notes.

4.3 Mrs Spurgin a very elderly lady of 92 years, had a number of chronic conditions including poor eyesight, depression, mild memory impairment, ischaemic heart disease, previous fracture of her right hip and known Paget's disease of her pelvis. She had a fall at home resulting in a further proximal femoral fracture and required a dynamic hip screw. This would have been a more complex procedure because of the previous fracture and the possibility that there was Paget's disease in her femur. However, from the one page summary from Haslar, it would appear that she was making reasonable progress at the point of transfer to Gosport. The prognosis in a 92 year old lady with her previous problems, that she would be likely to return to independent existence at home, would already be extremely low.

4.4 The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary from Haslar, which says that Mrs Spurgin is purely on intermittent Paracetamol. There are various possibilities. She may have been undertreated for pain in Haslar, she may have had a dislocation in the ambulance transferring her (this does occur), she may have been starting to develop infection in the wound or she may have had some other orthopaedic problem that was not picked up between leaving Haslar and arriving in Gosport. I was also unable to find any report of the x-ray that was taken at Gosport on 7th April.

4.5 The medical assessment undertaken in Gosport was inadequate. There is no record of a significant history or general examination being performed, or if it was it was not recorded. No assessment or explanation at all is sought for why this lady is in pain, particularly if she had not been in pain in Haslar. The major gaps in the written notes particularly on admission represent poor clinical practice.

4.6 However, it was appropriate to provide pain relief to a patient with unresolved pain. Normally this would be done in a stepwise fashion, starting with the milder pain killers, such as the Paracetamol, she was already on in Haslar. Then to stronger oral medication (such as moderate opioids) and then to stronger opioid analgesia. However, she is started on a regular dosage of stronger opioid analgesia immediately from the point of her admission into Gosport. The reason for this is not documented and represents poor clinical practice.

4.7 The nursing notes document that her pain does not settle and is considerably interfering with her attempts at rehabilitation. She is then troubled with vomiting and the opioid analgesia is in fact stopped and replaced with oral co-dydramol (a moderate oral opioids). Her vomiting does apparently settle but her pain continues, so she is restarted on a strong opioid analgesia on 31st March.

4.8 She is seen by a consultant on 7th April, who is appropriately concerned that there is continuing pain and arranges for an x-ray. The failure to follow up this investigation is poor medical practice There is no record of the result of this x-ray in the notes. However, there appears to be a working assumption that she may have a wound infection and following Dr Reid's intervention is appropriately started on antibiotics. On 11th April there is a rapid deterioration in her condition. This is documented in the nursing notes but there is no medical note made on the 11th April. The nursing notes suggest that she was seen by Dr Barton on 11th April, and a decision was made to start a syringe driver. However, I do wonder if this is incorrect and that she was seen early in the morning of 12th April as a syringe driver starts at 8am and not on the 11th April. No medical note is made by Dr Barton on either the 11th April or the 12th of April, this is poor medical practice.

4.9 In view of the clinical deterioration on 11th April, despite the patient receiving appropriate antibiotics, I believe it was appropriate to start a syringe driver as she was drowsy and unrousable at times, as there is no doubt in my view that Mrs Spurgin was now dying. The likeliest cause is an unresolved infection in the wound and in her hip but the original cause of the pain remains undiagnosed. The opportunity for any possible remediation is well past at this stage. Diamorphine is then written up, prescribed at 80 mgs per 24 hours. The prescription in the notes was 20 – 200 mgs of Diamorphine in 24 hours and it is not clear whether Dr Barton or the nurse in charge choose the dose of 80 mgs. At that time Mrs Spurgin was on 20 mgs twice a day (i.e. 40 mgs total) of Morphine Sulphate, slow release although received 45 mgs in total on the 11th April. Diamorphine subcutaneously is usually given at a maximum ratio of 1 – 2 (i.e. up to 20 mgs Diamorphine in 24 hours for 40 mgs of Morphine) (Wessex Guidelines). However, her pain was not controlled and it would have been appropriate to give a higher dose of

Diamorphine. Conventionally this would be 50% greater than the previous days, (Wessex Guidelines). Some people might give up to 100%. Thus a maximum starting dose of Diamorphine of 40 mgs in 24 hours would seem arguable. Mrs Spurgin was prescribed 80 mgs which in my view was excessive, thus poor and negligent medical practice. This was reduced to 40 mgs after the intervention of the consultant Dr Reid, some 8 hours later. This was an appropriate intervention.

4.10 Midazolam was also added to the infusion pump on 12th April. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was originally 20 mgs for 24 hours which is within current guidelines. This was increased to 40 mgs later in the day, which although remains within current guidelines, many believe that elderly patients may need a lower dose of a maximum 20 mgs in 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th edition, 2003). There is no assessment or justification for this decision in the medical notes, nor is it possible to tell if this is a medical or nursing decision. Morphine is compatible with Midazolam and can be used in the same syringe driver.

4.11 As Mrs Spurgin is thought to have been excessively sedated and the dose of Diamorphine is reduced on 12th April, thus the decision to increase the dose of Midazolam at the same time seems inexplicable. Mrs Spurgin dies on the 13th April.

The prediction of how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

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

5. OPINION

5.1 Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularly in those patients with impairments of daily living before their fracture is generally poor, both in terms of mortality or in

terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

5.2 However there were failings in the medical care provide to Enid Spurgin, in particular:

- The failure to undertake a clinical assessment of Mrs Spurgin on admission to Gosport War Memorial Hospital.
- The failure to make any diagnosis or assessment of the cause of pain on admission and until 7th April.
- The prescription on admission, without explanation, of strong opioid analgesia, when apparently she had only need Paracetamol in Hasler.
- The failure to follow up the xray undertaken on the 7th April.
- The failure to document the reason for starting the syringe driver.
- The failure to explain in the notes the decision to start with 80 mgs of Diamorphine in the syringe driver, in my view a negligent decision.
- The failure to explain the decision to increase the dose of Midazolam at the same time as the Diamorphine is reduced on the 12th April.
- The failure to record a reason to give 2 doses of MST on the morning of the 6th April.
- Reporting the cause of death as 'Cerebrovascular Accident', without any clinical evidence.

5.3 There are also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The failure to give regularly prescribed dose of Oramorphine, without explanation.
- The failure to cross off the MST from the regular drug chart on the 11th April.
- The use of the regular side of the drug chart for variable doses of drugs given in the syringe driver.
- The failure to write dosages of controlled drugs in words and figures as well as the total to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the

opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS

Geoffrey PACKMAN
DOB: Code A
DOD: 03/09/1999

Mr Geoffrey Packman was a 67 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

However there were failings in the medical care provided to Geoffrey Packman and also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

3.1 Geoffrey Packman a sixty seven year old gentleman in 1999 was admitted as an emergency on the 6th August 1999 to Portsmouth Hospitals NHS Trust following an attendance at A&E (40,42).

3.2 Mr Packman had suffered from gross (morbid) obesity for many years, he had also had venous leg ulceration for at least five years (44), he was hypertensive and had a raised prostatic specific antigen, suggesting prostatic pathology. (8)

3.3 Following a fall at home he was completely immobile on the floor and two ambulance crews were needed to bring him to accident and emergency (42). He was currently receiving District Nursing three times a week for leg ulcer management (255). He had become increasingly immobile

complicated by the fact that his wife who lived with him and provided care was being investigated for breast cancer. The admission clerking showed that he not only had leg ulcers but he had marked cellulitis, was pyrexial and in atrial fibrillation. Cellulitis was both in his groin and the left lower limb (45). He was totally dependent needing all help (143) with a Barthel of 0 (163). His white cell count was significantly raised at 25.7 (48), his liver function tests were abnormal with an AST of 196 and his renal function was impaired with a urea of 14.9 and a creatinine of 173 (47). These had all been normal earlier in the year. He was treated with intravenous antibiotics (45) in a special bed (187).

3.4 He appeared to make some progress and on 9th August his cellulitis was settling (48). A Haemolytic Streptococcus sensitive to the penicillin he had been prescribed was identified (225). On 11th August the nursing cardex (134) stated that there appeared to have been a deterioration of his heel ulcers with a "large necrotic blister on the left heel". His haemoglobin on 12th August (211) was 13.5.

