14 July 2008

In reply please quote: BR/CC/H1-197783948
GMC Registration No: 1587920

Please address your reply to the Adjudication Section
Fax Code A
Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

Notification of Interim Conditional Registration by the Interim Orders Panel

On 11 July 2008 the Interim Orders Panel of the GMC considered whether it was necessary for the protection of members of the public or was otherwise in the public interest or in your own interests to make an order under Section 41A(1) of the Medical Act 1983 as amended (the Act).

You were present at the meeting and were represented by Mr Timothy Langdale, QC instructed by Mr Ian Barker of the Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Panel in your case on 11 July 2008 the Chairman announced the Panel's determination as follows:

> "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.

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

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

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

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

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

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

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

e. Your Regional Director of Public Health.

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

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

The Panel has also taken account of the information that the GMC has referred your case for a hearing by the Fitness to Practise Panel into allegations that your prescribing in relation to 12 patients at Gosport War Memorial Hospital was inappropriate. The Panel has noted that the GMC has decided to postpone the Fitness to Practise hearing until the outcome of the Coroner's inquest into the

deaths of 10 patients at Gosport War Memorial Hospital, eight of which are the subject of the Fitness to Practise hearing. The Panel notes that the inquest is expected to take place in the autumn of 2008.

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

The Panel also considered Mr Langdale's submission that there is no new information before the Panel today which justifies the imposition of an interim order. Mr Langdale submitted that although the allegation formulated by the GMC now relates to 12 patients rather than the five patients who were the subject of the investigation when the Interim Orders Committee last considered your case in October 2004, the position has not altered. Mr Langdale pointed out that you have continued to work as a general practitioner for the past four years and there have been no complaints about your practice.

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

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

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

The Panel has taken account of the issue of proportionality and has balanced the need to protect members of the public, the public interest and your own interests against the consequences for you of the imposition of conditions on your

registration. Whilst it notes that the above conditions restrict your ability to practise medicine, the Panel considers that the conditions are necessary to protect members of the public and the public interest whilst these matters are resolved. It is therefore satisfied that the imposition of the above conditions on your registration is a proportionate response to the risks posed by your remaining in unrestricted practice.

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

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

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

Your registration will therefore be subject to the conditions specified above for a period of eighteen months with effect from 11 July 2008. This order will be subject to review within six months in accordance with section 41A(2) of the Act.

It is your responsibility to ensure that you comply fully with the above conditions when undertaking any medical practice. The IOP will expect to receive information relating to your compliance with the conditions at any subsequent review of the interim order.

A copy of this notification has been sent to your solicitors.

Under Section 41A(10) of the Act, the Court may revoke or vary any order made by the IOP. Copies of Section 41A(10) and Section 40(5) of the Act are attached. If you wish to apply to the Court for the order to be revoked or varied you should seek legal advice or contact the Court without delay.

All orders imposed by the Interim Orders Panel are disclosed on our website and to any enquirer via the List of Registered Medical Practitioners. It remains Council policy that confidential information about a doctor's health will not be disclosed.

Please sign and return the green copy of this notification, where indicated, as confirmation that it has been received by you.

Yours sincerely

Christine Challis
Assistant Registrar
Fitness to Practise Directorate

Cc: Mr Ian Barker, MDU, 230 Blackfriars Street, London, SE1 8PJ.
Enc: Appeals Provision
Appeals Note (IOP)

I have received the original document of which this is a copy on the date shown below.

Signed .....

Date .....

Registration number: 1587920
Reference: BR/ID/H1-197783948

00172736

LETTER TO GMC FROM DR BARTON

Andrew Wood
Assistant Registrar
Fitness to Practise Directorate
5th Floor
St James' Building
79 Oxford Street
Manchester M1 6FQ

Dear Mr Wood

Interim Orders Panel Determination

As you will be aware, I was the subject of an Order from the Interim Orders Panel on **11 July 2008**.

In compliance with condition 1, I write to advise you of the fact that I am a Partner in the Practice at the Forton Medical Surgery, White's Pace, Gosport, Hampshire.PO12 3JP.
I am on the Hampshire Primary Care Trust Performers List.
For ease of reference, the contact details of the PCT are as follows:
Hampshire NHS Primary Care Trust.
Unit Three, Tidbury Farm,
Bullington Cross,
Sutton Scotney,
Hampshire
SO21 3QQ

Yours sincerely

Code A

J. A. BARTON

General Medical Council
Original was a Photocopy
Original was Poor Quality
Date Received
18 JUL 2008
Original has been Photocopied to Improve Scan Quality
Document has 329 pages

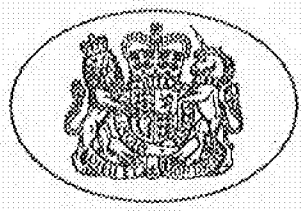
I have received the original document of which this is a copy on the date shown below.

Signed Code A

Date 17-7-08

Registration number: 1587920
Reference: BR/ID/H1-197783948

David C. Horsley LLB
Her Majesty's Coroner
for Portsmouth and
South East Hampshire



Coroner's Office
Room T20
The Guildhall
Guildhall Square
Portsmouth
PO1 2AJ

Fax: 023 9268 8331

Field Fisher Waterhouse LLP
Portland Tower
Portland Street
Manchester M1 3LF

05 NOV 2008

Attn: Tasmin Morris

Ref: TET/GML/00492-15579/8569402v1

4 November 2008

Dear Ms Morris,

Gosport War Memorial Hospital

Thank you for your letter of 28 October. This matter is now listed for 18 March 2009 at The Combined Court Centre Churchill Way Portsmouth although I have not yet had confirmation from the Court.

When I do I will send out proper notices

Yours sincerely

Code A

Andrew Bradley
HM Assistant Deputy Coroner
Portsmouth & SE Hampshire

24 November 2008

In reply please quote: VB/2000/2047/02

Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

As you are aware on 11 July 2008 the Interim Orders Panel (IOP) made an order imposing conditions on your registration for a period of 18 months, starting on 11 July 2008.

I am writing to let you know that the IOP will be reviewing the order made in relation to your registration at its meeting on 22 December 2008. In reviewing the order the IOP is empowered to direct that the order should remain in force, to amend the order or to revoke it.

You are therefore invited to appear before the IOP at **09:30** on **22 December 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 what action they should take in relation to your registration. You may, if you wish, be represented by Counsel, a solicitor, a representative of any professional organisation of which you may be a member or, at the discretion of the IOP, by a member of your family. The IOP is, however, empowered to review the order in relation to your registration irrespective of whether or not you are present or represented.

A copy of the information to be considered by the Panel which begins at page 1 and ends at page 334 is attached for your consideration.

You are invited to submit observations on the case in writing and these will be circulated to the IOP before they consider your case. In particular, you should seek to confirm whether you have complied with conditions imposed on your registration by the Panel and detail any arrangements that you have put in place to affect compliance. 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 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 IOP'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 will you 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

Simon Wood
Assistant Registrar
Fitness to Practise Directorate

Enc: Imposing Interim Orders - Guidance for the IOP and the FtP Panel
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
22 December 2008

Information: Letter of correspondence received from Doctor, confirming Representation, along with an Employer Details Form.

Dr Jane Barton MA, BM BCh,

Forton Medical Centre,

White's Place

Gosport

HANTS

PO12 3JP

YOUR REF VB/2000/2047/02 1ST DECEMBER 2008

Dear Sir,

I am writing to confirm my receipt of the paperwork for a review meeting of the IOP of the General Medical Council at Regents Place, 350 Euston Road London at 9.30 am on Monday 22nd December 2008.

I will be represented by Mr Ian Barker from the Medical Defence Union.

I enclose the relevant declarations.

Yours Faithfully

Code A

Jane Barton

General Medical Council

Employer Details Form

FPD Reference Number: 2000/2047/02
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 5PB	Mr Gareth Cruddace	GP	2007 – current

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.

as above

Declaration: I have provided the GMC with details of my current employment as required. I confirm that I have given this information truthfully and in good faith.

Name (please print) J A BARTON **Date of Birth** Code A

Signature Code A **Date** 1-12-08

Confidential
Addendum (II)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
22 December 2008

Information: Letter of correspondence received from The MDU, along with a letter from the Community Pharmacy Development Manager for Hampshire NHS PCT

Please quote our reference when communicating with us about this matter

Our ref: ISPB/JH/0005940/Legal
Your ref: VB/2000/2047/02
10 December 2008

THE MDU
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

The MDU
DX149141
Legal
Blackfriars 5

Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
Website www.the-mdu.com

Mr Adam Elliott
Adjudication Section
General Medical Council
Regent's Place
350 Euston Road
London, NW1 3JN

Dear Mr Elliott

Dr Jane Barton – Interim Orders panel Hearing – 22nd December 2008

As you know, I act for Dr Barton, and write in preparation for her hearing before the Panel on 22nd December.

At the hearing on 11th July 2008 the Panel made an Order imposing conditions on Dr Barton's registration which included the condition that she must not prescribe Diamorphine and should restrict her prescribing of Diazepam in line with BNF Guidance, and further that she should provide evidence of her compliance with that condition to the GMC prior to any review hearing.

On behalf of Dr Barton, in relation to that requirement to provide evidence of compliance, I have pleasure in enclosing a copy of a letter to me of 3rd December from Hazel Bagshaw, the Community Pharmacy Development Manager for the South East, North and Eastern areas of the Hampshire PCT. You may recall that evidence of Dr Barton's compliance with what was then a voluntary agreement with the PCT was provided on behalf of Dr Barton at the last hearing by way of a letter from Hazel Bagshaw, which is contained now in the Panel's papers at page 292. As the Panel will see, Hazel Bagshaw confirms in her latest letter that Dr Barton has maintained her compliance, and that she is content that Dr Barton has complied with the GMC condition and the PCT agreement.

It may be helpful if I add that mention is made in the first paragraph of Hazel Bagshaw's letter now to a prescription ascribed to Dr Barton for Morphine capsules. Of course any such prescription would not fall foul of the conditions imposed on Dr Barton's registration, but it may be helpful if I assist in explaining that this prescription was not actually issued by Dr Barton. One of Dr Barton's patients had been prescribed Morphine by an oncologist, and then came to the Practice for a repeat prescription of the same medication whilst Dr Barton was on holiday at the end of September this year. A repeat prescription was provided by one of Dr Barton's partners, but the prescription, being for one of Dr Barton's patients, then appeared under her name.

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MDU Services Limited is registered in England 3987086. Registered Office: 230 Blackfriars Road London SE1 8PJ.

Our ref ISPB/JH/0005940/Legal
Your ref VB/2000/2047/02
10 December 2008

I hope this assists, and of course as ever if I can help with any further information you should not hesitate to contact me.

Yours sincerely

Code A

Hampshire NHS
Primary Care Trust

Fareham and Gosport Office
Unit 180, Fareham Reach
166 Fareham Road
Gosport
Hampshire
PO13 0FH

Office Telephone: Code A
Facsimile:
Direct Dial:
Website: www.hampshirepct.nhs.uk
Email Address: Code A

03 December 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 continued to monitor Dr Barton's prescribing via the NHS Business Services Agency, Prescription Pricing Division (PPD) and to have regular meetings with Dr Barton to discus the data. In the period from April – September 2008, I have requested a copy of a prescription ascribed to Dr Barton for morphine capsules 30mg plus all the prescriptions for diamorphine issued by the practice in that period. This will enable me to check which GP signed and issued the prescription

Dr Barton has maintained her compliance with the agreement which has been in place with the PCT since October 2002. The agreement with the PCT is that Dr Barton will not prescribe diamorphine and will restrict her prescribing of diazepam in line with BNF guidance. I appreciate that this mirrors a condition imposed upon her by the GMC in July 2008. I have continued to monitor the position with reference to Dr Barton's prescribing, and I am content that she has complied with the condition and the PCT agreement.

Yours sincerely

Code A

Community Pharmacy Development Manager

A

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE (INTERIM ORDERS PANEL)

B

Monday, 22 December 2008.

350 Euston Road, London.

C

D

Chairman - Mr. Roger Thompson

Case of:

E

DR. BARTON, Jane Anne

F

G

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

H

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE (INTERIM ORDERS PANEL)

Monday, 22 December 2008.

350 Euston Road, London.

Chairman - Mr. Roger Thompson

Case of:

DR. BARTON, Jane Anne

Panel Members

Sir James Perowne
Mr. Alan Wood

Legal Assessor: Ms Julia Oakford

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

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

T A REED & CO

(The proceedings convened at 09.35)

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

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

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

DR. BARTON: Yes.

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

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

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

DR. BARTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DETERMINATION OF THE PANEL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Your Regional Director of Public Health.

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

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

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

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

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

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

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

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

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

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

.....

Paul Brincau MBIVR
For TA REED & CO LTD
22 Dec 2008

23 December 2008

In reply please quote: NP/CT/H1-202863465
GMC Registration No: 1587920

Please address your reply to the Adjudication Section
Fax Code A

Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

Notification of Further Interim Conditional Registration by the Interim Orders Panel

In pursuance of Section 41A(2) of the Medical Act 1983, as amended (the Act), formal notice is given to you that on 22 December 2008, the Interim Orders Panel (IOP) reviewed the order made on 11 July 2008 imposing conditions on your registration.

You were present at the meeting, and were represented by Mr Ian Barker of the MDU.

At the conclusion of the proceedings of the Interim Orders Panel in your case on 22 December 2008 the Chairman announced the Panel's determination as follows:

> "Dr Barton
>
> When the Interim Orders Committee considered your case on 21 June 2001 it determined that it was not necessary for the protection of members of the public, in the public interest and in your own interest to make an order on your registration. Your case was reviewed and no order imposed on a further four occasions. On 11 July 2008, the Interim Orders Panel considered it necessary to impose conditions on your registration.
>
> The Panel has comprehensively reviewed the order today and, in doing so, has considered the information before it previously, the transcripts of the previous hearings and the further information received today, including Mr Brassington's submissions on behalf of the General Medical Council (GMC) who submits that your registration should remain subject to conditional registration. Mr Barker on your behalf submits that as you are no longer subject to police investigation, there should no longer be an interim order imposed.
>
> The Panel is satisfied that it continues to be necessary for the protection of members of the public, in the public interest and in your own interests for your registration to remain subject to conditions. The Panel has therefore directed that for the remainder of the duration of the order your registration should remain subject to the following conditions:

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

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

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

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

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

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

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

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

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

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

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

    e. Your Regional Director of Public Health.

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

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

criticisms in respect of your prescribing and record keeping contained in the report by Professor Black, an expert commissioned by the GMC.

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

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

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

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

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

The Panel has also taken account of the principle of proportionality, and has balanced the need to protect members of the public, the public interest and your own interests against the consequences for you of the imposition of conditions on your registration. Whilst it notes that its order has placed restrictions on your

ability to practise medicine, the Panel is satisfied that these conditions are a proportionate response to the risk posed by you remaining in unrestricted practice.

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

The order imposing conditions upon your registration, made on 11 July 2008, remains in force and will be reviewed in six months in accordance with section 41A(2) of the Act.

It is your responsibility to ensure that you comply fully with the above conditions when undertaking any medical practice. The IOP will expect to receive information relating to your compliance with the conditions at any subsequent review of the interim order.

A copy of this notification has been sent to your solicitors.

Under Section 41A(10) of the Act, the Court may revoke or vary any order made by the IOP. Copies of Section 41A(10) and Section 40(5) of the Act are attached. If you wish to apply to the Court for the order to be revoked or varied you should seek legal advice or contact the Court without delay.

All orders imposed by the Interim Orders Panel are disclosed on our website and to any enquirer via the List of Registered Medical Practitioners. It remains Council policy that confidential information about a doctor's health will not be disclosed.

Please sign and return the green copy of this notification, where indicated, as confirmation that it has been received by you.

Yours sincerely

Code A
Assistant Registrar
Fitness to Practise Directorate

Cc: Mr Ian Barker- The MDU, 230 Blackfriars Road, London SE1 8PJ

Enc: Appeals Provision
Appeal Note (IOP)

I have received the original document of which this is a copy on the date shown below.

Signed .....

Date .....

Registration number: 1587920
Reference: NP/CT/H1-202863465

GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Monday 20 April 2009

The Law Courts
Winston Churchill Avenue
Portsmouth,
PO1 2DQ

B E F O R E:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY TWENTY-ONE)

MR ALAN JENKINS QC, instructed by **, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by **, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
13 The Lynch, Hoddesdon, Herts, EN11 8EU
Tel No: 01992 465900)

INDEX

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(In the presence of the jury)

THE CORONER: Good morning and welcome back. I am going to ask you to retire again for the moment. There is the question of room availability and you may find that there will be delays coming in and going out because of alternative uses of this room. Without putting any pressure on you and without requiring you to answer the question, is there any question we might finish today? Are you close enough to a decision to give that indication? It is questionable? [Yes]

I will ask you to retire and if there is anything further you need, let the usher know.

(The jury bailiff was sworn)

(The jury further retired to consider their verdict)

THE CORONER: Ladies and gentlemen, you have a clear indication there of a long day.

(The court was adjourned)

(In the presence of the jury)

THE CORONER: What I will do is I will ask you if you have reached a verdict on each case. I will ask you if that is a unanimous verdict. I will ask you for the cause of death. I will ask you for the answers to the three questions. If there are dissenters I will ask you all to sign the inquisition but if there are dissenters to note by their names that they are dissenting from the verdict. I will give you an inquisition as we go through each one.

Can we take Mr Pittock first? You have decided on a cause of death?

THE FOREMAN OF THE JURY: We have.

THE CORONER: What is it?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia and (2) severe depression.

THE CORONER: In response to the questions: (1) Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased?

THE FOREMAN OF THE JURY: No.

THE CORONER: I will give you that inquisition which I have signed. If you could each sign that, please. Any dissenters if you could just put after your name "dissenting", please. (Pause)

THE CORONER: Elsie Lavender – can we do a bit of multi-tasking?

THE FOREMAN OF THE JURY: Yes, certainly.

THE CORONER: Cause of death for Elsie?

THE FOREMAN OF THE JURY: 1(a) high cervical cord injury.

THE CORONER: Nothing else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question the administration of medication contributing more than minimally or negligibly to the death of the deceased?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was the medication given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given appropriately for the condition or symptoms?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Helena Service: cause of death?

THE FOREMAN OF THE JURY: Congestive cardiac failure.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: In response to the question: the administration of medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Ruby Lake: cause of death?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia and (2) fractured neck of femur repaired on 5/8/98.

THE CORONER: And in response to the questions: the administration of medication?

THE FOREMAN OF THE JURY: No.

THE CORONER: Arthur Cunningham: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) bronchial pneumonia; 1(b) sacral ulcer and (2) Parkinson's disease.

THE CORONER: In response to the questions: the medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Robert Wilson: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) congestive cardiac failure and (2) alcoholic cirrhosis.

THE CORONER: Given as a (2)?

THE FOREMAN OF THE JURY: As a (2).

THE CORONER: The medication – did it contribute minimally or negligibly to death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition?

THE FOREMAN OF THE JURY: No.

THE CORONER: Enid Spurgeon: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) infected wound and 1(b) fractured right hip repaired 20/3/99.

THE CORONER: Medication: did it contribute to death?

THE FOREMAN OF THE JURY: No.

THE CORONER: Geoffrey Packman: cause of death?

THE FOREMAN OF THE JURY: 1(a) gastrointestinal haemorrhage.

THE CORONER: Anything else?

THE FOREMAN OF THE JURY: No.

THE CORONER: On the question of medication, did it contribute?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Elise Devine: cause of death?

THE FOREMAN OF THE JURY: 1(a) chronic renal failure; 1(b) ameloidosis and 1(c) IgA paraproteinaemia.

THE CORONER: In response to the question medication contributing to the death?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it given for therapeutic purposes?

THE FOREMAN OF THE JURY: Yes.

THE CORONER: Was it appropriate for the condition and symptoms?

THE FOREMAN OF THE JURY: No.

THE CORONER: Finally, Sheila Gregory: cause of death, please?

THE FOREMAN OF THE JURY: 1(a) pulmonary embolus and (2) fractured neck of femur.

THE CORONER: In response to the questions did the medication contribute?

THE FOREMAN OF THE JURY: No.

THE CORONER: Thank you. Ladies and gentlemen, can I say that you have my undying admiration. To unscramble all that was quite extraordinary. I am sorry it was presented to you in that way but I could not think of any other way of putting ten together and taking generic evidence and the personal evidence and the expert evidence in one lump, as it were, but you have done a sterling job. Thank you very much indeed. You really have served us very well. I will formally discharge you and I sincerely hope that you never have to do a job like this again. It is the only time I have ever done one like this and it is the only time that I have had to face those issues. I do not think I will do one again either. Thank you for what you have done, I am very grateful.

That completes the proceedings. Unless there is anything anyone wants to say, I will formally conclude. Ladies and gentlemen, thank you very much indeed. My sympathy to the family members; I am sure it has been very difficult for you to sit through this but I am glad you have and I hope you have achieved something.

(The inquest was concluded)

GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Generic Report on Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital

This report is provided for the General Medical Council at the request of Field Fisher Waterhouse solicitors. It covers principles of medical care and matters specific to Gosport Memorial Hospital and relates to separate individual reports provided on eleven patients.

Declaration of Interest in matters relating to Gosport War Memorial Hospital

1. I previously provided a report dated 12 December 2001, at the request of Hampshire Constabulary to examine the clinical notes of five patients treated at Gosport War Memorial Hospital and comment on a number of issues relating to patient management and clinical practices at the hospital. I have reviewed and refer to this report in reference to five patients I have been asked to provide reports on to the General Medical Council. I have not changed the views or opinions I expressed in that report. There are some typographical errors in that report that I have corrected in the relevant supplementary patient reports. I have also referred to additional information in some of the relevant supplementary patient reports.

2. I was a member of the Medical Case Note Review Team that supported the Commission for Health Improvement investigation of Gosport War Memorial Hospital (http://www.cqc.org.uk/_db/_documents/04005353.pdf).

Principles of Medical Care

3. **Pain Relief**

Pain is a common health problem faced by older people and relief of pain is one of the most important duties of a doctor. Pain may be defined as *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".* [1] Pain is usually grouped into 4 main classes: nocioceptive, neuropathic, undetermined and psychological. These are usually managed in different ways. Nocioceptive pain such as due to arthritis is generally treated with analgesics. Neuropathic pain due to the nervous system is treated with anti-depressants and/or anticonvulsants. Pain of unclear or undetermined origin is treated with these and other approaches and psychological pain due to sanitization of conversion disorders with psychological approaches.

4. The principles of treatment of acute pain are to determine the underlying cause from history examination and appropriate investigation and to then treat the underlying cause and give adequate pain relief. The nature of the underlying cause and the severity of pain reported by the patient would influence the decision whether to start with a mild analgesic or proceed to use a more potent drug. Because the response to analgesia is unpredictable and there is a risk, particularly in older people, of drug toxicity the general approach of starting low and progressively increasing the dose and potency of drugs used is followed in older people. However to avoid patients remaining in pain with inadequate analgesia good management of severe pain requires the use of as required (prn) drugs in addition to

regular drug doses and the re-evaluation of patients. Increases in drug dose or substitution of a more powerful analgesic is required if analgesia is not achieved. If patients experience adverse effects a reduction in dose or change in drug is required.

5. The management of chronic pain is more complex and requires a consideration of potential long-term adverse effects of drugs and consideration of risks of addiction and the use of other psychological interventional approaches. [1]

6. Good basic principles to follow are to keep drug regimens simple, to reassess patients frequently and recognise that drug doses need to be individualised and that in some patients large doses may be required. There have been concerns that older people may be denied adequate analgesia because of undue concerns about adverse effects from moderate and potent analgesics.

7. The analgesic ladder is a commonly used framework for using analgesic drugs. Drugs are grouped into 3 main classes related to the severity of pain for which they are suitable to be prescribed. For mild pain non-opioid analgesics such as aspirin, paracetamol and ibuprofen are recommended. If these are ineffective or if the patient has more severe pain more potent anti-inflammatory drugs, such as diclofenac or naproxen, or mild opioids (codeine or dihydrocodeine) should be given in combination with paracetamol. For patients who are in severe pain or fail to achieve pain control on drugs for moderate pain more potent opioids (morphine, diamorphine) are recommended.

8. In the majority of patients with acute pain initial treatment would therefore be with drugs from the first two steps of the analgesic ladder (mild or moderate pain) with initial use of opioids only in patients with very severe pain (such as a fractured limb) or in patients who have failed to respond to appropriate doses of drugs used for moderate pain. In addition other therapies particularly anti-depressants and anti-epileptic drugs are used in patients with severe or chronic pain.

9. The most important aspect of good pain management is regular review of the patient and identification of adverse effects. Initial use of potent opioid drugs carries a risk particularly in older people of adverse effects with respiratory depression, hypotension, constipation, drowsiness, nausea and vomiting which could be avoided if pain is controlled with mild or moderate analgesics.

Use of opioid medication

10. The most commonly prescribed opioid is morphine and unless patients are unable to swallow initial dosing should be orally. The British National Formulary[2] states that morphine should be given regularly every 4 hours orally with an initial dose of 5-10mg. In frail elderly patients a starting dose of 5mg is preferred. The BNF states *"to reduce doses recommended in elderly or debilitated patients"*. If pain relief is not obtained or is not sustained for 4 hours dose is usually increased by 50%. When pain is controlled it is common practice to switch patients to an oral sustained release preparation to reduce the frequency with which patients need to take medication. Laxatives such as senna or lactulose should be commenced to avoid constipation when morphine or other potent opioids are prescribed, nausea and vomiting should be treated with metoclopramide or haloperidol as required.

11. The parenteral route and that is the administration of opioids by intramuscular intravenous or percutaneous injection is used where more rapid pain relief is required or patients are unable to swallow as is commonly the case in patients who are receiving palliative care and deteriorating. The parenteral route is also used if bowel obstruction is present and absorption may be impaired or if patients express the desire not to take the medication. Diamorphine is the preferred opioid to use for injection[3] because it is more soluble than morphine and can be given in a smaller volume. The equivalent intramuscular or subcutaneous dose is approximately one third of the oral dose of morphine.

12. Syringe drivers are used to give a continuous subcutaneous infusion of a drug or drugs. This avoids the problems of repeated intramuscular or subcutaneous injections which can be a source of discomfort in older cachectic (frail, thin, muscle wasted) patients. The BNF confirms that indications for use of the parenteral route are patients unable to take medicines by mouth because of nausea and vomiting, drowsiness or coma, bowel obstruction and if the patient does not wish to take regular medication by mouth. Incorrect use of syringe drivers are common cause of drug errors therefore it is important that staff using syringe drivers are appropriately trained and the rate settings on syringe drivers are clearly identified and differentiated[2].

13. The BNF reports a number of potential problems with syringe drivers. If an infusion runs too quickly patients may experience considerable toxicity and adverse effects. If an infusion runs too slowly patients will not receive adequate analgesia. There may also be injection site reactions. Infusions can run too quickly if the rate setting is set incorrectly, or drug calculations have been incorrectly performed. Infusions can run too slowly if the start button has not been used correctly, the batteries run out or there are problems with the syringe driver or cannula connections. Use of a syringe driver is an important clinical decision and the reasons why this is done should always be clearly documented in the medical records.

14. The British National Formulary provides clear advice on the process of administering equivalent doses of orally administered morphine and parentrally administered diamorphine[2]. There are situations where it is appropriate to administer sedative drugs in conjunction with opioid analgesics. However in these circumstances close monitoring is required. Failing to adequately monitor patient may result in life-threatening respiratory depression.

Issues in elderly patients

15. It is well described that older individuals are more sensitive to opioid drugs and older individuals clear the drug less rapidly from the body and studies suggest the duration of pain relief is 50% more in individuals over the age of 70 compared to those under the age of 30 years. It is usual to start with 5 mg rather than 10mg initial oral dose of morphine in frail older people. If an older individual is in considerable acute severe pain or is not frail and above average height and weight is not necessarily unreasonable to start with 10mg dose but patients need to be closely monitored.

16. In the chapter on pain relief in 'Drugs and the Older Person;' Crome writes on the treatment of acute pain; *'Treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patients and the presence of comorbidity will dictate whether to start with a mild analgesic of or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be*

followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

17. The British National Formulary states in the 'Prescribing for the Elderly' section: *'The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and anti parkinsonian drugs, all of which must be used with caution' (BNF 36 1998 page 15).*

Medical Assessment

18. Doctors have a responsibility to provide good standards of care. GMC guidelines on good medical practice (1995) state; *Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."* The section on good clinical care states;

"You must take suitable and prompt action when necessary. This must include:

- *An adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination*
- *providing or arranging investigations or treatment where necessary*
- *Referring the patient to another practitioner, when indicated*

In providing care you must:

- *recognise the limits of your professional competence*
- *be willing to consult colleagues*
- *be competent when making diagnoses and when giving or arranging treatment*
- *keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatment prescribed*
- *keep colleagues informed when sharing the care of patients*
- *pay due regard to efficacy and the use of resources*
- *prescribe only the treatment, drugs, or appliances that serve patients' needs*

The 1995 GMC Guidelines state in the section on delegating care to non-medical staff and students *"You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care."*

19. The 1995 GMC Guidelines state in the section on arranging cover *"You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.'* The 1998 GMC Guidelines on Good Medical Practice which replaced the 1995 guidelines in July 1998 did not change any of the above recommendations.

20. There are important reasons why good medical practice places these responsibilities on doctors. Failing to undertake an adequate assessment of the patient's condition means that an inaccurate diagnosis may be made and inappropriate treatment given. Similarly failing to recognise limits of professional competence results in patients are put at risk from potentially incompetent treatment decisions. Failure to keep clear, accurate and contemporaneous patient records means there is no clear information in the notes concerning the patient's condition for other health professionals to refer to and appropriately base their care. If there are no entries in the medical notes that record the thinking, diagnosis and treatment plan put in place at the time, the doctor relies entirely on their memory for making future treatment decisions and for justifying treatment decisions if these are challenged at a future date. Failure to record any adverse effects of treatment means there is no record in the notes for health care professionals to avoid re-providing this treatment.

21. A medical assessment is generally performed in any patient admitted to hospital shortly after their arrival on a ward. In most cases unless clerical and nursing staff record patient details and nursing assessments before a patient is seen by a doctor. Medical assessment of a patient on arrival to a hospital ward to review their history and current problems, perform a physical examination, arrange any appropriate investigations and prescribe necessary drug and other treatments. This baseline assessment is important in establishing a diagnosis, and implementing an appropriate management plan. It also provides a baseline assessment against which future symptoms and problems can be assessed.

22. A medical assessment is required when a patient is transferred from one hospital to another for a number of reasons. The patient may develop new problems during transfer. The referring hospital may not have recorded or transferred all necessary information. For older patients transferring from an acute ward to a rehabilitation or continuing care environment a medical assessment is important to confirm they are medically stable and appropriate to stay in a ward environment where there is a lower level of medical and other support services.

23. It is important that the results of an initial medical assessment are recorded in the notes are available for other medical and health care staff to refer to if a patient has new symptoms or problems. On call doctors are called to assess patients and information on their baseline function active problems and level of intervention agreed to be appropriate, is important in helping staff to make appropriate decisions about treatment.

24. A general principle well recognised in medical practice is that if a doctor does not record the results of a history or clinical examination they undertake the assumption is that no such assessment was undertaken. Given the busy nature and multiple patient contacts doctors have, retrospective recall by doctors of the details of the assessment that they took in an individual patients in the absence of a record in the medical notes, either by themselves or another member of the medical team is unlikely to be reliable.

25. GMC guidance in 1995 and 1998 emphasised the importance that doctors recognise limits of their professional competence and be willing to consult colleagues. This is a particularly important for doctors who are trainees or non-specialists working under the supervision of a consultant specialist as was the case with Dr Barton a general practitioner acting as a clinical assistant. In a setting such as Gosport War Memorial Hospital it would be appropriate to discuss and seek advice from the responsible consultant for any patient

where the management plan was unclear, where there were complex or difficult management issues where diagnosis or treatment was not clear-cut it would have also been appropriate to seek advice and discuss with the responsible consultants any major change in a patient's medical status particularly if there was unexpected deterioration. If a patient had not been identified and admitted for palliative terminal care I would consider it important any decision about palliative care was discussed with the responsible consultant.

26. When patients deteriorate in a setting such as Gosport War Memorial Hospital where modern diagnostic services and specialist advice is not easily available it may be necessary for patients to return to the main district general hospital for further assessment. It would be appropriate and expected for a clinical assistant to discuss this with the responsible consultant or another consultant who was acting on behalf of the responsible consultant if he/she was not available.

Medical records and Drug Prescription Charts

27. As previously mentioned GMC guidance places clear emphasis on importance of keeping clear, accurate and contemporaneous patient records. Failing to follow this approach results in the problems already outlined in section 6.

28. Drug charts play and important role in treatment prescribed by doctors the details of the drug dose and time and route through the drug should be administered. It is important that drug charts are clearly completed by medical staff as drugs are generally given by nursing staff who need to be able to clearly identify the drug dose, date and time that drugs should be administered to patients.

29. Many drugs are prescribed at a fixed dose on a regular basis. Sometimes drugs are prescribed as a single dose or written on "as required" basis (often referred to as PRN *pro re nata* meaning as necessary). The administration of drug therapy is recorded in a column on the drug chart relating to a specific day and time usually the initialled signature of the member of nursing staff responsible for administering the medication. Treatment instructions may be given to discontinue treatment on a certain date. This is commonly the case for antibiotic prescriptions. If a drug is discontinued the prescription has a line put through and the date of discontinuation inserted along the initials of the doctor making this treatment change.

30. When drugs are prescribed on an "as required" basis nursing staff are able to use their judgement as to when the drug needs to be administered to the patient and to decide on an appropriate dose if there is a range of doses written. It is common for patients to be written up for a range of opiate doses when requiring potent analgesia. This allows a member of nursing staff to adjust the dose according to a response from previous doses. Usually the range of doses prescribed is small for example 5-10mg of morphine or 2.5mg of diamorphine. If a large dose range is written for a PRN drug there is a risk, unless the drugs are being administered according to a clear protocol understood by all nursing staff, that a patient may be administered an inappropriately high dose of opiate which could lead to respiratory depression, coma and in some cases death.

Standards and Guidelines

31. The British National Formulary is the main reference text doctors should generally refer to in obtaining information about drugs they prescribe to ensure an appropriate drug is

chosen for the condition being treated and is given at the correct dose. The BNF has a section on analgesics (4.7 BNF 36,September) with a section on the use of opioid analgesics. This states that a reduced dose is recommended in elderly or debilitated patients. Side effects are listed including respiratory depression, confusion and drowsiness. Recommended doses for individual drugs are listed. The BNF also contains sections on prescribing in the elderly and the use of syringe drivers in palliative care (see sections 8 and 9 of this report).

32. I have also seen The Palliative care Handbook produced by Portsmouth Healthcare NHS Trust known as the Wessex Protocols, produced to help GPs and other healthcare professionals in managing problems in specialist care. The general principles of symptom management in this document (page 4) state *'Accurate and full assessment is essential for both diagnosis and treatment'*, *'Be careful that drug side effects to not become worse than the original problem'* and *'continually reassess'*. The WHO analgesic ladder is described. In the use of morphine the recommend starting with a low dose and increase by 30-50% increments each day until pain is controlled or side effects prevent any further increase. In an older patient an appropriate low dose would be 5 mg morphine.

33. The 'Wessex Protocols' recommend that prn doses are prescribed at the same dose as the 4 hourly dose and repeated as often as necessary (hourly if necessary) for breakthrough pain and to review every 24 hours. A syringe drive is recommended when oral administration is not possible because of dysphagia, vomiting or weakness and the conversion of oral morphine to subcutaneous diamorphine should be one third to one half of the morphine dose i.e. a 24 hour oral dose of 30 mg morphine should be replaced with a 10-15 mg diamorphine infusion over 24hr.

34. In the management of anxiety, diazepam is recommended and if a patient is unable to swallow midazolam 10-20mg per 24 hours by continuous subcutaneous infusion. Opioids are not recommended as a treatment for anxiety. For terminal restlessness drug therapy with diazepam (20-60mg per 24 hours orally or rectally), midazolam (10-60mg per 24 hours orally or by subcutaneous infusion) are recommended as possible treatment options.

Matters specific to Gosport War Memorial Hospital

'Clinical Assistant' Position

35. Clinical assistant posts are non-training service, usually part time posts established by hospitals generally undertaken by general practitioners. Theses posts generally work a number of half days (often referred to as sessions) and the person reports to a consultant responsible for the care of the patients. The job description (undated) for the post of clinical assistant to the Geriatric Division in Gosport that was undertaken by Dr Barton states *'This is a new post of 5 sessions a week worked flexibly to provide a 24 hour Medical cover to the Long stay patients in Gosport. The patients are slow stream or slow stream rehabilitation but holiday relief and shared care patients are admitted.'*

36. How many hours Dr Barton should have worked on the ward during the usual working week Monday – Friday 8am -5pm is unclear. I would estimate out of ours calls to the wards would not account for more than 4 hours time in a working week on average so it might be reasonably expected that Dr Barton in her position as Clinical Assistant was present on the wards for 16 hours a week i.e. about 3 hours per day.

37. The job description suggests the post had responsibility for 11 patients at Gosport War Memorial Hospital, 12 patients at Northcott Annexe and 23 patients at Redclyffe Annexe. However the Commission for Healthcare Improvement report states that in Dr Barton had responsibility for Dryad (20 beds) and Daedalus (24 beds) wards. In 1997/8 there were 169 finished consultant episodes (which equates to admissions) for these wards and in 1998/99 197 finished consultant episodes[5]. Therefore on average Dr Barton would have 3-4 newly admitted patients each week to assess. As many of the patients would be stable continuing care or 'slow stream' rehabilitation patients I would consider this was adequate time to assess new patients (which should take 30-40 minutes per patient to conduct a comprehensive medical assessment) and assess any deterioration or major problems in existing patients, to document such assessments in the medical notes and attend a weekly consultant ward round. It would be insufficient time to see all patients every day or document every contact with patients and relatives.

38. The Duties described include *'To visit the units on a regular basis and to be available 'on call' as necessary. To ensure that all new patients are seen promptly after admission. To be responsible for the day to day Medical management of the patients. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date. To take part in weekly consultant rounds. To prescribe, as required, drugs for the patients under the care of the consultant Physicians in Geriatric Medicine. To provide clinical advice and professional support to other members of the caring team.'* The job description states that the sessions may be split between two separate general Practitioners, ideally from the same Practice.

39. Clinical assistants are usually not required to have any specialist training in the specialty they are working in. Many Clinical Assistants would not have had specialist training as a trainee in the area of practice they work in as a general practitioner. My understanding is that Dr Barton had received no specialist training or qualifications in Geriatric Medicine such as the Diploma in Geriatric Medicine that some general practitioners take. Because of the lack of specialist training it is important that they seek advice from Consultant colleagues for any aspect of patient care where they lack specialist expertise or where decisions might be seen to be contentious with patients, relatives or other health care professionals.

Continuing Care, Slow Stream Rehabilitation and Palliative Care at Gosport War Memorial Hospital

40. There appears to have been some lack of clarity of the role of the wards at Gosport War Memorial Hospital. Although the wards were continuing care wards in practice patients who required a period of rehabilitation or further assessment prior or returning to their own home or entering residential or nursing home care were admitted to these wards. Transcribed interviews with nursing staff suggest there may have been insufficient rehabilitation and nursing staff to adequately meet the needs of such patients at all times.

41. A further problem is that having two different groups of elderly patients in the wards, those requiring continuing medical and nursing care with others requiring rehabilitation patients, may lead to confusion amongst staff about the management of individual patients unless patient management plans are very clearly understood by all staff. For some of the patients transferred to Gosport War Memorial Hospital it appears to have been unclear to all staff whether individual patients were for continuing care or a period of rehabilitation. Most elderly care services in the 1990s separated out continuing care from rehabilitation beds and often changed continuing care wards into rehabilitation wards and this process appears to have been eventually completed after 2000 at Gosport War Memorial Hospital.