3.5 On 13th August white count was improved at 12.4 (50,52), his U's and E's were normal and the notes recorded a planned transfer to the Gosport War Memorial Hospital on 16th August.

3.6 Later on the 13th black bowel motion is noted but the doctor who examines him records a brown stool only. It is not clear whether he has had a gastro intestinal bleed (52). On 16th August no comment is made on the possible gastrointestinal (G.I) bleed, but on 20th August his haemoglobin is noted to be 12.9 (53) no further black stools have been reported so he is planned for transfer on 23rd August. Albumin at this stage is now reduced at 29 (190).

3.7 On 17th August sacral sores are now noted in the nursing cardex (118) which by the 20th are now recorded as "deep and malodorous" (125).

3.8 He is transferred to the Gosport War Memorial Hospital on 23rd August (54). A brief history and examination is undertaken which notes that there was a history of possible melaena, the clinical examination recorded suggests that he is stable. Blood tests are requested for the next day. The drug chart (168) suggests that his weight is 148 kgs but it is not clear if this is an estimate or a measurement. He is very dependent with a Barthel of 6 and a Waterlow score of 18, putting him in high risk. His haemoglobin on 24th is 12 (207). The nursing cardex on the 24th notes the multiple complex pressure sores on both the buttocks and the sacrum (96-100).

3.9 On 25th August the nursing cardex reports that he is passing blood rectally and also vomiting (62, 82).

3.10 On 26th August Dr Barton is asked to see him and records that he is clammy and unwell. (55) The notes suggest that he might have had a myocardial infarction and suggests treating him with Diamorphine and Oramorphine overnight. It records that as an alternative there might be a G.I. bleed but this is recorded as unlikely because he has not had haematemesis. It also notes that he is not well enough to transfer to an acute unit and he should be kept comfortable, including "I am happy for the nursing staff to confirm death". His Clexane (an anticoagulant given to prevent pulmonary embolus) is now stopped. The nursing cardex (62) on the same day records further deterioration throughout the day with pain in his throat and records a verbal request for Diamorphine. A full blood count is taken (this fact is not recorded in the notes) but the result is filed in the notes recording a haemoglobin markedly reduced at 7.7 (205). It also states "many attempts were made to phone Gosport War Memorial Hospital but no response from switchboard". These significant results are not commented on at any stage in the nursing or clinical notes.

3.11 On 27th August (63) the nursing notes record some improvement in the morning but discomfort in the afternoon especially with dressings. On 28th August both the medical (55) and the nursing records (63) are noted to be very poorly with no appetite. Opiates are to continue over the weekend. 29th August he is sleeping for long periods (63) and on 30th he is still in a very poor clinical condition but eating very small amounts of diet. He is re-catheterised the same day (55).

3.12 On 31st he is recorded as passing a large amount of blood rectally (83) and on the 1st September (55 and 64) he is reviewed by a consultant Dr Reid who notes that he is continuing to pass melaena stool, there are pressure sores across the buttocks and posterior aspects of both thighs, he is now significantly confused. Dr Reid records that he should be for TLC only and that his wife is now aware of the poor prognosis. Nursing notes (64) note that the dose of drugs in the syringe driver should be increased; the previous doses were not controlling his symptoms. The nursing notes of the 2nd September (62) record the fact the Diamorphine is again increased on the 2nd to 90mgs and on 3rd September he dies at 13.50 in the afternoon (55, 64).

3.13 Drug Chart review: There are two drug charts. Chart 1 (174-178) confirms his original admission to Portsmouth Hospital Trust in particular the appropriate use of the antibiotics, Penicillin, Flucloxacillin and the prescription of the anticoagulant Clexane. This goes from 6th August – 23rd August. Paracetamol is the only analgesic given in Portsmouth.

3.14 The second drug chart (168-172) goes from his admission to the Gosport War Memorial Hospital on 23rd August to his death on the 3rd September. The once only part of this drug chart on 26th August states Diamorphine IM 10 mgs verbal message given 18.00 hours. Then apparently two days later on 28th August, Diamorphine IM 10 mgs signed Dr Barton. This is never given, this may be a retrospective attempt to legitimise the prescription given verbally 2 days before.

3.15 On the 'as required' part of the drug chart only Gaviscon and Temazepam are written up. On the regular side of the drug chart Doxazosin, Frusemide, Clexane (until 25th August) Paracetamol, Magnesium, Metoclopramide and Loperamide are all written up. Though some of these drugs like the Magnesium appear to have been given in a "as required" fashion. Oramorphine (171) though written up regularly is never given. Diamorphine 40 – 200 mgs subcut in 24 hours is prescribed on the 26th (171) and appears to have been given as 40mgs on 30th, 31st, 1st changed to 60 mgs on 1st September and 90mgs on 2nd September. The drug chart is extremely confusing (171) as these prescriptions have not been properly put in the day and date boxes required, and the nursing staff appear to be putting two days of prescribing into a single day box. Midazolam 20 – 80 mgs subcut in 24 hours is written up and Midazolam is probably given 20 mgs on the 30th and 31th August, 40mgs on 1st September, changed to 60mgs on 1st September and given 80mgs on 2nd September.

3.16 On the next regular page of the drug chart (172) Oramorphine 10-20mgs 4 hourly is written up and is signed up to have been given for 4 doses daily on 27th, 28th and 29th August, with two further doses in the morning of the 30th August. I cannot tell from the drug chart whether 10mgs or 20mgs is actually given. Oramorphine is written up 20mgs at night and given on 26th, 27th, 28th and 29th August. Hyoscine is written up but never given, although it is prescribed as a regular prescription.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Diamorphine	'verbal message'	10 mgs I/M start Once only part of drug chart	Dr Barton	26/08 1800
Diamorphine	28/08 (?)	10 mgs I/M start Once only part of drug chart	Dr Barton	Never given
Oramorphine	26/08	10 mgs 4 hourly oral Regular	Dr Barton	Never given Never crossed off
Oramorphine	26/08	10 mgs in 5 mls 10 - 20 mgs oral Regular	Dr Barton	27/08 4 doses 28/08 4 doses 29/08 3 doses 30/08 2 doses to 10am (Actual dose given never recorded)

Oramorphine	26/08	10 mgs in 5 mls 20 mgs nocte Regular	Dr Barton	26/08 2200 27/08 2200 28/08 2200 29/08 2200 Never crossed off
Diamorphine	26/08	40 – 200 mgs S/C in 24 hours Regular	Dr Barton	Not given until 30/08 30/08 1445 40 mgs 31/08 1545 40 mgs 01/09 1545 40 mgs changed to: 01/09 1915 60 mgs 02/09 1540 90 mgs
Midazolam	26/08	20 - 80 mgs S/C in 24 hours Regular	Dr Barton	Not given until 30/08 30/08 1445 20 mgs 31/08 1545 20 mgs 01/09 1545 40 mgs changed to: 01/09 1915 60 mgs 02/09 1540 80 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Geoffrey Packman. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Geoffrey Packman, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 Mr Packman had a number of chronic diseases prior to his terminal admission. The most serious was his gross (morbid) obesity which led to severe immobility and non-healing leg ulcers.

4.3 He then develops an infection (cellulitis) of his leg ulcers which has spread to his groin causing his high white count, his pyrexia, then his total immobility requiring appropriate admission to the Portsmouth Hospitals NHS Trust. On admission he is recognised to be at high risk of pressure sore development and appears to have been put on a special bed. He is put "not for resuscitation" on the 11th August. This would have reflected the medical futility of trying to undertake resuscitation, but would have had no implication for any other medical treatment or decision.

4.4 He appears to make reasonable progress from the point of view of his cellulitis and is treated with appropriate antibiotics, however is noted to have developed buttock and sacral pressure sores by 17th August which are in a serious condition by 20th August.