42. Palliative care is a very important aspect of management in frail older people who develop acute illness they are unlikely to survive or have progressive disabling disease. By definition patients in NHS continuing care beds are very dependent and are expected to die on the ward. A significant number of older frail patients in rehabilitation beds will deteriorate and palliation of symptoms prior to death will be necessary. There is no generally agreed definition of palliative care but palliative care is not confined to end-of life care. NICE has defined palliative care as *'the holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families'.* Many frail older people require and benefit from such an approach.

43. In many frail older patients receiving palliative care a decision will have been made to limit the extent of other medical interventions, for example surgery, ventilation, and antibiotics. However treatment of active medical problems is compatible and often appropriate in patients receiving palliative care. Prediction of death in frail older people is difficult. Experienced clinicians recognise that patients may die and deteriorate more quickly than anticipated or alternatively that patients who are deteriorating may improve. For these reasons management plans need to be reviewed if a patients' condition changes significantly.

Use of Drug Charts in the Gosport War Memorial Hospital

44. The drug charts in use in Gosport War Memorial Hospital have a format used in most hospitals with a section for drugs given as a single dose, a section for regular drug prescriptions, a section for 'prn' drugs to be taken as required and a section for prescribing of infusions and fluid management. Drug therapy for the patients under the care of Consultant Geriatricians at Gosport War Memorial Hospital would usually be written up by Dr Barton in her role as Clinical Assistant and sometimes by one of the consultant physicians with patients on the wards.

45. A legal prescription requires a clear written record usually placed in a drug chart of the drug dose (usually in mg or other units), frequency (e.g. once, twice daily) and route of administration (oral, intramuscular etc), start and end date to be written with the signature and date of the prescribing doctor. The responsibility for the appropriateness, accuracy and legibility of a prescription lies with the prescribing doctor. When a drug is discontinued the doctor must draw a line through the prescription and sign their initials and date. The drug chart must have the name and hospital number of the patient inserted.

46. The term 'written up' indicates that a drug prescription has been written by a doctor in the notes. The term 'prescribed' means that the drug involved has been written in the drug chart and should be given to the patient as instructed; this may be a drug administered once, regularly or 'as required' where the drug is administered by the nursing staff is specific symptoms are present. A prescription is usually made by the writing up of a prescription by the responsible doctor or sometimes by a verbal order taken by a member of nursing staff. The term administered means that a drug has been given to the patient. This might be through oral, intravenous, intramuscular injection or infusion or other routes of administration.

47. It is the responsibility of registered nursing staff to administer prescribed drugs according to the instructions written in the drug chart. Registered nursing staff work within a code of professional practice and are expected to carry out administration of medicines to certain standards. Nurses are required to act in the best interest of their patients and this may require nursing staff to challenge prescribing decisions by medical staff.

48. As required or prn prescriptions are usually expected to include a specific instruction by doctors as to the circumstances under which the prescribed drug should be administered including how frequently the drug may be administered e.g. paracetamol up to 4g /24 hours. A prn prescription of GTN might include an instruction 'for angina' or for chest pain'. Prn prescriptions do not always include instructions for drugs which have a good safety profile where it would be expected nursing staff would understand the circumstances under which drugs should be administered e.g. senna or paracetamol where it would be expected nursing staff would understand that the drugs are indicated for constipation and mild pain respectively.

49. It is important that prn "as required" prescriptions for controlled drugs, such as opioids, and other drugs with potentially severe adverse effects, such as midazolam and haloperidol, include clear instructions of the circumstances under which the drugs should be administered. This can be done through the prescriber writing instructions such as 'for severe pain' for diamorphine or by nurses using an agreed protocols or policies for the drugs or the symptoms being managed. There were no unit policies or protocols for the use of opioids and other drugs or the management of pain in the late 1990s at Gosport War Memorial Hospital. Staff at the hospital did refer to the 'Wessex protocols' but these did not appear to be followed in all patients.

50. It is possible Dr Barton trusted nursing staff to know the circumstances under which prescriptions for morphine, diamorphine and midazolam were appropriately administered and the appropriate dose that should be used. However this appears not to have been clear to nursing staff in some patients. For example patient F was prescribed prn morphine without any instructions that this was for pain. Patient F was then administered oral morphine for anxiety and distress when not in pain by nursing staff when this is not an appropriate indication.

51. If wide dose ranges are prescribe for prn drugs there needs to be clear instructions or a policy in place to ensure an appropriate starting dose is commenced by nursing staff. In many patients prn prescriptions of diamorphine and midazolam were very wide e.g. 20-200 mg/24 hr and 20-80mg/24hr. Without clear instructions in the medical notes and drug chart or a policy in place which details appropriate staring dose there is a risk that patients will be administered an inappropriately high dose of a prn drug by nursing staff.

52. Out of hours or when Dr Barton was on leave, other general practitioners covering the hospital would be expected to write up any drugs required out of hours. It is not clear how often on call doctors visited the wards out of hours and in some cases drugs were prescribed by a 'verbal order'. In such a system the nurse writes down the drug prescribed over the phone by the doctor and this is usually confirmed by a second nurse to reduce the chances of any error on the drug or dose prescribed. The potential problem with 'verbal orders' for drug prescriptions is that they involve the prescription of a drug for a problem that may not have been assessed by a doctor taking a history, examining and investigating the patient where this might be required.

53. Review of the notes and interviews suggest that 'anticipatory prescribing' was undertaken where drugs were prescribed for problems that patients might develop. This is sometimes done to avoid the need for a doctor to come to a ward out of hours to prescribe for a simple complaint that does not require urgent medical evaluation.

54. It was common practice in many wards in the 1980s and 1990s for mild analgesics such as paracetamol, laxatives and hypnotic drugs such as temazepam. In recent years anticipatory prescribing of hypnotic drugs in patients who are not already receiving them is now not advised because of the risk of patients developing long term dependence on benzodiazepines as these may be continued after discharge. Because the use of benzodiazepines in older people is associated with falls and hip fracture, and may produce confusion and cognitive impairment, many geriatricians avoid and limit the use of benzodiazepines in older people.

55. Anticipatory prescribing of powerful opioids and sedatives in patients who do not require them when assessed is potentially highly dangerous as the prescribing of such drugs requires careful evaluation of the patient because of the risk of serious adverse effects such as respiratory depression and coma.

56. In the late 1990s the General Medical Council had not produced guidance on prescribing. However Good Practice in Prescribing Medicines was published by the GMC in 2006 and the principles applied in the 1990s. The Guidance refers to the importance of ensuring familiarity with guidance published in the BNF, the need to be in possession of or take an adequate history from the patient, to reach agreement with the patient on the use of any proposed medication, establishing the patient's priorities, preference and concerns, to satisfy oneself that the patient has been given appropriate information in a way they can understand about drug therapy. The guidance also states that doses should be prescribed appropriate for the patient and their condition and that there must be a clear, accurate, legible and contemporaneous record of all medicines prescribed.

57. **Declaration**

a) I understand that my overriding duty is to the panel, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.

b) I have set out in my report what I understand from those instructing me to the questions in respect of which my opinions as an expert are required.

c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.

d) I have drawn to the attention of the court all matters, of which I am aware which might adversely affect my opinion.

e) Wherever I have no personal knowledge, I have indicated the source of factual information.

f) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me without forming my own independent view of the matter.

g) Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

h) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires correction or qualification.

i) I understand that the report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.

jj) I have included in this and the supplementary reports a statement setting out the substance of al acts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

k) I have read and understood the Civil Procedure Rules Part 35 –Experts and Assessors.

Statement of Truth

I confirm insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

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Gary A Ford

References

1. Drugs In the Older Population. Edited Crome & Ford. Imperial College Press. 2000; 580-600.
2. British National Formulary 36 1998 page 11
3. British National Formulary 36 1998 page 11
4. British National Formulary 36 1998 page 14
5. Commission for Healthcare Improvement Investigation of Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. July 2002

GMC and Dr Barton
Report on Elsie Lavender (Patient B)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient B

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient B commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practise Panel that the prescriptions for diamorphine on 26 February and for diamorphine and midazolam on 5 March were too wide; that the lowest commencing dose of diamorphine on 5 March of 100mg per 24 hours was excessive to Patient B's needs; that these prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her needs; that these prescriptions and the prescription of Morphine Slow Release (MST) tables on 24 February were inappropriate, potentially hazardous and not in the best interests of Patient B; that Dr Barton did not perform an appropriate examination or assessment of Patient B on admission or an adequate assessment when Patient B's condition deteriorated; did not provide a plan treatment or obtain the advice of a specialist when Patient B's condition deteriorated and that Dr Barton's actions and omissions in relation to Patient B were therefore inadequate and not in the best interests of Patient B.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient B; statements of Alan Lavender, Sheelagh Joines, Margaret Couchman, Dr Althea Lord, Elizabeth Thomas, Fiona Walker; statement made by Dr Barton in relation to Patient B; Dr Barton's police interview 24 March 2005.

5. **Course of events**

5.1 Patient B was 83 years of age when she was admitted to the Royal Hospital Haslar on 5 February 1996 following a fall, was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996. Patient B died on Daedalus Ward, Gosport War Memorial Hospital on 6 March 1996. Prior to her fall and admission on 5 February 1996, Patient B lived alone at home with her bed downstairs. She had a history of long-standing insulin dependent diabetes and was registered blind due to cataracts (page 79). The admission

clerking notes (page 127) record she could walk about 10 yards with a stick, that her son did her shopping and she was supported with daily home help and nurse visits to administer her insulin.

5.2 On 5 February 1996, Patient B had been found at home, lying at the bottom of her stairs by her home help. Patient B was unable to recall events but it seemed clear that she had fallen down the stairs as she was complaining of pain in both shoulders and a sore head. She was taken to the Accident & Emergency Department at Royal Hospital Haslar where she was found to have a laceration on the scalp, laceration on the right lower leg and tenderness over the acromioclavicular region of the right shoulder and tenderness over the left humerus (page 130). X-rays were obtained of the skull and left and right shoulder. The notes record (page 134) that there was no bony injury evident. I could not find a formal report of these x-rays in the medical notes. On neurological examination she was found to have general weakness and was unable to move her right fingers. The impression of the assessing doctor in Accident & Emergency was that she had had a fall either due to a slip or stroke (CVA). She noted she was a little drowsy and arranged for admission.

5.3 On admission (page 140) the admitting doctor noted she looked frail but was fully alert and orientated. No focal arm or leg weakness was noted although power was generally weak throughout and an upgoing right plantar reflex was observed. Other findings were of a laceration (now sutured) and cut on the right leg with a small ulcer over the left tibia. Blood tests on admission were unremarkable and the electrocardiogram (ECG) showed atrial fibrillation (p143). Further enquiry into her history indicated she had had an episode of hypoglycaemia one month previously (page 143). The notes record (page 144) that she was independent but could only walk a few yards and went out of the house once a week when taken out by her son.

5.4 On 6 February the medical notes record that Patient B was complaining of pain in the right arm and had tenderness over the humerus and that the x-rays were not on the ward. Later that evening the medical notes record (page 145) that Patient B developed a temperature of 38.5°C. Examination reports chest and abdomen were normal and there was no obvious source of infection, however she was commenced on amoxicillin most likely to cover the possibility of a chest or urinary tract infection.

5.5 On 7 February the notes record that she still had left shoulder and upper arm pain and her hands were a problem (p145). On 8 February she was seen by Elizabeth Thomas, physiotherapist (page 146) who noted that Patient B was complaining of shoulder/upper limb tenderness and abdominal pain that she required the assistance of two people to move from sitting to standing with full support for a few steps. She noted the pain Patient B was having in her shoulder was a major problem leading her to require assistance with feeding, washing and dressing when she had previously been independent in these activities. An entry later that day indicates the need for analgesia. On 12 February the medical records note Patient B's shoulder was still very painful. On 13 February a referral was made to Dr Lord, Consultant in Elderly Medicine. I have not been able to find a record of the analgesia and other drug therapy Patient B received at Royal Hospital Haslar in the medical notes.

5.6 The referral to Dr Lord (page 146) state that x-rays showed no fractures, that her diabetes was under control, that she was not able to do anything for herself and that she needed help to walk. The medical records on 14 February record that *"Patient B was still not able to do much for herself because of pain in her arms"* (page 150).

5.7 On 16 February Patient B was seen by Dr Tandy, Consultant Geriatrician in response to the referral made to Dr Lord. Dr Tandy noted the history of the fall on 5 February. That her full blood count suggested the presence of iron deficient anaemia and that Patient B still had pain in her arms and shoulders. At this stage she was walking a few steps with a physiotherapist, required two people to transfer and had no problems eating or drinking. Dr Tandy noted (page 151) that she had been unable to use her fingers since admission, but this was improving.

5.8 Dr Tandy's examination of Patient B at this time indicated she had 4/5 weakness of the fingers and wrists in both arms and a decreased measurement in both shoulders. On sensory examination there was a possible loss of sensation in the median nerve territory of the right hand which Dr Tandy thought was long-standing. Reflexes were generally decreased, right plantar reflex was equivocal and left plantar was upgoing. Dr Tandy's impression was of a probable brain stem stroke (b. stem CVA page 152). Dr Tandy stated in the medical notes *"she had her neck x-rayed – I assume it was normal"*. Her notes record *"sounds as though only just managing at home prior – but would like to get back. Therefore to Daedalus GWMH"*. She requested (page 153) that notes and x-rays be sent with Patient B when a bed was available on the ward. Dr Tandy stated at the end of her assessment *"I am not sure whether we'll be able to get her home, but we will try"*.

5.9 An entry in the medical notes on 20 February stating mobility was improving in her arms and Patient B was now able to feed herself but was still unable to use cutlery. Dr Tandy's assessment is summarised in a letter dated 16 February 1996 (pages 242, 244).

5.10 Patient B was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996, under the care of Dr Lord, Consultant Geriatrician. An entry from Dr Barton in the medical notes on 22 February 1996 (p175) states *"Transfer to Daedalus Ward, GWMH. Past medical history fall at home top to bottom of stairs, laceration on head. Leg ulcers. Severe incontinence, needs a catheter. Insulin dependent diabetes mellitus. Needs Mixtard insulin bd. Regular series blood sugar. Transfers with two. Incontinent of urine. Help to feed and dress. Barthel 2. Assess general mobility. ? suitable rest home if home found for cat"*.

5.11 The next entry from Dr Barton in the medical notes on 23 February states *"catheterised last night. 500ml residue. Blood and protein. Trimethoprim"*. The next entry in the medical notes is on 26 February by Dr Barton *"not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress. Institute subcutaneous analgesia if necessary"*. As required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800ucg/24hr were written by Dr Barton on 26 February but none administered.

5.12 The next entry is on 5 March 1996 by Dr Barton in the medical notes and states *"has deteriorated over last few days. Not eating or drinking. In some pain therefore start subcutaneous analgesia. Let family know"*. On 6 March 1996 Dr Barton writes in the medical notes (page 975) *"further deterioration. Subcutaneous analgesia commenced. Comfortable and peaceful. I am happy for medical staff to confirm death"*. There is an entry in the medical records on 6 March 1996 at 2128h confirming death by a member of nursing staff. The death certificate records cause of death as 'CVA' with diabetes mellitus as a contributory factor (CVA is an abbreviation for cerebrovascular accident i.e. stroke).

5.13 The nursing summary records (page 1021) state *"patient having problems with grip in both hands and pain in her arms and shoulders"*. On 20 February the nursing summary states she

was referred to physiotherapy. On 24 February the nursing notes state *"Patient B's pain was not controlled by DF118, that the patient was seen by Dr Barton and commenced on morphine (MST 10mg bd)"* (Page 1021). On 26 February 1996 the nursing notes record that Patient B was seen by Dr Barton and the MST morphine dose increased to 20mg bd (page 1022). The nursing notes later that day (1430h) indicate the son of Patient B and his wife were seen by Dr Barton, that the prognosis was discussed and *"son is happy for us to just make Patient B comfortable and pain-free. Syringe driver explained"*.

5.14 On 4 March 1996 the notes record patient B was complaining of pain and of having extra as required doses of analgesia. Morphine sustained release tablets were increased to 30mg twice daily by Dr Barton. On 5 March the nursing summary records Patient's B pain was uncontrolled and a syringe driver was commenced at 0930h with diamorphine 100mg/24hr and midazolam 40mg/24hr. On 6 March 1996 the nursing records state that patient B was seen by Dr Barton and that medication other than that through the syringe driver was discontinued as Patient B was not unrousable.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 832-848. All prescriptions written by Dr Barton unless otherwise marked.

Regular prescriptions

Digoxin 125ug od Prescribed 22 Feb	23 Feb – 4 Mar then discontinued
Digoxin 125ug od Prescribed 4 Mar	5 Mar no further doses
Co-amilofruse 1 tablet once daily Prescribed 22 Feb	23 Feb – 4 Mar then discontinued
Co-amilofruse 1 tablet once daily Prescribed 4 Mar	4 Mar then no further doses
Ferrous sulphate 200mg bd Prescribed 22 Feb and further continuation prescription 4 Mar	23 Feb – 4 Mar then discontinued
Beclomethasone inhaler 2 puffs twice daily Prescribed 22 Feb	22 Feb – 4 Mar then discontinued
Salbutamol inhaler 2 puffs four times daily Prescribed 22 Feb	22 Feb – 4 Mar then discontinued
Insulin mixtard 50 units once daily 0730h Prescribed 22 February 1996	23-26 Feb
Insulin mixtard 50 units once daily 1800h Prescribed 22 February 1996	22-25 Feb
Insulin mixtard dose unclear	23 Feb – 4 Mar (omitted 28 Feb)
Insulin mixtard dose unclear Insulin mixtard 30 units morning Prescribed 4 March	4-5 March
Insulin mixtard 20 units evening Prescribed 4 March	No doses administered
Trimethoprim 200mg bd Prescribed 23 Feb	23-27 Feb then discontinued.
MST 10mg bd 0600h, 1800h Prescribed 24 Feb	24-26 Feb discontinued after morning dose

MST 20mg bd Prescribed date unclear	26 Feb 2200h – 3 Mar 2200h then discontinued
MST 30mg bd Prescribed 4 Mar	4 Mar 2 doses then discontinued
Diamorphine subcut via syringe driver 100-200mg/24hr Prescribed 5 Mar	5 Mar 100mg/24hr 6 Mar 100mg/24hr
Midazolam subcut via syringe driver 40-80mg/24h Prescribed 5 March 1996	5 Mar 40mg/24hr 6 Mar 40mg/24hr
As required prescriptions	
Dihydrocodeine ? dose Prescribed 22 Feb	9 doses, 2 tablets received dates and times unclear
Diamorphine subcut via syringe driver 80-160mg/24hr Prescribed 26 Feb	None administered
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 26 Feb	None administered
Hyoscine sub-cut via syringe driver 400-800ug/24hr Prescribed 26 Feb	None administered

Opinion on Patient Management

7. Patient B was an elderly lady with long standing diabetes who had significant impairments and comorbidites prior to her fall and admission to hospital in February 1996. Although she was registered blind and had previous falls at home she was living alone at home with support. Following the fall her functional abilities were significantly impaired because she was unable to use her hands. This was attributed to a brain stem stroke although I consider the clinical evidence does not support this diagnosis. Bilateral hand weakness and arm and shoulder pain would be an unusual presentation for a brain stem stroke. No radiological brain imaging was undertaken which might have helped confirm the diagnosis. However as Dr Tandy rightly commented CT brain imaging at the time she assessed the patient would be unlikely to have demonstrated a brain stem stroke.

8. In a patient who has had a significant fall downstairs it is crucial to exclude injury to the head or cervical spine and in particular in patients with neurological deficits to exclude cervical cord compression. Dr Tandy recognised the importance of this through her comment asking whether the medical team responsible for her care had obtained and reviewed neck X-rays. I have been unable to find a record of any X-rays of Patient B's neck in the medical records and it is not clear that any X-rays of Patient B's cervical spine were obtained. In this context I think it is much more likely Patient B's symptoms were related to cervical spine cord injury. Her clinical symptoms are more in keeping with this diagnosis than a stroke. Ideally MR

scanning of the brain and cervical spine would have been requested to assess whether this was present and consideration given to obtaining a neurological or neurosurgical opinion. Not withstanding the possible presence of cervical spine and cord injury Patient B eventually started to gain improved function of her hands although her general function was significantly reduced to that prior to her fall.

9. At the time of her transfer to Daedalus Ward the plan was to attempt to mobilise Patient B. The initial assessment of Patient B by Dr Barton was in my view inadequate. There was no assessment of her pain and no neurological examination. The latter should have been performed because of the continuing arm weakness and the working diagnosis of a possible brain stem stroke. There was no record of the analgesia she had received prior to transfer to Daedalus Ward. The prescription of mild opioid drug dihydrocodeine for her pain was in my view reasonable and appropriate. It seems likely that her pain was attributed to musculoskeletal injuries although this is not stated by Dr Barton. In my view continuing pain in the absence of fracture more than two weeks after a fall should have prompted a clinical review including a detailed history and re-examination of the patient with consideration of alternative causes of the pain.

10. The prescription by Dr Barton of MST (sustained release morphine) on 24 February was in my view not justified or best practice by the information available in the medical records. The response to dihydrocodeine was not recorded. It would have been more appropriate to prescribe as required oral morphine before prescribing a sustained release preparation. Both the medical and nursing notes lack information on Patient B's symptoms of pain although it seems likely that she was having persisting pain as the MST dose was increased to a total of 60mg daily. However the medical and records do not record that Patient B remained in pain on the initial dose of MST and do not provide any justification for the increase in dose to 60 mg daily over the following days.

11. The prescriptions on 26 February of as required prescriptions for subcutaneous infusions of diamorphine 80-160 mg/24hr, midazolam 40-80mg/24 hr and hyoscine 400-800ucg/24hr were in my opinion, not justified, reckless and potentially very dangerous. In the event none of these were administered by nursing staff. At this time there was no evidence in the notes that Patient B was unable to swallow. She was receiving 40mg oral morphine in a 24 hour period and the equivalent dose of subcutaneous diamorphine would have been approximately 15-20mg/24hr. Had the diamorphine been administered this would have been 4-8 fold increase and would have been highly likely to cause respiratory depression and coma. Had the midazolam infusion been commenced this would have even more powerfully suppressed Patient B's respiration and conscious level.

12. Dr Barton documents on the 5 March that Patient B was deteriorating and was not eating or drinking. No assessment was recorded or appears to have made by Dr Barton as to the cause of this deterioration. In particular she does not appear to have considered that the deterioration in patient B may have been due to adverse effects of the morphine prescribed to her. In this context it is difficult to know whether continuing opioid drugs was appropriate in Patient B. If Patient B's deterioration was not due to opiates it was appropriate to continue an equivalent opioid dose by the subcutaneous route. The equivalent diamorphine subcutaneous dose is one third to one half of the oral morphine dose received over a 24 hour period. Patient B was receiving 60mg/24hr of oral morphine. Therefore an equivalent dose of subcutaneous diamorphine would have been 20-30mg/24hr.

13. The prescription of a subcutaneous infusion of diamorphine that was 3-5 times higher than the oral morphine she had received was in my view reckless and dangerous and highly likely to precipitate respiratory depression and coma in Patient B. The prescription of 40mg/24hr midazolam was in my opinion also not justified as the medical and nursing notes do not record and agitation or other symptoms justifying the prescription of a sedative drug. The dose range prescribed was in my view excessive and reckless and likely to cause further respiratory depression and coma. If agitation or restlessness was present a single dose of haloperidol or other sedative would have been appropriate initial therapy. Close monitoring of Patient B was required once the combination of diamorphine and midazolam was infused with the nursing and medical staff understanding the high risk of respiratory depression and coma that these drugs can produce.

14. The subsequent deterioration of Patient B on 6 March is in my view most likely due to the combined effects of the diamorphine and midazolam infusions. The description of Patient B being comfortable and peaceful most likely reflects Patient B was in a drug induced coma at this stage. In my opinion the diamorphine infusion was inappropriately high and the midazolam infusion was not indicated in Patient B. I consider these drugs very likely produced respiratory depression and coma in Patient B and hastened her death.

Summary of Conclusions

15. Patient B was an elderly lady with diabetes who developed persisting bilateral hand weakness and shoulder and arm pain following a fall. The underlying cause of her persisting weakness and pain was in my opinion not clearly established. Patient B was transferred to Daedalus ward with the intent to try and mobilise her. The information in the notes suggests there was inadequate assessment of patient B by Dr Barton as the doctor responsible for the day to day medical care of the patient. Dr Barton's prescription of Morphine Slow Release Tablets on 24 February was inappropriate because an adequate clinical assessment had not been performed and the response to paracetamol and moderate analgesia had not been assessed. The prescriptions of subcutaneous diamorphine and midazolam by Dr Barton on 26 February were too wide a dose range and potentially hazardous. The prescriptions of subcutaneous diamorphine and midazolam on 5 March were not justified, reckless and in my opinion led to deterioration in Patient B contributing to her death.

16. In my opinion Dr Barton in her care of Patient B failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

17. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

GARY A FORD

General Medical Council and Dr Barton
Report on Eva Page (Patient C)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Patient C

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of patient C, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were made with too wide a dose range and were there inappropriate and potentially hazardous and not in the best interests of Mrs Page.

2. **Code A**

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 30-34 I described the course of events relating to Mrs Page's admission to the Department of Medicine for Elderly People at Queen Alexandra Hospital on 6 February 1998 and subsequent care following her transfer to Dryad Ward at Gosport War Memorial Hospital on 27 February 1998 prior to her death on 3 March 1998.

4. This report is based on my review of the following documents: medical records of patient C; statements of Bernard Page, and various nurse statements.

5. **Course of events**

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make to my statement in that report.

6. **Drug therapy prescribed and received at Gosport War Memorial Hospital.**

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 6.9 of my report to Hampshire Constabulary (12 December 2001).

Pages 272 – 284. All prescriptions written by Dr Barton unless otherwise marked.

Once only prescription

Diamorphine im 5mg	administered twice. First date unclear, 0800 h Second date unclear, 1500 h

As required prescriptions

Thioridazine 25mg Prescribed 27 Feb	28 Mar 1300h
Oramorph 10mg per 5mls, 5mg Prescribed 27 Feb	28 Feb 1620h
Fentanyl '25' patch x 3 days Prescribed 2 Mar	2 Mar 0800h

Regular prescriptions

Digoxin 125ug od
Frusemide 40mg od
Ramipril 5mg od
Sotalol 40mg od
Sertraline 50mg od

All 5 drugs above prescribed 27 Feb
No drugs administered, discontinued date unclear

Lactulose 10ml bd Prescribed 27 Feb	27 Feb 1 dose 28 Feb 2 doses 29 Feb 1 dose
Thioridazine dose unclear tds Prescribed 28 Feb	1 Mar 2 doses 2 Mar 1 dose then discontinued
Heminevrin dose unclear nocte Prescribed 28 Feb	28 Feb 1 dose 1 Mar 1 dose then discontinued

Daily review prescriptions

Diamorphine sub cut via syringe driver 20-200mg/24hr Prescription date unclear MARKED PRN	3 Mar 20mg/24hr 1050h
Hyoscine subcut via syringe driver 200-800ug/24hr Prescription date unclear	None administered
Midazolam subcut via syringe driver 20-80mg/24hr Prescription date unclear	3 Mar 20mg/24hr 1050h

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing.

8. As previously stated I consider the prescription of oral morphine on 28 February was probably appropriate. If this had failed to control her symptoms which the notes suggest was the case by 2 March. Patient C had received oral morphine, thioridazine and heminevrin and was reported to be unsettled following intra-muscular diamorphine and to be spitting out oral medication. I would consider the decision to prescribe a transdermal patch was appropriate. Dr Barton recorded the rationale for prescribing a fentanyl patch in her entry to the medical notes on 2 March.

9. After the fentanyl patch (25ug per hour) was applied Patient C became more drowsy. The fentanyl 25ug patch is equivalent to 90mg of oral morphine (ref BNF 36 September 1998 page 204). Patient C had received substantially less than the equivalent of 90mg oral morphine in the previous 24 hours. It is difficult to determine how much opioid drugs she had received because the dates of two administered 5 mg intramuscular doses of diamorphine are unclear. However if it is assumed these two doses were administered on 1 March this was equivalent to 20-30mg morphine. Dr Barton had therefore prescribed at least a three fold higher dose of opioid, and if the diamorphine doses were administered on separate days the increase in opioid dose was even higher. There was a sigificant risk of adverse effects from the fentanyl patch and this was the most likely cause of Patient C developing drowsiness.

10. The notes record Mrs Page's son was concerned about the deterioration. Dr Lord appeared to recognise the deterioration could be due to adverse affects of opiates although she states in her entry that patient C was receiving diamorphine when she was only receiving a fentanyl patch at this point. It would have been appropriate for the fentanyl patch to be removed although it is not clear if this was done.

11. I cannot find any justification of the subsequent commencement of midazolam and diamorphine as a subcutaneous infusion on 3 March. Dr Barton recorded no indication for this in the medical records. At this time the nursing records do not indicate patient was in any pain or distress. In my view there was no indication to prescribe additional opiates or sedative by continuous syringe driver infusion when patient C had already deteriorated following the application of the fentanyl patch. The infusion of diamorphine and midazolam would be expected to result in further depression of conscious level and respiratory depression. These drugs likely contributed to her death.

12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The medical notes should have recorded clear reasons why these powerful drugs were being prescribed. In the absence of any clear protocol the prescription of such a wide dose range was hazardous in a patient such as Patient C.

Summary of Conclusions

13. Patient C was a frail elderly lady with probable carcinoma of the bronchus who had background problems of depression, dementia, ischaemic heart disease and congestive heart failure. Dr Barton was responsible for her day to day medical care on Dryad Ward. The information recorded in the medical records suggests there was an inadequate medical assessment when she was initially admitted to Dryad ward. The medical records also suggest that an adequate medical assessment was not performed by Dr Barton prior to the prescription of midazolam, diamorphine and hyoscine by subcutaneous infusion using a syringe driver. The dose ranges were inappropriate and potentially hazardous. In my

opinion the prescription of these drugs in conjunction with the previous prescription of a fentanyl patch at a much higher equivalent dose then the oral morphine may have contributed to her death. However Patient C was a frail woman with probable carcinoma of the bronchus who was deteriorating prior to her admission to Dryad ward and other medical problems may have caused her deterioration and death.

14. In my opinion, Dr Barton in her care of patient C failed to meet the requirements of good medical practice to:
    - provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
    - prescribe only the treatment drugs or appliances that serve the patient's needs.

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Barton
Report on Alice Wilkie (Patient D)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient D

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient D commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions of diamorphine and midazolam were in too wide a dose range, creating a situation whereby drugs could be administered to Patient D which were excessive to her needs and were inappropriate, potentially hazardous and not in the best interests of Patient D.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 21-24 of that report I describe the course of events relating to Patient D's admission to the Queen Alexandra Hospital on 31 July 1998, transfer to Daedalus Ward Gosport War Memorial Hospital on 6 August 1998 prior to her death on 21 August 1998.

4. This report is based on my review of the following documents; medical records of Patient D; statements of Mrs Marilyn Jackson, Dr Althea Lord, various nurse statements.

5. **Course of events**

5.1 I have described the course of events in my report to Hampshire Constabulary dated 12 December 2001. A correction I have to that statement relates to section 4.4 where I stated the nursing care plan recorded no significant deterioration until 21 August 1998. The nursing notes record a deterioration in Patient D's condition over the weekend on 17 August 1998 (p635). Otherwise I have no changes or corrections to make to my statement in that report.

6. **Drug therapy prescribed and received at Gosport War Memorial Hospital.**

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 4.5 of my report to Hampshire Constabulary (12 December 2001).

Pages 138-145. All prescriptions written by Dr Barton unless otherwise marked.

Note the drug chart used at Queen Alexandra Hospital was used following transfer on 6 August 1998 to Daedalus Ward with the hospital and ward being changed from 'Q.A. to 'GWMH' and 'Philip' to 'Daedalus' ward.' (p139)

As required prescriptions	
Promazine syrup 25mg Prescribed 31 Jul 1998 by Dr Wilson	None administered
Haloperidol subcut 2.5-10mg maximum 60mg in 24 hours Prescribed 1 Aug 1998 by Dr Wilson	1 Aug 2045h 2.5mg
Magnesium hydroxide 10mls Prescribed 4 Aug 1998 Dr Wilson	None administered
Regular prescriptions	
Fluoxetine (Prozac) 20mg od Prescribed 31 Jul 1998 Dr Wilson	1-9 Aug then discontinued
Co-danthramer 5-10mls Prescribed 31 Jul 1998 Dr Wilson	31 Jul – 19 Aug
Zopiclone 3.75mg Prescribed 31 Jul 1998 Dr Wilson	3-19 Aug
Lactulose 10mls Prescribed 31 Jul 1998 Dr Wilson	1 - 4 Aug then discontinued
Promazine 25mg od Prescribed 31 Jul 1998 Dr Wilson	None administered
Augmentin1.2 g iv tds Prescribed 1 Aug 1998 Dr Wilson	1 Aug 2 doses Discontinued 2 August
Augmentin elixir 250-62 500mg tds Prescribed 2 Aug 1998 Dr Wilson	2-9 Aug then discontinued
Daily review prescriptions	
Diamorphine subcut via syringe driver Prescribed date unclear 20–200mg/24hr	20 Aug 30mg /24hr 1350h 21 Aug 30mg /24hr
Hyoscine subcut via syringe driver 200-800ug/24hr Prescribed date unclear	None administered
Midazolam subcut syringe driver 20-80mg/24hr Prescribed date unclear	20 Aug 20mg /24hr 1350h 21 Aug 20mg /24hr

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing.

8. Patient D was a frail elderly woman with dementia resident in a psychogeriatric care home (Addenbrooke's) prior to her admission to hospital. Dr Lord had outlined the management plan for Patient D on 4 Aug 1998 (p99A) with continuation of oral antibiotics to treat her urinary tract infection, administration of subcutaneous fluids and transfer to Daedalus NHS Continuing Care Ward for 4-6 weeks for observation prior to a decision about placement. At this stage Patient D could not return to her bed at Addenbrooke's care home but her bed was to be kept there until it became clear whether she would recover sufficiently to return to the care home. A decision was made that Patient D was not for resuscitation in the event of a cardiac arrest but active treatment was continuing. I would consider both these decisions were appropriate and reasonable.

9. There are very few medical records following Patient D's transfer to Daedalus ward. There is a brief entry on 6 August by Dr Peters documenting her transfer and plan for 4-6 weeks observation. The entry in the medical notes by Dr Lord on 10 August indicates Patient D had shown some improvement and was eating and drinking better but remained confused and slow (page 99B). Dr Lord made a decision that the place at Addenbrooke's care home should be given and Patient D reviewed in one month time to assess if she continued to have specialist medical or nursing problems which would have meant long term care in an NHS continuing care bed was appropriate.

10. The nursing notes indicated on 17 August that Patient D's condition had deteriorated over the weekend (p635). The nursing notes do not record Patient D was in pain or distress. The next entry in the nursing records on 21 August after Patient D had been commenced on diamorphine and midazolam by Dr Barton do not record Patient D having any pain or distress. Subcutaneous infusions of diamorphine and midazolam were commenced on 20 August by nursing staff. It is unclear when the prescription for these drugs was written by Dr Barton as this section of the drug chart does not have a date box to record the prescribing date. However Dr Barton presumably wrote this prescription on or before Thursday 20 August and later made an entry in the notes on 21 August when she documents subcutaneous analgesia was commenced the previous day.

11. The deterioration that occurred in Patient D required a medical assessment to be performed to determine the cause of the deterioration such as infection or electrolyte disturbance. However the information in the medical records suggests that no such assessment was undertaken by Dr Barton which was necessary to meet the requirements of good medical practice. In my opinion Dr Barton's failure to record any indication for the commencement of subcutaneous infusions of diamorphine and midazolam was not good medical practice and the decision to commence these drugs was not justified or appropriate.

12. In my opinion the prescription of subcutaneous diamorphine and midazolam in the wide dose range was poor practice, potentially very hazardous and not consistent with good medical practice. The prescription of large dose ranges of these drugs in the absence of a clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs, doses to be used and monitoring undertaken, placed Patient D at high risk of being administered an inappropriately high dose of opiate. In my opinion it is likely that the administration of the diamorphine and midazolam infusions produced depression of her respiration and conscious level. However as there are no clear observations of Patient D's respiratory rate it is difficult to assess whether significant deterioration occurred before or after administration of the diamorphine and midazolam and whether these drugs hastened death.

Summary of Conclusions

13. Patient D was a frail elderly woman with dementia who was transferred to Daedalus ward for observation prior to a decision about appropriate long term placement. After initial improvement following admissions to the ward Patient D deteriorated and was prescribed and commenced on diamorphine and midazolam subcutaneous infusions and died the following day. The information in the notes suggests there was an inadequate assessment of patient D by Dr Barton when the deterioration occurred. In my opinion the prescriptions of diamorphine and midazolam by subcutaneous infusion were not justified by the information recorded in the medical records, were in too wide a dose range and were potentially hazardous.

14. In my opinion Dr Barton in her care of Patient D failed to meet the requirements of good medical practice to:
    - Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
    - Prescribe only the treatment, drugs or appliances that serve the patient's need

13. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

GMC and Dr Barton
Report on Gladys Richards (Patient E)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient E

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient E, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegations presented to the Fitness to Practice Panel that prescriptions by Dr Barton on 11 August 1998 of diamorphine and midazolam were in too wide a dose range and created a situation whereby drugs could be administered to patient E which were excessive to her needs; that prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient E.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I provided to Hampshire Constabulary dated 12 December 2001. In that report pages 4-13 I described the course of events relating to Patient E's admission to the Royal Hospital Haslar on 29 July 1998 subsequent care following her transfer to Daedalus ward, Gosport War Memorial Hospital on 11 August prior to her death on 21 August 1998.

4. This report is based on my review of the following documents: medical records of Patient E; statements of Lesley Richards, Philip Beed, Margaret Couchman, Gillian Hamblin, Fiona Walker, Dr Richard Reid, Gillian McKenzie Dr Althea Lord, Anita Tubbritt; police statements of Dr Barton; statement made by Dr Barton in relation to patient E.

5. **Course of events**

   I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no changes or corrections to make to my statement of the course of events as outlined in that report.

6. **Drug therapy prescribed and received at Gosport War Memorial Hospital.**

   In the next section I list all drug therapy received providing more detail of Dr Barton's prescribing previously outlined in section 2.11 of my report to Hampshire Constabulary (12 December 2001).

   Pages 62-All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Oramorphine 10mg/5ml	11 Aug 1115h	10mg
2.5-5ml	1145h	10mg
Prescribed 11 Aug	12 Aug 0615h	10mg
	13 Aug 2050h	10mg
	14 Aug 1150h	10mg
	17 Aug 1300h	5mg
	?	5mg
	1645h	5mg
	2030h	10mg
	18 Aug 0230h	10mg
	?	10mg
Diamorphine subcut via syringe driver	None administered	
20-200mg/24hr		
Prescribed 11 Aug		
Hyoscine subcut via syringe driver	19 Aug 1120h	200ucg/24hr *? 400*
200-800 ucg/24hr	20 Aug 1045h	400ucg/24hr
Prescribed 11 Aug	21 Aug 1155h	40ucg/24hr
Midazolam subcut via syringe driver	18 Aug 1145h	20mg/24hr
20-80mg / 24 hr	19 Aug 1120h	20mg/24hr
Prescribed 11 Aug	20 Aug 1045h	20mg/24hr
	21 Aug 1155h	20mg/24hr

Regular prescriptions

Haloperidol 2mg/ml oral	13 Aug One dose administered	
0.5ml 'If noisy'		
Heading 'REGULAR PRESCRIPTION' crossed out and replaced with 'PRN' for this prescription		
Haloperidol 2mg/ml, l mg twice daily	11 -14 Aug	
Prescribed 11 Aug	17 Aug then none administered	
Oramorphine 10mg/5ml	None administered	
2.5 ml four time daily		
Prescribed 12 Aug. Marked 'PRN'		
Oramorphine 10mg/5ml	None administered	
5ml nocte		
Prescribed 12 Aug. Marked 'PRN'		
Diamorphine subcut via syringe driver	18 Aug 1145h	40mg/24hr
40-200mg/24hr	19 Aug 1120h	40mg/24hr
Prescribed 17 Aug	20 Aug 1045h	40mg/24hr
	21 Aug 1155h	40mg/24hr
Haloperidol subcut via syringe driver	18 Aug 1145h	5mg/24hr
5-10mg/24hr	19 Aug 1120h	5mg/24hr
Prescribed 17 Aug	20 Aug 1045h	5mg/24hr
	21 Aug 1155h	5mg/24hr

Lactulose 10ml twice daily	11-14 Aug
Prescribed 11 Aug	17 Aug then none administered

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing. I have the following corrections to make to my report to Hampshire Constabulary:
   i) 2.26 line 11 *'The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate'* is incorrect as Dr Barton had prescribed two sedative drugs diamorphine and midazolam on 11th August. In this report I comment on the initial prescription of the two drugs in this report and the prescription of haloperidol by subcutaneous infusion on 17 August.
   ii) 2.30 line 13 *'In the absence of post-mortem. Radiological data (chest Xray) or recordings of Mr _____ respiratory rate...'* should read *"In the absence of post-mortem. Radiological data (chest Xray) or recordings of Patient E's respiratory rate...'.*

8. Patient E was a frail elderly woman with dementia who was living in a nursing home prior to admission following a fractured hip secondary to a fall. Following assessment by Dr Reid (page 24,26 letter summarising assessment) on 3 Aug 1998 she was transferred to Daedalus Ward, Gosport War Memorial Hospital with the aim to improve her mobility. Prior to her transfer to Daedalus ward the orthopaedic nursing team documented on the 10 August that she was fully weight bearing and walking with the aid of two nurses and a Zimmer Frame.

9. The medical notes record a limited assessment by Dr Barton of patient E on 11 August following her admission to Daedalus ward but indicate she was *'not obviously in pain'*. The nursing records on 12 August also state that patient E did not appear to be in pain when she awoke from sleep very agitated. Prior to her transfer to Daedalus ward patient E had been taking cocodamol (paracetamol and codeine) as required. As I have previously commented (section 2.21 report to Hampshire Constabulary) I do not consider it was appropriate to prescribe oramorphine and a subcutaneous diamorphine infusion to patient E on 11 August. The medical records contain no information suggesting patient E's pain would not be controlled by as required or regular cocodamol which she had already been receiving.

10. The oramorphine patient E received between 11-13 August may have contributed to her confusion and agitation following admission to Daedalus ward and to her fall on 13 August leading to dislocation of the hip. However she had dementia, had been agitated prior to receiving the oramorphine and was also taking haloperidol, all of which increase the risk of falls and hip dislocation.

11. The prescription by Dr Barton of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient E at a high risk of developing respiratory depression and coma if a higher infusion rate had been commenced. In my opinion from the information available in the notes the prescriptions on 11 August of as required oramorphine and diamorphine by subcutaneous infusion by Dr Barton were inappropriate and potentially hazardous to patient E. The recorded clinical assessment of patient E undertaken by Dr Barton did not justify the prescription of powerful opioid drugs at this stage, and no instructions were recorded in the medical or nursing records as to the circumstances under which oramorphine or diamorphine should be administered.

12. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion prescribed by Dr Barton to patient E on 11 August. Patient E had intermittent episodes of agitation and regular haloperidol with additional as required doses was appropriate to manage these symptoms. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. None of these applied to patient E.

13. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. In an older frail patient in whom a midazolam infusion as indicated an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr unacceptably high. The prescribed dose range of midazolam particularly in conjunction with the diamorphine prescribed placed Patient E at risk of developing life threatening complications if these doses were administered by nursing staff.

14. Following patient E's readmission to Daedalus ward on 17 August the medical and nursing notes document that Patient E had hip pain. I consider the administration of opioids at this point was reasonable and appropriate. The cause of the hip pain was unclear and it would have been good practice for Dr Barton to discuss patient E with the responsible consultant and/or the orthopaedic team. However as no dislocation was present on the repeat XRay the focus would have been on the provision of effective pain relief. The medical and nursing notes Patient E was deteriorating rapidly at this stage. Hip fracture is often a pre-terminal event in frail patients with dementia. I would consider the focus of care was appropriately on palliating Patient E's symptoms of pain and agitation.

15. Oral morphine was initially used and a total of 45 mg morphine was administered to patient E between 17 August 1300h and 18 August 1145h when a diamorphine infusion was commenced. The medical notes do not record the justification for commencing a subcutaneous infusion rather than continuing to administer drugs by the oral route. The equivalent dose of subcutaneous diamorphine is one third to one half of the total oral morphine dose received which would have equated to 15-23mg/24hr. Patient E was still in pain so a further 50% increase in dose was reasonable which would equate to about 35mg/24hr subcutaneous diamorphine. I would consider the dose of diamorphine infused was high but not unreasonably so, although careful monitoring of patient E's conscious level and respiratory rate was required.

16. The nursing and medical notes indicate patient E was in pain and distressed on 17 August and it was appropriate to continue to administer haloperidol via a syringe driver which was commenced on 18 August at an equivalent dose to that she had been receiving orally. On 16 August patient E received 6 mg oral haloperidol (section 2.10 report to Hampshire Constabulary) whilst at Royal Hospital Haslar. Patient E received one dose of haloperidol on 17 August after transfer back to Daedalus ward and the medical notes record she was in pain and distress. I consider the prescription of haloperidol 5mg/24hr by syringe driver on 17 August was reasonable as this equated to the total oral dose received on 16 August. The administration of diamorphine and haloperidol required careful monitoring because these drugs alone or in combination may produce coma and/or respiratory depression.

17. In my view it was appropriate to prescribe opioid analgesia for pain and haloperidol for distress and agitation on 18 August. The medical notes do not record a clear indication for using subcutaneous infusion rather than continuing oral adminstration. However the doses of morphine and haloperidol that were commenced by subcutaneous infusion on 18 August were in my view reasonable.

18. The medical notes provide no justification for the administration of midazolam to patient E on 18 August. It would have been appropriate to observe the response of patient E to the infusion of diamorphine and haloperidol. If patient E remained agitated and distressed and this was not thought to be due to pain it would have been appropriate to increase the dose of haloperidol infused to 10mg/24hr the upper limit of the haloperidol infusion dose range. If this did not relieve Patient E's symptoms it would have been appropriate to consider replacing the haloperidol with midazolam. However as outlined in my report to Hampshire Constabulary II consider the prescription and administration of midazolam with haloperidol and diamorphine in the doses prescribed to be inappropriate and highly risky because of the combined risk of these three drugs to produce respiratory depression and coma. If patient E had remained highly distressed on adequate doses of diamorphine analgesia and haloperidol and substitution of midazolam for haloperidol had not improved control of symptoms of distress and restlessness it would then have been reasonable to consider administering both haloperidol and midazolam to patient E with careful monitoring to ensure patient E's symptoms were controlled without unnecessary adverse effects.

19. Dr Barton stated that she used midazolam in patient E as a muscle relaxant (section 2.27 report to Hampshire Constabulary). This is not an appropriate use. The medical and nursing notes at the time of the midazolam prescription and administration do not contain any record of an assessment of tone or muscle stiffness in patient E. In my opinion the dose range of subcutaneous midazolam prescribed by Dr Barton was in excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older frail patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The dose of 40mg/24hr hat was administered was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine and haloperidol prescribed placed Patient E at high risk of developing life threatening complications.

20. I consider it likely that the diamorphine, midazolam and haloperidol infusions commenced on 18 August very likely produced respiratory depression and coma that led to her dying earlier than she would have done. However patient E required palliative care following her and was likely to die within a few days or weeks after her transfer back to Daedalus ward on 17 August and was likely to die within a short time period. The doses of subcutaneous diamorphine and haloperidol infusions administered were in my view appropriate but there was no justification in the medical notes for the prescription and administration of midazolam in addition to these drugs.

Summary of Conclusions

21. Patient E was a frail older lady with dementia who sustained a fractured neck of femur, which was successfully surgically treated but then complicated by dislocation and continuing pain following successful manipulation. She had a high risk of dying in hospital following these events. She was initially transferred to Daedalus ward with the aim of improving her

mobility before discharging her back to the nursing home she lived in. The information in the notes suggest there was inadequate assessment of patient E by Dr Barton as the doctor responsible for the day to day medical care of the patient when transferred to Deadalus ward on 11 August 1998. The medical notes record no evidence of hip pain at this time and no justification was provided for the prescriptions of oramorphine and subcutaneous diamorphine and midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

22. Patient E deteriorated rapidly after dislocating her hip on 14 August and treatment with opioids and haloperidol was appropriate. The medical records do not provide any justification for the prescription of midazolam by subcutaneous infusion or is administration on 18 August until Patient E's death on 21 August. In my opinion the midazolam infusion at the dose infused very likely led to respiratory depression and shortened patient E's life although at this stage she required palliative care and was likely to die within a few days or weeks.

23. In my opinion, Dr Barton in her care of Patient E failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

24. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Jane Barton
Report on Ruby Lake (Patient F)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient F

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient F commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that the prescriptions by Dr Barton on 18 August 1998 of oramorphine, and on 19 August 1998 of diamorphine and midazolam were inappropriate, potentially dangerous and not in the best interests of patient F.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient F; statements of Lynne Barnet; Dr David Barrett; Adele Bindloss; Beverly Turnbull; Shirley Hallman; Dr Althea Lord; statement by Dr Barton in relation to Ruby Lake; Dr Barton's police interview 14 July 2005.

5. **Course of events**

5.1 Patient F was 84 years of age when she was admitted to Royal Hospital Haslar, Ward 3 on 5 August 1998 and transferred to Dryad ward, Gosport War Memorial Hospital on 18 August 1998. Patient Fdied on Dryad ward, Gosport War Memorial Hospital on 21 August 1998. Past medical history prior to this admission included inflammatory arthritis which had been considered to be possibly rheumatoid arthritis. When assessed by a consultant rheumatologist Dr McCrae in 1998 the diagnosis was thought to be CREST (Calcinosis, Raynauds, Eosphageal dysfunction, Sclerodactyl, Telangiectasia) syndrome. Other past medical problems were gout, hypertension, renal impairment which had previously been assessed by Dr Lord (p26-33). She had previous admissions for shortness of breath chest pain, atrial fibrillation and a myocardial infarction. In June 1998 she was admitted from home for a treatment of leg ulcers. The medical records state (p495) she had been *'mobile, independent and self caring'* prior to admission on 5 August 1998.

5.2 Following a fall at home on 5 August 1998 Patient F was admitted to the accident and emergency department at Royal Hospital Haslar and found to have a fractured left neck of femur. She underwent surgery the same day with an insertion of left cemented hemiarthroplasty. A nursing transfer letter by a staff nurse dated 15 August 1998 (page 23-

25) summarises her course during her stay Royal Hospital Haslar prior to her transfer Dryad ward, Gosport War Memorial Hospital on 18 August. She had a slow recovery following surgery problems of angina and breathlessness. At the time of the transfer letter she was mobile with a Zimmer frame and supervision and could wash her top half independently. She had bilateral leg ulcers which were present prior to admission and a broken area on her left buttock that was improving. She had a urinary catheter in place, had been occasionally confused at night and her hearing aid had gone missing.

5.3 On 9 August the medical notes (p508) record *"slow progress, nausea, diarrhoea yesterday, poor mobilising, on examination pyrexial, pulse 80, wound fine, urine output good (illegible word) poor "*. On 10 August the medical notes (p509) record *"patient unwell, vomiting, diarrhoea, drowsy, denies pain, orientated in time and place o/e pulse 129 bpm irreg irreg BP 120/60 mmHg. Apyrexial chest clear, oxygen sats on air 94%, plan 1. ECG 2. continue IV fluid, rediscuss with SHO"*. An ECG was noted to show a sinus tachycardia (increased heart rate) ST depression in leads V5 and 6V. Blood tests including cardiac enzymes (p552) were taken at this stage showing a normal creatinine kinase (CK) at 68 (increased if a myocardial infarct occurs) and an elevated white cell count. An entry in the medical notes later that day by a medical SHO documents respiratory crackles in the left base and a possible diagnosis of a chest infection. A further note (p511) states by Surgeon Captain Farquharson Robert states *"for all necessary treatments and resuscitation..."*. A chest x-ray showed left-sided basal chest infection. Antibiotics were commenced.

5.4On 12 August the medical notes record an entry by the registrar (page 514) *"much improved, has sat out today, not in failure, no further deterioration, developing sacral bedsore"*. A plan was to mobilise with physiotherapy, encourage oral fluid intake and stop antibiotics and intravenous fluids. On 13 August a referral was sent from the orthopaedic team to Dr Lord, consultant geriatrician, requesting assessment from the point of her future management. The referral notes her post-op recovery was slow with periods of confusion and pulmonary oedema and that she suffered vomiting, diarrhoea but that over the last 2 days she had been alert and well and the intention was to improve her immobilisation. The referral notes she lived in a ground floor house and was visited twice daily by the district nurse for the previous four weeks prior to admission.

5.5On 13 August there is an entry from Dr Lord (p516). She records that Patient F is a frail 85 year old who had problems of a left cemented hemiarthroplasty of the hip, left bundle branch block and left ventricular failure which was improving sick, sinus syndrome/atrial fibrillation, dehydration that was improving, bilateral buttock ulcers, bilateral leg ulcers, hypokalaemia (low blood potassium), normochromic anaemia, vomiting and diarrhoea ? cause. Dr Lord suggested prescribing potassium supplements, hydrating orally and sending stool for culture and sensitivity if not already sent. Dr Lord states *"it is difficult to know how much she will improve but I will take her to a NHS continuing care bed at Gosport War Memorial Hospital next week"*. There is a letter summarising her assessment dictated 14 August 1998 (p466).

5.6On 15 August (p 518) an entry by a house officer in the medical notes documents left-sided chest pain *'since being manhandled'*. An electrocardiogram showed no new changes and there was response of the pain to due to GTN. The clinical impression was of a musculoskeletal pain although a pulmonary embolus (clot to the lung) or angina were considered as alternative diagnoses, and a comment was made that further investigation with spiral CT or VQ scanning might be necessary. Codeine phosphate was prescribed as an analgesic. On 17 August an entry in the medical notes (p519) by the SHO notes she is

well with no chest pain and was mobilising slowly and was awaiting transfer to Gosport War Memorial Hospital.

5.7 On 18 August Patient F was transferred to Dryad ward and an entry (p78) by Dr Barton states *"HPC fracture neck of femur left 05/08/98 past medical history angina, CCF* (Congestive Cardiac Failure)*. catheterised, transferring with 2, needs some help with ADL* (Activities Daily Living)*, Barthel 6. Get to know, gentle rehabilitation. I am happy for nursing staff to confirm death"*. There is one other entry in the medical notes on 21st August 1998 by nursing staff confirming death at 1825h that evening (page 78).

5.8 Nursing notes on 18 August (page 394) record Patient F is *"for slow mobilisation"*. There is no documentation of any pain or discomfort in the initial nursing assessment. Another entry on 18 August (p388) states *"Settled and slept well from 2200 until midnight. Woke very distressed and anxious. Says she needs someone with her. Oramorph 10mg given 0015 with little effect. Very anxious during the night. Confused at times"*. An entry on the 19 August states *"Comfortable night. settled well". Drowsy but rousable this am. Sips of oral fluid tolerated. Syringe driver satisfactory"*.

5.9 On 19 August the nursing notes (p394) state *"1150 c/o chest pain. Not radiating down arm - no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg/5ml given r notified'.* A further note states *"pain only relieved for a short period, very anxious. Diamorphine 20mg Midazolam 20mg commenced via syringe driver"*. The next entry in the nursing summary on 20 August 1215h states *'Condition appears to have deteriorated over night driver recharged 1010 diamorphine 20mg, midazolam 20mg, hyoscine 400ug. Family informed of condition. Daughter present a time of report'*. An entry later that night states *'General condition continued to deteriorated very "bubbly" suction attempted without success'*. An entry on 21 August in the nursing notes at 1855h (page 395) states *"Condition continued to deteriorate slowly"*.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

P368–369. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions	
Temazepam 10-20mg	not administered
Oramorph 10mg/5ml sc 2.5-5mg	18 Aug 1415h 5mg dose 19 Aug 0015 10mg dose 19 Aug 1150 10mg dose
Regular prescriptions	
Digoxin 62.5ug od	18 -20 Aug
Slow K one tablet bd	18 -19 Aug
Bumetanide 1mg od	19 -20 Aug
Allopurinol 100mg od	18 -20Aug
Daily review prescriptions	
Diamorphine sc via syringe driver 20-200mg/24 hr Prescribed (date unclear)	19 Aug 20mg/24 hr 1600h 20 Aug 20mg/24hr 21 Aug 60mg/24 hr 0735hr

Hyoscine sc via syringe driver 200-800ug/24hr Prescribed (date unclear)	20 Aug 400ug/24hr 0915hr increased to 800ug/24hr 1050hr 21 Aug 800ug/24hr 0735hr
Midazolam sc via syringe driver 20-80mg/24hr Prescribed (date unclear)	19 Aug 20mg/24hr 1600hr 20 Aug 20mg/24hr 0915hr increased to 40mg/24hr 1015hr 21 Aug 60 mg/24hr 0735hr

Opinion on Patient Management

7. Patient F was making slow progress at Royal Hospital Haslar following her left hip hemiarthroplasty on 5 August. She had a number of episodes of chest pain. Investigation into these did not reveal any increase in her cardiac enzymes or change in her ECG. Therefore the most likely cause of her episodes of chest pain was angina or possibly musculoskeletal pain. At the time of her transfer she appeared to be stable the assessment by Dr Lord on 13 August is comprehensive and notes a number of problems leading to Dr Lord to include that the rate and level of final of improvement she would achieve following mobilisation was unclear. It is unclear from Dr Lord's assessment whether she thought there was a reasonable possibility she could improve sufficiently to return home. In my opinion from the description of her problems it was appropriate and reasonable to transfer her to an elderly care ward for continued assessment and rehabilitation with a view as to assessing whether she would regain mobility and sufficient independence to be able to return to her home.

8. The medical assessment by Dr Barton on transfer to Dryad ward describes her past medical history and current function. There is no record of any physical examination being performed. It would be usual to expect a description of any current symptoms or complaints a patient had and for a physical examination to be performed on admission of a patient to rehabilitation ward to establish their baseline problems. Dr Baton's assessment failed to document episodes of chest pain or the problems with diarrhoea. An adequate assessment would have noted these and recorded current blood pressure and recent blood results. There is no documentation that Patient F had pain in this assessment. I find it of concern that there are no further entries in the medical records following this initial entry despite the deterioration in Patient F's condition. In my opinion there was a failure to maintain adequate medical records. Dr Barton was responsible for day to day care of Patient F and this failure must be attributable to her.

9. The failure to document any problems of pain or other indication for opioids make it difficult to justify the prescription by Dr Barton of "as required" oramorphine on 18 August. I would consider this prescription was not appropriate. Patient F was administered morphine later that night when she became distressed and anxious. I do not consider the administration of morphine was appropriate for these symptoms. The notes record that Patient F wished someone to be with her and a more appropriate response would have been for a nurse to sit with Patient F for a while and if her symptoms failed to improve to either to administer temazepam which had been prescribed or arrange for the prescription of another sedative such as a small dose of haloperidol.

10. The lack of clear instructions for the use of "as required" oramorphine may explain why the oramorphine was given for distress and anxiety by nursing staff. Although oramorphine is

used by some doctors to treat distress and anxiety in older people it is not an appropriate first line treatment for a patient who develops distress and anxiety shortly after admission to a rehabilitation ward. Although opiates usually more commonly produce drowsiness or sedation that may cause or exacerbate anxiety or distress in older people. The development of anxiety or distress in older people requires medical evaluation and assessment to determine the underlying cause before the administration of any drug but particularly opioids.

11. The prescription of diamorphine and midazolam and hyoscine (undated) by Dr Barton was in my opinion not justified. There is no evidence recorded in the notes that she was experiencing significant pain or distress. The medical records do not record the indication for prescribing diamorphine and midazolam. It is possible this was prescribed as treatment for her chest pain which is recorded in the nursing notes as occurring on the morning of 19 August. An electrocardiogram was not obtained which might have found evidence of changes consistent with angina or a myocardial infarct. I can find no record of any observations of Patient F's pulse or heart rate or examination of her heart and lungs.

12. In my opinion there was an inadequate medical assessment of this problem. An adequate medical assessment would have sought to determine a diagnosis responsible for the chest pain and provided appropriate treatment. If it was musculoskeletal a mild or moderate analgesia therapy such as paracetamol or a non-steroidal anti- inflammatory drug would have been appropriate. If it was cardiac pain appropriate treatment would have been with a nitrate and possibly a dose of oral morphine if the pain failed to respond to nitrate therapy and there was clear evidence pain was cardiac in nature. A 10mg dose of oramorphine was administered at 1150h. No justification was given for the commencement of a continuous infusion by syringe driver with the combination of diamorphine and midazolam. On 19 August and 20 August Patient F was able to take oral medication as evidenced by the prescription chart recording the administration of oral bumetanide and allopurinol.

13. Patient F's condition deteriorated after the commencement of diamorphine and midazolam. This deterioration should have led to a full medical assessment. It is highly likely her deterioration was due to the combined sedative effects of diamorphine and midazolam and if the infusion had been discontinued her drowsiness may have resolved. However her deterioration was interpreted as requiring further sedative and drugs and the midazolam dose was increased twofold to 40mg over 24 hours and hyoscine was also commenced. These would have further contributed to Patient F's decline in my opinion. In my opinion there is no clear evidence presented to support the diagnosis of a myocardial infarct or cardiogenic shock as the cause of death in Patient F. It is much more likely she died from the sedative and depressant effects of the diamorphine and midazolam infusion that she received. There was no justification provided in the notes for the syringe driver as Patient F was able to swallow medication.

Summary of Conclusions

14. Patient F was a frail older lady who had a number of medical problems. Following her left hip fracture she was making slow progress. When transferred to Dryad ward she was medically stable. Dr Barton was responsible for her day to day medical care there was inadequate medical assessment both when she was initially admitted and then a failure to adequately assess Patient F when she developed agitation and then chest pain. The prescription of opioids was in my opinion not justified and there was no justification provided for the prescription of diamorphine and midazolam by subcutaneous. The

prescription and administration of these drugs are the most likely cause of Patient F's subsequent deterioration and her death. There was a failure of adequate assessment by Dr Barton in particular when Patient F developed chest pain there should have been a physical examination and investigations undertaken and recorded in medical notes.

15. In my opinion Dr Barton in her care of Patient F failed to meet the requirements of good medical practice to:
    - Provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - Consult colleagues
    - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
    - Provide or arranging necessary investigations
    - Prescribe only the treatment, drugs or appliances that serve patient's need

14. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

GMC and Dr Barton
Report on Arthur Cunningham (Patient G)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient G

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient G commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that Dr Barton prescribed diamorphine and midazolam subcutaneously over a 24 hour period in a dose range that was too wide, thereby creating a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs; that the prescribing of these drugs was inappropriate, potentially hazardous, not in the best interests of Patient G.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital, and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 14-20 of that report I describe the course of events relating to Patient G's admission to Dryad Ward, Gosport War Memorial Hospital on 21 September 1998 prior to his death on 26 September 1998.

4. This report is based on my review of the following documents; medical records of Patient G; witness statements of Charles Farthing, Shirley Sellwood, Dr Victoria Banks, Dr Joanna Taylor, Gillian Hamblin, Freda Shaw, Beverly Turnbull, Shirley Hallman, Dr Althea Lord; statement made by Dr Barton in relation to Patient G; interview of Dr Barton dated 21 April 2005.

Course of events

5. I have described these in my report to Hampshire Constabulary dated 12 December 2001. I have no major changes to make to that report. The statement in course of events *"on 24 September Dr Lord has written "Remains unwell. Son has visited again today..."* is incorrect. The entry in the medical notes on 24 September was by Dr Barton (page 646). The entry I record by Dr Lord in the medical notes on 21 September 1998 is correct except for the final sentence *"analgesics prn"* which on re-reading the medical notes I believe stated *"prognosis poor"*. Otherwise I have no changes to make to the course of events as recorded in my report to Hampshire Constabulary.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list drug therapy received providing more detail of Dr Barton's prescribing in section 3.3 of my report to Hampshire Constabulary.

Pages 753-758 and page 831. All prescriptions written by Dr Barton unless otherwise marked.

Regular Prescriptions

Diamorphine subcut via syringe driver 40-200mg/24hr Prescribed 25 Sep	25 Sep 26 Sep	60mg/24hr 80mg/24hr	1015h 1150h
Hyoscine subcut via syringe driver 800ug-2mg/24hr Prescribed 25 Sep	25 Sep 26 Sep	1200ucg/24hr 1200ucg/24hr	1015h 1150h
Midazolam subcut via syringe driver 20-200mg/24hr Prescribed 25 Sep	25 Sep 26 Sep	80mg/24hr 100mg/24hr	1015h 1150h

As required prescription

Oramorph 2.5-10mg Prescribed 21 Sep (Dr Lord)	21 Sep 1415h 5mg 21 Sep 2015h 10mg
Actrapid insulin sub-cut 10 units Prescribed date unclear	None administered

Daily Review Prescriptions (written as prn)

Diamorphine sc via syringe driver 20-200mg/24hr Prescribed date unclear	21 Sep 20mg/24hr 2310h 22 Sep 20mg/24hr 2029h 23 Sep 20mg/24hr 0925h discarded 20mg/24hr 2000h 24 Sep 40mg/24hr 1055h 24 Sep 60mg/24hr time unclear
Midazolam sub-cut via syringe driver 20-80mg/24hr Prescribed date unclear	21 Sep 20mg/24hr 2310h 22 Sep 20mg/24hr 2020h 23 Sep 20mg/24hr 0925h discarded 60mg/24hr 2000h 24 Sep 80mg/24hr 1055h
Hyoscine sub-cut via syringe driver 200-800ug/24hr Prescribed date unclear	23 Sep 400ug/24hr 0925h discarded 400ug/24hr 2000h 24 Sep 800ug/24hr 1055h

Opinion on Patient Management

7. I have provided an opinion on the management of Patient G in my report to Hampshire Constabulary. I have no changes to make to my opinions expressed in that report except to correct my statement 3.9 where I state *"when Dr Lord reviewed Patient G on 24 September..."*. This should state *"when Dr Barton reviewed Patient G on 24 September the notes implied that he was much worse than when he had been assessed by Dr Lord three days earlier."*

8. In the following sections I summarise my opinions on the management of Patient G by Dr Barton and other staff and the actions taken particularly with respect to the prescribing of midazolam and diamorphine.

9. Although review of the notes suggests it was clear that Patient G was in pain from his sacral sore, there is little information in the medical and nursing notes that describes the location or severity of his pain. The initial assessment by Dr Barton on 21 September is very brief. Although a reference is made to making Patient G comfortable there is no description of the cause of his pain or its severity. There had been clear instructions from Dr Lord that Patient G was to receive oramorph "as required" for his pain. This prn ('pro re nata') as required instruction had been underlined by Dr Lord.

10. As I have previously outlined in my report to Hampshire Constabulary I consider the decision by Dr Barton to prescribe and administer diamorphine in a very wide dose range (20-200mg/24hr) along with midazolam in a similarly wide dose range (20-80mg/24hr) was not justified by the information recorded in the medical records. The commencement of diamorphine and midazolam by subcutaneous infusion via syringe driver at 2310h on 21 September was in my opinion not justified and highly inappropriate. There is no evidence recorded in the notes that Patient G was unable to swallow oral medication. He had received only two doses or oramorphine which would be an inadequate number of doses over a very short time period to establish the total daily dose of opiate he would need over a 24 hour period to control his pain. Even if the decision had been made that Patient G required sustained administration of an opiate drug this could have been achieved through the prescribing of regular prn doses of morphine that had been prescribed by Dr Lord.

11. Although the nursing notes document that Patient G was agitated until 2330h there was no indication for prescribing subcutaneous midazolam by continuous infusion. Appropriate medication would have been either an oral benzodiazepine such as diazepam or an oral or intramuscular dose of a sedative such as haloperidol. The nursing notes during Patient G's admission are very limited but do not indicate any problem with swallowing. The nursing care plan of 21 September (page 869) states *"offer hot drink"* which suggests he was able to swallow on admission.

12. For reasons I have previously outlined in my report to Hampshire Constabulary the prescription of diamorphine at a dose of 20mg/24hr in conjunction with midazolam at a dose of 20mg/24hr was unnecessary and potentially highly dangerous in a frail elderly man such as Patient G because of the risk of the combination resulting in profound depression of respiration and/or conscious level. The subsequent deterioration of Patient G on 23 September was in my opinion most likely due to the combined effect of the diamorphine and midazolam infusions he had received. The nursing notes record that Patient G had become *"chesty"* and had possibly developed a chest infection.

13. The nursing notes also record that Patient G was seen by Dr Barton but there was no evidence in the medical records that she undertook an examination of the patient and

considered that he may have developed a chest infection that required treatment with antibiotics, or that his deterioration was due to diamorphine and/or midazolam. The decision to increase the midazolam dose on 23 September at 2000h from 20mg/24hr to 60mg/24hr was not justified by any information recorded in the medical notes. The decision to increase the dose three fold appears to have been made by nursing staff as the nursing notes state he Patient G was agitated at 2300h and the syringe driver was boosted "with effect". In my opinion this increase in midazolam does was inappropriate and dangerous and in combination with continuing diamorphine infusion was the most likely cause of his subsequent deterioration.

14. The use of a syringe driver was challenged by relatives of Patient G on 23 September (page 862) and the nursing record records that the consultant would need to give permission for the syringe driver to be discontinued. Given the concerns expressed by relatives and that the commencement of the syringe driver had not been at the instruction of the Responsible Consultant, Dr Lord, and indeed was against a specific direction that Patient G should receive prn analgesia, this should have led the nursing staff to contact Dr Lord or Dr Barton as the doctor responsible for Patient G's day to day care to discuss the management plan with Dr Lord.

15. There is no information presented in the nursing or medical notes to justify the three-fold increase in the diamorphine infusion from 20mg/24hr to 60mg/24hr. The nursing records record that Patient G had pain when attended to, especially in his knees. In my opinion, the three-fold increase in diamorphine dose infused with the very high dose of midazolam infused inevitably led to the further deterioration documented on 26 September.

16. There were a number of time points between 21 and 25 September when the appropriateness of continuing the infusion of diamorphine and midazolam should have been questioned and discussed with the responsible consultant. In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronchopneumonia. In my opinion it is very likely that the administration of midazolam and diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs.

Summary of Conclusions

17. Patient G was a frail older man with multiple medical problems. He was admitted to Dryad Ward, Gosport War Memorial Hospital for treatment of his sacral sores. The medical and nursing notes following Dr Lord's assessment provide little detail but in my view it was reasonable to commence Patient G on as required oral morphine and then move subsequently to regular administration of an opiate drug to control his pain, at a dose that did not cause undue side effects. I consider the prescription and administration of diamorphine and midazolam by subcutaneous infusion was not justified, and that there was inadequate assessment of Patient G's pain and the cause of his subsequent deterioration by Dr Barton. There was a failure to discuss the management and seek advice from Dr Lord or another Consultant when Patient G deteriorated. In my view the doses of diamorphine and midazolam used were inappropriately high and were increased excessively without good cause. These prescriptions likely led to the shortening of Patient G's life.

18. In my opinion Dr Barton in her care of Patient G failed to meet the requirements of good medical practice:

- to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
- to consult colleagues;
- to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
- to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

GMC and Dr Barton
Report on Robert Wilson (Patient H)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient H

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient H commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegation presented to the Fitness to Practice Panel that Patient H was not properly assessed upon admission; that the prescription of oramorphine was inappropriate, potentially hazardous and likely to lead to serious and harmful consequences for Patient H and not in his best interests; that the prescription of diamorphine was in too wide a dose range that created a situation whereby drugs could be administered to Patient H which were excessive to his needs; that the prescriptions of oramorphine, diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interests of Patient H.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital and the medico-legal report I have provided to Hampshire Constabulary dated 12 December 2001. In pages 25-29 of that report I describe the course of events relating to Patient H's admission to the Queen Alexandra Hospital on 22 September 1998 and following transfer to Dryad Ward at Gosport War Memorial Hospital on 14 October 1998 prior to his death on 18 October 1998.

4. This report is based on my review of the following documents; medical records of Patient H; statements of Dr Rosie Lusznat, Dr Ewenda Peters, Ruth Clemow, Gillian Kimberley, Dr Arumugam Ravindrane, Fred Shaw, Gill Hamblin, Shirley Hallman, Dr Althea Lord; statement made by Dr Barton in relation to Patient H.

5. **Course of events**

I have described these in my report to Hampshire Constabulary dated 12 December 2001 and have no changes or corrections to make or add to my statement in that report. In this report I comment on the potential influence of the past diagnosis of alcoholic liver disease on the prescribing of opioid drugs to Patient H, which I did not include in my report to Hampshire Constabulary. The recorded cause of death was congestive cardiac failure, renal failure and liver failure.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

In this section I list all drug therapy received providing more detail of Dr Barton's prescribing in section 5.4 and 5.5 of my report to Hampshire Constabulary (12 December 2001). Pages 258-263. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Paracetamol 1g 4 hourly Prescribed 14 Oct	None administered
Hyoscine subcut 600ug/24 hr Prescribed by another doctor	None administered

Regular prescriptions

Frusemide 80mg once daily Prescribed 14 Oct	15/16 Oct 1 dose
Spironolactone 50mg bd Prescribed 14 Oct	14 Oct 1 dose 15 Oct 2 doses then discontinued
Bendrofluazide 2.5mg od Prescribed 14 Oct	15 Oct 1 dose 16 Oct 1 dose then discontinued
Trazodone 50mg once daily Prescribed 14 Oct	14 Oct 1 dose 15 Oct 1 dose then discontinued
Thiamine 100mg once daily Prescribed 14 Oct	15 Oct then discontinued
Multivitamins 1 tablet Prescribed 14 Oct	15 Oct then discontinued
Magnesium hydroxide 1 tablet bd Prescribed 14 Oct	14 Oct 1 dose 15 Oct 2 doses then discontinued
Senna 2 tablets once daily Prescribed 14 Oct	14 Oct 2 tablets then discontinued
Oramorph 10mg / 5mls 10mg 4 times daily Prescribed 15 Oct	15 Oct 3 doses 1000h, 1400h, 1800h 16 Oct 3 doses 0600h, 1000h, 1400h
Oramorph 10mg / 5mls 20mg nocte prescribed 15 Oct Illegible prescription by another doctor	15 Oct 1 dose 2200h then discontinued

Daily review prescriptions

THE TYPED HEADING "REGULAR PRESCRIPTION" HAS BEEN CROSSED OUT AND REPLACED WITH THE HANDWRITTEN LETTERS "PRN"

Oramorph 10mg / 5mls 2.5-5mls 4 hourly Prescription date unclear	14 Oct 1445h 10mg 14 Oct 2245h 10mg
Diamorphine subcut via syringe driver 20–200mg/24hr Prescription date unclear	16 Oct 1610h 20mg/24 hr 17 Oct 0515h 20mg/24 hr 1550h increased to 40mg/24hr

	18 Oct	1450h 60mg/24 hr
Hyoscine subcut via syringe driver 200-800ug/24hr Prescription date unclear	16 Oct 17 Oct	1610 400ug / 24 hr 0515 600ug / 24 hrs 1550h increased to 800ug/24hr
Midazolam subcut via syringe driver 20-80mg/24hr Prescription date unclear	17 Oct 18 Oct	1550h 20 mg/24hr 1450h 40 mg/24hr
Hyoscine subcut 1200ug/24hr Verbal prescription Dr Peters 18 Oct	18 Oct	1450 1200ug / 24 hours

Opinion on Patient Management

7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's assessment and prescribing.

8. Patient H had a history of alcohol problems and had previously presented with ascites and had signs of chronic liver disease suggesting he had cirrhosis due to alcoholic liver disease (admission in January 1997). Ultrasound of the abdomen produced at that time (page153) had shown a smallish bright liver consistent with cirrhosis. Reduced dose of opioid analgesics is recommended in patients with hepatic and renal impairment with recommendations to avoid if severe hepatic impairment is present (BNF 55 page 229). Opioid analgesics may precipitate hepatic encephalopathy and coma in patients with cirrhosis. However when patients are in severe pain it may still be necessary to use opiates. In older people a lower dose should be used and patients need to be carefully monitored.

9. In 1997 Patient H had a low albumin indicating he had at least moderately severe liver disease. Prior to Patient H's admission to Dryad Ward he was receiving paracetamol 1g qds for analgesia and the transfer letter (page 81) notes he still had a lot of pain from the fractured left humerus. He had been receiving a combination of paracetamol and dihydrocodeine as codydramol until the 30 September when this was changed to paracetamol alone. After Dr Barton had assessed Patient H on 14 October she prescribed paracetamol four hourly prn and oramorphine 2.5-5mg four hourly.

10. Dr Barton does not provide any justification in the medical records for moving from paracetamol to the use of a strong opioid morphine, although the prescription of "as required" oral morphine controlled Patient H's pain without undue adverse effects initially on the 14 October. A more appropriate response to manage his continuing arm pain would have been to prescribe paracetamol with a mild opioid such as codeine or dihydrocodeine which he had previously been prescribed. He was prescribed 5-10mg morphine prn and then administered two doses of 10mg morphine. Given his age and chronic liver disease a lower 5mg dose would have been a more appropriate cautious response if opioid drugs were needed. The nursing notes report on 15 October that he had slept well.

11. On 15 October Dr Barton prescribed regular oramorphine at a dose of 10mg 4 times daily and 20mg nocte (60mg morphine daily). This was a high dose of morphine for an elderly man with chronic liver disease. Dr Barton had not undertaken a physical examination of

Patient H when transferred to Dryad Ward on 14 October and may not have been aware of his diagnosis of chronic liver disease, as this was not described in his recent medical notes, or taken into consideration the potential impact of this on his response to opiate drugs.

12. The nursing notes suggested he had had symptomatic improvement and control of his pain with the previous prn doses of morphine (20mg received over the 12 hour period) without any obvious problems. Although a more cautious and appropriate response would have been to increase his opiate dose to 40mg oral morphine over 24 hours, the prescription of regular oramorphine at the doses prescribed (60 mg/24hr) after he had experienced pain control from prn doses of morphine equate to a 50% increase in the 24 hour dose equivalent, would have been reasonable if Patient H did not have liver disease and he was monitored for adverse effects of opioids. However this is a large increase in an older patient with chronic liver disease who has only received two "as required' doses of morphine, and there was a significant risk the increased dose of morphine could precipitate liver failure.

13. On 16 October there was a clear deterioration after Patient H had received three 10mg doses and a 20mg night-time dose (total 50mg) of morphine. Dr Knapman who assessed Patient H appears not to have considered that the deterioration in conscious level could have been secondary to the oral morphine he had received and nursing staff administered further doses of oral morphine at 0600h, 1000h and 1400h on 16 October. It would have been appropriate for Dr Knapman to discuss Patient H's deterioration with a senior colleague.

14. Later that afternoon on 16 October, Dr Barton prescribed diamorphine by subcutaneous infusion to a syringe driver with a dose range of 20-200mg with midazolam in the dose range of 20-80mg and hyoscine in the dose range of 200-800ug per 24 hours. There is no evidence in the medical records that Dr Barton examined Patient H at this stage. Dr Barton was presumably informed of Patient H's deterioration and did not appear to have considered that the oral morphine he had received was the likely cause of the deterioration due to both its depressive effects on conscious level and ability to precipitate a hepatic encephalopathy in patients with chronic liver disease.