4.5 In the meantime, a black stool is noted on 13th August and the question of whether this is melaena (blood leaking from the upper gastro-intestinal tract which turns black when passing through the gastro-intestinal tract) and whether he has a gastric or duodenal ulcer. Normally this would be investigated with an endoscopy. However this would be quite a major procedure on such a dependent gentleman. Although in retrospect it is easy to say that this was the first bleed, it would not have been clear at the time, the lack of further melaena and the fact that haemoglobin does not significantly fall over the next week, suggests that conservative management was appropriate. However, he is not put on any prophylactic anti-ulcer medication and his anticoagulant is continued. In retrospect both of these decisions may have contributed to his subsequent problems.

4.6 He is transferred to the Gosport War Memorial Hospital on 23rd August. The prognosis for a patient with gross obesity, who is catheterised, and who has recent deep and complex pressure sores is terrible. In my experience such patients often deteriorate despite the best efforts of staff and die in hospital. He is clerked on admission and appropriate investigations carried out including haemoglobin which is now 12. Although by itself this is a normal haemoglobin his level of haemoglobin has very slowly drifted down and again in retrospect suggests that he was starting to bleed slowly.

4.7 On 25th August the nursing staff note that he is passing blood rectally and he is vomiting, although the medical staff do not appear to have been asked to seem him, or if they do, no notes are written and no examination is undertaken. However on the 26th August he is seen when he is unwell, very cold and clammy. Dr Barton suggests the likeliest diagnosis is a myocardial infarction, although appropriately she does think of a gastro-intestinal bleed. No examination is recorded in the notes, nor are some simple and appropriate investigations undertaken (for example an ECG), to try and differentiate these two problems. However a blood count is sent to the laboratory and haemoglobin has now fallen to 7.7. Mr Packman has had a massive gastro-intestinal bleed, this is now a re-bleed and in itself would be a marker of significant risk of death. Proven re-bleed needing more than 4 units of blood would in a previously fit patient over 65 be an indication for an emergency operation. However as the laboratory cannot inform the hospital of this result, no-one would appear to have brought it to medical or nursing attention.

4.8 Despite this there is an important decision to be made on the 26th August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the acute problems whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital.

Dr Barton makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no evidence of such a discussion in the notes. It is my view however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.

4.9 Mr Packman deteriorates further in the evening and is prescribed a single dose of Diamorphine as a result of a verbal request. In paragraphs 5.13 – 5.16 I have identified significant failings in the way the drug chart has been used and written up. Controlled drugs are given on at least one occasion based on a verbal request and the prescription apparently written 2 days later. Regular drugs are written up and never given. The drug chart is used in a most irregular fashion and I do not believe that the standards of medical prescribing or nursing delivery meet the expectations of regulations on the prescription in the use of controlled drugs.

4.10 From the 26th August Mr Packman is slowly deteriorating and after a single dose of Diamorphine, then from the evening of 26th August, receives regular Oramorphine, then Diamorphine, and Midazolam until his death. Both Oramorphine and Diamorphine while specifically prescribed for pain are commonly used to manage the stress and restlessness of terminal illness. Diamorphine is compatible with Midazolam and in itself is particularly used to terminal restlessness, and can be mixed in the same syringe driver. It is very difficult to assess the actual starting dose of Oramorphine from the notes and he appears to receive either 60mg or 100mg in total on the 27th. Calculating the dose would be complicated in this case due to his the massive obesity which might well effect the oral dose required, together with his serious pressure sores which might have been extremely painful on being dressed. However, there is no documentation in the notes to justify the decision as to why opioid drugs are actually started, or the choice of starting dose, nor is any pain problem or assessment mentioned. Indeed it is not clear if the decision to start the syringe driver is a medical or nursing decision. This lack of documentation is poor medical practice.

He appears subsequently to have been started on 40mgs of Diamorphine in 24 hours together with 20mgs of Midazolam. The dose of s/c Diamorphine is usually given in a ratio of 1:2, so 30mg might have been the equivalent of the dose of 60mg of Oramorphine. However I can find no evidence in the notes that there were any significant side effects from

the Oramorphine or the Diamorphine, and his symptoms do seem relatively well controlled as described in the nursing notes.

4.11 He is reviewed by a consultant (Dr Reid) on 1st September where it has now become absolutely clear that it is a gastro-intestinal haemorrhage which is causing his death on top of his other problems. Dr Reid is happy with the management and later in the day the Diamorphine is increased as the previous dose is aparently no longer controlling his symptoms. However, the dose of Midazolam is increased from 20 mgs to 60 mgs over 28 hours between 30th August and the 1st September. It is not clear if this is a medical or nursing decision and no record is made in the notes. This is poor medical practice. Further increase of 50% in dosage occurs on 2nd September and he dies the following day.

4.12 In my view a death certificate should read:
1a Gastro-intestinal haemorrhage
2 Pressure sores and morbid obesity

The police report states that the cause of death on the death certificate was 'myocardial infarction'. If so this was inaccurate and misleading.

5. OPINION

5.1 Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

5.2 However there were failings in medical care provided to Geoffrey Packman, in particular:

- Gastro-intestinal haemorrhage is suspected in Portsmouth but although never disproven he is continued on an anticoagulant.
- The failure to have a medical assessment, or to record one if it happened, after a gastro-intestinal bleed is recorded by the nursing staff on 25th August.
- The failure of Dr Barton on the 26th August to undertake investigation to exclude the first diagnosis made (myocardial infarction) and the failure to review the investigation that was undertaken, the full blood count.
- The apparent failure of the Gosport War Memorial Hospital switchboard to answer calls.

- The failure to ask for senior medical opinion at the time of a complex and serious medical decision on the 26th August.
- The failure to document any reason for both starting regular opioid medication and possible high starting dose of Oramorphine on the 27th August.
- The failure to document any reason to start the syringe driver on the 30th August and whether that was a medical or nursing decision.
- The failure to record any need for the 300% increase in Midazolam dosages between 31st August and the evening of 1st September.
- Writing myocardial infarction not gastro-intestinal haemorrhage as the cause of death on the death certificate.

5.3 There are also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The prescription of Diamorphine by verbal message.
- The regular prescription given for regular Oramorphine, which is never crossed out.
- The failure on 29th August to give a regular dose of Oramorphine, without explanation.
- The failure to give Diamorphine and Midazolam for the 26th, when written up as a regular prescription.
- The failure to cross off the regular dose of Oramorphine on the 30th August.
- The failure to record any of the actual doses of Oramorphine given between 27th and 30th August.
- The use of the regular side of the drug chart for variable doses of drugs given in the syringe driver, and the failure to rewrite prescriptions when changing doses.
- The failure to write dosages of controlled drugs in words and figures as well as the total to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS

Elsie DEVINE
DOB: Code A
DOD: 21/11/1999

Mrs Elsie Devine was an 88-year-old lady admitted to the Queen Alexandra Hospital following a crisis at home on the 9th October 1999. She has symptoms of confusion and aggression on a background of known chronic renal failure, IgA Paraproteinaemia, Hypothyroidism and a dementing illness. There was little improvement in the Queen Alexandra Hospital and she was transferred to the Gosport War Memorial Hospital on 21st October for continuing care.

In the Gosport War Memorial Hospital she deteriorates over the first two weeks in November and by 19th November is terminally ill. She receives palliation including subcutaneous Diamorphine and Midazolam and dies 21st November 1999.

However there were significant failings in the medical care provided to Mrs Devine as well as deficiencies in the use of the drug chart at Gosport War Memorial Hospital.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence)

3.1 In March 1998 (120) Mrs Devine was seen in a geriatric outpatient department with cellulitis, mild hypothyroidism, mild CCF, haemoglobin of 13 (317) and a creatinine of 90 (337).

3.2 In December 1998 she was seen in an orthopaedic clinic (102) and was found to be clinically fit for a knee replacement.

3.3 In March 1999 her haemoglobin was 12.8 (311) and her creatinine in February was 143 (325).

3.4 In April she was seen by a consultant geriatrician where she was found to be "moderately frail" although also noted to be "bright mentally" (84). Her weight was 58.8 kgs (144), her haemoglobin 11.5 (307) and a creatinine 151 (84).