15. At this stage as Patient H was unresponsive it is likely he was unable to take oral medication and this may explain the decision of Dr Barton to prescribe opioids and other drugs by subcutaneous route. However, the lack of medical assessment and failure to consider that Patient H's deterioration was secondary to the morphine he had received was not consistent with good medical practice. If Dr Barton was uncertain as to the cause of Patient H's deterioration she should have discussed this with the responsible medical consultant. If Dr Barton was aware Patient H had chronic liver disease it would have been particularly important for her to assess Patient H to determine if he had developed liver failure secondary to morphine. If Dr Barton had taken a full history from Patient H when he was admitted she might have obtained a history of ascites and chronic liver disease from Patient H.

16. The prescription of diamorphine and midazolam was inappropriate and not justified by any information presented in the notes. There is no evidence at this stage that Patient H was in pain. When his conscious level deteriorated an appropriate response would have been to discontinue opiates, and assess the cause of his deterioration. I can find no evidence of any symptoms which required the prescription of the midazolam, which can precipitate hepatic encephalopathy in patients with chronic liver disease. The dose range prescribed was highly inappropriate and potentially dangerous given Patient H's age, clinical condition with a

depressed conscious level and presence of chronic liver disease. The subsequent escalation of diamorphine and midazolam dose on 17 October inevitably led to his further deterioration and in my view contributed to his death through depression of his conscious level and respiration. The nursing notes of 15 October record no symptoms of pain and no justification is given for the prescribing of diamorphine and midazolam or the escalation in dose to diamorphine 60 mg/24hr and midazolam 40mg/24hr.

Summary of conclusions

17. Patient H was a frail older man with depression, alcoholic liver disease and a painful fracture of the left humerus transferred to Dryad ward for rehabilitation. Oral opioid drugs were an appropriate treatment for Patient H if his pain had been uncontrolled on mild opioid drugs and paracetamol but this combination was not first prescribed. Dr Barton failed to undertake or record an adequate clinical assessment of Patient H when he was admitted to Dryad ward or adequately assess his subsequent deterioration. The prescription by Dr Barton of subcutaneous diamorphine and midazolam infusions was not justified and the dose ranges used were inappropriately wide. The subsequent increase in diamorphine and midazolam doses that were infused were not justified. In my opinion the doses of diamorphine and midazolam received by Patient H led to his subsequent deterioration and most likely led to Patient H's death through producing respiratory depression.

18. In my opinion Dr Barton in her care of Patient H failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

General Medical Council and Dr Barton
Report on Enid Spurgin (Patient I)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient I

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient I, commenting on the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practising. I note the allegation presented to the Fitness to Practice Panel that the assessment of Patient I on admission was inadequate and not in her best interests, that the prescriptions of midazolam and diamorphine were in too wide a dose range and created a situation whereby drugs could be administered to Patient I that were excessive to her needs, and that actions in prescribing these drugs were inappropriate and potentially hazardous; and that the prescription of 80mg of diamorphine and 20mg of midazolam over 24 hours was excessive to Patient I's needs and was inappropriate, potentially hazardous and not in her best interests.

2. **Code A**

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient I; witness statements of Carl Jewell, Freda Shaw, Gillian Hamblin, Beverley Turnbull, Lynne Barrett, Anita Tubbritt, Fiona Walker; statement made by Dr Barton in relation to Patient I; interview of Dr Barton dated 15 September 2005.

5. **Course of events**

5.1 Patient I was 92 years of age when she was admitted to Royal Hospital Haslar on 19 March 1999 following a fall, was transferred to Dryad Ward, Gosport War Memorial Hospital on 20 March 1999. Patient I died on Dryad Ward, Gosport War Memorial Hospital on 13 April 1999. Prior to her admission on 19 March the admission notes to the orthopaedic service at Royal Hospital Haslar state *"lives alone, self caring, independent"* (page 356). There were no significant problems in her past medical history. A letter by Dr Reid, Consultant Physician in Geriatrics on 26 March states *"Before her fall, Patient I had been very active and had been in good health"* (page 464).

5.2 The orthopaedic medical notes record Patient I had sustained a right sub-trochanteric femur fracture (page 356) which had occurred after she had been pulled over by her dog and landed on her right hip. The notes record she underwent an anaesthetic pre-operative assessment on 20 March at 1200 hours (page 358) and was given Voltarol (diclofenac) 15mg

and paracetamol 1gm for analgesia. A further entry at 1400 hours (page359) indicates she had been given intravenous fluids, cyclizine 50mg and morphine 2mg IV. Following the 2mg morphine she had had hallucinations and the notes by an SHO anaesthetist state *"nil further opiates"*.

5.3 She underwent surgery under spinal anaesthesia on 20 March 1999 with insertion of a right dynamic hip screw. An entry by an SHO post-operative review on 20 March 1999 at 2130 hours (page 359) notes *"oozing from the wound with swelling of the right thigh."* The impression was of a potential bleeding vessel in the wound with risk of a compartment syndrome and hypovolaemia developing. She was monitored and received a blood transfusion. On 21 March 1999 at 2300h(page 371) the notes record a review by Dr Woods records *"R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor"*.

5.4 On 22 March the notes record a ward round and comment that she has poor oral fluid intake and required her haemoglobin to be checked. Her haemoglobin was 11.1 when checked. The next entry in the medical notes 24 March notes *"her skin is very thin and fragile on the lower legs"* and that Patient I would benefit from assessment by Dr Lord with a view to rehabilitation. The referral to Dr Lord notes that she was transfused with 3 units of blood but was otherwise making an unremarkable post-operative recovery (page 373). The referral letter stated *"was proving difficult to mobilise her and that the skin on her legs was at risk of breaking down"*. The referral states Surgeon Commander Scott would appreciate advice regarding her rehabilitation and consideration for a place at Gosport War Memorial Hospital (page 374).

5.5 An entry in the notes by Dr Reid Consultant in Elderly Medicine is dated 23 March states *"a delightful 92 year old lady, previously well, with sub-trochanteric fracture right femur. She is still in a lot of pain which is the main barrier to mobilisation at present. Could her analgesia be reviewed? I'd be happy to take her to GWMH provided you are satisfied that orthopaedically all is well with the right hip. Please let me know."*

5.6 The drug charts (pages 326-331) at Royal Hospital Haslar indicate Patient I had received 2mg of morphine intravenously on 20 March, diclofenac 50mg once only on 19 March, paracetamol 1g seven doses between 19-25 March, and three doses of 5mg morphine on 20 March and on two doses of 5mg morphine on 21 March. I can find no record of other analgesia being administered during her admission at Royal Hospital Haslar.

5.7 A transfer letter (undated) (page 23) indicates that at a time prior transfer to Dryad Ward, Patient I was mobile, walking short distances with a zimmer frame, that she required the assistance of two nurses to transfer from bed to chair, that she was continent during the day but incontinent at night. Her only medication on transfer was paracetamol. On 26 March Patient I was transferred to Dryad Ward, Gosport War Memorial Hospital. An entry by Dr Barton (page 27) states *"transfer to Dryad Ward HPC fracture neck of femur right 19.3.1999. PMH nil of significance, Barthel, no weight bearing, tissue paper skin, not continent, plan sort out analgesia."*

5.8 The next entry in the medical notes is dated 7 April by Dr Reid and states *"still in a lot of pain and very apprehensive. MST increased to 20mg bd yesterday. Try adding fluphenthixol for x-ray right hip as movement still quite painful also about 2 inch shortening right leg"*. The next entry following this is dated 12 April again by Dr Reid and states *"now v drowsy (since diamorphine infusion established) reduced to 40mg/24 hours. If pain recurs increase to*

60mg. Able to move legs without pain but patient not rousable." The final entry in the medical notes is 13 April at 0115 hours stating the patient died peacefully and death had been confirmed by nursing staff.

5.9 The nursing notes relating to admission to Dryad Ward note on 20 March that Patient I required assistance to settle for the night (page 89) and that she had pain in her hips (page 91). The nursing care plan (page 95) states *"..... is experiencing a lot of pain on movement"*. On 27 March state *"is having regular oramorph but still in pain"*. On 28 March *"has been vomiting with oramorph, advised by Dr Barton to stop oramorph. Is now having metoclopramide tds and co-dydramol. Vomited this afternoon after using commode"*. An entry in the nursing notes dated 29 March (page 97) states *"please review pain relief this morning"*. The next entry on 31 March states *"now commence on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain"*. A further entry on 3 April states *"MST 10mg bd continued. Still continues to complain of pain on movement"*. On 8 April *"MST increased to 20mg bd"*.

5.10 The nursing summary relating to Patient I's admission to Dryad Ward states on 26 March 1999 (page 132) *"admitted to Dryad Ward for rehabilitation and gentle mobilisation. In Haslar she was mobile with a zimmer frame and two nurses for short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. She has complained a lot of pain for which she is receiving oramorph regularly now, with effect"*. An entry on 6 April 1999 states *"seen by Dr Barton, MST increased to 20mg. Nephew has visited. If necessary once Enid is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in"*.

5.11 An entry on 11 April (page 134) states *"nephew telephoned at 1910 hours as Enid's condition has deteriorated during this afternoon. She is very drowsy, unrousable at times and refusing food and drink and asking to be left alone. Asked about her pain, Enid denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that ..... be kept as comfortable as possible. Seen by Dr Barton to commence syringe driver"*. An entry on 12 April (page 136) states *"seen by Dr Reid. Diamorphine to be reduced to 40mg over 24 hours. If pain recurs the dose can be gradually increased as and when necessary"*.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Pages 157-179. All prescriptions written by Dr Barton unless otherwise marked.

As required prescriptions

Oramorph 10mg/5ml sc 2.5-5mg	31 Mar	2.5mg
Prescribed 26 March	11 Apr	2.5mg

Regular prescriptions

Oramorph 10mg/5ml, 2.5mg four x day	26 Mar	3 doses received
	27 Mar	1 dose 0600h then discontinued
Oramorph 10mg/5ml, 5mg nocte	26 Mar	1 dose then discontinued
Oramorph 10mg/5mls, 5mg four x day	27 Mar	2 doses received 1800h dose not administered
	28 Mar	2 doses received then discontinued
Oramorph 10mg/5mls, 10mg nocte	27 Mar	1 dose

	28 Mar	not administered
Codydramol 2 tablets 4 x day Prescribed 27 March 1999	28 Mar – 31 Mar	
Metoclopramide 10mg tds Prescription date unclear pp Dr Barton and then counter-signed by Dr Barton	28 Mar 29-30 Mar 31 Mar 1-6 Apr 7/8 Apr 9-11 Apr	2 doses 3 doses per day 1 dose None administered 2 doses 3 doses per day
Morphine MST 10mg bd Prescribed 31 Mar	6 Apr	1 dose received then discontinued
Morphine MST 20mg bd Prescribed 6 Apr	6 Apr 7-11 Apr	1 dose administered 2 doses daily
Diamorphine sc via syringe driver 20-200mg /24 hr Prescribed 12 Apr	12 Apr	80mg / 24hr 0800h
Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 12 Apr. Marked PRN	Not administered	
Midazolam subcut via syringe driver 20-80mg/24hr Prescribed 12 Apr	12 Apr	30mg/24hr 0900h
Cyclizine sc via syringe driver 50-?600mg (unclear) per 24 hours Prescribed 12 Apr. Marked PRN	Not administered	
Ciprofloxacin 100mg bd Metronidazole 400mg bd Lactulose 10mls bd Senna 2 tablets once daily	7-11 Apr 7-11 Apr 26 Mar-11 Apr 29 Mar-10 Apr 11/12 April	2 tablets Not administered

Opinion on Patient Management

7. Patient I was an elderly independent lady with no active medical problems prior to admission with a hip fracture. This was repaired surgically on 19 March and over the following seven days she made slow progress with mobilisation but was walking with a zimmer frame prior to her transfer. She was referred to the Geriatrics Team for further rehabilitation and following assessment by Dr Reid transferred to Dryad Ward on 26 March.

8. The medical assessment by Dr Barton on 26 March following admission to Dryad Ward is very limited. It describes her having a fractured neck of femur and no significant past

medical history. There is no record of a physical examination. There is no record of her having any pain although there is a comment that she is not weight bearing. As the transfer letter from Royal Hospital Haslar had indicated she was mobilising this would suggest there had been a change in her mobility and functional and a physical examination particularly of the right hip was indicated. There should have been an assessment of whether the right hip was causing any pain at this stage. There is no record of the drug she is taking at this stage but there is a comment *"sort out analgesia"* which I would take to indicate Dr Barton considered she had pain which was not controlled. The nursing notes record on a number of occasions that Patient I had hip pain.

9. Dr Barton prescribed oramorphine on an as required basis on 26 March 1999 but no regular analgesia until the 27 March when codydramol (dihydrocodeine and paracetamol) was prescribed. This was signed as a pp signature suggesting this was commenced as a telephone order and subsequently counter-signed by Dr Barton. I would consider the prescription of codydramol was appropriate as an initial analgesic. Initially prescribing a regular combination of paracetamol and mild opioid drugs would have been appropriate before prescribing oramorphine. If pain was uncontrolled on the codydramol which appears to have been the case, the subsequent regular prescription of regular morphine (initially as oral morphine and then as sustained release preparation morphine MST) was reasonable and appropriate. However, there are no medical notes from Dr Barton which record her assessment or reasons for prescribing the drugs she did during this period. In this respect I would consider the medical notes are inadequate and Dr Barton failed to maintain adequate medical records as the doctor responsible for the day to day care of Patient I.

10. As Patient I's pain was not controlled on either mild or regular prescriptions of morphine there should have been re-examination of her hip to ascertain the cause of the hip pain and an x-ray of the hip should have been arranged to determine whether there was any mechanical problem with the dynamic hip screw which might account for the pain. It would not be usual for a patient to have severe pain at this stage following a hip fracture if there was no mechanical or other complication.

11. On 6 April Dr Barton increased the dose of morphine (MST) to 20mg twice daily after Dr Reid records this and suggested adding fluphenthixol but I can find no record that this was prescribed. However as the main problem appeared to be pain I think it was appropriate to first increase her analgesia. His assessment suggested there may have been a problem with the right hip dynamic hip screw as the right leg was 2 inches shorter and he requested an x-ray of the right hip be arranged. I can find no record of this x-ray of the right hip being requested by Dr Barton or any reason why it was not requested. I would consider the failure to arrange an x-ray of the hip when this had been recommended by Dr Reid was a failure of Dr Barton to provide and arrange a necessary investigation for Patient I.

12. On 11 April Patient I became very drowsy. This is likely to have been due to the increased dose of oral morphine (40mg daily) that she was receiving. The nursing notes indicate she was not in pain when left alone but complained of pain when moved. I consider the prescription of diamorphine in the dose range 20-200mg/24 hr was inappropriate and reckless. The 40mg or oral morphine Patient I was receiving every 24 hr would be equivalent to approximately 15-20 mg diamorphine administered by subcutaneous infusion over 24 hours. Patient I was already drowsy so increasing the opioid dose would have been expected to produce further depression in her conscious level. However as she was still in pain when being moved it would have been reasonable to consider an increase of 50% in the dose and monitor Patient I closely. An appropriate dose of diamorphine to prescribe over 24

hours would therefore have been 20-30mg/24hr. The prescription of 20-200mg was dangerous because if a dose greater than 30mg/24 hr was administered it was highly likely to produce coma and respiratory depression. In the event an infusion was commenced at 80mg/24hr four times greater than the equivalent dose received orally in the previous 24 hours.

13. In my opinion the additional prescription of midazolam 20-80mg/24hr was also reckless and inappropriate. No justification was given in the medical notes by Dr Barton for the prescription of midazolam. The 20mg/24hr midazolam infusion further contributed to respiratory depression and depressed conscious level. I consider the diamorphine and midazolam infusions directly contributed to Patient I's death on 13 April 1999. The reduction in dose by Dr Reid on 12 March was not sufficient to prevent the toxicity of these drugs and it would have been more appropriate to temporarily discontinue both the diamophine and midazolam infusions

Summary of Conclusions

14. Patient I was an elderly independent lady who sustained a fractured hip who underwent surgery and was referred for rehabilitation. Patient I experienced persistent pain in the right hip after transfer to Dryad Ward, Gosport War Memorial Hospital. Good medical practice required appropriate investigation to determine the cause of the hip pain and the administration and monitoring of analgesia. There was inadequate investigation of patient I's hip pain. Specifically there is no record of an adequate examination of the hip by Dr Barton as the doctor responsible for her day to day care, and an X-ray of the right hip was not obtained. In my opinion the prescriptions of diamorphine and midazolam by Dr Barton were dangerous and reckless and the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.

15. In my opinion, Dr Barton in her care of Patient I failed to meet the requirements of good medical practice to:
    - provide an adequate assessment of the patient's condition based on the history and clinical findings and including where necessary an appropriate examination
    - keep clear accurate contemporaneous patient records to support the relevant clinical findings, decisions made, information given to patients and any drugs or other treatments prescribed
    - prescribe only the treatment drugs or appliances that serve the patient's needs.

16. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Jane Barton
Report on Geoffrey Packman (Patient J)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient J

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Dr Barton in relation to patient J to assist the GMC panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that; the verbal prescribing of diamorphine, prescriptions of diamorphine and midazolam were inappropriate, potentially hazardous and not in the best interest of patient J; that the failure to obtain medical advice and/or undertake further investigation on 26 August was inappropriate and not n the best interests of Patient J.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. Documents reviewed this report is based on my review of the following documents; medical records of patient J, statements of Victoria Packman, Betty Packman, Dr Arumugam, Shirley Hallman, Gillian Hamblin, Beverley Turnbull, Anita Tubbritt, statement made by Dr Barton in relation to patient J, Interview of Dr Barton dated 17 November 2005, Interview of Dr Barton dated 6 April 2006.

5. **Course of Events**

5.1 Patient J was 67 years old when admitted to Dryad Ward on 23 August 1999. In July 1999 he was seen at the out-patient clinic of Dr Keohane, Consultant Dermatologist describe him having bilateral severe leg oedema (swelling) secondary to venous hypertension and secondary skin problems (p30). His wife describes him as having being overweight for many years and his legs being a *'constant problem to him'* because of weeping fluid (p2 BP1).

5.2 On 6 August he had a fall at home and was admitted to the Accident and Emergency department by his general practitioner (p43). The notes in A&E indicate problems of bilateral leg oedema, obesity and not coping. He was admitted to Anne Ward which I assume was a general medical ward.

5.3 The admission clerking on 6 August by a Senior House Officer describes the primary problem as decreased mobility (p44) with problems of obesity and bilateral lower

leg oedema with ulcers and erythema (redness) in the groin. Other medical problems listed were hypertension and arthritis. Drug therapy on admission was doxazosin, bendrofluazide and felodipine (all blood pressure lowering drugs). On examination there was a slight temperature, pulse was 80 irregular, BP was 128/81 mm Hg, erythema was seen in both groins, bilateral swelling of both legs. The left lower leg was noted to be swollen and erythematous. The examination notes nursing staff had reported blistering on buttocks. Problems were considered to be: bilateral leg oedema, cellulitis of the groin and left lower leg, decreased mobility due to obesity/oedema/infection and atrial fibrillation.

5.4 A number of investigations were performed at this stage. An ECG confirmed the presence of atrial fibrillation (irregular heart beat). A Chest X-ray, blood tests and swabs from the groin and leg ulcers were obtained. Blood tests showed a normal haemoglobin (Hb 15.7 g/dl) and an elevated white cell count 25.7 consistent with a bacterial skin infection in the groin and legs. Intravenous antibiotics were commenced to treat infection and diuretics were changed from bendrofluazide to frusemide.

5.5 Patient J was reviewed later the same afternoon by a Registrar, Dr Curtis, who agreed with the diagnoses and suggested stopping felodipine and doxazosin since they could be exacerbating his oedema. He indicated an echocardiogram might be obtained to assess his cardiac function. A separate note (signature unclear) at the bottom of the page (p47) states *'In view of premorbid sate and multiple medical problems not for CPR in event of arrest'.*

5.6 The following day 7 August, there is an entry from a different registrar (name unclear) (p48) noting that the patient has been seen by Dr Grunstein (I would assume this was the responsible consultant physician). The notes record he has 'morbid obesity' (the nursing notes record his weight was 148.6 Kg p108) and says Patient J reported *'walking till about a week before'.* The recorded plan was to obtain a good history from the next of kin, continue intravenous antibiotics over the weekend and considered his problems were mainly nursing. Renal impairment (creatinine 173) was also noted. There is a comment *"Agree not for 555"* (meaning not for attempted resuscitation).

5.7 On the 9 August the medical notes record the cellulitis of the left leg was improving and he should be switched to oral antibiotics. On the 11 August the notes record he was well and the cellulitis improved and physiotherapy should continue. On the 12 August a further entry states 'continue nursing care and try to mobilise'. The felodipine was stopped to try and improve his oedema. Again a note is made 'Not for 555'. On the 13 August the medical notes document the white cell count has fallen to 12.4 and the Hb is 13.5. Antibiotics were to continue for a total of 10 days and there is a comment to *'Transfer to Dryad ward on 16 August 1999'.* On the 16 August the notes state *'Dryad when bed available'.* On 18 August the medical notes record antibiotics were to be stopped the following day. A further entry on 18 August is by Dr Jane Tandy, Consultant Geriatrician, states *' P sores extensive, feed himself, not mobilising, black stool overnight – nil says bowels looser than usual, no pain. Abdomen soft, BS /, PR – normal brown stool. Check Hb R/O bleed. ? antibiotic related diarrhoea 'stool chart.'*

5.8 On 20 August the medical notes record *'no further black motion, nausea or epigastric pain, epigastric tenderness, BP 140/80 m Hg'*. The full blood count was checked with no significant change in Hb at 12.9. The notes record transfer to Gosport Hospital was to take place on 23 August (p54).

5.9 On Monday 23 August the medical notes (doctors name unclear) record problems of obesity, arthritis bilateral knees, immobility, pressure sores and note he is on a high protein diet and *'? Melaena 13/8/99 Hb stable, alb 29'*. There is a further note *'MTS very good'. Clinical examination records a normal cardiovascular and respiratory systems, obese, legs slightly ....., chronic skin disease, ulcers dressed yesterday. Needs review later this week'*. MTS is an abbreviation for Mental Test Score and the comment indicates he had no significant cognitive impairment. There is a note that Haemoglobin (Hb) and other blood tests are to be repeated on Friday.

5.10 On Wednesday 25 August the nursing notes (p63) record *'Passing fresh blood PR ?Clexane'. Verbal message from Dr Beasley to withhold 1500 dose and review with Dr Barton mane. Lunch also vomiting – metoclopramide 10 mg given im at 1755h. Good effect.'*

5.11 On 26 August the nursing notes state *'Fairly good morning no further vomiting, Dr Rabi contacted re Cleaxane, advised to discontinue and repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime, colour poor, c/o feeling unwell. Seen by Dr Barton this afternoon, await results of Hb, Further deterioration c/o indigestion – pain in throat not radiating – vomited again this evening. Verbal order from Dr Barton. Diamorphine 10 mg stat – same given at 1800. Metoclopramide 10mg given im.'* A blood sample was sent on 26 August. The notes include a laboratory report that the Hb was 7.7 g/dl (p210) and there is a comment on the report *'Many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard'*. The previous Haemoglobin was 12.0 g/dl from a sample taken on 24 August and analysed on the 25 August.

5.12 There is an entry in the medical notes on 26 August by Dr Barton which states *'Called to see. Pale, clammy, unwell. Suggests ?MI treat stat diamorph and oramorph overnight. Alternative possibility GI bleed but no haematemesis. Not well enough to transfer to acute unit, keep comfortable. I am happy for nursing staff to confirm death.'* I can find no records of any pulse, BP observations in the notes at this point or at any time relating to Patient J's admission on Dryad ward. A further entry in the nursing notes on 26h August 1900 (p63) states *'Dr Barton here. For Oramorph 4 hourly. Wife seen by Dr Barton, explained Patient Js condition and medication used.'*

5.13 On the 27 August the nursing notes state *'Some marked improvement since yesterday'. Seen by Dr Barton this am – to continue Diamorph 4 hourly same given tolerated well. Some discomfort this afternoon – especially when dressings being done'*. The next entry in the medical notes is on 28 August from Dr Barton and state *'remains poorly, but uncomfortable, please continue opiates over weekend.'*

5.14 On 30 August the nursing notes state *'condition remains poor. Syringe driver commenced at 1445 Diamorphine 40mg, midazolam 20mg no further complaints of abdominal pain. Very small amount diet taken.'*

5.15 On 1 September there is an entry from the Dr Reid, consultant Geriatrician, which states *'Rather drowsy, but comfortable. Passing melaena stools. Abdomen huge but quite soft. Pressure sores over buttock and across the posterior aspects of both thighs. Remains confused. For T.L.C – stop frusemide and doxazosin, wife aware of poor prognosis'.* Death was confirmed on 3 September at 1350h. I understand the death certificate stated he died from myocardial infarction.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 167-172. All prescriptions written by Dr Barton unless otherwise marked.

Once only drugs

Diamorphine im 10mg	26 Aug 1800h

Verbal message, subsequent prescription by Dr Barton date unclear

As required prescriptions

Gaviscon 10ml	25 Aug 1200h

Prescription date unclear (Doctor other than Dr Barton)

Temazepam 10-20mg	24 Aug 2210h 10mg
Prescribed 24 Aug	25 Aug 2205h 20mg

Regular prescriptions

Doxazosin 4mg od	24 Aug -31 Aug
Frusemide 80mg od	24 Aug -31 Aug
Clexane 40mg sc bd	24 Aug -25 Aug (morning dose only received 25 Aug)
Paracetamol 1 g qds	23 Aug -26 Aug

None of above 4 drugs prescribed by Dr Barton

Daily review prescriptions

Metoclopramide 10 mg im 8hrly	25 Aug 1755h
Verbal order 25 Aug Dr Beasley	26 Aug 1740h
Oramorph 10mg 4hrly	None administered
Prescribed 26 Aug	
Oramorph 10mg/5ml (10-20mg) qds	26 Aug 20 mg nocte
Oramorph 10 mg/5ml 20mg nocte	27 Aug 4 doses administered unclear if 10 or 20 mg
Prescribed 26 Aug	20 mg nocte
	28 Aug 4 doses administered unclear if 10 or 20 mg
	20 mg nocte
	29 Aug 4 doses administered unclear if 10 or 20 mg
	20 mg nocte
	30 Aug 2 doses administered unclear if 10 or 20 mg
Diamorphine sc via syringe driver	30 Aug 1445h 40mg/24hr
40-200mg/24hr	31 Aug 1545h 40mg/24hr
Prescription date not written	1 Sep 1545h 40mg/24hr
	1915h increased to 60mg/24hr
	2 Sep 1540h 90mg/24hr

Midazolam subcut via syringe driver 20-80mg/24hr Prescription date not written	30 Aug	1445h	20 mg/24hr
	31 Aug	1540h	20 mg/24hr
	1 Sep	1545h	40 mg/24hr
		1915h	increased to 60 mg/24hr
	2 Sep	1540h	80mg/24hr
Hyoscine subcut via syringe driver 800-2000ucg/24hr Prescribed 2 Sep	No doses administered		

Opinion on Patient Management

7. The initial assessment and management of patient J during his admission to Anne Ward was in my view competent. The information in the medical records suggests appropriate clinical assessments were undertaken, investigations obtained and management initiated. The main initial problem was cellulitis (skin infection) of the groin and legs in the setting of chronic leg swelling. Secondary skin infections are a common problem in patients with chronic leg oedema. He responded to antibiotics and was commenced on subcutaneous heparin (Clexane) to reduce his risk of developing a deep vein thrombosis. There was a clear plan to mobilise patient J with the intention of him then being able to return home.

8. Dr Jane Tandy assessed patient J presumably at the request of the responsible medical team. She identified a possible episode of melaena (black stool due to bleeding from the gut). It is not uncommon for nursing staff to see dark stools and for it to be unclear if these are due to melaena. Dr Tandy examined patient J and performed a rectal examination to see if there was any evidence of bleeding from the gut. She gave clear instructions to check the haemoglobin and rule out a gastro intestinal bleed. This was done prior to his transfer to Dryad ward. I consider the management on Anne ward and Dr Tandy's assessment were competent.

9. The one aspect of his management on Anne Ward that could be questioned was the decision to make patient J not for attempted resuscitation without this being discussed with him or his next of kin and without a clear statement of the level of medical intervention that was appropriate. The decision that patient J was not for attempted resuscitation appears to have influenced subsequent management decisions on Dryad ward. The decision was not necessarily inappropriate since if he had experienced a cardiac or respiratory arrest he would have been unlikely to survive this.

10. Current medical practice is for decisions about resuscitation status to be discussed with patients or their next of kin. In 1999 such decisions were not always discussed with older patients or their relatives. There is no evidence from the medical notes or relative statements that patient J expressed any wishes that he did not want any medical intervention that might prolong his life. A very important principle in the medical care of patients, particularly for older people, is that the decision not for attempted resuscitation is separate from other decisions about other medical interventions. The majority of patients where a decision has been made that attempted resuscitation should not be undertaken in cardiac or respiratory arrest occurs still receive active medical treatment including surgery, antibiotic and other medical treatments.

11. A key principle of decision making about active treatment is that that treatments should be given that serve the patients needs. Therefore unless patients express or have expressed a

wish not to receive certain treatments, these should be provided by doctors unless other barriers, such as resource limitations prevent this. In the case of patient J there are no entries in the medical records to suggest that the medical team or Dr Tandy intended patient J should not receive treatment that might prevent early death or further disability. Dr Tandy's assessment and investigation of patient J suggest if he had been identified to have a gastrointestinal bleed he would have received further investigation (such as gastroscopy), treatment with blood transfusion and to be considered for surgery.

12. Primary responsibility for the medical care of patient J whilst he was on Dryad ward lay with Dr Reid the consultant responsible of his care. Day to day medical care was the responsibility of Dr Barton as clinical assistant and during out of hours period on call medical staff. Ward nursing staff were responsible for assessing, monitoring, and administering treatment to patient J and informing medical staff of any significant deterioration.

13. I consider there are many aspects of patient J's management that were of concern. Review of the medical and nursing notes indicates that patient J died from massive gastrointestinal haemorrhage most likely contributed to in part by the Clexane (enoxaparin) he received to reduce his risk of developing a deep vein thrombosis, and possibly opiate and sedative induced respiratory depression. There was no evidence to support a diagnosis of myocardial infarction (such as ECG changes, cardiac enzyme changes) which was given as the cause of his death.

14. Had patient J been readmitted to an acute hospital unit alternative actions would have been taken including blood transfusion and possibly therapeutic endoscopy (if available) or surgery and he might have survived the gastrointestinal bleed. Although his severe obesity would be expected to place him at risk of a number of complications, he was not dying or expected to die prior to his deterioration on Dryad ward on 26 August. His pressure sores were treatable and there was a reasonable possibility that he might regain limited mobility. The available evidence suggests patient J's had a reasonable quality of life and would wish to be treated. Patient J's wife states that they were told patient J was to be transferred to Gosport War Memorial Hospital for recuperation and rehabilitation (p4 BP/1).

15. Dr Barton as the doctor responsible for the day to day management of patient J had a responsibility to obtain, review and act upon the results of blood tests. The medical notes on 23 August indicated repeat blood tests were to be performed. The nursing notes indicate the haemoglobin result was to be reviewed by Dr Barton. On 26 August Dr Barton was called to see patient J as he was unwell and she had recognised that patient J might have had a gastrointestinal bleed. Had this result been obtained it would have indicated that patient J had experienced a large bleed and required blood transfusion and transfer to an acute medical unit for further care. I find the comment by Dr Barton that patient J was too unwell to transfer to an acute unit difficult to understand when at no point had it been suggested that patient J was for palliative care. On the contrary it was clear he was too unwell to be safely investigated and managed at Gosport War Memorial Hospital. This decision was not appropriately made by a clinical assistant without discussion with a consultant colleague and Dr Barton should have discussed patient J with a consultant Geriatrician or the on call Acute Medical Team.

16. The medical notes suggest the medical assessment of patient J by Dr Barton on 26 August were in my view inadequate. The standard of note keeping falls below the expected level of documentation on a continuing care of rehabilitation ward. Dr Barton describes patient J as being clammy and unwell but does not appear to have performed a physical examination of

his chest and abdomen, recorded the results of any examination and did not instruct nurses or obtain herself his pulse rate and blood pressure. She did not obtain appropriate further investigations such as an electrocardiogram and blood tests to obtain further information supporting a diagnosis of a myocardial infarct. Had she done this and discussed the results with a consultant colleague it is likely patient J would have been transferred to an acute medical unit at another hospital. Dr Barton's own provisional diagnosis of a myocardial infarct should have prompted her to discuss transferring patient J to a coronary care unit or acute medical unit so that he could be assessed and be in an appropriate environment where complications of a myocardial infarct such as cardiac arrhythmias could be monitored and treated. For these reasons I consider Dr Barton failed to provide appropriate medical care to patient J.

17. The verbal message by Dr Barton to administer diamorphine to patient J on 26 August before she had seen and assessed patient J was inappropriate as no medical assessment was undertaken and no clear diagnosis had been made. If the pain was considered severe enough to require diamorphine patient J should have been assessed immediately by Dr Barton or another doctor to establish whether he had experienced a myocardial infarction or other serious problem.

18. The rationale for commencement of regular oral morphine is not recorded in the medical notes on 26 August by Dr Barton. On the 28 August Dr Barton records that patient J is uncomfortable but does not record the site of pain or justification for continuing morphine. There is no record in the medical notes explaining why diamorphine and midazolam were administered by syringe driver on 30 August or why the doses of diamorphine were increased from 40mg/24hr to 90mg/24hr and midazolam from 20mg/24hr to 80mg/24hr between 31 and 2 September.

19. The medical records contain no information indicating why patient J required midazolam as neither the medical or nursing notes record that he had symptoms of restlessness or agitation requiring administration of a sedative drug. Dr Barton did not record the reasons why the diamorphine and midazolam doses were increased on the 1 and 2 September.

20. The dose ranges of diamorphine and midazolam prescribed were inappropriate and hazardous. After the commencement of diamorphine and midazolam patient J became drowsy. There are no records of his respiratory rate or detailed assessments of his conscious level but the progressive increase in diamorphine and midazolam doses after 1 September may have led to respiratory depression and contributed to his death, although he primary cause of death appears to be due to massive gastrointestinal haemorrhage. The medical records do not contain a record of an adequate medical assessment by Dr Barton or record the reasons for her treatment decisions. In my opinion the prescriptions of oramorphine, diamorphine and midazolam were inappropriate and hazardous.

21. Dr Reid assessed patient J on 1 September. At this stage it was clear patient J had bleeding from the gut and was drowsy. The notes suggest Dr Reid did not review the full blood count results and did not consider the possibility that his drowsiness and confusion might be secondary to the diamorphine infusion. The notes suggest Dr Reid did not consider transferring patient J to an acute medical unit. This was possibly because Dr Reid considered Patient J would inevitably die whatever actions were taken.

Summary of Conclusions

22. Patient J was a man with severe obesity and long standing leg oedema who was admitted to hospital because of mobility problems and difficulties managing at home. He was transferred to Dryad ward for rehabilitation. Shortly after transfer he deteriorated on the 26 August 1999 and died on 3 September 1999 from gastrointestinal bleeding and possibly diamorphine and midazolam induced respiratory depression. In my opinion the information in the medical records indicates an adequate medical assessment was not performed by Dr Barton when patient J deteriorated on 26 August and the verbal order to administer diamorphine before a medical assessment was not justified. The prescriptions of diamorphine and midazolam and the reasons for increasing the doses infused were not justified by the information in the medical records.

23. In my opinion Dr Barton in her care of patient J failed to meet the requirements of good medical practice to:
    - Provide an adequate assessment of the patients condition based on the history and clinical findings and including where necessary an appropriate examination
    - Consult colleagues
    - Keep clear, accurate contemporaneous patient records which report the relevant clinical findings the decisions made, information given to patients and any drugs or other treatments prescribed
    - Provide or arranging necessary investigations
    - Prescribe only the treatment, drugs or appliances that serve patient's need

20. I understand my dutles as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

GMC and Dr Barton
Report on Elsie Devine (Patient K)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient K

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient K commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that the prescription by Dr Barton of morphine solution was not justified by the patient's presenting symptoms; that the prescription of diamorphine and midazolam by subcutaneous infusion was in too wide a dose range and created a situation whereby drugs could be excessive to the patient's need; that the prescription of morphine solution, fentanyl 25 patch and diamorphine with midazolam infusions were inappropriate, potentially hazardous and not in the best interests of Patient K.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient K; statements of Ann Reeves, Dr Ian Reckless, Dr Walter Jayawardena, Dr Judith Stevens, Dr Tanja Cranfield, Dr Ravindrane, Dr Joanna Taylor, Freda Shaw, Lynn Barrett, Gillian Hamblin, Anita Tubbritt, Dr Richard Reid, Dr Althea Lord, Fiona Walker; statement made by Dr Barton in relation to Patient K; interview of Dr Barton dated 4 November 2004 (three transcripts).

5. **Course of events**

5.1 Patient K was an 88 year old lady who was admitted to Queen Alexandra Hospital, Ward 3 on 9 October 1999 with an episode of acute confusion. Some of the medical records relating to this admission appear not to be in the copy of medical notes provided to me but a letter by Dr Taylor, Clinical Assistant in Old Age Psychiatry summarises Patient K's problems at this time (page 29, 30). Dr Taylor saw Patient K on behalf of Dr Lusznat, Consultant in Old Age Psychiatry, at the request of the responsible Consultant Physician, Dr Duncan. Prior to her admission, her daughter indicated Patient K had been wandering and aggressive.

5.2 Patient K remained confused following admission to the Ward, had tried to get out of windows and was possibly hallucinating. Her behaviour had settled but she remained confused and disorientated. Until January 1999 Patient K had been able to look after herself but her family had noticed a decline in her memory since that time and she was no longer able to cook. She had background medical problems of hypothyroidism, treated with thyroxine, chronic renal failure and an IgA paraprotein. A bone marrow biopsy had shown a 6% plasma cell infiltrate. On assessment in June 1999 by Dr Cranfield, Consultant Haematologist (page 63) she did not consider there was sufficient evidence to make diagnosis of myeloma. Patient K also had a diagnosis of nephrotic syndrome (renal impairment with loss of protein through the kidneys). Examination of Patient K's skeletal system in May 1999 (page 75) had not shown any bone lesions due to plasma cell infiltration.

5.3 Dr Taylor's letter indicated that Patient K's daughter was currently unable to provide support to her mother due to other family illness. On the ward Patient K was mobile, able to wash with prompting and independent in her self-care but did tend to get lost on the ward. At this time Patient K was sleeping well and settled during the day but had been aggressive at times towards her daughter. Dr Taylor found Patient K had hearing difficulties and scored low (9/30) on the mini-mental state examination – an assessment of cognitive function. Dr Taylor considered Patient K had a diagnosis of dementia and that she would not be able to return home and recommended referring her to Social Services for consideration for residential care in a home with experience dealing with memory problems. As her behaviour was settled, Dr Taylor did not think she required an EMI (Elderly Mental Infirm) home.