3.5 She was referred to a renal physician and was also seen by a haematologist between June 1999 and September 1999. In June 1999 (60) her creatinine was 160, her haemoglobin 11.2 (297), her weight was 55.4 kgs (151). In July 1991 (50) the haematologist found 6% plasma cells and an albumen of 22 (52), immune paresis (70) and suggested a watch and wait approach. In September 1999 her renal physician noted that she had chronic renal failure with small kidneys and nephrotic syndrome with marked oedema. It was thought likely that this was on a background of progressive glumerulonenephritis (60) and she had an incidental IgA paraproteinaemia. Her Creatinine was 192 and her haemoglobin 10.5 (295).

3.6 On 9th October, she was admitted to the Queen Alexandra Hospital following a social crisis at home as Mrs Devine lived with her daughter and son-in-law. Mrs Devine's son-in-law had [redacted] and her daughter could no longer cope. There was a story of confusion and aggression, which was suggested, had become worse prior to her admission. The clinical diagnosis was of a possible urinary tract infection, with an underlying dementing illness. However, Mrs Devine was never documented to be pyrexial (256) and the mid-stream urine sample had no growth (367). There is no full blood count available in the notes for the 9th October. The admission clerking, which would be expected to be available, either before page 31 or around pages 157 and 158 also appears to be missing from the notes.

3.7 On the 12th October (31) she is noted to be distressed and agitated and undergoes a CT scan of her head, which shows involutional changes only (24). She receives a single dose of Haloperidol (160) (267). On the 13th October her haemoglobin is 10.8 with a white cell count of 14.5 (293).

3.8 On the 15th October she is noted to be wandering (166) on the same day she is assessed by Dr Taylor, Clinical Assistant for the Mental Health Team

who noted the history of confusion and disorientation and a 10 months history of mental deterioration (28). She was confused and disorientated but no longer aggressive. She was now mostly co-operative and friendly but tended to get lost, he also noted she was deaf. Her Mini Mental Test Score was 9/30, indicating moderate to severe dementia and he suggested that she would need ongoing institutional care. On the 18th October her creatinine was 201 (171).

3.9 On 20th October, there is a letter of an assessment from a locum consultant geriatrician (20). Who notes that she can stand, may have had a urinary tract infection on top of her chronic renal failure and that she was quite alert.

3.10 She is then transferred to the Gosport War Memorial Hospital with a discharge summary (24) that states she has chronic renal failure, paraproteinaemia, multiple infarct disease and an Abbreviated Mental Test Score of 3/10.

3.11 On 21st October she is transferred to the Gosport War Memorial Hospital and is for "continuing care" (154). Her Barthel dependency is noted to be 8 with a Mini Mental Score of 9/30. Dr Barton incorrectly writes that she has 'Myeloma' (154) in the notes.

3.12 On 25th October she is mobile unaided, washes with supervision, remains confused.

3.13 On the 1st November she is quite confused (155) and is wandering. On the 9th November investigations show haemoglobin of 9.9, white cell count of 12.6 (289) and a creatinine of 200 (349). An M.S.U reported on 11th November (363) shows no growth.

3.14 15th November she is noted to be very aggressive, very restless (155) and "is on treatment for a urinary tract infection". However, it is noted that the MSU from 11th November showed no growth. The medical note for the 15th is unsigned, I presume to be Dr Reid.

3.15 18th November (156) she is seen by the mental health team who note that in their view that "this lady has deteriorated and become more restless and aggressive, is refusing medication and not eating" but also noted "her physical condition is stable". She is put on the waiting list for Mulberry Ward. Creatinine on 16th November is 360 and a potassium 5.6 (349).

3.16 19th November there has been marked deterioration over night. The notes state "confused, aggressive, Creatinine 360, Fentanyl patch commences yesterday, today further deterioration in general condition needs subcut analgesia with Midazolam. Son seen and aware of condition and diagnosis, hence make comfortable. I am happy for nursing staff to confirm death"

(156). The nursing notes (222) confirm marked deterioration over last 24 hours. "Chlorpromazine given IM. 9.25. Subcut syringe commenced Diamorphine 40 mgs and Midazolam 40 mgs, Fentanyl patch removed. Son seen by Dr Barton at 13.00 and situation explained to him. He will contact his sister regarding and inform her of Elsie's poor condition. 20.00 daughter visited and seen by Dr Barton. Nocte: peaceful night syringe driver recharged at 07.25."

3.17 20th November the nursing notes (223) state, "condition remains poor, family have visited and are aware of poorly condition. Seen by Pastor Mary. Nocte: peaceful night extremities remain oedematous, skin mottling, syringe driver changed at 07.15. Dose of Diamorphine 40 mgs. Midazolam 40."

3.18 21st November. Nursing notes (223), "condition continues to deteriorate slowly. Asked to see at 20.30 hours patient died peacefully"

3.19 Barthel scores are recorded on 21st October 8; 31st October 16, 17th November 10; 14th November 10; 21st November 1 (202) Her weight on 21st October was 52.5 kgs (200).

Drug Chart analysis: 1 dose of Haloperidol was given in the Queen Elizabeth hospital on the 13th October (269). Drug chart at Gosport showed a single dose of Chlorpromazine given at 08.30 on 19th November (277) confirming the nurses' cardex.

The patient had received regular doses of Thioridazine (often given for confused behaviour) from the 11th November up unto 17th November (277). A small dose of prn 2.5 – 5 mgs Oramorphine had been written up on admission to Gosport but had never been prescribed. Hyoscine had also been written up and not prescribed.

Trimethoprim (for a presumed urinary tract infection) is prescribed on 11th November (277 & 276) and continued until 15th November. A 25-microgram patch per hour of Fentanyl is written up on the 18th November and a single patch is prescribed at 9.15 on 18th November (276). The evidence from the nursing cardex is that the Fentanyl patch is removed on the morning of the 19th (223) at 12.30 (275) 3 hours after the time the subcutaneous infusion was started.

A new drug chart is written up on 19th November for Diamorphine 40 – 80 mgs subcut in 24 hours and Midazolam 20 – 80 mgs subcut in 24 hours. The drug card (279) confirms that 40 mgs is put into the syringe driver at 09.25 19th, 7.35 on 20th and 7.15 on 21st and 40 mgs of Midazolam at each of those times. All other drugs had been stopped.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Oramorphine	21/10	10 mgs in 5 mls	Barton	---

		2.5 – 5 mls PRN				
Fentanyl	18/11	25 µg Skin – 3 days Regular	Barton	18/11	0915	
POSSIBLE NEW DRUG CHART						
Diamorphine	19/11	40 - 80 mgs S/C in 24 hours Regular	Barton	19/11 20/11 21/11	0925 0735 0715	40 mgs 40 mgs 40 mgs
Midazolam	19/11	80 – 120 mgs S/C in 24 hours PRN	Barton	19/11 20/11 21/11	0925 0735 0715	40 mgs 40 mgs 40 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Elsie Devine. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Devine, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2 In particular I will discuss:
a) whether it was appropriate to decide on 19th November that Mrs Devine was terminally ill and if so whether symptomatic treatment was appropriate and
b) whether the treatment that was provided was then appropriate.

4.3 Mrs Devine had progressive mental and physical deterioration starting in January 1999. Before that she had had relatively minor medical problems, a normal haemoglobin and creatinine and was put on a waiting list for a knee replacement at the end of 1998. Orthopaedic surgeons do not generally list people for knee replacements if they look or are significantly frail. Such patients tend to make poor functional recoveries.

4.4 Mrs Devine's physical deterioration can be marked by her slowly falling haemoglobin from 13 in 1998 (317) to 9.9 (289) in November 1999. Her albumin also falls and is documented at 22 in July 1999 (52) then extremely low at 18 (349) on admission to Gosport. At the same time her creatinine rises over the course of the year from 90 in 1998 to 160 in June 1999 and around 200 on admission to the Queen Alexandra Hospital in October 1999. The physicians, including the renal physician and the haematologist that she saw, all conclude this was a progressive problem with no easily treatable or remedial cause. The small kidneys shown on ultrasound usually suggest irreversible kidney pathology. I would agree with that assessment.