5.4 On 15 October the notes record a discussion with Dr Smith, Patient K's GP, and a plan to transfer her to St Christopher's. This appears to have been planned as a temporary transfer prior to placement in a suitable home in the community. A referral was made to Dr Jay, Consultant Geriatrician who saw Patient K on 19 October and stated in the notes that she was suitable for rehabilitation and had arranged a transfer to Gosport War Memorial Hospital (page 169). A letter relating to that assessment dated 20 October (page 21) stated she was alert, could stand but was unsteady on walking. A transfer letter dated 20 October 1999 summarises Patient K's admission prior to transfer to Gosport War Memorial Hospital and states *"Patient admitted with increasing confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her crp* (C reactive protein) *we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and now she needs temporary placement with you until a permanent place is..."*

5.5 The medical notes record Patient K's transfer to Dryad Ward on 21 October and an entry by Dr Barton states *"transfer to Dryad Ward, continuing care. HPC acute confusion, admitted to Mulberry → Dryad. Past medical history dementia, myeloma, hypothyroidism, Barthel transfers with one. So far continent. Needs some help with ADL MMSE 9/30. Barthel 8. Plan get to know. Assess rehab potential probably for rest home in due course".*

5.6 The next entry in the medical notes is by Dr Reid, Consultant Geriatrician on 25 October. This states *"mobile unaided. Washes with supervision. Dresses self. Continent. Mildly confused. BP 110/70. Normochromic anaemia-chronic renal failure. Was living with daughter and son-in-law. ?Son-in-law awaiting bone marrow transplant. Need to find out more [illegible] etc".* A further entry by Dr Reid on 1 November states *"physically independent but needs supervision with W and D help with bathing, continent. Quite*

confused and disorientated e.g. wandering during the day. Unlikely to get much social support at home therefore try home visit to see if functions better in own home".

5.7 There is a further unsigned entry in the medical notes dated 15 November indicating Patient K had been aggressive at times and restless and that needed thioridazine. She was on treatment for a urinary tract infection after a urine specimen had shown blood and protein. Examination at this time showed Patient K was apyrexial, had some peripheral oedema but had a clear chest. The notes state that a request would go to Dr Lusznat to review Patient K.

5.8 There is then an entry by Dr Barton dated 16 November which states *"Dear Rosie. Thank you so much for seeing Patient K. I gather she is well known to you. Her confusional state has increased in the last few days to the point where we are using thioridazine. Her renal function is decreasing. Her MSU showed no growth. Can you help? Many thanks."*

5.9 Patient K was seen by Dr Taylor on 18 November. The medical notes record *"this lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward".* The next entry is on 19 November 1999 by Dr Barton and records *"marked deterioration over-night. Confused aggressive, creatinine 300, fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs sc analgesia with midzolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death".* A final entry in the medical notes on 21 November records Patient K had died at 2030h (page 157).

5.10 The nursing summary notes (page 223) record on 21 October 1999 Patient K was admitted with increasing confusion and aggression which had resolved. The notes state *"a very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet".* An entry on 19 November which is difficult to read states *"Extremely aggressive..... Two staff to special. Syringe driver commenced at 0925h diamorphine 40mg + midazolam 40m. fentanyl patch removed".* The nursing notes record Patient K was seen by Dr Barton at 1300h (page 224). An entry on 21 November records that her condition had continued to deteriorate slowly. I can find no record in the nursing notes indicating Patient K was at any time in pain.

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 279 -281. All prescriptions written by Dr Barton unless otherwise marked.

Once only drugs	
Chlorpromazine 50mg im	Date unclear November 0830h
Regular prescriptions	
Thyroxine 100ug od Prescribed 21 Oct	22 Oct-17 Nov. Not administered 2 Nov or 18 Nov onwards
Frusemide 40mg od Prescribed 21 Oct	22 Oct – 17 Nov. Not administered 18 Nov onwards
Amiloride 5 mg od Prescribed 1 Nov	2 Nov-18 Nov. Not administered 19 Nov onwards
Trimethoprim 200mg bd	11 Nov – 15 Nov. Then discontinued

Prescribed 11 Nov Fentanyl 25ug skin (every three days) Prescribed 18 Nov	18 Nov 0915h
Diamorphine subcut via syringe driver 40-80mg/24hr Prescribed 19 Nov	19 Nov 40mg/24hr 20 Nov 40mg/24hr 21 Nov 40mg/24hr
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 19 Nov	19 Nov 40mg/24hr 20 Nov 40mg/24hr 21 Nov 40mg/24hr
As required prescriptions Temazepam 10mg nocte Prescribed 21 October 1999	11 Nov
Oramorph 10mg/5ml 2.5-5ml Prescribed 21 Oct	None administered
Thiordiazine 10mg tds Prescribed 11 Nov	11 Nov 0830h 12 Nov 1320h 13 Nov 0825h, 1800h 14 Nov 0825h, 1945h 15 Nov 0830h, 2130h 16 Nov 0845h 17 Nov 1740h

Opinion on Patient Management

7. Patient K was an elderly woman with dementia who prior to admission to hospital in October 1999 had been living at home with increasing difficulties and was likely to move into a residential care home. She had been admitted to Queen Alexandra Hospital after being found wandering and aggressive and continued to exhibit some behavioural difficulties. These were not judged sufficiently severe to merit moving into an Elderly Mental Infirm home rather than a residential home. She was referred to Gosport War Memorial Hospital for temporary placement prior to a suitable residential home being found for her to move into.

8. Following transfer to Dryad ward Dr Reid had suggested Patient K be taken on a home visit to see if she functioned better in her own home than on the ward. This is common and good practice in elderly care medicine as some patients function better in their own homes than when observed in a ward environment. Observation of the patient in their own home allows a decision to be made as to whether they can continue to manage at home and what level of support services might be required to support this. At this point Patient K was independently mobile, continent, able to wash with supervision and dress herself. It was reasonable to consider the possibility that Patient K might be able to manage to live in the community with support from her family and social services.

9. Patient K was intermittently aggressive on the ward. Aggression is a well recognised and troublesome symptom in some patients with dementia and is often worse when patients are in a new environment such as a hospital ward. It can also be precipitated or worsened by

other medical problems particularly chest or urinary tract infections. Thiordiazine had been prescribed on 11 November. Neuroleptic drugs such as thioridazine are commonly used to try and improve symptoms of aggressions in people with dementia. I would consider this was an appropriate treatment approach.

10. When her aggressive behaviour persisted a request for consultation was sent to Dr Lusznat, Consultant Old Age Psychiatrist who had previously assessed Patient K. This was appropriate and good medical practice. Dr Taylor, a member of Dr Lusznat's team assessed Patient K and noted she was refusing medication and not eating well. Dr Taylor made plans to transfer her to an Old Age Psychiatry ward for further assessment and management. This suggests that Dr Taylor considered Patient K's main problems were related to her dementia and she had no other significant active medical problems.

11. On 18 November when Dr Taylor saw Patient K Dr Barton prescribed a fentanyl patch to Patient K. Dr Barton's entry in the medical records on 19 November indicates Patient K deteriorated the day before. The medical and nursing notes contain no evidence that Patient K was in pain and the indication for prescribing the fentanyl patch is not recorded. Good medical practice requires the reasons for commencement of any drug but particularly a controlled drug such as an opiate to be recorded in the medical notes. If Patient K was in pain the details of the pain should have been recorded in the medical notes and a physical examination should have been performed to further assess the pain. Patients with dementia may not always communicate they are in pain, but may become confused and aggressive because of pain. Examination may reveal a patient has a musculoskeletal injury, such as a hip fracture, or other problem such as a distended bladder or other acute painful condition which require specific treatments.

12. Nursing and medical review of Patient K was indicated when she deteriorated on the 18 November. There is no evidence in the medical and nursing notes that Dr Barton examined Patient K. In my opinion the prescription of fentanyl by Dr Barton was not justified as there is no evidence Patient K was in pain. I consider Dr Barton failed to meet the requirements of good medical practice to adequately assess Patient K, keep contemporaneous patient records and provide appropriate treatment.

13. A medical assessment was also indicated when she became very aggressive, which appears to have been on the 19 November but could have been on the 18 November. The nursing and medical notes lack sufficient information to be clear when she became aggressive. Dr Barton's notes document that Patient K deteriorated overnight but she does not record what the cause of this deterioration in her condition was due to. One key issue that should have been considered at this stage was that Patient K's further deterioration and aggression might have been related in part to adverse effects of the fentanyl patch that had been commenced. Opioid drugs commonly cause sedation but can precipitate confusion and aggression in some older people.

14. When Patient K deteriorated Dr Barton's notes document an increased blood creatinine concentration suggesting her renal function had deteriorated. This was possibly due to dehydration but could have been also due to a urinary tract or other infection. There is also a comment that Patient K needed subcutaneous analgesia with midazolam but her notes do not record why. The specific reference to analgesia suggests Dr Barton considered Patient K was in pain but neither the medical or nursing notes record any information suggesting she was in pain. As Patient K was not able to swallow use of the transdermal or subcutaneous

route to administer analgesia and/or sedation if she required this would have been appropriate if these treatments were indicated.

15. The prescription of subcutaneous diamorphine by Dr Baton on 19 November was in my opinion not appropriate or justified as there was no evidence she was in pain. The dose prescribed was also in my opinion excessively high if she had been in pain. In an older frail patient an appropriate dose would have been 10mg/24hr or 20mg/24 hr particularly when midazolam was also prescribed. The prescription of diamorphine 40-80mg/24hr placed Patient K at risk of developing respiratory depression and coma.

16. The prescription of subcutaneous midazolam by Dr Barton on 19 November was in my opinion not justified by the information recorded in the medical recotrds. The Wessex Protocols list midazolam by subcutaneous infusion as a treatment option for agitation (10 mg im stat then 10-100mg/24hr) in patients receiving palliative care who have a syringe driver for other reasons. The notes indicate patient K was extremely aggressive. In my opinion midazolam by subcutaneous infusion was not the optimal initial treatment for her aggression. She had previously been receiving thioridazine until 17 November and it would have been appropriate to administer thrioridazine by intramuscular injection or use an alternative neuroleptic drug such as haloperidol.

17. In patients who are very aggressive single doses of drugs, repeated as necessary if aggression continues without significant adverse effects from the drugs administered, are a more appropriate approach to controlling symptoms. This is rationale for the Wessex Protocols recommend an initial loading dose by intramuscular midazolam to treat agitation. Commencing a midazolam infusion without an initial loading dose leads to the maximal effect of the drug not being observed until 'steady state' concentrations are reached which may be more than 24 hours later. Therefore the initial response may be inadequate and there may be adverse effects that occur much later as the drug accumulates in the patient.

18. If Dr Barton considered Patient K was terminally ill her medical records do not indicate why this was the case. Given that the day before the plan had been to transfer Patient K for further assessment on an Old Age Psychiatry ward it would have been appropriate for Dr Barton, as the doctor responsible for Patient K's day to day care, to discuss the sudden deterioration in Patient K with Dr Reid the responsible consultant or another senior colleague.

19. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-100mg/24hr. In an older frail patient an appropriate dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 40mg/24hr was therefore inappropriately high. The prescribed dose range of midazolam with an upper limit of 80mg/24hr particularly in conjunction with the diamorphine prescribed placed patient K at high risk of developing life threatening complications.

20. In my opinion the subsequent deterioration in Patient K after 19 November until her death on 21 November was very likely due to diamorphine and midazolam leading to respiratory depression and coma.

Summary of Conclusions

21. Patient K was an elderly lady with dementia who developed aggressive behavioural problems whilst on Dryad ward and awaiting transfer to an Old Age Psychiatry ward. The notes do not suggest that Dr Barton conducted an adequate assessment of patient K before prescribing the opiate fentanyl and then subcutaneous infusions of diamorphine and midazolam. In my opinion fentanyl and diamorphine were not indicated. The prescription of a midazolam infusion without an initial loading dose was not in my view optimal management, but if this had been administered alone without diamorphine would not in my opinion have been a breach of a duty of care if there had been an adequate clinical assessment. The doses of diamorphine and midazlolam prescribed by Dr Barton were excessive, dangerous and reckless. In my opinion the administration of these drugs by subcutaneous infusion at the doses used led to depression of her conscious level and respiration and most likely contributed to her death.

22. In my opinion Dr Barton in her care of Patient K failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

23. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD

General Medical Council and Dr Barton
Report on Jean Stevens (Patient L)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient L

1. This report is provided on the instruction of Field Fisher Waterhouse Solicitors. I have been asked to prepare a report on the medical care of Patient L commenting on the care and treatment carried out by Dr Barton in relation to this patient, to assist the GMC Panel in determining whether Dr Barton has fallen short of what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the Fitness to Practice Panel that; Dr Barton did not properly assess patient L on admission; the prescriptions by Dr Barton of oramorphine, diamorphine and midazolam were not clinically justified and created a situation whereby drugs could be administered which were excessive to patient L's need; that the prescriptions were inappropriate, potentially hazardous and not in the best interests of Patient L.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient L; statements of Ernest Stevens, June Bailey and various nurse statements.

5. **Course of events**

5.1 Patient L was a 73 years old when admitted to Royal Hospital Haslar on 26 April 1999 after experiencing chest pain and then collapsed at home after developing left arm and leg weakness. She was transferred to Daedalus ward, Gosport War Memorial Hospital on 20 May and died on that ward on 22 May 1999. Prior to this admission she was living at home with her husband. Her past medical history (page 174) included ischaemic heart disease and previous myocardial infarction, atrial fibrillation, asthma and chronic airways disease, and surgery for diverticular disease and a stricture. She had problems with recurrent lower abdominal pain thought to be due to adhesions (page 129) or irritable bowel syndrome (page 125). She had rated her health as poor in October 1997 (page 150).

5.2 The admission clerking to Royal Hospital Haslar documents she had developed new left face, arm and leg weakness and slurred speech. She was complaining of a headache and was thought to have had a stroke. A CT brain scan was obtained on 26 April (page 177) and demonstrated infarction in the right parietal lobe indicating she had a stroke due to cerebral infarction (blocked blood vessel). The notes state that an ECG showed atrial

fibrillation and ischaemic changes. Cardiac enzymes were elevated (CKMB 65) suggesting she had possibly sustained a myocardial infarction as the cause of her chest pain.

5.3 The notes record on 27 April (page 178) that she was alert and had left sided neglect. A nasogastric tube was paced to commence feeding as to swallow was unsafe. On 28 April the notes record she was experiencing continuing chest pain thought to be due to angina (page 180). An ECG showed ST elevation and she was transferred to the coronary care unit (CCU) and treated with a nitrate infusion (page 182). An entry in the medical notes on 30 April states that ECGs had confirmed she had experienced an anterior myocardial infarct. Later that day she developed increasing shortness of breath (page 183). The notes record she was hypoxic (low oxygen in the blood) and had signs on examination suggesting she had either a chest infection or pulmonary oedema due to fluid overload. A chest XRay found the nasogastric tube was not in the stomach and feed had been passed into the nasopharynx suggesting she had developed an aspiration pneumonia. Antibiotics were commenced (Page 184).

5.4 On 5 May 1999 the notes record patient L was able to start taking food (page 190). A referral was made by the medical team to Dr Lord, Consultant Geriatrician (page 190) stating that she was improving and requesting Dr Lord's opinion on the provision of rehabilitation. Later that day the notes record she was less well (page 191) and was in respiratory failure. She was treated with oxygen and small doses of diamorphine. The notes record patient L had a reasonable quality of life prior to her stroke (page 192). After discussion with the family a decision was made that she was for active treatment but not for ventilation if she deteriorated. An entry in the notes the following day records a discussion with the consultant and a decision that she was not for resuscitation.

5.5 Dr Lord assessed patient L on 6 May (page 194). Dr Lord records in the notes that patient L was extremely unwell with problems of a dense left hemiparesis due to stroke, myocardial infarction, atrial fibrillation, and aspiration pneumonia. The notes document she was *'chesty, flushed and tachypnoeic'*. Dr Lord's assessment was that she was not well enough to transfer to Gosport War Memorial Hospital and she thought she was unlikely to survive. She recommended patient L be given intravenous fluids, salbutamol nebulisers, and diamorphine if distressed. Dr Lord states *'If stable early next week for transfer to slow stream stroke care GWMH later in the week'*.

5.6 On 10 May the notes record patient L was improving and nasogastric feeding was recommenced. Dr Tandy, consultant Geriatrician reviewed patient L on 10 May (page 196-198) and noted that she was experiencing chest pain and had an elevated blood sodium (Na 165). Dr Tandy states *'If...(illegible) will take to GWMH. Please normalise Na+(has had 5% dextrose). Rule out MI ensure angina reasonable 'sable'. Make sure tolerating ng. If above OK, please transfer to GWMH next week'*. A letter dated 12 May also summarises her assessment (page 68)

5.7 Later on 10 May the notes record patient L had a further episode of central chest pain which was relieved by GTN spray and her pain settled. On 12 May the notes record Captain Boos spoke to patient L's family and explained her poor prognosis and the rationale for making her not for resuscitation or care on an intensive care unit if she deteriorated (p200). On 14 May she was reviewed by an orthopaedic specialist as it was thought she might have dislocated her left shoulder. This was found to be subluxation of the shoulder and no active intervention was needed (page 202). On 18 May the notes record the medical team liaised with Gosport War Memorial Hospital (page 204) and that she was tolerating her

nasogastric feeding, was recovering from her aspiration pneumonia and showing improvement in her orientation, speech and strength, but was faecally incontinent and had a urinary catheter in place. The transfer note states that patient L was for rehabilitation (p70). On transfer she was taking prescribed aspirin, enalapril, digoxin, isosorbide mononitrate (Imdur) and "as required" subcutaneous diamorphine 5mg.

5.8 Patient L was transferred to Daedalus ward on 20 May. The medical records do not state the time patient L arrived on Daedalus ward. The first timed entry is at 1340h in the nursing summary. The medical notes (Vol 3 page 20) contain an entry from Dr Barton which states *'Transfer to Daedalus ward S.S.S.R* (Slow Stream Stroke Rehabilitation) *HPC. R CVA 26-4-99. Dense L Hemi. Aspiration pneumonia and MI 28-4-99. P.M.H. IHD MI x 2. AF, COPD asthma, sigmoid resection due to diverticular disease. Barthel needs help c ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.'* There are no further medical entries in the notes. The notes record in an entry by staff nurse Tubbritt that patient L died at 2230h on 22 May.

5.9 Mr Stevens states in his statement of 5 April 2008 that Dr Barton did not see patient L whilst at Gosport War Memorial Hospital. In his statement dated 16 April 2004 Mr Stevens states he arrived on Daedalus Ward at 1330h on 20 May and had to wait to see patient L as the nurses were attending to her.

5.10 The nursing note summary on 20 May records *'.... Appears quite alert and aware of surroundings'*. The notes do not record that patient L appeared distressed or in pain (vol 3 page 26). However the nursing records record *'c/o abdo pain. Due to Hx bowel problems. Oramorph given o/a* (on arrival)' (Vol 3 page 28). An entry in the nursing night care plan on 20 May (Vol 3 page 60) states *'oramoprh 2.5 ml given as per kardex. c/o pain in stomach and arm. Condition poor'*. On 21 May the nursing records state that Isosorbide was discontinued and patient L was to have GTN spray "as required". A separate entry that day states *'now on regular (4 hourly) Oramorph 10mg/5ml'*.

5.11 At 1800h on 21 May the nursing records (Vol 3 page 34) state *'uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen and care discussed. Very upset. Agreed to commence syringe driver for pain at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.'* An entry at 1945h records a syringe driver was commenced at 1945h with 20mg oramorphine and 20mg midazolam over 24 hours. On 22 May 0800h the nursing notes state *'condition has deteriorated. Very bubbly. 800mcg hyoscine, 20 mg diamorphine, 20 mg midazolam commenced via syringe driver at 8am'*. A further entry at 1020h states *'Dr Beasley contacted and verbal order to increase hyoscine to 1600mcg.'*

6. Drug therapy prescribed and received at Gosport War Memorial Hospital.

Page 64 - 69. All prescriptions written by Dr Barton unless otherwise marked.

Regular prescriptions

Digoxin elixir 1.2 ml od Prescribed 20 May	21 May 1 dose
Enalapril 5mg od Prescribed 20 May	21 May 1 dose
Aspirin 75mg od Prescribed 20 May	21 May 1 dose

Isosorbide Mononitrate 60mg Prescribed 20 May	None administered. Discontinued (date unclear)
Suby C Prescribed 20 May	None administered
GTN spray 2 puffs (prn) Prescribed 21 May	None administered
Hyoscine subcut via syringe driver 1600ucg/24hr Prescribed 22 May (verbal message D Beasley)	22 May 1030h 1600mcg/24hr
Oramorph 10mg/5ml 10 mg 4 times a day Prescribed 21 May	21 May 2 doses 1000h, 1400h
Oramorph 10mg/5ml 20mg nocte Prescribed 21 May	None administered
Daily review prescriptions	
Liquid .....? ng tube 4mg qds No prescription date	None administered
As required prescriptions	
Oramorphine 10mg/5ml 2.5-5ml Prescribed 20 May	20 May 1430h 5mg 1830h 2.5mg 2245h 2.5mg 21 May 0735h 2.5mg
Diamorphine subcut via syringe driver 20-200mg/24hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr
Hyoscine subcut via syringe driver 200-800 ucg/24hr Prescribed 20 May	22 May 0800h 800ucg/24hr
Midazolam subcut via syringe driver 20-80mg/24 hr Prescribed 20 May	21 May 1920h 20mg/24hr 22 May 0800h 20mg/24hr 22 May 1030h 20mg/24hr

Opinion on Patient Management

7. Patient L was a 73 year old woman with pre-existing cardiac disease and chronic abdominal pain who was living at home independently prior to being admitted with cardiac chest pain and a stroke in April 1999. Her stroke was severe leaving her with significant problems of left sided weakness, swallowing difficulties and inattention, which would almost certainly have left her with long term disabilities requiring care and support, either at home with the support of her husband and carers or in a nursing home. Following her admission she had continuing problems from a myocardial infarction, aspiration pneumonia and hypernatraemia (high blood sodium). Her problems were clearly summarised by Dr Lord following her assessment 10 days after admission. She considered patient L was unlikely to

survive and I agree with this assessment. A patient aged over 70 years of age with a severe stroke, myocardial infarction and these complications would have a high likelihood of dying from these problems.

8. Dr Lord recommended a treatment plan for patient L including diamorphine if distressed. I consider this was an appropriate recommendation. Patient L had cardiac chest pain and evidence of pulmonary odema both of which are appropriately treated with diamorphine. I have been unable to find the prescription chart in the medical records during her admission to Royal Hospital Haslar to determine the amount of opioid analgesia patient L received during this admission. Despite her poor state at this time Dr Lord recognised that patient L might improve and indicated that if she became medically stable she would be suitable to transfer to slow stream stroke care at Gosport War Memorial Hospital. In my opinion this was an appropriate plan.

9. Slow stream stroke care or rehabilitation is a commonly used term used to describe a period of rehabilitation over a few months required for patients with severe strokes, who are often elderly and/or have other medical complications, such as in the case of patient L. Such rehabilitation often takes place in rehabilitation wards that are not on acute hospital sites. It is important that patients are medically stable before transfer to such units which usually do not have a resident on site doctor or facilities to investigate patients if they develop new medical problems.

10. Patient L was still very unwell when seen four days later on 10 May by Dr Tandy who summarised the ongoing medical problems that needed to be stabilised before transfer to Gosport War Memorial Hospital could be considered. One week later patient L had improved and her ongoing medical problems had stabilised with normalisation of her blood sodium, stabilisation of her chest pain and her pneumonia was resolving. She was judged to be sufficiently stable for her to be transferred to Daedalus ward for rehabilitation. At this point she had an ongoing prescription for 5mg diamorphine "as required" but I have not been able to establish how many doses she had received. From the information available in the medical notes I consider patient L was sufficiently stable on 20 May for her to be transferred to Daedalus ward, although she was at risk of developing further medical complications.

11. The nursing notes state that patient L was complaining of abdominal pain and was administered oramorphine on arrival at Daedalus ward. The drug chart indicates that the first dose of oramoprhine was administered at 1430h. I would estimate that patient L arrived at Daedalus ward shortly around 1300h as the first entry on the nursing notes was timed at 1340h. Dr Barton was the doctor responsible for the initial assessment of patient L. She prescribed oral morphine to patient L which was administered shortly after patient L's arrival. I would expect the nurse who initially assessed patient L and documented she had abdominal pain on arrival at the ward would have informed Dr Barton of this. It is routine practice for nursing staff to admit and assess a patient before the admitting doctor sees a patient arriving on a ward. Even if the nurse had not informed Dr Barton that patient L was complaining of abdominal pain I would have expected Dr Barton to assess patient L as a new patient arriving on the ward, and note any current symptoms and examine the patient L. Given the medical problems patient L had recently experienced it would be particularly important that Dr Barton undertook such an assessment of patient L.

12. Dr Barton's entry on 20 May makes no mention of patient L being in pain and contains no record of a physical examination of patient L. As patient L was complaining of abdominal

pain, it would have been appropriate for Dr Barton to have recorded the patient's account of pain if she was able to give such an account, or that the nursing staff had noted she was in pain. The medical notes suggest abdominal pain was a new complaint of patient L's since her admission to hospital although she had a history of chronic abdominal pain. It would have been appropriate for Dr Barton to undertake a clinical assessment of patient L including examining her abdomen. There is no evidence in the notes that Dr Barton undertook such a clinical assessment. The information recorded by Dr Barton could have been obtained entirely from the information contained in the Royal Hospital Haslar notes and transfer letter, and from the nursing assessment. In my opinion the information available in the notes suggests Dr Barton failed to undertake an adequate clinical assessment of patient L after she arrived on the ward on 20 May.

13. On 20 May Dr Barton prescribed oramorphine and also subcutaneous infusions of diamorphine, hyoscine and midazolam. It is not clear if the last three prescriptions for subcutaneous drug infusions were written at the same time as the oramorphine. Dr Barton did not record in the records why she prescribed oramorphine to patient L. It is unclear if this was to replace the diamorphine "as required" prescription that was in place or was commenced for the treatment of the abdominal pain patient L was complaining of on admission to Daedalus ward.

14. I consider the prescription by Dr Barton of oramorphine to replace the "as required "diamorphine for chest pain or distress related to pulmonary oedema if this occurred in patient L would not be optimal because when patient are acutely unwell with such symptoms the oral route for administering opiates leads to slower absorption and patients may be too unwell or nauseated to take oral medication. It would have been preferable to continue the prn subcutaneous diamorphine prescription which had been in place for patient L at Royal Hospital Haslar. The "as required" prescription for oramorphine should have specified the symptoms that Dr Barton intended the oramorphine be given for. In my opinion the prescription of oramorphine was not optimal practice if it was a replacement for the diamorphine prescription.

15. However if Dr Barton had given clear written instructions to nursing staff, in either the drug chart or in the medical notes I would not consider such an action constituted a failure of good medical practice. If Dr Barton had given clear verbal instructions to the nursing staff that the oramorphine was replacing the "as required" diamorphine prescription and the circumstances under which it should be administered there would be a risk of nursing staff misunderstanding the reasons oramorphine was prescribed. The nursing records state that the initial dose of oramorphine was given to patient L for abdominal pain. On the basis of the information available in the medical records Dr Barton failed to either record or inform the nursing staff that the oramorphine was replacing the "as required" diamorphine and the circumstances under which the oramorphine should be given if this had been her intention. Therefore if the oramorphine was intended to replace the diamorphine prescription I consider the oramorphine prescription was not appropriately prescribed and potentially hazardous, as the oramorphine could have been given for other symptoms for which it was not intended such as abdominal pain.

16. If Dr Barton prescribed the "as required" oramorphine to relieve abdominal pain in patient L, I consider this was inappropriate and potentially hazardous, since there is no record in the medical notes that Dr Barton performed a clinical assessment, or considered whether any investigations, such as an abdominal Xray and blood tests were required, or discussion with a senior colleague was required. If as seems possible the abdominal pain was a recurrence

of her chronic abdominal pain, opioids were not an appropriate treatment. Opioid drugs had not been prescribed to patient L for abdominal pain in the past when patient L had been assessed by consultant specialists. In my opinion from the information available in the notes the prescription on 20 May of "as required" oramorphine by Dr Barton was inappropriate and potentially hazardous to patient L, as the oramoprhine was administered for abdominal pain and there had not been an adequate clinical assessment of patient L undertaken by Dr Barton, and no instructions had been given as to the circumstances under which oramorphine should be administered.

17. It is unclear who made the decision that diamorphine and midazolam infusions should be administered to patient L on 21 May. The nursing notes record this was discussed with patient L's husband that evening and the infusion commenced at 1945h. The notes do not record if the decision to commence these infusions was discussed with Dr Barton or another member of medical staff. The nursing notes suggest that these were commenced because patient L was uncomfortable despite 4 hourly oramorphine. Dr Barton had commenced regular oramorphine the morning of 21 May, although the notes do not record the symptoms being treated or the underlying diagnosis considered responsible for the pain. Before prescribing a diamorphine infusion there should have been a clinical assessment of the cause of the pain and response to oramorphine and the reasons why a subcutaneous infusion was necessary, but there is no evidence in the notes that this took place.

18. Patient L was able to receive oramorphine through the nasogastric tube she was being fed through. This had been pulled out on the morning of 20 May. If the nasogastric tube was not in place and patient L was unable to swallow oral medication, this might have been a reason to consider administering opioids by a subcutaneous infusion if they were indicated. The nursing notes do not record there was a problem with administering oramorphine and she had received two doses at 1000h and 1400h before the diamorphine infusion was commenced at 1920h.

19. In the preceding 24 hours patient L had received 27.5 mg oramorphine (2.5+2.5+25+10+10). An equivalent dose of subcutaneous diamorphine would be one third to a half of the dose of morphine received i.e. 9mg-14mg over 24 hours. The diamorphine infusion was commenced at 20mg/24hr was within an acceptable starting dose if continuing opioid drugs by using a subcutaneous infusion as appropriate and patient L's pain was uncontrolled on the oramorphine and this would be 50% greater than the equivalent dose. The prescription by Dr Barton of diamorphine in the dose range 20-200mg/24hr was excessively wide and placed patient L at risk of developing respiratory depression and coma if a higher infusion rate had been commenced.

20. I can find no justification in the medical or nursing notes for the prescription and commencement of the midazolam infusion. Patient L was medically stable and transferred for rehabilitation on 20 May when Dr Barton wrote the prescription for midazolam. Midazolam is indicated for terminal restlessness and is also indicated in the Wessex Protocol' for the management of anxiety in a palliative care setting for patients already receiving drugs through a syringe driver. The notes contain no information which suggests patient L was restless or agitated. If patient L had been agitated or restless a clinical assessment was indicated to establish the cause, but there is no evidence in the notes that this occurred.

21. The dose of subcutaneous midazolam prescribed by Dr Barton was in also in my opinion excessively high. Older patients are more susceptible to midazolam and at increased risk of

developing respiratory and central nervous system depression. The Wessex Protocols recommended a dose range of 10-60mg/24hr. In an older patient an appropriate starting dose would have been 10mg/24hr particularly when diamorphine had also been prescribed. The lower dose of 20mg/24hr was inappropriately high and the upper limit of the dose range prescribed 80mg/24hr beyond that recommended. The prescribed dose range of midazolam prescribed particularly in conjunction with the diamorphine prescribed placed Patient L at high risk of developing life threatening complications.

22. On the morning of 22 May, a Saturday, the on call doctor Dr Beasley was contacted because patient L had deteriorated and was experiencing increasing secretions from her chest and airways. Ideally a clinical assessment should have taken place at this time point and the cause of the deterioration and possible contributory role of the drugs she was receiving considered. However if Dr Beasley had been told by ward nursing staff that patient L had been assessed by the medical team and was terminally ill, and for palliative care I would not consider there was a duty of care for Dr Beasley to visit Daedalus ward and assess patient L unless the nursing staff had very clearly requested this.

23. In my opinion the subsequent deterioration in Patient L on 21 May until her death the following was very likely due to diamorphine and midazolam leading to respiratory depression and coma. However because of the limited detail in the nursing and medical notes and lack of a clinical assessment I cannot exclude the possibility that patient L died from another undiagnosed problem that developed immediately after she was transferred to Daedalus ward.

24. Although patient L had been seriously ill and was not expected to survive 10-14 days prior to her transfer this was not the case when she was transferred to Daedalus ward. Patient L and was not expected to die within a few days or weeks from a progressive non curable condition. I cannot determine from the medical records whether Dr Barton considered patient L had deteriorated and was dying, but if this was her view she should have assessed patient L and discussed the change in her status with the responsible consultant or another senior colleague.

25. Patient L was transferred from Royal Hospital Haslar for rehabilitation and was considered medically stable on the morning of 20 May. Within 24 hours of transfer she was receiving diamorphine and midazolam infusions and died within 48 hours of transfer. This dramatic change in her condition should have led to a detailed medical assessment by Dr Barton, discussion with the consultant responsible for Daedalus ward and the referring medical team but there is no evidence in the notes that any of these took place. The reference in the nursing records to patient L's husband not wishing the medications should shorten her life also indicates he wished appropriate active measures to be taken to enable her to survive.

Summary of Conclusions

26. Patient L was a 73 year old woman with a disabling stroke and recent myocardial infarct transferred to Daedalus ward for stroke rehabilitation. She was considered medically stable for transfer and was not expected to die within a few days unless new complications developed. The information in the notes suggest there was inadequate assessment of patient L by Dr Barton as the doctor responsible for the day to day medical care of the patient with no clinical findings recorded of an assessment of patient L's abdominal pain, or justification for the prescriptions of oramorphine and subcutaneous diamorphine and

midazolam. The prescriptions of subcutaneous infusions of diamorphine and midazolam in the wide dose ranges used were highly risky.

27. In my opinion the combination of diamorphine and midazolam very likely shorten Patient L's life. However the very limited content of the medical notes make it difficult to exclude the possibility that patient L developed a new medical problem on transfer to Daedalus ward that led to her deterioration and death.

28. In my opinion Dr Barton in her care of Patient L failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to consult colleagues;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

29. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....

GARY A FORD

1 May 2009

In reply please quote: VB/2000/2047/02

Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

As you are aware on 11 July 2008 the Interim Orders Panel (IOP) made an order imposing conditions on your registration for a period of 18 months, starting on 11 July 2008. This order was reviewed and maintained by the IOP on 22 December 2008.

I am writing to let you know that the IOP will be reviewing the order made in relation to your registration at its meeting on 26 May 2009. In reviewing the order the IOP is empowered to direct that the order should remain in force, to amend the order or to revoke it.

You are therefore invited to appear before the IOP at **09:30** on **26 May 2009** at the Council's offices at **5th Floor, St James's Buildings, 79 Oxford Street, Manchester M1 6FQ**, if you so wish, to address the IOP on what action they should take in relation to your registration. You may, if you wish, be represented by Counsel, a solicitor, a representative of any professional organisation of which you may be a member or, at the discretion of the IOP, by a member of your family. The IOP is, however, empowered to review the order in relation to your registration irrespective of whether or not you are present or represented.

I attach a copy of the paperwork to be considered by the IOP which begins at page 1 and ends at page 458, for your consideration.

You are invited to submit observations on the case in writing and these will be circulated to the IOP before they consider your case. In particular, you should seek to confirm whether you have complied with conditions imposed on your registration by the Panel and detail any arrangements that you have put in place to affect compliance. 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 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 IOP'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 will you 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
Assistant Registrar
Fitness to Practise Directorate

Enc: Imposing Interim Orders - Guidance for the IOP and the FtP Panel
Investigating concerns factsheet
Employer details form
General Medical Council (Fitness to Practise) Rules 2004
S 41A extract from 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
1 June 2009

Information: Email correspondence regarding re-listing the hearing to I June 2009.

Code A

From: Code A
Sent: 06 May 2009 11:09
To: IOP Team
Subject: FW: Code A IOP Hearing - Date Change
Follow Up Flag: Follow up
Flag Status: Red

From: Code A [mailto: Code A
Sent: 06 May 2009 11:08
To:
Cc: Code A
Subject: RE: Code A - IOP Hearing - Date Change

Dear Code A

Many thanks indeed, and I am grateful to you for facilitating this. Counsel attending will be Code A

Best wishes

Code A

-----Original Message-----
From: Code A Code A Code A
Sent: 06 May 2009 11:03
To: Code A
Cc: Code A
Subject: Code A - IOP Hearing - Date Change

Dear Code A

I am writing to confirm, as per our conversation of this morning, and in response to your request, that Code A IOP hearing will now take place at **10.30** on **1 June 2009**. The hearing will take place at the GMC's London office.

I would be grateful if you could confirm the name of Counsel, who will attend with Code A on 1 June 2009.

Kind regards

Code A

Unless otherwise expressly agreed by the sender of this email, this communication may contain privileged or confidential information which is exempt from disclosure under UK law. This email and its attachments may not be used or disclosed except for the purpose for which it has been sent.

If you are not the addressee or have received this email in error, please do not read, print, re-transmit, store or act in reliance on it or any attachments. Instead, please email the sender and then immediately delete it.

General Medical Council

St James Building, 79 Oxford Street, Manchester, M1 6FQ

Regents Place, 350 Euston Road, London, NW1 3JN

Confidential
Addendum (II)
BARTON

General Medical Council

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Interim Orders Panel
1 June 2009

Information: Letter received from Dr Barton enclosing the Employer Details Form.

LETTER TO GMC FROM DR BARTON

Adam Elliott
Adjudication Section
Regents Place
350 Euston Road
LONDON NW1 3JN
Your ref VB/2000/2047/02

Dr Jane Barton

Code A

Dear Mr Elliott

Interim Orders Panel Hearing 1st June 2009 10.30 .

As you will be aware, I am the subject of a review of an Interim Order from the Interim Orders Panel on **1st June 2009** .
In compliance with condition 1, I write to acknowledge your letter and advise you of the fact that I am a Partner in the Practice at the Forton Medical Surgery, White's Place, Gosport, Hampshire.PO12 3JP.
I am on the HCHC Performers List.
For ease of reference, the contact details of the PCT are as follows:
Hampshire Community Health Care
HCHC HQ
8 Sterne Road
Tatchbury Mount
Calmore
Southampton SO402RZ.
I intend to attend.
I will be represented by my solicitor Mr Ian Barker from the MDU.

Yours Sincerely

Code A

Dr Jane Barton

General Medical Council

Employer Details Form

FPD Reference Number: 2000/2047/02
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 Community Healthcare 8 Sterne Road Tatchbury Mount Calmore Southampton SO40 2RZ	Mr Gareth Cuddihe	General Practitioner	1-4-80 — current

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
NA	

7) Please indicate which employer you were working for in respect of the complaint which we are considering.

Portsmouth Health Care Trust

Declaration: I have provided the GMC with details of my current employment as required. I confirm that I have given this information truthfully and in good faith.

Name (please print) J A BARROW **Date of Birth** Code A

Signature Code A **Date** 6-5-09

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Addendum (III)
BARTON

General Medical Council

Regulating doctors
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Interim Orders Panel
1 June 2009

Information: Letter notifying Dr Barton that a FTP Hearing has been scheduled for 8 June 2009.