4.5 The history taken by the mental health team from her daughter, also describe mental deterioration and increasing confusion over the course of

the year. Such confusion is often missed in hospital appointments, although the comment that she did not bring her drugs or know what drugs she was taking in September 1999 (40) is a marker of probable mental impairment. The notes fail to come to any definitive diagnosis as to whether this is Alzheimer's disease or vascular dementia. This is difficult and cannot be criticised. It is probably more likely to be vascular dementia on its basis of its moderately rapid progression, and that she had another systematic illness going on identified by the renal physician as probable glomerulonenephritis.

4.6 When admitted to the Queen Alexandra Hospital with significant behavioural problems the original working assumption was that this was an acute event, caused by a probable underlying infection. However, no infection was ever demonstrated on the investigations ordered, and no pyrexia was identified, although the admission notes are missing. It is likely that her behaviour had gradually been deteriorating, the crisis then occurred with the social crisis in her family. Admitting patients acutely to hospital will often exacerbate confusion in an already underlying dementing illness.

4.7 The natural history of most dementia's is of some fluctuation on a downward course, both in terms of symptoms and progression of the underlying disease. When seen by the mental health team on 15th October (28), though her behaviour was not seriously disturbed at that time, they documented a mini-mental state examination of 9/30 indicating moderate to severe underlying dementia. The mental decline had been rapidly progressive over the same year, as had her physical decline. Although she received Haloperidol at Queen Alexandra, and Thioridazine at Gosport I think it is unlikely that any therapeutic intervention significantly altered the progression of either her mental or her physical deterioration.

4.8 On admission to Gosport Dr Barton writes in the notes that the patient has Myeloma (a malignant disease) rather than the Paraproteinaemia (a pre-malignant condition) that has actually been diagnosed. She may have mistakenly believed that she had a progressive cancer as well as her dementia and renal failure. This (not uncommon mistake by non-specialists) might have influenced the management of care, by making Dr Barton think the patient had an untreated malignant condition.

There is no physical examination of the patient on admission, or if there was, it is not recorded in the notes.

When transferred to the Gosport Hospital on 21st October, probably to await nursing home placement, she had a number of markers suggesting a very high risk of in-hospital death. She had been in hospital over two weeks, the longer you are in hospital the more likely you are to die in hospital. She had a possibility of delirium on top of a rapidly progressive dementing illness, again a marker of high in-hospital mortality and finally,

she had an extremely low albumin of 18, probably one of the strongest markers of a poor outcome. Serum albumin is an indirect marker of nutritional status, in particular a marker of protein metabolism. A low albumin and poor nutritional status makes a patient highly susceptible to infection, pressure sores and an inability to cope with the physiological stresses.

4.9 On 25th October she appears to be stable in the ward environment at Gosport, however, by the 1st November there has been a deterioration and she is noted to have become quite confused and is wandering again.

4.10 On admission under the routine drugs that were prescribed, it is noted that both Hyoscine and a dose of Diamorphine were written up prn. No explanation of this management decision is made in the notes, nor has any pain been recorded in the notes.

4.11 There are no medical notes between the 1st November and the 15th November at which time she is noted to be very aggressive and very restless, there must have been clinical deterioration over that period of time. Blood tests are sent on 9th November (289) and an MSU has also been sent and reported on 11th November (363) although this is normal. It is unlikely that these tests would have been done if there had not been a significant change in her condition. Indeed, it appears that she was put on antibiotics for a presumed (subsequently proved mistakenly) urinary tract infection. Either the tests and antibiotics prescription were undertaken without seeing the patient, or the patient was seen and no record was made in the notes. Both would be poor medical practice.

The drug chart analysis also demonstrates she was now receiving regular Thioridazine, an anti-psychotic medication which is often prescribed for significantly disturbed behaviour in older patients. The change in behaviour noted, the new medication started, the antibiotics prescribed (277,276) and the blood and urine tests carried out (289,363) all suggest a significant change in condition. Yet the lack of medical notes makes a proper assessment of the situation difficult and is poor clinical practice.

4.12 The simple investigations and pragmatic management does not work though. By 18th November she has deteriorated further, is very restless and confused and is now refusing medication. Further blood tests have been carried out on 16th November that now show that creatinine has almost doubled to 360 and her potassium is 5.6. She is now in established acute on chronic renal failure. A patient who is already frail and running with a creatinine of over 200 can extremely rapidly decompensate and become seriously ill. On 19th November there is further marked deterioration overnight.

4.13 There is no doubt this lady is now very seriously ill. The question that would have to be answered between the 15th and 19th,was this a further acute event that could be easily reversed. The straightforward investigations had been performed and the decision would presumably be to have to return the lady to the District General Hospital for further investigation and management, possibly even on a high dependency unit. The other possible decision to be made was that this was a progression of a number of incurable problems and actually she was terminally ill. In these circumstances the decision would then be to decide what form of symptomatic or palliative care was most appropriate.

Mrs Devine was seen by Dr Reid on 15th and Dr Barton may have seen her on the on 18th, the day Fentanyl was started. This should be clarified as no clinical note is made on the 18th. This is poor practice.

4.14 It may have been in the mind of the doctor who (possibly) saw her on 18th that she probably was terminally ill. Evidence for this is that she started her on a Fentanyl patch on top of the regular Thioridazine, which she was already receiving. However, the logic of starting the Fentanyl patch is not explained in the notes, and the psychiatric doctor who saw her the same day thought her physical condition "was stable". Further Fentanyl is a slow release opioid analgesic, which the BNF states it is not suitable for acute pain or when rapid changes in analgesia are required. The reason is that although Fentanyl 25 is the equivalent of 90 mgs of Morphine a day it will take several days to get to a steady state drug leve. However, the normal starting dose of Morphine for pain is 30 – 60 mgs a day thus the lack of explanation for the choice of Fentanyl, or the dose chosen, in a patient without documented pain is poor clinical practice.

4.15 It is my opinion, certainly by the 19th November, this lady was terminally ill and it was a reasonable decision to come to this conclusion. However, it is possible that her more rapid deterioration was due to the use of Fentanyl on top of her other medical problems. Equally not all clinicians would come to exactly the same conclusion and some might have referred her back to the DGH when a creatinine of 360 was noted on 16th November. However, on balance I believe that many clinicians would come to the same conclusion after a month in hospital.

4.16 Having made the decision that the lady was terminally ill, the next decision was whether or not to offer palliative care. Mrs Devine was reported as extremely restless and aggressive and in some distress. In my view it would now be appropriate to provide high quality palliative care.

4.17 She is then written up for Diamorphine and Midazolam by subcutaneous infusion and the Fentanyl patch prescribed the previous day is removed. There was a three-hour overlap in the prescription of these drugs but this is unlikely to have had a major clinical effect. There is also a discussion regarding her status with a member of her family. There appears to be no dissent as to the appropriateness of her proposed care with either the nurses or the family.

4.18 Two drugs are used, Diamorphine and Midazolam intravenous infusion pump. The main reason for using both was terminal restlessness. There is no doubt that Midazolam is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours. The dose of Midazolam used was 40 mgs per 24 hours, which is within current guidance although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

4.19 The addition of Diamorphine is more contentious. Although there was serious restlessness and agitation in this lady, no pain was definitively documented and Diamorphine is particularly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. However, despite the lack of pain Diamorphine is widely used, and believed to be a useful drug, in supporting patients in the terminal phase of restlessness. One study of patients on a long stay ward (Wilson J.A et al Palliative Medicine 1987; 149 – 153) found that 56% of terminally ill patients on a long-stay ward received opiate analgesia. The dose of Diamorphine actually prescribed was 40 mgs. The normal starting dose for pain, of morphine, is 30 – 60 mgs and Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. 15 – 30 mgs). Mrs Devine was prescribed on an unusually high starting dose of Diamorphine although probably equivalent to the dose of Fentanyl already started. There is no explanation of this decision in the notes.

4.20 24 hours later Mrs Devine is reported to be comfortable and without distress, she finally dies approximately 58 hours after starting the mixture of Diamorphine and Midazolam, and as far as can be deciphered from the notes, without distress.

4.21 The prediction how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A Prospective Cohort Study. BMC Palliative Care 2002 1:1.) I believe that it is certainly possible; that without any treatment, considering her creatinine of 360 on 16th November, she would have been dead on the 21st November.