5 May 2009

In reply please quote: BO'S/55-900722
Reference number: 1587920

Royal Mail Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

Notice of Hearing

Notice is hereby given to you that in consequence of information received by us a hearing is to be held into the following allegation against you,

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

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

'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 5mg 5 times daily, as well as Diamorphine with a dose range of 40 - 80 mg over a twentyfour hour period to be administered subcutaneously ("SC") on a continuing daily basis,

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

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

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

vi. on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

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

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

ii. the dose range was too wide,

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

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

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

e. Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and vi. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient A;

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

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

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

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

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

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

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

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 3.a. 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 colleague 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;

'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 twentyfour hour period on a continuing daily basis,

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

i. the dose range of Diamorphine and Midazolam was too wide,

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 4.a. ii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of your patient;

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

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

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

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient D;

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

ii. on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required),

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

b. In relation to your prescription for drugs described in paragraph 6.a.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 6.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient E;

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

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

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

b. In relation to your prescription for drugs described in paragraph 7.a.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 7.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient F;

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

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

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

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

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient G,

d. You did not obtain the advice of a colleague when Patient G's condition deteriorated;

'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 as a result of alcoholism and other medical conditions,

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

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

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

b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was,

i inappropriate,

ii. potentially hazardous,

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

iv. not in the best interests of Patient H,

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

i. the dose range was too wide,

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

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

i. inappropriate,

ii. potentially hazardous,

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

e. You did not obtain the advice of a colleague when Patient H's condition deteriorated;

'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 1999 you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis,

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

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

i. inadequate,

ii. not in the best interests of Patient I,

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

i. the dose range was too wide,

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 10.a. 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 10.a. iii. was excessive to Patient I's needs. This was,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I;

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

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 1999 you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

vi. on 26 August 1999 you also prescribed Oramorphine 20 mg at night'

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

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

ii. the dose range was too wide,

iii. 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 11.a. 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 11.a. iv. was,

i. inappropriate,

ii. not in the best interests of Patient J;

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

ii. on admission you prescribed Morphine solution 10mg in 5 ml as required,

iii. on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch,

iv. on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis,

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

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

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

ii. the dose range was too wide,

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

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

i inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient K,

e. You did not obtain the advice of a colleague when Patient K's condition deteriorated;

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

ii. on 20 May 1999 you prescribed,

a. Oramorphine 10 mgs in 5 mls 2.5-5mls,

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 4 times a day and 20 mgs nocte (at night) 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. In relation to your prescription for drugs described in paragraph 13.a.ii and/or iii.,

i. there was insufficient clinical justification for such prescriptions,

ii. the dose range of Diamorphine and Midazolam was too wide,

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

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

a. Inappropriate,

b. Potentially hazardous,

c. Not in the best interests of patient L,

c. You did not obtain the advice of a colleague when Patient L's condition deteriorated;

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

i. the findings upon each examination,

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, K and/or L were,

i. inappropriate,

ii. not in the best interests of your patients;

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

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

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

Notice is further given to you that **at 09:30 on 8 June 2009 a Fitness to Practise Panel hearing will be held at the offices of the General Medical Council on the Third Floor at Regents Place, 350 Euston Road, London NW1 3JN** to consider the allegation against you and to determine whether or not to direct the Registrar to erase your name from the Register, or to suspend your registration therein, or to impose conditions on your

registration pursuant to Section 35 of the Medical Act 1983, as amended (the Medical Act). The hearing is expected to last 56 days. Please attend at **09:00** on the first day of the hearing.

As you may be aware, cases referred for adjudication prior to 1 November 2004 but heard on or after that date, such as yours, will be considered by a Fitness to Practise Panel applying the old rules and procedures. Your case will therefore be heard before the FTP Panel which will apply at the hearing the General medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 rules (the Rules), which relate to the proceedings of the Professional Conduct Committee. I enclose a copy of the Rules.

If the Fitness to Practise Panel (the Panel) makes a finding of serious professional misconduct and goes on to direct that your name shall be erased or suspended from the Register under Section 35 of the Medical Act, then the Panel may also consider making an order under Section 38 for the immediate suspension of your registration.

You should be aware that if the Panel is unable to conclude its consideration of your case, or considers it necessary to adjourn proceedings for any reason, Section 41A of the Medical Act confers upon the Panel the power to place an interim order on your registration. This means that, if the Panel is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or in your own interest, the Panel may make an order suspending your registration, or placing conditions upon your registration, until such time as it is able to conclude your case. Any such order would be reviewed after six months, and at regular intervals thereafter, as set out in Section 41A(2).

You are hereby invited to appear before the Panel at the place and time specified above, for the purpose of answering the allegation. You may appear in person or by counsel or solicitor, or by any officer or member of any professional organisation of which you are a member, or by any member of your family. The Panel has the power, if you do not appear, to hear and decide upon the said charge in your absence.

Any answer, admission, or other statement or communication, which you may desire to make with respect to the said charge, should be addressed to the GMC's Solicitors:

Sarah Ellson & Rachel Cooper
Field Fisher Waterhouse LLP
35 Vine Street
London EC3N 2AA

If you wish to make any application that the inquiry should be postponed, you should send the application to us as soon as possible, stating the grounds on which you desire a postponement. Any such application will be considered in accordance with Rule 18 of the Rules.

If you are proposing to produce any patient identifiable information at the hearing we would remind you of our guidance: Confidentiality: protecting and providing information. The Panel will expect either explicit consent to have been obtained for the production of the medical records or in the alternative, such information must be completely anonymised.

I also enclose a copy of the current Indicative Sanctions Guidance for the Panel. This guidance will be referred to by the GMC once a case reaches the appropriate stage. It will similarly be open to doctors and their representatives to make submissions which refer to it.

Also enclosed is an information sheet detailing your right of appeal if the Panel makes a finding against you, and summarising the powers of the Council for Healthcare Regulatory Excellence in such cases.

Yours sincerely

Code A
Assistant Registrar
Fitness to Practise Directorate

Enc: Patient Schedule
Indicative Sanctions Guidance 2009
General medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988
Schedule 2, Article 16(2) – Transitional Provisions
Right of Appeal/CHRE Information Sheet

Copy Mr Ian Barker, The MDU, 230 Blackfriars Road, London SE1 8PJ

Sarah Ellson & Rachel Copoper, Field Fisher Waterhouse

Code A Investigation Officer

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR JANE BARTON

Patient Schedule

Patient A	-	Leslie Pittock
Patient B	-	Elsie Lavender
Patient C	-	Eva Page
Patient D	-	Alice Wilkie
Patient E	-	Gladys Richards
Patient F	-	Ruby Lake
Patient G	-	Arthur Cunningham
Patient H	-	Robert Wilson
Patient I	-	Enid Spurgin
Patient J	-	Geoffrey Packman
Patient K	-	Elsie Devine
Patient L	-	Jean Stevens

Confidential
Addendum (IV)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
1 June 2009

Information: Correspondence received from the MDU enclosing a letter from Mr Neil Hardy, NHS Hampshire.

THE MDU

MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

www.the-mdu.com

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

Mr Adam Elliott
Adjudication Section
General Medical Council
Regent's Place
350 Euston Road
London NW1 3JN

Please quote our reference in your reply
Our ref:
Your ref: Code A
Date: 22nd May 2009

By Fax to: Code A

Dear Mr Elliott

DR JANE BARTON – INTERIM ORDERS PANEL HEARING – 1ST JUNE 2009

I write with reference to the forthcoming hearing before the Interim Orders Panel. As you know, I act for Dr Barton.

Dr Barton is presently subject to conditions upon her registration. The fifth condition is that she must not prescribe Diamorphine and must restrict her prescribing of Diazepam in line with BNF guidance. The sixth condition is that she must provide evidence of her compliance with that preceding condition to the GMC prior to any review hearing of the IOP.

In compliance with that sixth condition, I have pleasure in enclosing a copy of a letter from Mr Neil Hardy, Head of Medicines Management at NHS Hampshire, dated 13th May 2009. This letter is in a similar form to previous letters which have been supplied from Hazel Bagshaw of the Hampshire NHS Primary Care Trust. Ms Bagshaw having retired, Mr Hardy has taken her place, and has been pleased to provide the requisite information to assist.

Please do let me know if I can help with any further information.

Yours sincerely,

Code A

MDU Services Limited (MDUSL) is authorised and regulated by the Financial Services Authority in respect of insurance mediation activities only. MDUSL is an agent for The Medical Defence Union Limited (the MDU). The MDU is not an insurance company. The benefits of membership of the MDU are all discretionary and are subject to the Memorandum and Articles of Association

NHS
Hampshire
Medicines Management Team
Omega House
112 Southampton Road
Eastleigh
SO50 5PB

Direct Dial: Code A
Facsimile:
Website: www.hampshirepct.nhs.uk
Email Address: Code A

Our Ref: NH/CS

Date: 13 May 2009

Mr I Barker
The Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Ian

Re: **Dr Jane Barton**

As requested I am happy to confirm that the PCT continues to monitor Dr Barton's prescribing using data from the Prescription Pricing Division of the NHS Business Services Agency. We also have regular meetings with Dr Barton to discuss the data. This monitoring includes regular analysis of prescribing data, both for Dr Barton as an individual prescriber and for the Practice. Where appropriate, individual prescriptions are recalled for confirmation of the prescriber's signature.

I am happy to confirm that Dr Barton has maintained her compliance with the agreement which has been in place with this, and predecessor, PCTs since October 2002. The agreement with the PCT is that Dr Barton will not prescribe Diamorphine and will restrict her prescribing of Diazepam in line with BNF guidance. I appreciate that this mirrors a condition imposed upon Dr Barton by the General Medical Council in July 2008. I have continued to monitor the position with reference to Dr Barton's prescribing and I am happy that she has complied with the condition and PCT agreement.

If you would like to discuss this further please do not hesitate to contact me.

Best wishes.

Yours sincerely

Neil Hardy
Head of Medicines Management

Confidential
Addendum (V)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
1 June 2009

Information: - Report on Patient A by Professor Gary Ford.

General Medical Council and Dr Jane Barton
Report on Mr Lesley Pittock (Patient A)

Professor Gary A Ford, FRCP
Consultant Physician

13 May 2009

General Medical Council and Dr Jane Barton
Report on Patient A

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC panel in determining whether Dr Barton has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that Dr Barton prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; and that Dr Barton's prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2. Code A

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient A; statement of Dr Jane Barton re Patient A; witness statements of Lynda Wiles, Dr Jane Tandy, Tina Douglas, Dr Victoria Banks, Freda Shaw, Lynn Barrett, Gillian Hamblin, Dr Althea Lord, Fiona Walker; statement made by Dr Barton in relation to Patient A, interview of Dr Barton dated 23 March 2005.

5. Course of events.

5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152) and died on 24 January 1996. His past medical history was notable for recurrent depression which had been treated with electro convulsive therapy

1992. He was admitted under the care of Dr Banks consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.

5.2 Patient A was admitted under Dr Banks' care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December the notes record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated with antibiotics. On the 27 December the notes record (p66) a ward round by Dr Banks and that Patient A was *"chesty, poorly, abusive, not himself at all'*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

5.3 On 2 January a referral was made by Dr Bank's team to Dr Lord consultant geriatrician (page 67) states *'his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die'*. The referral says *"this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health"*.

5.4 On the 3 January on a ward round by Dr Banks the notes record that Patient A *"needs more time to convalesce"* and that he would probably need a nursing home. On the 4 January the notes record Patient A was seen by Dr Lord (page 68). Dr Lord noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) Dr Lord states that his prognosis is poor and that she understood Patient A's wife was aware of the poor prognosis. The nursing records on the psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.

5.5 On the 5 January (page 196) an entry by Dr Barton in the medical notes at Gosport War Memorial Hospital states *'Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L ankle, both heels suspect. Catheterised. Transfers with hoist. May help*

to feed himself, long standing depression on lithium and sertraline'. The next entry in the medical notes is on the 9 January by Dr Barton and states *'Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation? sufficient diazepam ? needs opiates.'*

5.6 On Friday 10 January an entry by Dr Tandy states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w wife – agrees .....(illegible)..... TLC'*. The next entry in the medical notes dated 18 January is by Dr Barton and states *'Further deterioration, sc analgesia continues, difficulty controlling symptoms try Nozinan.*

5.7 The next entry in the medical notes is dated 20 January (p198) and is unsigned but as it refers to a verbal order is likely to be by a member of nursing staff. *Has been unsettled on haloperidol in syringe driver. diamorphine (illegible) to higher dose (illegible words), Nozinan 50mg to 100m in 24 hrs (verbal order)*. There is an entry the following day dated 21 January 1996 (signature unclear) *'much more settled, quiet breathing, respiratory rate 6 / minute, not distressed continue'*. There is an entry in the notes on 24 January 1996 confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.

5.8 Nursing assessment on the 5 January at Gosport on Dryad ward records Patient A had a poor physical condition with broken pressure areas to his buttocks and hips, and broken skin on his scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).

5.9 An entry in the nursing notes on the 10 January states *'condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on oramorph 4 hourly this evening'*. A nursing entry on the 15 January states *'Seen by Dr Barton has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug'*. A second entry that day states his daughter was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet.

5.10 On the 16 January the nursing notes record *'Condition remains very poor, some agitation was noticed when being attended to. Seen by Dr Barton haloperidol 5-10mg to be added to the driver'*. An entry later that day at 1300h states *'previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly'*. There was a note to nurse him on his back and left side only.

5.11 An entry in the nursing note on 17 January indicates Patient A was seen by Dr Barton and that his medication was increased as he remained *'tense and agitated, chest very "bubbly"'*. On the same day at 1430h the nursing notes record Patient A was again seen by Dr Barton (page 210) his medication reviewed and altered, and that his syringe driver

renewed at 15:30 with two drivers. The nursing records note at 2030h that he had deteriorated further but appeared more settled.

5.12 An entry on the 18 January in the nursing notes record that he appears comfortable. On 19 January *'marked deterioration in already poor condition'* is reported (page 211). Over the next 3 days the notes record he is settled and that an infusion of diamorphine, midazolam, levomepromazine (Nozinan), haloperidol and hyoscine was continuing.

5.13 An entry in the medical notes dated 20 January records Patient A was unsettled and that the dose of levomepromazine (Nozinan) was to be increased from 50mg/24hr to 100mg/24hr (page 198). The nursing notes (page 211) record that Dr Brigg gave a verbal order to double the levomepromazine (Nozinan) and omit haloperidol.

5.14 The drug charts indicate on the 5 January that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195). There is an undated prescription by Dr Barton (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear when this prescription was written by Dr Barton. Regular oramorph (5mg 5 times a day) was prescribed on 10 January. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January a further prescription is written by Dr Barton for oramorphine 2.5ml (5mg) 4 times daily with 5ml (10mg) at 2000h and this dose regimen of morphine is given until the morning of 15 January with a last dose administered at 0600h with Patient A receiving a total of 30mg morphine daily (page 202).

5.15 On 11 January Dr Barton prescribed diamorphine 80-120mg/24hr subcutaneous, hyoscine 200-400ug/24hr, midazolam 40-80mg/24hr, and diamorphine 80mg/24hr, hyoscine 400ug/24hr, midazolam 60mg/24hr were then commenced on 15 January and the oramorphine discontinued.

5.16 On 16 January, haloperidol 5-10mg/24hr was prescribed by Dr Barton. Haloperidol was administered on the 16 January (5mg/24hr) and 17 January (10mg/24hr) in addition to the continuing infusions of diamorphine and midazolam. There is a prescription dated 18 January by Dr Barton where the doses of drugs were increased to diamorphine 120mg/24hr, midazolam 80mg/24hr, hyoscine 1200ucg/24hr, and haloperidol 20mg/24hr. These were administered from 17 January onwards, until Patient A's death with the exception of haloperidol which was stopped on 20 January. It is unclear if this prescription was incorrectly dated by Dr Barton and was written on 17 January.

5.17 On 18 January Nozinan 50mg/24hr was prescribed by Dr Barton and commenced that day. The dose of Nozinan was the then increased to 100mg/24hr on 20 January with a verbal prescription from Dr Brigg,

who I assume was the on call doctor. An entry in the nursing notes on 20 January (page 211) states *'verbal order taken to double nozinan and omit haloperidol'.*

5.18 There is a prescription for diamorphine 120mg/24hr and hyoscine 600ug/24hr dated 18 January although the nursing entries on the drug chart suggest these were administered on 17 January.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 189-191 and 199-204
All prescriptions written by Dr Barton unless otherwise marked.

Regular Prescriptions
Page 199 (5-10 Jan) and page 202 (11 Jan onwards)

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)
Thyroxine 50ucg od	5 Jan - 15 Jan (dose not administered after 15 Jan)
Illegible prescription	*tick mark 7 Jan*
Arthrotec one tab bd	8 Jan - 10 Jan (discontinued after 0900 10 Jan)

Page 200

Oramorph (10mg/5ml) 5mg nocte	10 Jan 5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan One 5mg dose

Page 202

Oramorph (10mg/5ml) 10 mg nocte	11 Jan Three 5 mg doses
	11 Jan 10mg nocte
	12 Jan Four 5 mg doses
	12 Jan 10mg nocte
	13 Jan Four 5mg doses
	13 Jan 10mg nocte
	14 Jan Four 5 mg doses
	14 Jan 10mg nocte
	15 Jan one 5mg dose then discontinued

Page 200

Diamorphine subcut via syringe driver 40-? mg/24hr Prescription date not marked	None administered
Hyoscine subcut via syringe driver 200-400ucg/24hr	None administered

Prescription date not marked

Midazolam subcut via syringe driver 20-40mg/24hr Prescription date not marked	None administered
Page 203 Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan 0830h
Hyoscine subcut via syringe driver 600ucg/24hr Prescribed 18 Jan	17 Jan 0827h
Haloperidol subcut via syringe driver 5-10mg/24hr Prescribed 16 Jan	16 Jan ? h 5mg/24hr 17 Jan 08??h 10 mg/24hr
Page 190 Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan 1530h 18 Jan 1615h 19 Jan 1500h 20 Jan Entry crossed out 20Jan 1800h 21 Jan 1745h 22 Jan 1515h 23 Jan 1505h
Midazolam subcut via syringe driver 80mg/24hr Prescribed 18 Jan	17 Jan ?h 18 Jan 1615h 19 Jan 1500h 20 Jan Entry crossed out 20 Jan 1800h 21 Jan 1745h 22 Jan 1515h 23 Jan 1805h
Hyoscine subcut via syringe driver 1200ucg/24hr Prescribed 18 Jan	17 Jan ?h 18 Jan 1615h 19 Jan 1500h 20 Jan Entry crossed out 20 Jan 1800h 21 Jan 1745h 22 Jan 1515h 23 Jan 1500h
Haloperidol subcut via syringe driver 20mg/24hr Prescribed 18 Jan	17 Jan ?h 18 Jan 1605h 19 Jan 1800h

	20 Jan	Entry crossed out.
Discontinued		
Nozinan subcut 100mg/24hr Prescribed 22 Jan	23 Jan	1500h

As required prescriptions

Page 201

Diamorphine subcut via syringe driver 80-120mg/24hr Prescribed 11 Jan	15 Jan	?h	80mg/24hr
	16 Jan	?h	80mg/24hr
	17 Jan	?h	80mg/24hr
Hyoscine subcut via syringe driver ucg/24hr 200-400 ucg/24hr Prescribed 11 Jan	15 Jan	0825h	400
	16 Jan	0825h	400 ucg/24hr
	17 Jan	?h	400 ucg/24hr
Midazolam subcut via syringe driver 40-80mg/24hr Prescribed 11 Jan	15 Jan	?h	60mg/24hr
	16 Jan	?h	60mg/24hr
	17 Jan	?h	60 mg/24hr
	18 Jan	0825h	60 mg/24hr
Midazolam subcut via syringe driver 80mg/24hr Prescribed 16 Jan	None administered		

Page 189

Nozinan subcut via syringe driver 50mg/24hr Prescribed 18 Jan	18 Jan	?h
	19 Jan	?h
Nozinan subcut via syringe driver 100mg/24hr Prescribed verbal order Dr Brigg 1720h	20 Jan	?h
	21 Jan	1745h
	22 Jan	1615h

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction, and had become immobile with malnutrition and bedsores. Dr Lord's assessment indicates he was very ill and would possibly not survive to leave hospital. Dr Lord appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and

unstable enough that he should continue to be managed in a continuing care bed.

8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by Dr Barton at regular intervals during this period. On admission Dr Barton summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether Dr Barton considered Patient A was for palliative care only.

9. The previous assessment by Dr Lord and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with Dr Tandy as the responsible consultant. Day to day medical care was the responsibility of Dr Barton and during out of hours the on call doctors.

10. Despite the limited medical documentation the decision of Dr Barton to prescribe 5mg of oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates Dr Tandy considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.

11. I consider the discontinuation of sertaline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.

12. In my opinion the prescription by Dr Barton on 11 January of subcutaneous diamorphine 80-120mg/24hr and midazolam 40-80mg/24hr, was poor practice, potentially very hazardous and not consistent with good medical practice. The lower dose range of 80mg/24hr diamorphine was inappropriately high. The subcutaneous diamorphine prescribed on 11 January was not justified by information recorded in the notes. Patient A was receiving 30mg oral morphine/24 hour on 14 January. The equivalent dose of subcutaneous diamorphine would have been 15-20mg/24hr. The

prescription of diamorphine 80-120mg/24hr meant the minimum 80mg/24hr dose was a four-fold increase in the equivalent opioid dose he had been receiving. An appropriate dose to commence with if a diamorphine infusion had been justified would have been 15-20mg/24hr and up to 30mg/hr if Patient A was showing signs of still being in pain.

13. The prescribed dose of midazolam of 40-80mg/24hr was excessively high and the notes contain no entry from Dr Barton justifying such a high starting dose. An appropriate starting dose in a frail older man if a subcutaneous infusion had been indicated would have been 10mg/24hr particularly when a diamorphine infusion was also being administered. The prescription of large dose ranges of these drugs in the absence of a clear protocol understood by all nursing staff indicating the symptoms that should lead to the administration of the drugs, doses to be used and monitoring undertaken, placed Patient D at high risk of being administered an inappropriately high dose of opiate.

14. The prescriptions of diamorphine and midazolam on the 11 January carried a high risk of producing respiratory depression and/or coma.

15. The change on 15 January from regular oral doses of morphine to syringe driver subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion not justified by any information recorded in the medical notes. The nursing notes suggest Patient A was agitated at times but there is no record that he was in pain. The medical records contain no information that justifies the need to change from oral morphine to subcutaneous diamorphine infusion. However Patient A's fluid intake was poor and the decision to administer an opioid drug by the subcutaneous drugs route appropriate if he was having difficulty taking regular oral medication. The administration of diamorphine 80mg/24hr with midazolam 60 mg/24hr on 15 January carried a very high risk of producing respiratory depression and/or coma and the notes suggest Patient A's condition deteriorated after these were commenced.

16. It would have been appropriate for Dr Barton to perform a clinical assessment on 15 January prior to prescribing subcutaneous diamorphine and midazolam but there is no evidence in the notes that this took place. Dr Barton does not appear to have considered the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think Dr Barton need necessarily have discussed Patient A's problems with the consultant Dr Tandy but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam and hyoscine on 11 January when Patient A was able to swallow.

17. The medical notes contain no justification for the prescription by Dr Barton of haloperidol on 16 January of 5-10mg/24hr. The nursing notes record Patient A was agitated. In my opinion this should have led to a medical

assessment by Dr Barton to assess the cause of is agitation but the medical records do not suggest this occurred. No rational is recorded in the notes by Dr Barton for the prescription of Haloperidol in addition to midazolam.

18. On 17 January the drug chart is difficult to interpret. The administered doses of diamorphine, midazolam and haloperidol were all increased; diamorphine from 80 to 120mg/24hr, midazolam from 60 to 80 mg/24hr and haloperidol from 10-20mg/24h. Patient A received an 'as required' infusion of diamorphine 80mg/24hr under the 11 January prescription by Dr Barton. There is a further prescriptions by Dr Barton dated 17 January of regular diamorphine 120mg/24hr which was administered (page 203). Confusingly there is another prescription dated 18 January for a for regular diamorphine 120 mg/24hr infusion which is administered at 1530h (page 190).

19. There are a number of possible explanations for the administration of drugs before the prescribed date but I consider the most likely explanation is that Dr Barton misdated the prescription and wrote it on 17 December intending the drugs be administered that day. This is supported by a statement in the nursing notes (page 210) dated 17 January 1430h that states *'s/b Dr Barton. Medication reviewed and altered. Syringe driver renewed at 1530'* which equates to the recorded administration time. Similar discrepancies are present for midazolam and haloperidol.

20. In my opinion the entry in the nursing notes that Patient A was 'tense and agitated' does not justify the combined increases in diamorphine (50%; 80 to 120mg/24h), midazolam (33%; 60 to 80mg/24hr) and haloperidol (400%; 5 to 20 mg/24hr). There was a further prescription of diamorphine by Dr Barton for 120mg/24hr although this dose could have been administered under the existing 11 January as required prescription. I do not understand why a prescription for 120mg/24hr diamorphine appears to have been written twice that day. The prescribing by Dr Barton was in my opinion extremely hazardous not only due to the increased doses of all three drugs which carried a high risk of producing respiratory depression and coma if administered but also because Dr Barton left three active prescriptions for diamorphine, two of which were regular prescriptions (page 202 and 201) and did not cross out and discontinue two of these prescriptions. This was in my opinion extremely hazardous as it could have led to nursing staff administering two possibly three infusions of diamorphine to Patient A who would have received a total dose of 240mg/24hr diamorphine if these were administered as regular prescriptions.

21. Similarly there were two active prescriptions by Dr Barton for the regular administration of haloperidol (pages 190 and 203) which was hazardous and put Patient A at risk of developing coma had both been administered. The risk also existed for midazolam to be administered from two active prescriptions (page 201) although these were 'as required' prescriptions. In my opinion the drug chart prescribing by Dr Barton was confusing, not consistent with good medical practice and could have easily been misinterpreted by nursing staff. There were no instructions recorded in the medical records by Dr Barton or nursing staff concerning

the maximum dose of diamorphine, midazolam or haloperidol that was to be administered to Patient A. There was also the possibility that the undated prescriptions (page 200) for diamorphine and midazolam could have been administered in addition to the above.

22. On 18 January Dr Barton prescribed levomepromazine (Nozinan), a more sedating neuroleptic drug that is used for treating terminal restlessness and agitation. Dr Barton recorded in the medical notes that there was difficulty controlling Patient A's symptoms but does not state what symptoms these are. The failure to document which symptoms were not controlled is not optimal but would appear to suggest that Patient A experiencing agitation or other symptoms. The nursing records contain no information suggesting Patient A was agitated or restless on 18 January but record that he was deteriorating but comfortable. Whilst it would be a reasonable course of action if Patient A had been agitated and restless to substitute levomepromazine for haloperidol, I consider the prescription of two neuroleptic drugs, haloperidol and levomepromazine, in addition to midazolam and diamorphine carried a high risk of producing coma and respiratory depression. Overall I consider the prescribing of levomepromazine was not consistent with good medical practice because the notes do not suggest a sufficiently detailed medical assessment was performed and the prescription of levomepromazine in addition to the other drugs was hazardous.

23. On 20 January Dr Brigg who I assume was the on call doctor was contacted as Patient A was agitated. He did not assess the patient but increased the levomepromazine and discontinued the haloperidol. I would consider this was reasonable action to take and avoided the potential interaction of using two neuroleptic drugs. Unless nursing staff specifically requested Dr Brigg come and assess the patient I would not consider he or she should have attended the ward and assessed Patient A.

24. In my opinion the infusions of diamorphine, midazolam and haloperidol and then levomepromazine (Nozinan), very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs.

Summary of Conclusions

25. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by Dr Barton as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam.

The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. The prescribing of diamorphine and haloperidol on 17 January was hazardous as more than one regular prescription for both these drugs was active on the drug chart. There was no clear justification in the medical or nursing notes for the prescription of levomepromazine (Nozinan) by Dr Barton.

26. In my opinion Dr Barton in her care of Patient A failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

27. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

.....
GARY A FORD

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL

Monday 1 June 2009

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

Chairman: DR ANANTA KIDAMBI

Panel Members: DR EVE MILLER
MR ROGER THOMPSON

Legal Assessor: MR KEITH BROWN

Case of

BARTON, Jane Ann

IN PUBLIC

MR MARIOS LAMBIS, Counsel, instructed by the GMC Legal Team, appeared on behalf of the Council.

MR ALAN JENKINS, Counsel, instructed by Medical Defence Union, appeared on behalf of the doctor

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THE CHAIRMAN: We will now proceed with the case of Dr Barton. Dr Barton is present and is represented by Mr Alan Jenkins, Counsel, instructed by the Medical Defence Union. Mr Marios Lambis, Counsel, instructed by GMC Legal is representing the General Medical Council. Dr Barton, can you first of all give us your full name and your registration number, please?

DR BARTON: My name is Dr Jane Ann Barton, and my registration number is 1587920.

THE CHAIRMAN: Thank you very much. I take it that the person sitting at the back of your room is your husband who was previously present.

DR BARTON: Yes.

THE CHAIRMAN: Mr Lambis, would you like to proceed?

MR LAMBIS: Thank you, Sir. Sir, this is a review case of fitness to practise with, as you will have no doubt gleaned from the papers, a long and detailed history. In my respectful submission, however, the two most relevant issues in respect of this review are the two IOP appearances that have already taken place, the first being on 11 July 2008, when the doctor was present and represented by Timothy Langdale, QC, and the Council was represented by Mr Brassington, whose detailed and lengthy opening you will have seen appears between page 297 to 309 of your bundles, and most recently on 22 December 2008, when the doctor again was present and was represented by my learned friend, Mr Jenkins, again. Again Mr Brassington appeared on behalf of the Council and whose opening appears at pages 347 to 349. Rather than repeat those openings and the background facts that gave rise to them, may I adopt them for the purposes of today's hearing, and simply say this, that for reasons that will become self evident in a moment I intend to take the matter fairly swiftly because, as you will have seen, perhaps the other significant issue is that from a practical reality this doctor's fitness to practise panel hearing is scheduled to take place next week on 8 June.

In very brief form you will recall that the case involves the alleged inappropriate prescribing to patients at Gosport War Memorial Hospital between February 1996 and October 1998. The patients' ages ranged between 67 and 92. It is said that all died at the hospital where Dr Barton at the material time was a clinical assistant in Elderly Medicine. At the hearing on 11 July 2008 and indeed at the review on 22 December you will have seen that the Panel imposed conditions. I say at the outset that notwithstanding material that has come to light which forms part of the addendum which you have before you today, the Council does not seek to persuade you to change that order. In other words, we simply invite you to maintain the *status quo* until such time as the fitness to practise panel hearing takes place.

You will have seen that the substantive case was due to be heard in fact in September of last year but it was postponed pending the outcome, as you will have seen from your reading of the papers, of the Coroner's inquest into the deaths of ten patients at that hospital to which I have alluded to, eight of which are the subject of the FTP hearing.

That inquest was listed for 18 March 2009 and consequently the FTP hearing has been listed, as I say, on 8 June, next week. It is expected to last 55 days.

From pages 358 it 363 you will have seen the transcripts of the verdicts of the inquests delivered on 20 April of this year and no doubt you will have noted that in three out of the ten cases considered, the jury, in respect of three of the patients, gave the verdict that the medication was inappropriate for the condition and symptoms and that its administration had potentially contributed more than minimally or negligibly to the death of the deceased. That is set out at your page 361.

As I say, you will have seen a further report from Professor Gary Ford. I do not intend to take you through that because, as I say, there is no disagreement between the parties that the present order should remain in place. Therefore, I see very little value in taking up your time to refer you to material which does not change, as it were, the *status quo*. In short, we submit that it remains necessary to maintain the present order of conditions until such time as the fitness to practise panel hearing commences and the issues concerning this practitioner's fitness to practise are resolved. Unless I can be of any further assistance, those are the Council's submissions.

THE CHAIRMAN: No members of the Panel have any questions. Mr Jenkins.

MR JENKINS: Sir, thank you very much. I can be extremely brief. You will know that Dr Barton is a general practitioner and that from 1988 until 2000 she worked as a clinical assistant at the Gosport War Memorial Hospital. She worked there on a limited basis. In your pages, at page 23, there is a letter from the Medical Defence solicitor which sets out a little of the background, and which I do not think I need to repeat to you.

Dr Barton was present at the War Memorial Hospital as often as she could be and was working certainly her full commitment in terms of hours but the hospital was severely under resourced so far as doctors were concerned and, as a result of that, there were shortcomings in the note keeping and some anticipatory prescribing was undertaken, that is patients were prescribed medication in advance of them requiring it. It was done that way because for 23 hours or so out of every 24 there was no doctor anywhere near the ward.

Those matters are gone into in a little more detail in the letter that you have at page 23. What you will know is that a police investigation was started after 2000 and that police investigation, after enormous length and number of cases looked at, the police decided there was no basis for prosecuting anybody for anything. The case has been brought to the interim orders panel, and subsequently to an interim orders panel, on a significant number of occasions. You have in your case summary the full history.

There were four attempts by the General Medical Council to bring this matter before interim orders panels and no order was made on four occasions between 2001 and 2004. You will see again from your case overview, on the second page of it, that in January 2007 the police concluded their investigation, and the Crown Prosecution Service took advice and the case stopped at that point.

It was only when it was known that there was going to be an inquest that the matter was brought again before the GMC and at that time, anticipating perhaps that there would be a lot of publicity, some restrictions were placed on Dr Barton's practice.

What you will know from the papers is that Dr Barton resigned from her clinical assistant post in 2000. She has not treated patients in a hospital setting since that time. In October 2002 she entered a voluntary arrangement with the PCT that she would not prescribe Diamorphine and that she would restrict her prescribing of Diazepam to within BNF guidelines. There are copies of the confirmation of that in the bundle. I know there is a recent letter dated 13 May of this year from Hampshire NHS which confirms that the PCT continues to monitor Dr Barton's prescribing, and I have a letter which confirms that Dr Barton has maintained her compliance with the agreement since 2002, namely that she will not prescribe Diamorphine and that she will restrict her prescribing of Diazepam to within BNF guidelines. I had hoped that would have been included within the bundle. I do not think it has reached you.

MR LAMBIS: Page 487.

MR JENKINS: Thank you. That confirms, I hope, that Dr Barton is compliant with the arrangement. There is no need to go beyond conditions. We would say that there is no need for conditions at all, but we recognise that there is likely to be some publicity and the GMC has concerns that would go beyond mere clinical practice. In those circumstances I would not resist the continuation of the conditions as they presently stand. It would be wholly wrong to go further than to impose conditions. This doctor has not prescribed Diamorphine for the best part of a decade. Patients are not put at any risk. She is an excellent GP. All the nurses who gave evidence recently at the inquest had only praise for Dr Barton's commitment to patient care and the dedication that she applied when she was working as a clinical assistant.

The evidence that came clearly from the inquest was that there was a considerable lack of resources in terms of doctors' time and Dr Barton was effectively the only doctor there looking after the patients, a significant number of patients, and she had extremely little time in which to deal with them. In those circumstances her note keeping was rather less than she would have wished. The calculations that everyone agreed on at the inquest was that Dr Barton would have about two minutes with each of the 40-odd patients every day, and some of these patients were at the end stage of life. The consultants knew what notes were being kept and what prescribing was being done on the two wards. The nursing staff were all fully aware of what was going on and they understood it. But in those circumstances what I suggest is that you continue the conditions but you should not be going beyond that.

THE CHAIRMAN: Thank you. Members of the Panel, any questions? (No questions) I turn to the Legal Assessor for advice.

THE LEGAL ASSESSOR: Thank you, Chair. I shall be very brief because I know you are an experienced Panel. You are well aware of your powers and responsibilities which you derive from the Medical Act. This is a case where no issue is being taken

with the *status quo*, ie that certain conditions should remain pending the full fitness to practise panel hearing.

I would remind you that you should undertake a comprehensive review of the previous order that has been made. The statutory criteria and the tests you must apply are set out in the previous transcripts that Mr Lambis has pointed you to and the GMC's own guidance imposing interim orders' document published in April 2008. Chairman, unless there is anything else that is all the advice I wish to offer.

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

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

STRANGERS HAVING BEEN READMITTED

DETERMINATION

THE CHAIRMAN: I will now read the determination. Dr Barton, when the Interim Orders Committee considered your case on 21 June 2001 it determined that it was not necessary for the protection of members of the public, in the public interest and in your own interest to make an order on your registration. Your case was reviewed and no order imposed on a further three occasions. On 11 July 2008, the Interim Orders Panel considered it necessary to impose conditions on your registration. The order was reviewed on 22 December 2008 and was maintained.

The Panel has comprehensively reviewed the order today and, in doing so, has considered the information before it previously, the transcripts of the previous hearings and the further information received today, including Mr Lambis' submissions on behalf of the General Medical Council (GMC) and those made by Mr Jenkins on your behalf. The Panel has noted that both Counsel agree that it would be appropriate for the present order for conditions to remain in place pending the

outcome of the Fitness to Practise hearing into your case which is scheduled to begin on 8 June 2009.

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

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

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

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

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

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

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

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

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

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

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

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

e. Your Regional Director of Public Health.

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

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 decided not to proceed with a criminal prosecution. 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. It has also noted the report provided by Dr Gary Ford, dated 21 April 2009, which is among the new material before the Panel today. The Panel has also had regard to the verdict of the Inquest into the deaths of 10 patients concluded on 20 April 2009.

Mr Jenkins drew the Panel's attention to the information before it previously that you entered voluntarily into an agreement with the Fareham and Gosport Healthcare Trust (the Trust) that you would not prescribe Diamorphine and would restrict your prescribing of Diazepam in line with BNF guidance. The Panel has noted the letter dated 13 May 2009 from Mr Neil Hardy, Head of Medicines Management at Hampshire NHS Primary Trust, confirming that the Primary Care Trust continues to monitor your prescribing of benzodiazepines and opioid analgesics since your undertaking to restrict your prescribing of Diazepam and Diamorphine and that you have maintained your compliance with the voluntary agreement.

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. It is satisfied that your remaining in unrestricted practice could seriously undermine the trust that members of the public are entitled to place in the medical profession and its practitioners.

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

The order will be reviewed within six months if the matters are not concluded within that period.

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

That concludes your interim orders hearing. Thank you very much for coming. And, thank you very much, Mr Jenkins.

(The hearing concluded at 11.35 am)

2 June 2009

In reply please quote: NP/CC/H1-253820773
GMC Registration No: 1587920

Please address your reply to the Adjudication Section
Fax Code A

Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

Notification of Further Interim Conditional Registration by the Interim Orders Panel

In pursuance of Section 41A(2) of the Medical Act 1983, as amended (the Act), formal notice is given to you that on 1 June 2009, the Interim Orders Panel (IOP) reviewed the order made on 11 July 2008 imposing conditions on your registration.

You were present at the meeting, and were represented by Mr Alan Jenkins, Counsel, instructed by The Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Panel in your case on 1 June 2009 the Chairman announced the Panel's determination as follows:

> "Dr Barton
>
> When the Interim Orders Committee considered your case on 21 June 2001 it determined that it was not necessary for the protection of members of the public, in the public interest and in your own interest to make an order on your registration. Your case was reviewed and no order imposed on a further three occasions. On 11 July 2008, the Interim Orders Panel considered it necessary to impose conditions on your registration. The order was reviewed on 22 December 2008 and was maintained.
>
> The Panel has comprehensively reviewed the order today and, in doing so, has considered the information before it previously, the transcripts of the previous hearings and the further information received today, including Mr Lambis' submissions on behalf of the General Medical Council (GMC) and those made by Mr Jenkins on your behalf. The Panel has noted that both Counsel agree that it would be appropriate for the present order for conditions to remain in place pending the outcome of the Fitness to Practise hearing into your case which is scheduled to begin on 8 June 2009.
>
> The Panel is satisfied that it continues to be necessary for the protection of members of the public, in the public interest and in your own interests for your

registration to remain subject to conditions. The Panel has therefore directed that for the remainder of the duration of the order your registration should remain subject to the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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 decided not to proceed with a criminal prosecution. 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. It has also noted the report provided by Dr Gary Ford dated 21 April 2009 which is among the new material before the Panel today. The Panel has also had regard to the verdict of the Inquest into the deaths of 10 patients concluded on 20 April 2009.

Mr Jenkins drew the Panel's attention to the information before it previously that you entered voluntarily into an agreement with the Fareham and Gosport Healthcare Trust (the Trust) that you would not prescribe diamorphine and would restrict your prescribing of diazepam in line with BNF guidance. The Panel has noted the letter dated 13 May 2009 from Neil Hardy, Head of Medicines Management at Hampshire NHS Primary Trust confirming that the Primary Care Trust continues to monitor your prescribing of benzodiazepines and opioid analgesics since your undertaking to restrict your prescribing of diazepam and diamorphine and that you have maintained your compliance with the voluntary agreement.

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. It is satisfied that your remaining in unrestricted practice could seriously undermine the trust that members of the public are entitled to place in the medical profession and its practitioners.

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

The order will be reviewed within six months if matters are not concluded within that period.

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

The order imposing conditions upon your registration, made on 11 July 2008, remains in force and will be reviewed in six months in accordance with section 41A(2) of the Act.

It is your responsibility to ensure that you comply fully with the above conditions when undertaking any medical practice. The IOP will expect to receive information relating to your compliance with the conditions at any subsequent review of the interim order.

A copy of this notification has been sent to your solicitors.

Under Section 41A(10) of the Act, the Court may revoke or vary any order made by the IOP. Copies of Section 41A(10) and Section 40(5) of the Act are attached. If you wish to apply to the Court for the order to be revoked or varied you should seek legal advice or contact the Court without delay.

All orders imposed by the Interim Orders Panel are disclosed on our website and to any enquirer via the List of Registered Medical Practitioners. It remains Council policy that confidential information about a doctor's health will not be disclosed.

Please sign and return the green copy of this notification, where indicated, as confirmation that it has been received by you.

Yours sincerely

Christine Challis
Assistant Registrar
Fitness to Practise Directorate

Cc: Mr Ian Barker- The Medical Defence Union, 230 Blackfriars Road, London SE1 8PJ

Enc: Appeals Provision
Appeal Note (IOP)

I have received the original document of which this is a copy on the date shown below.

Signed .....

Date .....

Registration number: 1587920
Reference: NP/CC/H1-253820773

Revised version showing agreed amendments as at 12 June 2009

General Medical Council

Regulating doctors
Ensuring good medical practice

FITNESS TO PRACTISE PANEL HEARING

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

Dr Jane Ann BARTON
GMC Reference Number: 1587920

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

The hearing will commence at 09:30 at:

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

Type of case: New case of serious professional misconduct.

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

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

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

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

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

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

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

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

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

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

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

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

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

ii. the dose range was too wide,

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient A;

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

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

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

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

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient B,

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

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

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

iii. did not provide a plan of treatment,

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

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

i. inadequate,

ii. not in the best interests of Patient B;

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

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of your patient;

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

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient D;

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

ii. on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required), **Admitted and found proved.**

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient E;

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

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

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient F;

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

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

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

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient G,

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

'9. a. i. Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus,

liver disease as a result of alcoholism and other medical conditions, **Admitted and found proved**

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

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

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

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

i inappropriate,

ii. potentially hazardous,

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

iv. not in the best interests of Patient H,

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

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

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

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

i. inappropriate,

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

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

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

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

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

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

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

i. inadequate,

ii. not in the best interests of Patient I,

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

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

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

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

i. inappropriate,

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

iii. not in the best interests of Patient I,

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

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I;

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

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

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

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

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

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

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

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

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

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

c. Your actions in prescribing the drugs described in paragraphs 11.a. ii. and/or v. were,

i. inappropriate,

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

iii. not in the best interests of Patient J,

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

i. inappropriate,

ii. not in the best interests of Patient J;

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

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

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

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

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

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

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

ii. the dose range was too wide,

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

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

i inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient K,

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

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

ii. on 20 May 1999 you prescribed,

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

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

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

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

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

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

i. there was insufficient clinical justification for such prescriptions,

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

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

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

a. Inappropriate,

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

c. Not in the best interests of patient L,

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

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

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

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

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

iv. the drug regime,

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

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

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

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

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

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

patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K **and/or** L,

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

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

Checked: 20 August 2009 (CMC)

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

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

20 August 2009

Dr Barton

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

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

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

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

PART ONE

1. Inappropriate transfers onto Dryad and Daedalus wards

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

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

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

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

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

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

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

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

3. Your dealings with patients' relatives

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

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

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

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

4. 'Happy for nurses to confirm death.'

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

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

5. The role of note-taking in clinical care

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

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

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

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

6. The absence of notes of specific events

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

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

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

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

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

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

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

8. Euphemisms relating to end of life status

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

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

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

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

9. Guidelines and the Analgesic Ladder

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

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

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

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

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

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

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

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

11. Side effects / adverse consequences of opiates

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

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

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

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

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

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

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

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

12. The Diamorphine / Midazolam mix

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

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

13. Prescribing opiates outside the guidelines

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

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

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

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

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

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

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

14. Anticipatory prescribing and the delegation of powers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Syringe Drivers

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

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

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

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

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

16. Syringe drivers and the immediate relief of pain

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

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

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

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

Your response: 'I did.'

17. Titration and the use of syringe drivers

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

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

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

iii. In Professor Ford's view:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19. The role of consultants

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

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

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

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

21. The principle of double effect

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO

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

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

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

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

Head 1 has been admitted and found proved.

Mr Leslie Pittock (Patient A)

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

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

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

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

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

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

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

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

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

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

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

Head 2b iii has been admitted and found proved.

Head 2c has been found not proved.

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

Head 2d has been found proved.

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

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

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

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

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

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

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

Given that the charge relating to the doses of Diamorphine administered on both 15 and 17 January 1996 was not found proved the Panel could not be sure that the prescription was either inappropriate or not in the best interests of Patient A although,

by the nature of the prescription, the Panel did conclude that it was potentially hazardous.

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Elsie Lavender (Patient B)

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

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

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

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

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

Head 3b i in relation to head 3a iv in relation to the Diamorphine has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person prior to issuing this prescription, and that you exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the lowest dose prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Midazolam has been found proved.

In reaching this finding, the Panel has accepted Professor Ford's evidence that Midazolam is not indicated for pain. Further, the Panel reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 x above in relation to the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 3b ii and iii have been admitted and found proved.

Heads 3c i - iii in relation to head 3a ii have been found not proved.

The Panel noted Professor Ford's opinion that the prescription of Morphine Slow Release Tablets (MST) 10 mg twice a day might be acceptable. Accordingly, the Panel could not be sure that this prescription was inappropriate, potentially hazardous and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iii have been found proved.
Head 3c ii in relation to head 3a iii has been admitted and found proved.

On 26 February 1996 you increased the prescription for MST from 10 mg to 20 mg twice a day and prescribed a variable dose combination of Diamorphine and Midazolam on syringe driver. The Panel considers that the increased dose of MST was in itself high. The Panel has noted that at the outset of the hearing you admitted that this

prescription was too wide, potentially hazardous and created a situation whereby drugs could be administered which were excessive to the patient's needs. Further, and having regard to paragraphs 11 – 14 above, in relation to the prescription of opiates, their side-effects and effect in combination with Midazolam, the Panel is satisfied that your actions in issuing this prescription were inappropriate and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iv have been found proved.
Head 3c ii in relation to head 3a iv has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above in relation to prescribing opiates outside the guidelines and the effects of opiates in combination with Midazolam. In addition, you admitted that your prescription for Diamorphine and Midazolam in combination was too wide, was potentially hazardous, and created a situation whereby drugs could be administered which were excessive to the patient's needs. Accordingly the Panel has found that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Head 3d i has been found not proved.

In reaching this finding, the Panel noted Mr Kark's concession in his closing submissions that Professor Ford found no fault with your management of the patient at the time of her admission and that your examination of her was appropriate.

Head 3d ii has been found proved.

The Panel accepted Professor Ford's view that you should have addressed the question of the cause of pain complained of by the patient. Your continuing failure to address the reason why she was experiencing pain rendered your assessment of her, as her condition deteriorated, inadequate.

Head 3d iii has been found not proved.

The Panel has noted that you saw the patient's family on 26 February 1996 and that they were aware of your assessment that she was now on the terminal pathway. Other than this, your clinical notes did not include a treatment plan beyond the need for a Pegasus mattress and analgesia if necessary. Nonetheless, whether adequate or not, there was a treatment plan.

Head 3d iv has been admitted and found proved.

Heads 3e i and ii have been found proved.

In the light of the Panel's multiple findings against you in relation to your management of the patient, the Panel concluded that your actions and omissions were inadequate and not in the patient's best interests.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Eva Page (Patient C)

Heads 4a and b in their entirety have been admitted and found proved.

Heads 4c i and iii have been found proved.
Head 4c ii has been admitted and found proved.

The Panel has had regard to paragraphs 12, 14 x, 16 and 17 above in relation to the combination of Diamorphine and Midazolam and the use of syringe drivers. In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient. The Panel further noted that at the time you made this prescription you had also prescribed a Fentanyl patch.

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

Head 14a iv has been found proved.

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

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

Head 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

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

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

Mrs Alice Wilkie (Patient D)

Heads 5a and b in their entirety have been admitted and found proved.

Heads 5c i and iii have been found proved.
Head 5c ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

Further, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

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

Head 14a iv has been found proved.

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

Heads 14a v and vi have been admitted and found proved.
Heads14b i and ii have been admitted and found proved.

Heads 15a and b have been found proved.

The Panel has received no documentary evidence to indicate that you assessed this opiate naïve patient prior to prescribing opiates. You told the Panel that you could not be sure that you had formally assessed the patient as you might have been away around that time. You told the Panel that on your return to the ward on about 17 August

1998 that "we had mayhem occurring", and that though you might have seen the patient, you would have relied on the verbal reporting of assessments made by nursing staff. It follows that this prescription to an opiate naïve patient was not based on an appropriate assessment by you, and that your failure was not in the patient's best interests.

Mrs Gladys Richards (Patient E)

Heads 6a and b in their entirety have been admitted and found proved.

Heads 6c i – iii in relation to head 6a ii have been found proved.

You conceded that although this patient had experienced an earlier adverse reaction to Morphine, she was effectively opiate naïve on admission to Daedalus ward on 11 August 1998. At this time her pain was being managed by Co-codamol. Accordingly the Panel had regard to paragraphs 9 and 14 ix above as to guidelines and the Analgesic Ladder and the equivalence of doses, and accepted the view of Professor Ford that you should have followed the Analgesic Ladder in prescribing for this patient.

Heads 6c i and iii in relation to head 6a iii have been found proved.
Head 6c ii in relation to head 6a iii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel accepted Professor Ford's view that you should have followed the Analgesic Ladder in prescribing for this patient.

In addition, the Panel noted that you admitted that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Ruby Lake (Patient F)

Heads 7a and b in their entirety have been admitted and found proved.

Head 7c i in relation to head 7a ii has been found not proved.

The Panel noted that you prescribed Oramorphine in response to complaints of pain by an opiate naïve patient. The Panel further noted that it is your view that this was justified as you considered her to be exhibiting symptoms of congestive cardiac failure. In the circumstances, the Panel could not be satisfied that this prescription was inappropriate.

Head 7c ii in relation to head 7a ii has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel noted that by its very nature, any prescription of opiates is potentially hazardous.

Head 7c iii in relation to head 7a ii has been found not proved.

The Panel concluded that the prescription may by its nature be potentially hazardous, but nonetheless in the best interests of the patient, and not inappropriate. That was the case here.

Heads 7c i and iii in relation to head 7a iii have been found proved.
Head 7c ii in relation to head 7a iii has been admitted and found proved.

You admitted that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In the circumstances, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mr Arthur Cunningham (Patient G)

Heads 8a and b have been admitted and found proved.

Heads 8c i and iii in relation to head 8a ii have been found proved.
Head 8c ii in relation to head 8a ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

In addition, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 8c i and iii in relation to head 8a iii have been found proved.
Head 8c ii in relation to head 8a iii has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above as to combining Diamorphine and Midazolam, prescribing opiates outside the guidelines, and anticipatory prescribing, and noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that your actions in prescribing the drugs were potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing these drugs were inappropriate and not in the best interests of the patient.

Head 8d has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mr Robert Wilson (Patient H)

Head 9a in its entirety has been admitted and found proved.

Heads 9b i, ii and iv in relation to head 9a ii have been found proved.
Head 9b iii in relation to head 9a ii has been found not proved.

The Panel noted that this was a prescription for immediate administration, and the Panel had regard to paragraph 13 above with reference to prescribing opiates outside the guidelines. The Panel noted however that the patient's Code A liver disease fundamentally altered the prescribing situation. The Panel accepted Professor Ford's view that "best practice would have been to go through the Analgesic Ladder through a moderate opioid to begin with, with paracetamol ..."

The Panel further accepted Professor Ford's view that, if Oramorphine became appropriate, it would have been important to have started with a low dose, bearing in mind the increased risks the prescription of opiates posed to a patient with alcohol related liver disease.

In all the circumstances the Panel concluded that the prescription at this time was:

- inappropriate;
- potentially hazardous in that it had the potential to lead to serious and harmful consequences for the patient. The Panel was unable to be sure however that the prescription was likely to lead to serious and harmful consequences for the patient;
- not in the best interests of the patient.

Head 9c in its entirety has been admitted and found proved.

Heads 9d i – iii in relation to head 9a ii have been found proved.

The Panel relies on its findings above in relation to heads 9b i – iii.

Heads 9d i and iii in relation to head 9a iii have been found proved.
Head 9d ii in relation to head 9 a iii has been admitted and found proved.

At the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above concerning equivalence of doses, and applying the appropriate conversion rate, noted that the anticipatory prescription did provide for an increase in the lowest level of analgesia, and was therefore too high. The Panel further noted your admissions in relation to your prescription that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drug was potentially hazardous.

Heads 9d i and iii in relation to head 9a iv have been found proved.
Head 9d ii in relation to head 9 a iv has been admitted and found proved.

The Panel concluded that in the light of the patient's alcohol related liver disease the prescription of even a small amount of Midazolam was inappropriate and not in the best interests of the patient, especially given that the patient had already been prescribed a significant dose of Diamorphine. The Panel further noted your admission that your actions in prescribing Midazolam were potentially hazardous.

Head 9e has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Enid Spurgin (Patient I)

Head 10a in its entirety has been admitted and found proved.

Head 10b in its entirety has been found not proved.

The Panel noted that Dr Reid had assessed the patient shortly before her transfer to the ward. The Panel also noted Professor Ford's view that it would not have been necessary for you to investigate the cause of the patient's pain at the time of admission; albeit that he felt such an investigation would have been necessary at a later stage. In the circumstances, the Panel could not be satisfied that your assessment of the patient on admission was either inadequate or not in her best interests.

Head 10c in its entirety has been admitted and found proved.

Heads 10d i and iii in relation to head 10a ii have been found proved.
Head 10d ii in relation to head 10a ii has been admitted and found proved.

In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient.

Heads 10e i – iii in relation to head 10a iii have been found proved.

The Panel had regard to paragraph 13 above relating to prescribing opiates outside the guidelines. However, it noted that when Dr Reid saw this patient on his ward round, he observed that she was over-sedated and that the width of dosage range was too wide. He ordered the dosage of Diamorphine to be reduced by 50%. In the circumstances the Panel was sure that the dosage authorised/directed by you was excessive to the patient's needs and was inappropriate, potentially hazardous and not in the best interests of the patient.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mr Geoffrey Packman (Patient J)

Head 11a in its entirety has been admitted and found proved.

Head 11b i in relation to head 11a v in relation to the Diamorphine has been found not proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. Having regard to paragraph 14 above concerning equivalence of doses, and applying the appropriate conversion rate, the Panel calculated that the anticipatory prescription did not provide for an increase in the equivalent level of analgesia provided for in the existing prescription, and was not therefore too high.

Head 11b i in relation to head 11a v in relation to Midazolam has been found proved.

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

Heads 11b ii and iii have been admitted and found proved.

Heads 11c i – iii in relation to head 11a ii have been found not proved.

Professor Ford was not critical of you for giving verbal permission for 10 mg of Diamorphine to be administered to the patient on 26 August 1999. In his closing submissions, Mr Kark conceded that in the light of Professor Ford's concession in respect of this head, the Panel might think it appropriate that it should fall. The Panel accepted that view.

Heads 11c i and iii in relation to head 11a v have been found proved.
Head 11c ii in relation to head 11a v has been admitted and found proved.

The Panel has found that the lowest dose of Midazolam prescribed was too high, and you have admitted that the dose range of Diamorphine and Midazolam was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drugs was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 11d i and ii in relation to head 11a iv have been found proved.

The Panel had regard to paragraph 2 iv above in relation to investigating the patient's condition. It noted Professor Ford's view that "...there would have to be a clear senior decision in a man like this ... to make a decision not to undertake active intervention for his problem...".

The Panel noted with concern your assertion that it would have made no difference to this patient's care/condition if you had obtained further medical advice and/or undertaken further investigations. In the Panel's view you should have done both before making the decision to put the patient onto the syringe driver. Accordingly, the Panel has concluded that your failure was inappropriate and not in the patient's best interests.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Elsie Devine (Patient K)

Head 12a in its entirety has been admitted and found proved.

Head 12b has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

The Panel noted Professor Ford's view that your prescription was not justified in the light of the patient's presenting symptoms, i.e. confused and agitated but no complaint of pain. The Panel accepted his view that if there were to be an anticipatory prescription for this opiate naïve patient, 2.5 mg would be the appropriate starting dose and 10 mg would be high. In all the circumstances, the Panel concluded that this prescription was not justified.

Head 12c i in relation to head 12a iv has been found proved.

The Panel noted that there had been no attempt at titration, and that even the lowest doses of Diamorphine and Midazolam would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression.

The Panel had regard to paragraphs 11, 13 ii, 16 and 17 above in relation to the side-effects / adverse consequences of opiates, prescribing opiates outside the guidelines, and the use of syringe drivers. The Panel accepted Professor Ford's view that the lowest doses of Diamorphine and Midazolam would have had a profoundly sedating effect, especially in combination with the Fentanyl which was already prescribed. Professor Ford told the Panel that when the syringe driver started the level of Fentanyl already in the patient's blood stream would have been at its peak. The Panel took the view that, as a consequence, this prescription put the patient at severe risk of respiratory depression, coma and premature death. The Panel noted that the patient lapsed into unconsciousness shortly after the syringe driver commenced at 09:25 on 19 November and that she remained unconscious until her death at 20:30 on 21 November.

Head 12c ii in relation to head 12a iv in relation to Diamorphine has been found not proved.

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

Head 12c ii in relation to head 12a iv in relation to Midazolam has been found proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range offended against that principle.

Head 12c iii in relation to head 12a iv has been found proved.

It follows from the Panel's finding that the lowest doses of Diamorphine and Midazolam prescribed were too high that your prescribing created a situation whereby drugs could be administered which were excessive to the patient's needs.

Heads 12d i – iii in relation to head 12a ii have been found proved.

In the light of the Panel's finding that your prescription of Morphine solution was not justified, the Panel concluded that your actions in prescribing it were inappropriate, potentially hazardous (by the very nature of the drug prescribed) and not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iii have been found proved.

The Panel accepted Professor Ford's view that, given the patient's condition, especially her dementia, and the potential side-effects of Fentanyl on such a patient, made it an inappropriate and potentially hazardous prescription which was not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iv have been found proved.

The Panel having found that the lowest doses of Diamorphine and Midazolam prescribed were too high, that the dose range in respect of the Midazolam was too wide, and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that your actions in prescribing these drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 12e has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Mrs Jean Stevens (Patient L)

Head 13a has been admitted in its entirety and found proved.

Head 13b i in relation to head 13a ii has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient had already been receiving low levels of opiates. The Panel had regard to paragraph 14 ix above in relation to equivalence of doses, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of opiates which the patient had already been receiving. Consequently, there was insufficient clinical justification for this prescription of the opiates.

With regard to the anticipatory prescription for Midazolam, the Panel noted Professor Ford's view that there was no clear evidence that the patient was suffering terminal restlessness. Further, the Panel had regard to paragraphs 12 and 14 x above concerning the caution required before prescribing Midazolam for a patient who was already receiving opiates. The Panel concluded that in light of the inherent dangers in prescribing Midazolam in conjunction with opiates, and its acceptance of the view that there was no clear evidence that the patient was suffering from terminal restlessness, there was insufficient clinical justification for the prescription of Midazolam.

Heads 13b ii and iii in relation to head 13a ii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a ii have all been found proved, save for head 13b iv b which in relation to Diamorphine has been admitted and found proved.

You admitted and the Panel found proved that the dose range of Diamorphine and Midazolam was too wide, that the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription of the Diamorphine was potentially hazardous. The Panel further found that there was insufficient clinical justification for the prescriptions. In all the circumstances, the Panel concluded that your actions in prescribing the drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 13b i in relation to head 13a iii has been found proved

The Panel having found that there was no clinical justification for the 20 May prescription of Oramorphine, and there being no evidence of relevant change in the patient's condition at the time of this regular prescription for Oramorphine, it follows that there was insufficient clinical justification for this prescription also.

Heads 13b ii and iii in relation to head 13a iii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a iii have been found proved.

You admitted and the Panel found proved that this prescription created a situation whereby drugs could be administered which were excessive to the patient's needs. The Panel further found that there was insufficient clinical justification for this prescription. In all the circumstances, the Panel concluded that your action in prescribing the Oramorphine was inappropriate, by its nature potentially hazardous, and not in the best interests of the patient.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

PART THREE

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

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

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

6 October 2009

In reply please quote: VB/2000/2047/02

Special Delivery

Dr Jane Barton

Code A

Dear Dr Barton

As you are aware on 11 July 2008 the Interim Orders Panel (IOP) made an order imposing conditions on your registration for a period of 18 months, starting on 11 July 2008. This order was reviewed and maintained by the IOP on 22 December 2008 and 1 June 2009.

I am writing to notify you that the IOP will be reviewing the order made in relation to your registration at its meeting on 3 November 2009. In reviewing the order the IOP is empowered to direct that the order should remain in force, to amend the order or to revoke it. At this hearing the IOP shall in addition to reviewing the order, determine whether it is necessary to direct the Registrar to apply to the court for the order to be extended, in accordance with Rule 27(6) of the GMC's (Fitness to Practise) Rules 2004.

You are therefore invited to appear before the IOP at **10:00** on **3 November 2009** at the Council's offices at **5th Floor, St James's Buildings, 79 Oxford Street, Manchester M1 6FQ**, if you so wish, to address the IOP on what action they should take in relation to your registration. 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 review the order in relation to your registration irrespective of whether or not you are present or represented.

I attach a copy of the paperwork to be considered by the Panel which starts at page 1 and ends at page 567, for your consideration.

You are invited to submit observations on the case in writing and these will be circulated to the IOP before they consider your case. In particular, you should seek to confirm whether you have complied with conditions imposed on your registration by the Panel and detail any arrangements that you have put in place to affect compliance. 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/agencies with whom you are registered, and
- the hospital/surgery at which you are currently working.
- If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the IOP'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 (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. The documents 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

Andrew Wood
Assistant Registrar
Fitness to Practise Directorate

Enc: Imposing Interim Orders - Guidance for the IOP and the FtP Panel
Investigating concerns factsheet
Employer details form
General Medical Council (Fitness to Practise) Rules 2004
S 41A extract from 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
12 November 2009

Information: Correspondence from Dr Barton.

18 NOV 2009

M Swanick

Adam Elliott
Adjudication Section
Regent's Place
350 Euston Road
LONDON
NW1 3JN

Dr Jane Barton

Code A

Reference VB/2000/2047/02

Dear Mr Elliott,

Re IOP MEETING OF GMC ON 12th NOVEMBER 2009

This is to confirm that I will be attending the above hearing.
I will be represented by Mr Ian Barker of the MDU and Mr Alan Jenkins.
I can confirm that I have been complying with the conditions imposed on my registration by the Panel and will be producing the relevant documentation.

Yours Sincerely

Code A

Jane Barton

Confidential
Addendum (II)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
12 November 2009

Information: Correspondence from the MDU.

THE MDU

MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

www.the-mdu.com

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

Mr Adam Elliott
Adjudication Section
General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN

BY COURIER

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

Dear Mr Elliott

DR JANE BARTON – INTERIM ORDERS PANEL HEARING – 12 NOVEMBER 2009

As you will know, I act for Dr Barton, who comes before the Interim Orders Panel again on 12th November.

In preparation for the hearing, I have pleasure in enclosing several documents.

The first of these is a letter dated 20th October from the Head of Medicines Management at NHS Hampshire. This letter confirms Dr Barton's compliance in relation to the conditions which apply to her prescribing. As you know, provision of this information is of itself a condition of Dr Barton's registration.

In addition, to assist the Panel I am enclosing a copy of the expert report of Professor Karol Sikora which was served for the purposes of the recent Fitness to Practise Panel hearing, together with the evidence of Professor Sikora at that hearing.

In the usual way, if I can assist with any further information you should not hesitate to contact me.

Yours sincerely

Code A

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MEDICAL REPORT

Dr JANE BARTON

Prepared for MDU Services Ltd.
230 Blackfriars Rd.
London SE1 8PJ

Professor Karol Sikora MA PhD FRCR FRCP FFPM

21 Barrett Street
London W1U 1BD

JUNE 2009

Code A

This report has been prepared after reviewing the following documents:

- *GMC Fitness to Practice Panel Hearing Notice of Inquiry Revised Version 12.06.09*
- *Commission for Health Improvement Investigation July 2002*
- *Reports from Professor Gary Ford*
- *General Police statement of Dr. Jane Barton*
- *Statements of Dr. Jane Barton on 12 patients*

Dr. Barton's post at Gosport

Dr. Jane Barton was contracted as a Clinical Assistant for 4-5 sessions a week at Gosport War Memorial Hospital between 1988 and April 2000. The hours were flexible to allow her and her general practice to provide 24 hour cover to the patients at Gosport. There were a total of 48 beds designed for the long term care of elderly patients. However, the nature of the clinical case-mix changed during the 1990's to include patients transferred from the acute sector for rehabilitation. There was, however, no increase in medical or nursing time and no enhancement of social services, physiotherapy, occupational therapy or support staff to help meet this new function effectively. Dr. Barton also worked as a part time GP locally with a personal list of approximately 1,500 patients.

Dr. Barton had no specific training or postgraduate qualifications in internal medicine, care of the elderly or rehabilitation. This is normally the case with Clinical Assistant posts. Her work was supervised by two consultants Drs Lord and Tandy with Dr Reid replacing Dr Tandy in 1999. They all had major clinical responsibilities elsewhere and their contribution to the care of the Gosport patients was apparently limited to a weekly ward round which did not always take place. During April 1998 Dr Tandy was away on maternity leave and the Trust made the decision not to provide any locum cover for her until she returned in February 1999.

Dr Barton's work pattern (which I believe was devised by her and not part of a formal job plan) consisted of an early morning visit between 07.30-09.00; a lunchtime visit on most days to clerk in any new patients and an evening visit around 7pm if she had any patients or relatives to see. In 1998 Dr Barton raised the increasing workload issue with the Trust management, but no changes were implemented. At no time during her 12 years at Gosport were any changes suggested to Dr Barton's mode of work, her prescription habits or her abbreviated style of note keeping. There seems to have been no formal appraisal system in place. Her rapport with the nursing staff appears to have been excellent and the unit dealt efficiently with a huge patient volume with minimal staff.

Expert criticisms of Dr Barton's work

Despite the volume of text available to me the exact details of where Dr Barton's care fell below a reasonable standard is not explicit in the various reports. The common themes in the accusations against her are described in the Fitness to Practice document as:

1. the lowest doses in the sliding scales of her prescriptions for diamorphine and midazolam were too high
2. the dose range of these drugs was too wide
3. the prescription created a situation where by drugs could be administered that were excessive to the patients' needs
4. adequate assessment of patients was not made and properly recorded
5. advice from a senior colleague was not obtained when patients deteriorated

The CHI investigation is not at all specific on these issues although it does on page 36 address items of corrective action on the prescribing of opiates and the documentation of their use together with the keeping of an effective record of communications with patients' relatives. Most of the report covers general governance issues. However on page 12 it lists five concerns on the prescription system in place.

1. no evidence of Trust policy
2. inappropriate combination of drugs (diamorphine, midazolam and haloperidol) given subcutaneously
3. no distinction between patients for palliative care or rehabilitation
4. failure to recognise adverse effects of prescribed drugs
5. failure by management to supervise care

The report, however, is careful to avoid any apportionment of the blame for these concerns.

The report by Professor Ford examines in an academic way the generic issues around the use of pain control medication. In reality the only way to judge accurately a patient's need for analgesics would be by careful clinical observation over time at the bedside. It is not possible to judge this by the study of abbreviated medical records alone. Professor Ford examines the specific issues pertaining to Gosport including:

1. wide dose ranges of opiates
2. use of p.r.n. prescriptions
3. multiple drug combinations
4. widespread use of subcutaneous infusions
5. use of anticipatory prescribing

All these issues were clearly the responsibility of Dr Barton as the physician responsible for the Gosport site. However Dr Barton was only one member of a team. Professor Ford's report fails to address any practical solution for the circumstances that Dr Barton found herself in during the late 1990's. Furthermore it does not address the wide individual variation between patients to opiate need nor the balance between effective psychological support through good nursing care and drug therapy to relieve anxiety and distress.

Clinical opinion

My area of expertise is cancer medicine and I have been a consultant in this discipline for nearly 30 years. This includes the palliative care of elderly patients with cancer. I have worked as a consultant in two teaching hospitals – Addenbrookes Hospital, Cambridge and Hammersmith Hospital, London where I have had excellent support from more junior colleagues. I have never had to practice in an isolated clinical environment. I was Clinical Director for Cancer Services from 1986-1998 of the Hammersmith Hospitals NHS Trust and this included the management of the palliative care services.

I believe that Dr Barton took on the Gosport work believing it to be a commitment that could initially be managed within the time constraints of her limited sessions. I also believe the nature of the clinical workload at Gosport changed very significantly indeed during her tenure and that she strove to do the best she could under difficult circumstances. As Dr Barton writes in the statement re Enid Spurgin:

"The demands on my time and that of the nursing staff were considerable. I was in effect left with the choice of attending to my patients and making notes as best as I could, or making more detailed notes about those I did see, but potentially neglecting other patients."

There is clear evidence that she had inadequate clinical consultant support and that the staffing model at Gosport continued to be based on the low dependency care of elderly patients despite the radical change in case-mix over the 1990's.

Drugs form an important part of good palliative care to relieve pain, anxiety and distress. Another important component is good nursing care with adequate staffing ratios and regular patient supervision. Where this is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and their loved ones. I believe this to have been the situation pertaining at Gosport. There was no possibility of a patient, however distressed, being cared for one on one by a nurse or auxillary to continuously monitor their need for analgesics and sedation.

There is no doubt that opiates were prescribed at wide dose ranges with an effective minimal dose and complete discretion to dose selection given to the

nursing staff. Doctors in palliative care teams vary in their philosophy on the actual level of the starting dose of diamorphine for symptom control based on their past experience and the level of observation maintained over their patients. A range of starting doses between 10mg to 20mg subcutaneously delivered by a syringe driver over 24 hours would in my opinion be reasonable. The plasma levels of active drug achieved over a 24 hour period at these doses would be low and unlikely to lead to any dangerous side effects. On review of the 12 cases I note the maximum dose of 200mg that had been written up was never in fact given. The maximum doses actually achieved in the 12 patients were: 120, 100, 90, 80, 80, 60, 60, 40, 40, 30, 20 and 20 mgs. It is well recognised that the dose of analgesic and anxiolytic needed to allay symptoms in an individual is increased by fear, isolation and an unfamiliar environment.

As the workload pattern changed the clinical team found the intensity of care difficult to cope with and this led to complaints and ultimately three police enquiries. Until then no corrective action was taken by the consultants, pharmacists or the management.

It is impossible to determine in advance the opiate dose required to control pain in an individual. The WHO pain control ladder is a widely used tool to enhance effective pain control. A key feature is the administration of analgesics by the clock to avoid the intermittent onset of pain as the drug levels in the circulation fall. In dying patients there is no risk of drug dependency and large doses of opiates are sometimes required. Only by careful patient assessment can the dose be effectively titrated against symptoms.

Pain and distress are enormously variable. The severity of pain depends on the clinical situation and its perception varies with anxiety, fear, other symptoms and whether the patient has come to terms with the fact they are dying. It is impossible to determine clinically the causes of deterioration in elderly patients with multiple co-morbidities. The only certain way to determine the contribution from symptom control medication is to stop it completely for at least 24 hours. Clearly this would be unethical in this patient group. When there are serious staff shortages, proper assessment and care becomes difficult and more reliance on pharmacological intervention is inevitable.

The use of parenteral fluids is a difficult area in patients such as those admitted to Gosport. Our policy at Hammersmith is to only use the intravenous route if such hydration is required. Subcutaneous infusion of the 2 litres of fluid required over 24 hours is impossible without causing discomfort in elderly patients and its absorption is variable. I understand that facilities for intravenous fluid administration were not available at Gosport and if required the patient would need to be transferred back to an acute facility.

Diamorphine and other opiates are extremely useful not only for pain control but for relieving the secondary anxiety and distress caused by the fear of death. It is

valid to combine anxiolitics such as midazolam and haloperidol even given in the same syringe driver if necessary. Hyoscine – an anti-muscarinic agent which dries up bronchial secretions is also applicable especially with distressing respiratory symptoms that may occur as a terminal event. Only careful assessment can determine the drug requirement in a dying patient and if this is not possible then erring on a higher dose of drug is a kinder way to relieve suffering. At no time do I believe Dr. Barton was prescribing drugs to hasten a patients' demise but to relieve pain and suffering. In her statement she says:

"I felt obliged to adopt a policy of pro-active prescribing, giving the nurses a degree of discretion and administering within a range of medication. As a result, if the patients' condition deteriorated such that they required further medication to ease pain and suffering, the medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient....prescriptions of this nature were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate."

Although Dr. Barton was very much part of this process of anticipatory prescribing, I do not believe she was its cause. In fact she did her best to implement policies to reduce the level of suffering in the patients under her care. As the staff levels could not be increased she used the pharmacological route to improve symptom control. Dr Barton's protocols were apparently in place with the approval of the consultants, nursing staff and the pharmacist who was a regular ward visitor to review the drug charts. Although these protocols may have been devised by Dr Barton, there was at no time any recorded dissent to the use of anticipatory prescribing of the variable dosages of diamorphine, midazolam or haloperidol. Dr Barton received no negative feedback whatsoever. She was subsequently placed in an impossible situation which was only reversed after her resignation.

Dr Barton was only a small cog working part-time in a large machine. She was a member of a team of consultants, nurses, pharmacists and support staff responsible for patient care at Gosport. I cannot see how any doctor placed in a similar position who cares for their patients could have done anything different than Dr Barton. She was the victim of circumstances in a very isolated and vulnerable part of the National Health Service. I believe she is simply a convenient scapegoat for a more widespread system failure that resulted in inadequate numbers of medical and nursing staff to ensure optimal care being delivered to patients at Gosport during the period of her tenure.

Karol Sikora

Code A

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 29 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-FOUR)

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

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

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

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THE CHAIRMAN: Good morning everybody. Mr Jenkins?

MR JENKINS: I know that a problem has arisen with the Panel secretary. We had anticipated there might be a slight delay but, obviously, things go seamlessly as always; I should have known better. I am going to ask for 10 or 15 minutes. I am hoping to call a witness first thing this morning. I have raised certain matters with Mr Kark and, indeed, with your Legal Assessor. We were having a discussion about certain legal matters which we had not quite concluded when the Panel came in. I am going to ask for 10 or 15 minutes so we can finish that discussion. It may be things can move on smoothly after we have had that time.

THE CHAIRMAN: I am wondering how firm that time is likely to be. In other words, whether the Panel should remain in or should we wait to be called in.

MR JENKINS: I would take your ease as they say. You will have made your own judgment yesterday about my time estimates and the reliability of them.

THE CHAIRMAN: They are no worse than mine!

MR JENKINS: Mr Kark is laughing. When I said to you I would be 15 minutes with a witness, Mr Kark says I was half an hour, so when I say it will be 10 or 15 minutes it may be better for the Panel ---

THE CHAIRMAN: Very well, we will rise now and we will return when we are told that you are ready for us.

(The Panel adjourned for a short time)

MR JENKINS: We have had some discussions. I am not going to pursue matters with that witness now. It may be there will be legal argument about that witness at a later stage. We have asked the lady to go home.

MR LANGDALE: The next witness to be called is Dr Sikora. He is sitting at the back of the room and I will call him forward now.

PROFESSOR KAROL SIKORA, Sworn

(Following introductions by the Chairman)

Examined by MR LANGDALE

MR LANGDALE: I announced you as Dr Sikora, but I think it is Professor Sikora. Is that correct?

A Correct.

Q Your first name is Karol – K A R O L?

A Correct.

Q I would like you to tell the Panel your qualifications, medical and otherwise.
A I qualified in 1972. I pursued a career in oncology, cancer medicine. My longest job was Professor of cancer medicine at Hammersmith Hospital where I have been for 23 years. I am now Medical Director of a joint venture between the NHS and the private sector, Cancer Partners UK.

Q Forgive me for interrupting, would you, first, just give your qualifications and then I will go through the history in a moment.
A My qualifications are BA from Cambridge; MBBCh Cambridge, having done that at Middlesex Hospital; MRCP which became FRCP; FRCR which is Fellow of the Royal College of Radiologists to learn radiotherapy; I am also a Fellow of the Faculty of Pharmaceutical Medicine at the College of Physicians.

Q Medical Director currently of Cancer Partners UK?
A Correct.

Q What are Cancer Partners UK?
A It is an interesting joint venture between the private and public sector to improve capacity in cancer services around the UK, both radiotherapy and chemotherapy.

Q Is it right that you were Professor and Chairman of the Department of Cancer Medicine at Imperial College School of Medicine?
A That is correct.

Q I think you are still a consultant oncologist at Hammersmith?
A I am. I spend one day a week running clinics at Hammersmith.

Q Is it also right that you run a Chair of Scientific Advisory Board of Source BioScience Plc, which is one of this country's leading diagnostic companies?
A That is correct.

Q I think you have said something about this already in your evidence – are you Dean and Professor of Medicine at what is this country's first independent medical school at the University of Buckingham?
A That is correct.

Q Also a Fellow of Corpus Christi, Cambridge?
A Yes.

Q I think you have indicated that you studied medical science and biochemistry at Cambridge, then after clinical training where was your first post at a hospital?
A My first consultant post was at Cambridge Addenbrooke's Hospital, where I was a consultant oncologist for five years.

Q After your training had you been, initially, a house physician at the Middlesex?
A Yes.

Q And then a registrar in oncology at St Bartholomew's?
A Yes.

Q You were then a research student at the MRC Laboratory of Molecular Biology in Cambridge?
A Yes.

Q You then obtained your PhD and became a clinical Fellow at Stanford University in California before returning to this country to direct the Ludwig Institute in Cambridge, so back in Cambridge again.
A Exactly.

Q As you indicated, you were a Clinical Director for cancer services at Hammersmith for 12 years. Is that right?
A Correct.

Q Involved in the setting up of a cancer research laboratory. Is that right?
A Correct.

Q Also chairing Help Hammer Cancer, an appeal, which raised a certain of amount of money, in terms of millions, towards the construction of a new cancer centre at Hammersmith?
A That is correct.

Q Just dealing with remaining matters, Deputy Director of Clinical Research of the ICRF?
A Correct.

Q From 1997 to 1999, Chief of World Health Organisation, WHO, cancer programme?
A Correct.

Q From 1999 to 2002 Vice President of Global Clinical Research Oncology at the Pharmacia Corporation?
A Correct.

Q I am not going to ask you all the detail, but I think you have published a number of papers and written or edited a number of books?
A Correct.

Q Are you also a member of the UK Health Department's Expert Advisory Group on cancer?
A Yes.

Q The Committee on Safety of Medicines?
A Yes.

Q Do you remain an adviser to the World Health Organisation?
A Correct.

Q I think, Professor Sikora, you prepared a report in connection with issues in this case?
A I have.

Q I am going to ask you, first, about the material that you have had the opportunity of seeing, in the sense of it being provided to you one way or another. I think you have reviewed the notice of inquiry, that is Fitness to Practise Panel hearing notice of inquiry setting out the allegations against Dr Barton?
A I have.

Q You also had the opportunity, although I am not going to ask you about it, but you saw the Commission for Health Improvement or CHI report material?
A I did.

Q Which was back in 2002. You had the opportunity of reading the reports of Professor Ford?
A I did.

Q Have you also had the opportunity of reading transcripts of the evidence he has given to this Panel?
A I have.

Q You have also had provided to you the general police statement, as we have called it, of Dr Barton herself and you have also seen the statements she made with regard to twelve patients?
A I have.