4.22 There is no explanation in the notes for the apparently high doses of drugs used to relieve her symptoms considering her age of 88 years and her previous lack of use of analgesia. It is possible that the medication did shorten her life by a short period of time but she was also out of distress for the last 58 hours.

5. OPINION

5.1 Mrs Elsie Devine presents an example of the most complex and challenging problems in geriatric medicine. This incluluded progressive medical and physical problems causing major clinical and behavioural management problems to all the care staff she comes into contact with.

5.2 However there were significant failing in the medical care provided to Mrs Devine, in particular:

- The failure to undertake a physical examination of the patient on admission to the Gosport War Memorial Hospital, or if it was undertaken the failure to record in the notes.
- The prescription of PRN Oramorphine in admission to the Gosport War Memorial Hospital in a patient with no recorded pain or condition likely to need Oramorphine.
- The failure to see the patient between the 1st – 15th November yet to order blood tests and antibiotics, or if she was seen, to make a record in the notes.
- The failure to make any medical notes or explanation on the 18th November as to why Fentanyl was started and why the dose chosen was used.
- The failure to provide any explanation for the use of Diamorphine and the choice of an apparently high starting dose in the syringe driver.

5.3 There was also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The 'Regular' prescription of Fentanyl is never crossed off the drug chart although replaced by the syringe driver.
- Prescribing a range of doses of both Diamorphine and Midazolam on the regular side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
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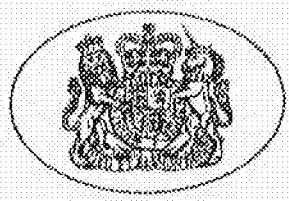
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire



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M1 3LF

28 APR 2008

For attention of Ms T Hall

Your Ref: ALW/00492-15579/7365557 v1

28 April 2008

Dear Ms Hall

Gosport War Memorial Hospital Inquests/Dr Jane Barton:

I refer to your letter dated 23 April and our telephone conversation of 28 April.

I confirm that I intend in the very near future to open Inquests into the deaths of ten people who died at Gosport War Memorial Hospital:

Mr Arthur Cunningham
Mr Geoffrey Packman
Mrs Ruby Lake
Mrs Sheila Gregory
Mr Robert Wilson
Mrs Enid Spurgin
Mrs Helena Service
Mr Leslie Pittock
Mrs Elsie Lavender
Mrs Elsie Devine

For logistical reasons, the Inquests will be conducted by Mr A M Bradley, HM Coroner for North Hampshire, acting as my Deputy. Mr Bradley intends to conduct all the Inquests simultaneously and at present estimates about a month in court to do this. It seems very unlikely, given the complex arrangements that will need to be made, for the Inquests to take place any earlier than the Autumn.

Of course, neither Mr Bradley nor I would wish to prejudice in any way the GMC's hearing on Dr Barton. I am copying your letter to him so that we can all liaise on a more definite hearing date for the Inquests.

Yours sincerely

Code A

cc Mr A Bradley

FILE COPY

Strictly Private & Confidential

Mr Ian Barker
230 Blackfriars Road
London
SE1 8JP

Our ref: Code A
Your ref:

Sarah Ellison
Partner
Code A

06 May 2008

Dear Mr Barker

General Medical Council - Dr Barton

I write further to your letter sent on 2 May 2008.

I understand this was faxed at around 5:15pm on Friday and was emailed to my colleague Tamsin Hall on Sunday (4 May). Unfortunately Tamsin Hall is away from the office and has been on all but 1.5 days since 21 April. In her absence I have picked up the file to try to address outstanding matters. My email of today's date was sent without sight of your fax.

You are entirely right to point out that on 22 April we indicated that the GMC would confirm if either or both of the additional cases (for which you have been sent expert evidence) would be included in the charge by the end of the week (25 April). The delay in communicating the GMC instructions to you is with Field Fisher Waterhouse and I must apologise that this arose as a result of the solicitor with conduct being on sick leave. I only identified the issue might be outstanding this morning at which point I emailed to confirm that our instructions are to include the case of Jean Stevens (Patient L).

We have now exchanged further emails and have spoken about the case. I will speak to the General Medical Council about the points you raise and your objection to the addition of the Stevens case at this stage. I will reply in more detail when I have instructions.

If you have any questions in the meantime please do not hesitate to contact me.

Yours sincerely

Sarah Ellson
for **Field Fisher Waterhouse LLP**

Patient L (Jean Stevens)

1.a) i) Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke;

ii) On 20 May 1999 you prescribed:

a) Oramorphine 10 mgs in 5 mls;

b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis;

c) Midazolam with a dose range of 20 to 80 mgs to be administered SC;

iii) You further prescribed Oramorphine 10 mgs in 5 mls as a regular prescription to start on 21 May 1999;

iv) Doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999.

b) You did not properly assess Patient L on admission. This was

i) inadequate;

ii) not in the best interests of the patient;

c) In relation to your prescription for drugs described in paragraph 1 a) ii) and/or iii):

i) There was insufficient clinical justification for such prescriptions;

ii) The dose range of Diamorphine was too wide;

iii) The prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs.

d) Your actions in prescribing the drugs described in paragraph 1a) ii) and or iii) were:

i) Inappropriate;

ii) Potentially hazardous;

iii) Not in the best interests of patient L.

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 20/05 21/05	1830 2245 0735	5 mgs 5 mgs 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1920 0830 1030	20 mgs 20 mgs 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1900 0800 1030	20 mgs 20 mgs 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

4.12. There are significant irregularities with the drug charts. Oramorphine has been written up on the regular side of the drug chart but not actually prescribed with no note to say why. A large range of Diamorphine is written up on the PRN part of the drug

chart before it is required and it is not written in words or figures nor is the total dose written.

4.13. Midazolam is a sedative which can be suitable for very restless patients and is usually given initially in a dose of 20 mgs in 24 hours although some people believe the dose should be much lower (5 – 20 mgs in older people, in particular the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view the regular doses of Oramorphine and then the syringe driver together with the 20 mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease.

5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

5.3. There is some evidence of poor medical practice in Haslar. In particular:

- Use of the drug chart in Hasler with the failure to write controlled doses of drugs in word and figures as well as the total dosages to be given.
- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the "as required" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I

subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature: _____ Date: _____

Strictly Private & Confidential

Mr Ian Barker
230 Blackfriars Road
London
SE1 8JP

Our ref: Code A
Your ref:

Sarah Ellson
Partner
Code A

30 May 2008

Dear Mr Barker

General Medical Council - Dr Barton

I write further to our recent emails and our telephone conversation on 23 May 2008.

I thought it would be helpful to confirm in writing a number of matters before our next protocol call.

Cases

We are bringing a case based upon 12 patients (A-L). You were provided with the draft charges for patients A-K on 3 March 2008. We provided draft charges for patient L on 6 May 2008.

Five of the 12 cases were originally referred by a Preliminary Proceedings Committee in 2002, these were Page, Wilkie, Richards, Cunningham and Wilson. We are running with all these cases (patients C, D, E, G and H).

The police had ten "class 3 cases", these were Cunningham, Wilson, Pittock, Lavender, Lake, Spurgin, Devine, Service, Gregory, Packman (these are also the ten cases we understand the Inquests are to cover). From this group (from which Cunningham and Wilson were already referred) we are adding Pittock (Patient A), Lavender (Patient B), Lake (Patient F), Spurgin (Patient I), Packman (Patient J) and Devine (Patient K). We are not pursuing Service or Gregory. Following receipt of further expert evidence we are also adding Stevens (Patient L). Although we obtained a report we are not adding Purnell. The additional cases will be added under the proviso to Rule 11(2).

Coroner's Inquests

We have discussed the Coroner having announced inquests into 10 patients, 8 of whom overlap with the GMC case. I have no further information since we spoke. The Coroner has indicated that his deputy Mr Bradley is reviewing the papers provided by the police and will in due course arrange a preliminary meeting to discuss matters such as the dates of the inquests.

It did seem to be accepted that the inquests could not run at the same time as the GMC hearing.

Listing

The GMC case is provisionally listed to start on 8 September 2008 for eight weeks. You and I have discussed whether this is sufficient time. Our expert Professor Black is not available to give evidence until the third week (he is away during weeks 1 and 2). We do not envisage this will cause any problems as we plan for him to read transcripts on his return and then to give evidence in week 3 (or later). Our discussions about very approximate time estimates have suggested that the GMC will need 4-5 weeks to present the case and then the defence will need 2-3 weeks (assuming we will be able to take each patient more quickly as the case progresses but recognising that Dr Barton and your expert will need to address each case).

I have made enquiries about extending the listing to accommodate the possibility that the Panel will require additional time for decision making. At present there is no capacity to do this but we are exploring the matter further. You mentioned your expert would have difficulties in attending beyond the current end date of 31 October but we might hope that his/her evidence would be completed by then.

Doctor witnesses

I know that you are waiting to hear from us in relation to Drs Lord, Tandy and Reid. They have each been sent a statement but each is taking legal advice before signing and returning it so we do not have signed statements as yet. Until we do we cannot finalise our views as to which witnesses we will be calling to give evidence. I will let you have this information as soon as possible.

Other witnesses

According to our records on 21 April 2008 we sent you a list of 39 possible witnesses whom we provisionally intended to call (in addition to referring to Drs Lord, Tandy and Reid).

We can now disclose further signed statements from:

* Dr Victoria Banks
* Alan Lavender
* Charles Stewart-Farthing (this may have been disclosed previously)

- Dr Arumugam Ravidrane
- Ernest Stevens
- Victoria Packman
- Dr Ian Reckless
- Gill Hamblin

We are still awaiting signed statements from:

- Lynda Wiles (this is just a production statement for police statements)
- Elizabeth Thomas (we have had some difficulty contacting this witness, we anticipate this will just be a production statement)
- Bernard Page (relative of Eva Page)
- Mrs M Jackson (relative of Alice Wilkie)
- Gillian McKenzie (relative of Gladys Richards)
- Michael Edmonson (we cannot trace this witness and will review whether we will apply to have previous evidence admitted)
- Diane Mussell (this is just a production statement with some minor alterations)
- Pauline Robinson (this is just a production statement with short additional comment)
- Dr Coltman (this is just a production statement. We have learned that Dr Coltman will be serving in Iraq at the time of the hearing and we may therefore seek to have his statement read)
- Shirley Selwood (this is just a production statement)
- Ian Wilson (this is just a production statement)
- Carl Jewell (he does not wish to sign his statement so there may be nothing further to disclose)
- June Bailey
- James Reeves (this is just a production statement)

- Carol Ball (this is just a production statement)
- Tina Douglas (this is just a production statement)
- Anita Tubbritt
- Beverley Turnbull
- Fiona Walker (this is just a production statement)
- Richard Samuel (he will produce some of the policies etc obtained from the CHI papers)
- Roy Stephenson (to the extent that a production statement is required for police documents)

Expert evidence

You have essentially had all of Professor Black's evidence. However he has been reviewing his evidence to the police and re-formatting his reports/statements into the same format used for his other GMC reports. These are being done at a rate of one a week and we intend to serve all the reports in mid June unless you require the ones that are already completed by return.

We have approached Jeffrey Watling who was the Pharmacy Services Manager at Gosport War Memorial Hospital with a question relating to how a hospital drug chart should be used/completed. This is the extent of any pharmacist expert evidence we are seeking. His report/statement will be served as soon as it is available.

Yours sincerely

Sarah Ellson
for Field Fisher Waterhouse LLP

Strictly Private & Confidential

FAO Ian Barker
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Our ref: Code A
Your ref:

Sent by e-mail and post

20 June 2008

Dear Sirs

General Medical Council - Dr Jane Barton

We write further to our recent correspondence and telephone calls regarding the impact of the proposed Inquest upon the provisional listing of the GMC Fitness to Practise Hearing. Thank you also for your letter of 19 June 2008.

Please accept this letter as formal notification of our client's decision to postpone the GMC Fitness to Practise Hearing until the Inquest has been held into the deaths of ten patients at the Gosport War Memorial Hospital, eight of which were due to be considered at the Fitness to Practise Panel hearing.

The GMC has taken legal advice and has decided that on balance it is preferable to await the outcome of the Inquest. The outcome of the inquest could give rise to further fitness to practise allegations or could lead to the GMC revising the charges that they are proposing to bring and so could be highly relevant to the GMC proceedings. Giving the Inquest primacy will also allow Dr Barton to deal with that inquiry and evidence for that process, ahead of having to finalise her response to the Fitness to Practise Panel.

At present we do not have any further indication from the Coroner as to when the Inquest is likely to be held other than their estimated date of "Autumn 2008". We intend to continue to seek information from the Coroner so that we are kept informed of developments and his proposals for the Inquest hearing. Once matters are clearer we may be able to revisit the provisional listing arrangements.

You have indicated that you accept the postponement, although we note you express this is with disappointment and concern.

As you are aware, the GMC have informed their adjudications department and they have now vacated the listing of 8 September 2008 for 8 weeks.

We note that a further telephone conference had been scheduled for 1 July 2008 at 10:00 a.m. In light of the recent developments we would propose that this is also postponed until such time as we have further information about potential dates for re-listing. We would be grateful if you would indicate if you agree with this course of action.

In the meantime, as Tamsin Hall has indicated to you, we will continue to finalise the outstanding witness statements and serve these upon you as and when these are received.

Yours faithfully

Field Fisher Waterhouse LLP

30 June 2008

In reply please quote: Code A

Special Delivery

Dr Jane Barton

Code A

United Kingdom

Dear Dr Barton

I am writing to let you know that the Case Examiner appointed by the Registrar has considered information received by the GMC from Hampshire Constabulary about you that suggests your fitness to practise may be impaired.

The Case Examiner, under Rule 8(6) of the General Medical Council (Fitness To Practise) Rules 2004, considers that you should be invited to appear before the Interim Orders Panel (IOP). The IOP will 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.

The Case Examiner's reasons for the referral are as follows;

'In September 2008 a Fitness to Practise Panel was due to consider 12 cases in which Dr Barton is alleged to have administered excessive doses of controlled drugs to patients while she was working as a Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital in the mid-late 1990s. In some cases the doctor was alleged to have failed to perform an appropriate examination and assessment of the patients prior to administration or to seek the advice of a specialist. In all cases the patients died shortly after the administration of the drugs.

Case examiners are instructed that they should refer cases to an IOP where the doctor faces allegations of such a nature that it may be necessary for the protection of members of the public, or otherwise in the public interest or the interest of the doctor, for the doctor's registration to be restricted.

The last time the IOC considered this case was in October 2004. At that stage only five cases had been referred to the PCC. The number of cases to be considered by the FTP is now much larger and the concerns about this doctor much greater. The IOP has had no chance to consider the new evidence, including expert evidence in relation to both the additional seven cases referred and the original five referrals.

The FTP hearing has now been put back following the decision to hold inquests into the deaths of 10 patients, eight of whom were among those whose cases were due to be considered by the FTP. In the meantime Dr Barton is able to practise without restriction.

The new evidence that has been collected since the IOC last considered this case, which has resulted in the referral of a substantial number of new cases to the FTP, make it

essential, in order to preserve public confidence in the profession and maintain good standards of conduct and performance, for the IOP to consider this case again.'

You are invited to appear before the IOP at **10.30 on Friday 11 July 2008** at the Council's offices at Regent's Place, 350 Euston Road, London NW1 3JN., if you so wish to address the IOP on whether such an order should be made in your case.

A copy of the information to be considered by the Panel which begins at page 1 and ends at page 285 is attached for your consideration.

You may, if you wish, be represented by Counsel, a solicitor, a representative of any professional organisation of which you are a member or, at the discretion of the IOP, by a member of your family. The IOP 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 IOP before they consider your case. Your observations should be marked for the attention of Adam Elliott, Adjudication Section, Regent's Place, 350 Euston Road, London NW1 3JN (fax no **Code A**).

You may also state in writing whether you propose to attend the meeting, whether you will be represented as indicated above, and if so, by whom.

You will be required to confirm your full name and your GMC reference number at the start of the hearing before the IOP. If you are not present at the hearing the Presenting Officer, representing the GMC will confirm this on your behalf.

The Interim Orders Panel normally meets in private but you may if you wish 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, Adjudication Section, as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOP 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, Adjudication Section, 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 or 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. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Panel's consideration of the matter.

- If you are approved under Section 12 of the Mental Health Act, or Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003, you must also notify us of this fact.

I enclose a copy of Section 41A of The Medical Act 1983 (as amended), the Fitness To Practise Rules, a paper about our fitness to practise procedures and a paper about the procedures of the IOP.

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 and must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

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

Should you wish to clarify any aspects of this letter please contact Code A on Code A

Yours sincerely

Code A

Enc: Interim Orders Panel: Note on functions and powers
Investigating concerns factsheet
Employer details form
General Medical Council (Fitness to Practise) Rules 2004
Section 41A of The Medical Act 1983 (as amended)

cc:
Mr Ian Barker
The Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Confidential
Addendum (I)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
11 July 2008

Information: Letter received from Dr Barton confirming attendance and representation at the IOP hearing. Employer Details Form attached.

Dr Jane Barton MA, BM BCh,

Forton Medical Centre,

White's Place

Gosport

HANTS

PO12 3JP

YOUR REF JS/2000/2047/02 1st JULY 2008

Dear Sir,

I am writing to confirm that I will be attending the meeting on Friday 11th July at 10.30 am.

I will be represented by Mr Ian Barker from the Medical Defence Union.

I understand that the Interim Orders Panel will meet in private.

Yours Faithfully

Code A

Jane Barton

General Medical Council

Employer Details Form

FPD Reference Number: Code A
FPD Investigation Officer: Code A

Doctor's Name: Dr Jane Barton
Doctor's Registration Number: 1587920

Please provide the information requested in the boxes below. If you need to continue on separate sheets please cross-reference these to the appropriate question number.

1) **If you work for the NHS**, please provide the following details about your current employment. If you are a GP this should be the PCT with whom you have a contract, or for hospital doctors, the employing NHS Trust. If you are a GP you need to also include details of the PCT on whose performers list your name appears.

Name & Address of PCT/NHS Trust	Name of Medical Director or Chief Executive	Job Title	Dates of Employment
Hampshire Primary Care Trust Omega House 112 Southampton Rd Eastleigh Hants SO50 5PA	Gareth Cuddie	General Practitioner	2002 - today

If you have **worked here for less than 6 months**, please also provide the same details for your previous employer.

Name & Address of previous PCT/NHS Trust	Name of Medical Director or Chief Executive	Job Title	Dates of Employment
N/a			

2) If you engage in any **non-NHS work**, please provide the following details of any organisation(s) or hospital(s) where you are employed, or where you have any working arrangements or practising privileges.

Name & Address of organisation/hospital	Name of Chief Executive	Job Title	Dates of Employment
N/a			

3) If you have issued any **private prescriptions** in the last year please state the name of the Primary Care Trust (PCT) which issued the private prescription pad, the number of the pad and the date it was issued to you.

Name & Address of PCT which issued private prescription pad	Name of Medical Director or Chief Executive	Private prescription pad number	Date of issue of pad
N/A			

4) If you have engaged in any **locum work in the last 6 months**, please provide the following details of **all the agencies** that you have been registered with and for whom you have worked for during this period.

Name & Address of Locum Agency	Named Contact	Dates
N/A		

5) If you are **self-employed or not currently employed** please provide details of the last employer or agency you were contracted to or with whom you had working arrangements if in the last five years. Please also state whether your name is on the Performers List of a Primary Care Trust or Board (formerly known as Principal or Supplementary List).

Name & Address of last Employer or Locum Agency	Named Contact	Dates
N/A		

6) Please state if you are approved under **Section 12 of the Mental Health Act**, or **Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003**. If possible, please state the area where you are registered.

Name & Address of Section 12/Section 22 Administrator	Area where registered
N/A	

7) Please indicate which employer you were working for in respect of the complaint which we are considering.

.....

The following question is optional and should be used only where there is a complaint about a medical report

8) If you have received a commission to prepare a medical report on **[name of patient]** then you must provide the name and address of the commissioning body or person

Name & Address of Commissioning body or person

Declaration: I have provided the GMC with details of my current employment as required [illegible] that I have given this information truthfully and in good faith.

Name (please print) E.A. BARTON **Date of Birth** Code A

Signature Code A **Date** 1-7-09

00171865

Hampshire NHS
Primary Care Trust

D1

Fareham and Gosport Office
Unit 180, Fareham Reach
166 Fareham Road
Gosport
Hampshire
PO13 0FH

Office Telephone: 01329 224500
Facsimile: 01329 234586
Direct Dial: Code A
Website:
Email Address:

09 July 2008

Mr Ian Barker
The Medical Defence Union

Dear Mr Barker

RE: Dr J A Barton and the Gosport War Memorial Hospital CHI Investigation

I have been closely monitoring Dr Barton's prescribing of benzodiazepines and opioid analgesics since 2002 following her voluntary agreement with the Fareham and Gosport Primary Care Trust to restrict her prescribing of diazepam and diamorphine. Any prescriptions for diazepam issued will be in line with BNF guidance with no prescribing of diamorphine. Prescribing data is available from April 2001 (prior to the voluntary agreement) through to May 2008. The data is obtained from the NHS Business Services Agency, Prescription Pricing Division.

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

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

Yours sincerely

Code A

Community Pharmacy Development Manager
South East, North and Eastern Areas

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Regents Place,
Euston Road,
London NW1 3JN.

Chairman: Mr Manny Devaux

Case of:

BARTON, Jane Ann

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

T A REED & CO

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Chairman: Mr Manny Devaux

Panel Members: Dr Eve Miller
Mr John Walsh

Legal Assessor: Mr Nigel Seed QC

CASE OF:

BARTON, Jane Ann

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

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

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

T A REED & CO

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

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

DR BARTON: That would be lovely.

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

MR BRASSINGTON: I have no problem with that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D

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

Those were patients CH, TJ, EC and NW.

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

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

H

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

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

Page 130 records:

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

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

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

That summary from Mr Williams is dated 16 January 2007.

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

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

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

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

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

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

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

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

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

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

Over the page at 4.8:

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

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

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

Professor Black says:

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

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

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

4.11:

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

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

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

Paragraph 4.4:

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

– from the hospital from which the patient was transferred:

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

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

Paragraph 2.12 on page 237:

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

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

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

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

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

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

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

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

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

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

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

Opinion at 5.2:

F

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

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

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

H

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

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

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

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

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

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

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

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

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

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

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

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

MR BRASSINGTON: No.

MR LANGDALE: I will be able to assist.

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

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

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

MR LANGDALE: They were.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Barton, of course, was a clinical assistant:

> "This lack of monitoring is still common practice within the NHS. A consultant submitting patients to Dryad and Daedalus Wards to whom the clinical assistant was accountable had no system for supervising the practice of the clinical assistant, including any review of prescribing. Staff interviewed commented on the long working hours of the clinical assistant in excess of the five contracted sessions."

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

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

Then reference to an agreed protocol.

> "Further correspondence in October 1999 indicated that a doctor working on the wards requested a Trust policy on the prescribing of opiates in community hospitals."

Then "Other Trust Lessons" paragraph 7.11:

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

A series of actions:

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

That being of course Dr Barton:

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

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

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

THE CHAIRMAN: Has he seen it?

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

THE CHAIRMAN: That will be D1.

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

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

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

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

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

That, I hope, deals with the matter clearly.

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

That is all I seek to say; thank you.

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

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

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

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

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

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

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

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

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

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

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

DR MILLER: But with no other clinical assistant position?

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

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

MR LANGDALE: She does.

DR MILLER: When was her last appraisal?

DR BARTON: January this year.

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

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

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

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

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

MR LANGDALE: Yes, may I very briefly?

THE CHAIRMAN: Of course.

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

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

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

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

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

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

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

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

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

PARTIES HAVING BEEN READMITTED

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

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

DETERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Barton and Mr Langdale that concludes your case today. Thank you very much for coming to assist the Panel. Can I also thank your husband for coming here. I

D know it is not easy, it is not very good news but thank you for coming to support your wife today.

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