Q It follows that you have seen statements that she made with regard to all twelve, nine of which I think were police statements prepared for the assistance of the police. May I also ask you, in terms of material that you have seen, you have seen transcripts of her evidence?
A I have.

Q Sir, I am going to ask a number of questions in leading form, simply to establish what it was this witness understood the position to be. It is all factual, it is not asking his opinion. I am trying to take you through certain matters of which you became aware with regard to the history of this case. On the information you have been able to gather from what you have seen and so on in terms of Dr Barton, you understood, you cannot give direct evidence for this, that she had been contracted as a clinical assistant for four to five sessions a week at the Gosport War Memorial Hospital?
A Correct.

Q We are familiar with the dates, 1988 to 2000. The hours, as you understood it, were flexible to allow her and her general practice to provide 24 hour cover to the patients at the hospital?
A Yes.

Q A total of 40 plus beds, I think it may have a total of 48 all together, designed for the long term care of elderly patients?
A Yes.

Q As you understand it on the information you have been given, the nature of the clinical case mix changed during the 1990s to include patients transferred from the acute sector for rehabilitation?
A That is my understanding.

Q As you understand it, no increase in medical or nursing time and no enhancement of social services, physiotherapy, occupational therapy or support staff to help to meet that new function?
A That is correct.

Q Is it your understanding that Dr Barton worked as a part-time GP locally with a personal list of something like 1500 patients?
A That is correct.

Q Furthermore, I am going to ask you more about what your understanding of the matter was because it will assist the Panel in terms of understanding the basis of your opinion about certain matters. Was it your understanding that Dr Barton had no specific training or postgraduate qualifications in internal medicine, care of the elderly or rehabilitation?
A That is correct.

Q In your experience is that normally the case with clinical assistant posts?
A That is the purpose of a clinical assistant.

Q Work, as you understand it, was supervised by two consultants initially, Doctors Lord and Tandy, with Dr Reid replacing Dr Tandy at some point in 1999?
A That is correct.

Q On your understanding those consultants all have major clinical responsibilities elsewhere and their contribution to the care of the Gosport patients was apparently limited to a weekly ward round which did not always take place?
A Correct.

Q Again, the Panel will have heard evidence about this but that is your understanding about the position. You were also informed about Dr Tandy being away on maternity leave from some point in the late 1990s, I think in April 1998, and the Trust made the decision not to provide any full-time locum cover for her until she returned in February 1999?
A That is correct.

Q We have heard evidence from Dr Tandy about it. You were also given information about Dr Barton's habitual work pattern – I am not going through it – the morning visit, returning not necessarily every day but around about lunch time to deal with the new admissions, clerking in and so on and then an evening visit depending on the needs of relatives and so on?
A Correct.

Q You were given the history about that?
A Yes.

Q You were aware of the evidence that Dr Barton raised the problem, or the difficulties, with increasing work load with more than one person, but no changes were implemented?
A That is correct.

Q Was it also your understanding, and the Panel have heard the evidence, that at no time during her twelve years at Gosport were any changes suggested to Dr Barton in relation to her mode of work, prescription habits or her abbreviated style of note keeping?
A Correct.

Q You have read the evidence that there has been in relation to her rapport with the nursing staff, which appears, so far as you can judge it, to have been excellent?
A It does.

Q What is your view in terms of the material you have seen as to whether it was effective or not in terms of the way her unit dealt with a pretty large patient volume with the staff that were available. What was your impression?
A My view, based on my experience as a clinical manager at Hammersmith including palliative care, is that the work load changed, the pattern of patients changed over a decade and although the staffing may have been suitable at the beginning of the decade, by the end of the decade the patient flows had changed, the dependency on nursing care had changed, but the staff had not changed in numbers.

Q In terms of criticisms of Dr Barton's work, is it right that you have summarised the common themes in the allegations against her as being – in relation to the fitness to practice allegations themselves, they can be summarised as being – that the lowest doses in the sliding scale of her prescriptions for diamorphine and midazolam were too high?
A Correct.

Q That the dose range was too wide?
A Correct.

Q Are you aware of the fact that Dr Barton has accepted, not in every case but in a number of cases, the dose range in the 20 to 200 mg range was too wide?
A Correct.

Q That the prescription created a situation whereby drugs could be administered but were excessive to the patient's needs, adequate assessment of patients was not made and properly recorded and, again, are you aware of the fact that Dr Barton has accepted that her recording, her note keeping and other recording, was not as it should have been?
A I do.

Q Also an allegation that advice from a senior colleague was not obtained when patients deteriorated?
A Yes.

Q In terms of Professor Ford's report, which you have considered and you have read transcripts of his evidence, you are aware of the fact that he looked at the generic issues around the use of pain control medication?
A Yes.

Q What is your view as to the only way to judge accurately a patient's needs for analgesics?
A The only way is to be with the patient and see what happens after a given dose of an analgesic that is given. The teaching in the World Health Organisation when I started ten

A years ago is very much doing things by the drugs; in other words where in the ladder of analgesics, strength of analgesics, you start; by the route, whether it is by mouth to start with or subcutaneous injection by infusion; by the clock, to avoid periods when the patient is in pain because the level of analgesic has dropped, and by the patient. The teaching is very much "by the patient" is the most important thing. So without seeing the patient, without looking at detailed notes, which are often not recorded in people that are terminally ill, it is impossible to make a judgment unless you were there.

B

Q Just going back over that, that sequence you have just dealt with in terms of the World Health Organisation approach, number one the drug?
A Correct.

Q What are we thinking of there?
A There are several drugs, increasing in strength, to get rid of pain. The WHO twenty
C years ago constructed what is called the WHO pain control ladder that is widely used round the world, especially in countries where there really is not much active treatment because of costs. The ladder is to begin with a mild analgesic – paracetamol, aspirin; to go to a middle analgesic, dihydrocodeine, for example, and then to go to an opiate such as morphine and diamorphine. That ladder is a way of getting the right drug in a sequence that is logical, to teach doctors and nurses to give a logical sequence for pain control.

D Q Would you look please at a file marked "1", in the collection of files to your left, in those boxes. Would you look, please, in file 1 at tab 4. In tab 4 we can see it contains a photocopy of something called the *Palliative Care Handbook*, which was something that was available at Gosport and other places as well known, I think also, as the Wessex Procedure. Look, please, at page 5 in tab 4. We can see there mention of the WHO analgesic ladder?
A Yes.

E Q Without troubling about the detail, is that the same thing, in effect, as what we were just talking about?
A The same one.

Q Thank you. That was the drug. We dealt with that. Then the route was the next thing itemised.
A The route – the most convenient route – for most patients is oral but some patients
F cannot swallow and sometimes the oral route is not adequate because they start vomiting because of the side effects of the drug. The next way to do it would be parenteral injection, which means injecting something under the skin. That could be subcutaneous, it could be intramuscular. Over the last twenty years the availability of subcutaneous pumps, relative cheaply, has meant that one can give 24-hour infusions, which give a much better pharmacological distribution of pain-killer drug, and therefore better pain control, over a longer period of time.

G

Q Does that bring us onto the clock, which was the next in the sequence you were citing?
A By the clock is the idea that you do not wait for the patient to complain. In every healthcare environment all over the world there will be a delay, even if the patient has one-to-one nursing, which is a great luxury. In most environments, patients do not have that, and therefore giving drugs by the clock means that you do not allow the analgesic level in the
H blood to drop to a level where the pain comes back and the patient is suffering, maybe for an

A hour or two hours, but intermittently. It is not just one or two hours. It is every few hours the level drops, and they start suffering. So "by the clock" is a way of teaching healthcare workers to avoid that trough in level, and therefore the pain.

Q Then you said "the patient".
A That is the most important. A patient's pain is judged by what they say it is. No one else can judge pain. Obviously if someone is completely well and they say they are in severe B pain you want to work out why, but if a diagnosis has been made of the cause of that pain or distress – and it can be caused by multiple factors, especially in the elderly – then you want to make sure that the patient has enough drug by the right route to get rid of that pain.

Q We may have to come back to it later, but may I just ask you in the context of what you just said about material in relation to which the Panel have heard quite a lot of evidence. As you are aware, no doubt, from read the transcripts, reference has been made to the BNF?
C A Yes.

Q Principally the *Palliative Care Handbook*, and so on, all of which set out particular matters with regard to, and we are focusing here obviously on analgesics.
A Yes.

Q They set out dose ranges, what the drugs can and cannot do?
D A Yes.

Q What are possible adverse side effects and so on. You will obviously be familiar with all this?
A I am.

Q But in relation to patients who are reaching, or who are on, what has been described in E the context of this hearing as a terminal care pathway is anything set out in any documentary material of which you are aware as to how much? In other words what sort of dosage and at what rate the patient should receive when they are on a terminal care pathway?
A There is no literature or guidelines on the actual doses because it is so patient sensitive. It is the individual patient who has to be judged there and then. There is no other way of doing it, so certainly in the WHO teaching literature, there is nothing about the absolute level at which to do things.

F

Q As you know, in relation to Professor Ford's report and his evidence, he was examining issues with regard to wide dose ranges, use of PRN prescriptions, drug combinations and the use of subcutaneous infusions and the use of anticipatory prescribing?
A That is correct.

Q We will come back to those, in some respects, later. Obviously everybody is G proceeding on this basis and I think you are proceeding on this basis. The responsibility of Dr Barton as the physician responsible for Gosport War Memorial Hospital on a day to day basis, her responsibility lay in relation o all of those issues?
A Yes.

Q They are matters for her to deal with?
A Yes.

H

Q But as you are aware, and Dr Barton was only one member of a team?
A That is correct.

Q We will come back to that in due course.
A Did you find in relation to Professor Ford's report and evidence on these wider issues, that he had really addressed the question as to whether there was any practical solution for the circumstances that Dr Barton found herself in in that period?
A I could not find the practical solution. I think Dr Barton was using various recipes because it was the only practical solution to the situation she found herself in.

Q Again, we can come back to that in some more detail. What was your view as to what degree Professor Ford addressed the wide, individual variation between patients with regard to opiate needs?
A You must not base that on the actual patient data because there was no patient data presented to consider. Therefore "by the patient" was not being considered in that. I think also the dose ranges presented were from 20 to 200 mg per 24 hours in the pump, but of the 12 patients only one got above 100 mg.

Q I think it was broken down for you, and you set it out in your report, that the ranges were 120 in terms of the twelve the Panel are considering – that is in one instance, Patient A, and then the variation was 100, 90, 80, 60, 40, 30 and 20, in terms of the maximum amount of diamorphine that was being received by the patient at the time of their death?
A That is correct.

Q In relation to those – we have heard these figures before – in two the maximum was 20; in one the maximum was 30; two, maximum 40; two, maximum 60; two, maximum 80; one at 90 and one at 100, in addition to the 120 we referred to?
A Correct.

Q Would you help, please, with regard to this question in individual variation between patients to opiate need in your experience?
A It is very complex. There are multiple factors. First of all, psychosocial factors – people that are disturbed in unfamiliar environments feel more pain than if they are in a more relaxed environment – the availability of skilled nursing care and close relatives able to help reduces the need for analgesics. Then there are pharmacological factors: the fact that the patient may be metabolising the drug in different ways, partly because they have other disease problems, such as liver and renal problems, and also because there are different kineties in how each of us as individuals disposes of morphine-like drugs. So there are many, many factors that play, and that is why the teaching is "Look at the patient and see what happens," rather than use any pre-conceived dosage or formula.

Q In terms of care for patients, we have heard evidence about this to some degree already. Does one have to look at the question of how is a patient best cared for by considering different aspects of care. We have heard about – and you have indeed just referred to, as it were – psychological support?
A Correct.

Q The importance of good nursing care?
A Yes.

Q And obviously drug therapy to relieve anxiety, distress, pain, whatever it might be?
A Correct.

Q Where does the balance lie? Is it impossible to say where the balance lies between those aspects of patient care in relation to the type of patient we are considering in this hearing?
A It is very difficult, and certainly in elderly patients it is much more difficult because they may not be able to communicate exactly what the problem is in the way a younger patient may be able to.

MR LANGDALE: I am going to ask, with some hesitation, that the Panel receive a document. My learned friend Mr Kark has seen it. It is not a document prepared by Professor Sikora himself. He has seen it. It has been prepared by those instructing me and it is an attempt to show by way of a chart that the level of morphine which a patient will receive if it is administered subcutaneously. It is not absolutely mathematically precise, and the Panel will see that it has been divided into two charts. One shows the picture if the half life of the morphine is two hours; the other shows the picture if the half life of the morphine is four hours. The Panel have heard a certain amount of evidence, in particular from Professor Ford, about the sort of level you would expect the morphine seemed to have peaked at, and so on, in the course of the evidence you have already heard. I am putting this in with the agreement – and I am grateful for it – of counsel for the GMC, simply to assist the Panel to get an idea. It is not set in stone, and I am going to ask Professor Sikora to deal with it in very general terms. I wonder, sir, if those documents could be put in.

THE CHAIRMAN: They will be D7.

MR LANGDALE: Thank you very much. That is D7. D7a will be the two hour one, and D7b for the four hour one, perhaps.

THE CHAIRMAN: By all means.

MR LANGDALE: Perhaps Professor Sikora could also have a copy. (Document marked and circulated) Sir, I stress, this is not his document. (To the witness) Professor Sikora, I am going to invite you to look at this with us and ask you some very general questions about it.
A Of course.

Q We are looking at subcutaneous infusion of diamorphine. Both of these charts are headed "Diamorphine Blood Levels" on the assumption that it is a dose of 20 mg subcutaneously over 24 hours. First of all 7a, with a two hour half life; secondly, 7b, a four hour half life. Looking first at 7a, the way in which this document has been set out shows on the left hand column the hours. In other words, after hour one – at the top on the left – 0.83 mg has (in my words) gone into the patient?
A Correct.

Q So at the end of an hour, it is 0.83, assuming a two hour half life. The rest of the plan sets out the figure you reach after each one of the hours up to and including hour eleven after administration?
A Correct.

A Q If it is a two hour half life we can see how the amount of morphine in the patient, allowing for the fact that at each stage you have to take into account the remaining morphine from the previous infusion and how it declines. On the right hand side you have the amount, so after two hours, 1.46 and so on. Then, after eleven hours it reaches the peak that at any one time would be in the patient's body, 2.86?
A Correct.

B Q I am told Mr Barker has rounded up these figures to avoid any kind of misleading impression. Looking at the position with regard to the four hour half life, 7b, the same method has been used, and we can see that in relation to the first hour the same amount has been received by the patient, but as you go on, if you assume a four hour half life, the amount in the patient's body is in general terms higher?
A Yes.

C Q Because the morphine is there (again in my words) for longer?
A Correct.

Q On this particular exercise, again staying with the 20 mg over 24 hours, after 21 hours the peak has been reached of 5.32?
A Correct.

D Q This is just an exercise to try and demonstrate a general picture. It is not meant to be, as I say, a certain standard, but in general terms without your having checked the figures – they are not yours – is that the sort of view or understanding we should have with regard to the way the morphine gets into the patient, stays there and eventually declines?
A Yes. It is a good teaching exercise on the value of a subcutaneous pump rather than intermittent injection, where you would have peaks and troughs. Peaks may have an overdose of morphine or diamorphine, and a trough where you get breakthrough pain. With a
E subcutaneous pump you reach a plateau and you can see with the two hours you reach the plateau actually at about the fifth or sixth hour. There is very little rise from 2.41 up to 2.86. With the four hour half life patient, you see you reached the plateau when you get to about 13 hours. It really goes up very little from then.

Q So in the case of the four hour half life plateau it is reached more or less after thirteen?
F A Correct, yes.

Q And the lower figure for the two hour half life. Thank you for dealing with that. I am going to ask you a little bit more about your area of expertise, and about your experience with regard to palliative care generally. As you set out in your report, your area of expertise is cancer medicine?
A Correct.
G

Q And you have been a consultant in that discipline for getting on for 30 years.
A I have.

Q Does that experience of yours include the palliative care of elderly patients suffering from cancer?
A It does. The majority of patients with cancer are elderly and palliative care is,
H unfortunately, necessary for many patients.

Q As you have already indicated you have worked as a consultant at two teaching hospitals, Addenbrookes and also the Hammersmith Hospital.
A I have.

Q You have obviously had appropriate support from more junior colleagues.
A I have.

Q It is also right to point out that you yourself have never had to practise in an isolated clinical environment.
A That is the case.

Q So you have never been in the same sort of situation as Dr Barton for instance.
A No.

Q When you were clinical director for cancer services between 1986 and 1998 at the Hammersmith Hospitals NHS Trust did that include the management of the palliative care services?
A It does. We created a palliative care position among the consultants and, with the local hospice, we developed palliative care as a separate sub-specialty within our department.

Q It may be that one will have to draw some distinction between the palliative care of cancer patients and patients who are not suffering from cancer. We can come on to that later and it may be an issue which will be explored with you, but I just want to ask you about this: in terms of the whole concept of palliative care – and your experience in this particular field obviously embraces the period of time that the Panel are concerned with in this hearing, the 1990s – can you give us a thumbnail sketch as to how you saw it in terms of palliative care either originating in hospices or whatever it might be; a little picture of how things have developed?
A When I began in cancer medicine as a registrar there was really no palliative care. It developed in London at St Christopher's Hospice and migrated around the UK, both in hospitals and in community settings, together with charitable support from the Macmillan Fund, which was one of the major drivers of the palliative care movement. Today it has changed beyond all recognition. Initially it was just for cancer patients, now the protocols and the way in which the teaching is given applies to all situations including a common pathway of terminal decline which happens in all diseases, so the lessons from cancer have been applied right across the board. Currently there are major forces trying to get palliative care more into the community; the current Government has an initiative to allow people to choose where they wish to die, and that is a very challenging effort, whether they wish to die at home or in a hospice or indeed in a hospital. It is difficult to implement because obviously it costs money – it is not about drugs necessarily, it is about staffing to make sure that people can die in the home, for example, which is much more consuming of staff time.

Q May I ask you this, again in general terms: is there any significant difference between the approach to be adopted in palliating symptoms of pain, distress, agitation and so on – again, my words because we have heard different labels such as terminal restlessness and so on – in patients who are suffering from some form of cancer and patients who are suffering as a result of some other problem such as illness, comorbidity, whatever words we use?
A I personally do not think there is and I think it has been very tragic that it has taken our profession so long to recognise that. The lessons from cancer, where palliative care has

really been developed, are now being applied across the board to all terminal phases of illness and, indeed, hospices are opening their doors now to non-cancer patients for the first time. I suspect the origin of this is that cancer is thought of as an incurable illness; many other diseases are not thought to be incurable and that was the reason for that distinction. A terminal pathway is a terminal pathway by definition.

Q We have heard evidence that certainly for a period in the early 1990s a nurse or two or three nurses at Gosport War Memorial Hospital were concerned about subcutaneous analgesia, in particular diamorphine, being administered to patients who were not cancer patients. There was a concern of that kind or at least a thinking process of a similar kind elsewhere was there?
A There was.

Q We heard evidence from Professor Ford who said in relation to Patient C – Eva Page, the lady who was suffering from the carcinoma of the bronchus – that in his view it was acceptable and appropriate to prescribe and administer opiates to relieve anxiety and distress, whereas he certainly seemed to be indicating at other parts of his evidence, as you may have read, that in his view opiates such as diamorphine should be administered simply for the relief of pain. What do you say about that?
A The only way to decide is to judge it by the patient. Diamorphine is a valid drug for people in severe distress and various other indications, not just for pain, but it has to be a clinical decision, done on the spot.

Q It is right to say that he accepted that there was a body of opinion which might hold the same view as you just expressed in the country at large. In looking at your consideration of the position Dr Barton was in, did you go on the basis that when she took on the job in the first place it was on the basis that she understood it would be a commitment which could initially be managed within the time constraints of her comparatively limited sessions?
A That is what I assumed.

Q And as you have already indicated you proceeded on the basis – I do not think there is any dispute about this – that the nature of the clinical workload at Gosport changed very significantly as the 1990s moved on.
A It did.

Q In terms of what you have seen of the evidential picture in this case, what do you say about the adequacy of clinical consultant support provided to her?
A Dr Barton was, however competent, untrained in any specialty other than general primary care, general practice, and the patients were managed by a named consultant. There would have been on the notes, maybe even above the bed, the name of that consultant. That is normal practice throughout the world. The consultant was responsible for patient care. My understanding is that the consultant ward round was once a week, sometimes once every two weeks, and for a period when there was maternity leave not at all – for nine months presumably. Clearly there was a system problem in terms of consultant monitoring of patient care. It may be acceptable if it really is a nursing home type of atmosphere with just long term admissions with no changes, but certainly towards the end of the nineties that was not the case. These people were being discharged from neighbouring acute hospitals with serious medical problems and it would imply there should be consultant cover almost on a two or three day a week basis.

A Q Similarly with regard to the evidential picture presented to you, did the staffing model at Gosport continue on the basis of low dependency care of elderly patients or did it in any way change as a result of the change in the patient mix?
A I only changed after the various investigations; until then there was no change and there was no change in the back-up professionals such as occupational therapy, physiotherapy, radiology and so on.

B Q If that is the right evidential picture I would just like to ask you about the situation that is created as a result for those concerned with trying to care for patients of this rather different kind. It is a truism perhaps for us to state, but perhaps one would make it clear with you, that obviously drugs form an important part of good palliative care. There is no dispute about that.
A Yes.

C Q In the context within which we are operating in this hearing there are drugs to control pain, anxiety and distress – I will use those three labels as being convenient shorthand ways of describing it. What about the importance of good nursing care, what would you say about that?
A Good nursing care is vital in this situation and obviously it allows not only psychological care for the patient but also the monitoring on a regular basis of what is happening and therefore there is an inter-relationship between drug therapy and its
D monitoring and the availability of staff.

Q What is the consequence, therefore, in terms of the practicalities as to what is to be done with any particular patient or patients within a particular category. What are the practical consequences if nurses are trying to provide good care, the clinical assistant is trying to provide good care, but the ratios and the resources are as you understand them to be? What is the practical consequence?
E A If we take the relationship between nursing care and drug therapy there is no doubt in my mind that if the availability of nursing care is low and there are few nurses for many patients, then in doing the prescribing you are going to have to start at a higher dose and have a sliding scale to allow decisions to be made quickly. There also was not medical cover as far as I can see, the medical cover was inadequate, and therefore the idea that you could call a doctor and get action within a three or four-hour time period was unrealistic in the set-up as described in the various documents, so the nursing, medical and drugs all are intertwined.

F Q You say the impact in terms of what the doctor is going to prescribe and have administered in terms of drugs is going to be affecting the doses. How do you square that with what is in the patient's best interest?
A The idea is to write out a prescription that can be delivered with freedom to the clinical observer at the time; in other words it does not require someone to be called from the other side of Portsmouth to come and make the decision, the people on the spot – who
G inevitably were the nursing staff – could make a decision about what to do. That is the attraction of having a sliding scale and a subcutaneous pump, it allows the person on the spot to take the clinical decision, looking at the clinical parameters and make their own decision. Of course, different people, different staff, will come to different conclusions, but at least they can do what they think is the best for the patient.

H Q Are you aware of the evidence from the nursing staff – although their evidence varied to some degree – about the practice of seeking approval or consent or authorisation (whatever

A the right word is) from Dr Barton, in default of her from an on-call doctor, in relation to decisions of that kind?
A I am, and that seemed an eminently sensible way to approach it. If Dr Barton was there she knew all the patients so she could guide the decision. If she could not be contacted someone in the practice who was on call could be contacted, but they would not know the patient so inevitably – and certainly in my experience – you would go with whatever the nurse was asking for, unless there was some special reason not to. The third way is that the B nurses make the decision on their own if they could not get hold of anybody.

Q Just looking at it as a matter of practicality, if you had got full resources – say in a teaching hospital – in terms of the administration of analgesia of the kind we are talking about, what is the best picture? Assuming you have got the resources what do you try to do with regard to administering opiates?
A If you have got a patient who is in distress what you really need is to assign much C more nursing time – maybe not one to one but getting towards that level. In a teaching hospital there may not be a resident doctor but there will be someone on call 24 hours a day who could come and change the prescription if necessary, so the combination of being able to change the prescription 24 hours a day, to have a doctor there 24 hours a day if necessary and to have good nursing care available, very frequently making observations, is a luxury that was not available, from what I have read, at Gosport.

D Q If the luxury is available does that have an impact on whether it is appropriate to titrate doses up? Just give us the picture with regard to what you would do if you had all those resources available.
A If you have all the resources available and you are able to titrate things in real time you do not need to leave a blanket prescription, you can just change it as you go. If the resources are not there you have to leave a wider range to allow whoever is there to adapt to the circumstances the patient finds themselves in.
E

Q If you have not got the resources to titrate up in steps, say after every four hours checking and so on and so forth, what is appropriate in terms of the initial dose if your objective is to prevent pain or to control pain?
A In terms of diamorphine I would say at least 20 mg to start with.

Q I will come on to that in a moment; so that may be affected by the practical situation F you are in.
A Absolutely.

Q Apart from relieving the distress of patients, if you are operating in the sort of circumstances that Dr Barton was operating in, what about the distress of their relatives or close family?
A That can be very distressing. It is part of therapy – one treats the patient but one is G treating the whole carer group as well and to see an older person who may be severely demented, suffering because of some physical illness as well, and disturbing the family is profoundly unpleasant. Doing something about that is part of good practice.

Q You have seen the general picture – I am not asking you about individual patients – with regard to opiates being prescribed with quite wide dose ranges and with, as I think you described it, an effective minimal dose.
H A Correct.

Q We have covered the picture with regard to what discretion the nursing staff had in relation to the administration of these drugs but in terms of your experience of doctors involved in palliative care teams, do they all share one philosophy in relation to the actual level of the starting dose of diamorphine?
A Absolutely not. In cancer medication the drugs for cancer are rigidly adhered to around the country. If you have 100 oncologists they will be using the same drug dose. If you go to palliative care it is much more subjective how you do palliative care and there is much greater variation between different palliative care physicians about the starting dose and the scales that they use.

Q Can I come back to something you mentioned a moment or two ago in relation to a starting dose with diamorphine. I appreciate different patients and different situations but in general a starting dose of diamorphine of, say, 10 to 20 – or 20 as we have commonly come across in this case – what do you say about that generally speaking, bearing in mind it is subcutaneous delivery by means of a syringe driver over 24 hours?
A To me 20 mg seems a reasonable starting dose.

Q I would like to ask you about plasma levels of active drug achieved over a 24 hour period. What do you say about that in terms of the level?
A The plasma level – one is trying to achieve a level where one can get rid of pain over a smooth curve of 24 hours and the levels with 20 mg depend on how quickly the drug is metabolised, how quickly it is destroyed by the body. That is a variable and we have seen the two charts, the two hours and the four hours, which show that in both cases you inevitably reach a plateau.

Q In relation to the sort of plateaus, appreciating it varies from patient to patient and so on, but just looking at the broad brush picture, with those sorts of levels of morphine in the body would they be such as to be likely to lead to dangerous side effects? Just taking our 20 mg administration.
A Over a 23 hour period, even in an opiate naïve patient – someone that has not received opiates before – it would not lead to serious consequences in most patients.

Q Again, there is no dispute in the evidence in this case that whether a patient has been on some form of opiate before subcutaneous administration may affect, first of all, when you start subcutaneous analgesia and the amount that it is appropriate to administer.
A That is correct.

Q That, I think is a given in this case. It is also the case, as you will see from the pattern of the prescriptions, that the analgesia administered in the form of diamorphine, also on many instances had the addition of a sedative or tranquilising drug, midazolam?
A It did.

Q First, in general terms, anything unusual with patients falling into this sort of category in the administration of diamorphine and midazolam together?
A No, and indeed the BNF is quite clear. There are a series of drugs tabled there that can be given in the same syringe driver at the same time.

Q In terms of any other drugs that had been administered in the syringe driver in this case, haloperidol is one we have seen from time to time and also hyoscine?

A A That is correct.

Q Looking at those.
A They can be mixed and the are used for different indications; haloperidol for people who are severely distressed and agitated depression, and hyoscine especially if the terminal event involves a lot of fluid gathering in the lung which is very distressing both for the patients and for relatives. Hyoscine essentially dries up the membranes of the lung.

B

Q In terms of the dose; the dose needed of an analgesic and an anxiolitic in relation to the dose, the amount, when considering the need to allay symptoms in the individual patient in general, is that affected by the increase that patients experience as a result of fear, isolation, unfamiliar environment and so on. Does that affect the dose that you think it is appropriate to administer?
A I believe it does and, basically, pain has multiple components and anxiety, distress
C and lack of familiarity increase fear. That fear means to get the same analgesic effect you have to give more drug. That is why cocktails of drugs, midazolam with diamorphine, are effective because one takes away some of the fear allowing the analgesic, where there is pain, to have a better effect.

Q So one has to be looking at the combined effect and the combined situation?
A Exactly, and the art of good palliative care is to make the decision as to what the key
D problem is to vary the doses appropriately.

Q In terms of patients who are on the terminal path, an expression that has been used in this case more than once – I am looking at your report on page 6, the third paragraph down – you deal with what you describe as dying patients. I would like you to deal with the question of the size of the dose that may be appropriate because, obviously, a given in this case, you do not have to worry about drug dependency with regard to a patient in that situation?
E A One of the fears in giving opiates to any patient is that they will become dependent on the drug and you will have to wean the patient off the drug just like an addict. That does not apply to people who are dying, whatever the cause of that death. The only way to sort out the correct dose is to make individual patient assessments. Physicians who are not in palliative care, or indeed in oncology, tend to be very sparing on opiates and one of the problems in many general wards for surgery and medicine is that there are patients in serious pain even still, and palliative care education is one of the ways to try and deal with that.

F

Q You have already covered the point, and we have already heard it from other witnesses in this case, that pain and distress are enormously variable from patient to patient. We have heard about what the severity of the pain may depend on and you have covered that in your evidence. In terms of the causes of deterioration – you will have seen from the transcripts you have read that patients are described as deteriorating and so on – I am not asking about individual patients in this case but, in general terms with elderly patients with
G multiple sometimes comorbidities, what is the practicality in terms of the clinician endeavouring to establish the cause of the deterioration?
A In most of the situations where patients are deteriorating, especially if they are doing so rapidly, there is absolutely no point doing more investigations. At Gosport it would not have been possible to get urgent investigations, x-rays or blood tests and unnecessary to do so. Only good clinical decision making can really contribute and a clinical assessment on the spot by a doctor or nurse and a decision how to vary the drugs appropriately.

H

A Q If I could ask you to deal with this issue in general terms. In terms of the doctor concerned, in this case obviously the clinical assistant Dr Barton, trying to determine what is the product or what is the contribution of the medication you are providing to control symptoms as to where the balance lies, how can you check whether you are right?
A The only way is to go back an hour, two hours, later and see what has happened. It is a continuous circle of monitoring and then varying the dose appropriately, changing the composition of the drugs in the syringe driver appropriately.

B Q What do you say about the stopping of subcutaneous analgesia, first stopping it to check whether the patient is suffering more from their condition or more from the sedating effect of the drug or the respiratory depressive side of the other drug that has been administered?
A I think it would be very difficult to do that. It is very rarely done in any clinical situation when one knows the patient is on the terminal pathway. It would almost, to me, be C unethical to make the patient suffer unnecessary pain in the last few hours or last few days of life by doing that experiment.

Q What about reducing to see if the pain breaks through again. What is the appropriate approach there?
A That is certainly possible, but on the whole a good clinical assessment would mean that it is unlikely that you get to a point in a dying patient where you start reducing the dose. D

Q The reasons for that being unlikely with a patient who is on a terminal pathway?
A Because, inevitably, if you reduce the dose enough, you will get symptoms coming back and why would you want to see that?

Q In your report you dealt with the issue of, what I always mispronounce, parenteral fluids. I do not think it is an issue that the Panel is any more concerned with in terms of E allegations in this case because it is clear that at Gosport they did not have the facilities to hydrate patients in that way and we have heard about the different views as to the propriety of trying to hydrate in these sort of circumstances. If anyone wants to raise the issue with you, no doubt you can deal with those questions but I am not going to ask you about it.

THE CHAIRMAN: Mr Langdale, the witness has been up for a little over an hour. Would that be a convenient moment? F

MR LANGDALE: Yes, I do not have a great deal more, but it is more than five minutes.

THE CHAIRMAN: We will have a break now. You will be taken somewhere you can get some refreshment and some rest before you come back for further questions. I am going to say 15 minutes, 11.20am.

G (The Panel adjourned for a short time)

THE CHAIRMAN: Professor, you of course remain on oath. Mr Langdale?

MR LANGDALE: Professor Sikora, I am dealing with matters which are contained on page 7 of your report. I have covered issues with you with regard to the combination of anxiolitics, such as midazolam and haloperidol with diamorphine and so on and I am not H going to go over that material with you again. I would like to ask you about the practical

position. In a hospital with full resources, if a doctor is able, with the aid of nursing staff and so on, to give a much more closely monitored assessment of the condition of a patient than if the resources are rather more limited because of the practical consequences of lesser resources, if it is the case that a doctor with less resources, with the sort of resources that we are talking about at Gosport War Memorial Hospital, is aiming to control pain and distress symptoms to prevent the patient suffering from pain and distress and with any one possible dose range – just take a dose – at which to start the administration of subcutaneous analgesia or indeed the level to which it is to be increased, if there is no absolute set rule as to precisely how much should be prescribed, there is a variation, in terms of a doctor tending to go higher rather than lower within the possible or permissible range, what do you say about where the choices really lie?

A I would believe the choices lie between increased suffering if the dose is not enough, or increased suffering is the delay in which you can get someone to rectify the low dose to convert it to a high dose, or starting at a higher dose. If there is one to one observation, if there is a doctor on call who can change the prescription, it is a very different situation to what was happening in Gosport.

Q You have covered the position with regard to anticipatory prescribing which you touch upon in relation to the third paragraph of this particular page of your report, and I am not going over the procedure, you have already indicated what your understanding of it was. What effect does the reduction of staff levels proportionate to the increased and different patient mix, what effect does that reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?

A It means that there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore, using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances.

Q Did you take on board the fact that so far as you could judge it – it is for the Panel to decide, not you, but as far as you could judge it – what Dr Barton was doing had the approval, certainly did not have the dissent, of the consultants, nursing staff and pharmacist?

A Absolutely, and there was no formal appraisal in those days and clinical assistants were exempt from appraisal until relatively recently so there was no mechanism of feed back, but there was tacit acceptance. The charts were written up and if a consultant does not look at the chart that is his responsibility in my mind.

Q Looking at the situation in general terms with regard to the general practice and the general procedure adopted by Dr Barton, taking into account the position that she was in – we have looked at the different aspects – what is your view as to what the alternatives were in terms of being available to her?

A She could live in the place 24 hours a day, that would be one alternative, or otherwise what she did seems to me perfectly reasonable. As I say in the report, it is a very vulnerable end of health care all over the world. It is a forgotten area, it is an area which not much is invested in: nothing to do with the NHS, it is throughout all health care systems.

Q Would you enlarge on that. You say "a vulnerable area" and isolated as it were, what do you mean by that?

A Isolated because geographically it was isolated from mainstream medicine. Junior doctors were not available to Dr Barton or the whole of Gosport War Memorial Hospital.

A The patients had multiple comorbidities. Once they went into the terminal phase they were outside mainstream medicine. That is quite fair, they needed to be given symptom control in an environment which is not luxurious in terms of staffing.

Q You say this is a world wide problem. In relation to palliative care generally, do you mean?
A Britain has exported some of the finest palliative care regimens outside to the rest of
B the world. I think we have driven that. There is no doubt that palliative care all over the place is under resourced and terminal care particularly so.

Q Considering the position again, broad bush, what were the practicalities, apart from walking away from the job, for any doctor in terms of doing anything different to what Dr Barton did?
A Developing systems internally to try and cope with the problem, which I think she
C did; trying to lobby for more staff which, from reading the various bits of evidence, she did. One of the problems is that it was an outpost of the main Hospital Trust and, therefore, the management control did not seem to be clear how the place was being managed from the centre. How would you actually go about getting better resources and whose responsibility was it? I would say it was not the responsibility of a five session clinical assistant to have to do that.

D MR LANGDALE: Professor Sikora, that is all I am going to ask you because were you not asked to look at the individual twelve patients and check all their records, and so on and so forth. Obviously you have seen material relating to them in your reading of the transcripts, but I am not asking you to go into individual cases. That is all from me at this stage. Would you wait there because you will be asked some more questions.

THE CHAIRMAN: Thank you, Mr Langdale. Yes, Mr Kark.
E

<u>Cross-examined by MR KARK</u>

Q Professor Sikora, I was going to start where Mr Langdale left off. That was to just examine with you what you have not reported on, as it were. So far as the material that you were given, I do not think you were given any of our patient notes, were you?
A That is correct.
F

Q So you have not actually examined the individual cases of those patients?
A That is correct.

Q In terms of what the Panel have looked at but you perhaps did not – and this is not criticism of you whatever – although you had Dr Barton's statements, the notice of inquiry, Professor Ford's reports, and you have read his evidence and her evidence – I do not think
G you were given the patients' relatives' statements?
A No, I was not.

Q The nurses' or the consultants'?
A I have seen the transcripts.

Q You have seen the transcripts – of whom?
H A The consultants.

Q And the nurses?
A Some of them.

Q And the actual prescriptions that were written by Dr Barton. I know, obviously, you have seen the reports about them. You have seen what people said about them. Have you examined the prescriptions yourself?
A I have not examined the original prescriptions.

Q For that reason, quite properly, you have not sought in your report or your verbal evidence now to comment on the treatment of any of the patients?
A That is correct.

Q So far as your own practice is concerned, you are a cancer specialist?
A I am.

Q You are, if I may say so, a very well known cancer specialist. You would not class yourself as a geriatrician?
A No.

Q And obviously you deal frequently with people who are in the terminal stages of illness, do you?
A I do.

Q And have to be treated with palliative care or by palliative care?
A I do.

Q As you are probably aware, I think only one of our patients in fact had a carcinoma of the bronchus?
A That is correct.

Q Just thinking about the position at the Gosport War Memorial Hospital obviously you have not practised anywhere similar to that community hospital, or the like?
A I have been responsible for palliative care in a community hospital.

Q In a consultant role?
A No. In a management role.

Q As I think you commented in your report, there are various things one can say about the Gosport War Memorial Hospital. First of all, there seems to have been a lack of supervision over what Dr Barton was doing?
A That is correct.

Q It may well be that the consultants whom you have spoken about were not as available or indeed as active as perhaps they should have been?
A It is difficult to judge.

A Q And you have also spoken about the changes in the nature of the patients in the latter half of the nineties. Just looking at that for a moment, that was a nationwide problem, I think. That is not restricted to the Gosport Peninsular, is it?
A No. It is ubiquitous.

Q That was happening, fortunately or quite possibly unfortunately, in community hospitals up and down the country?
B A Correct.

Q And so people in Dr Barton's role – and her role, again, was not unique, was it?
A No.

Q The role of clinical assistant where a doctor would be visiting a community hospital and not there on a full time basis is – was – a very well known position?
C A Correct.

Q And so people in Dr Barton's role would be having to deal with that sort of change nationwide in community hospitals, up and down the country?
A There would be local variation on the severity of the issue.

Q Absolutely. I absolutely take you point, and we all understand, that when a doctor is
D prescribing for a patient, and you have very much highlighted this, it is important obviously to observe the signs and symptoms of a patient?
A Correct.

Q And I think in your report you commented on the difficulty of going back through sparse, sometimes sparse, notes and then forming an opinion about the management of the patient?
E A Correct.

Q I expect that you accept that there are circumstances where a prescription can be so obviously wrong, or a plan of treatment or lack of treatment can be so obviously wrong, that an expert is entitled to comment?
A Yes.

F Q Because that, of course, is the nature of expert evidence?
A Absolutely.

Q So far as the issue of note-making is concerned, you have not commented on it particularly but, again, the vast majority of doctors working in a hospital environment, particularly one suspects in the NHS, would describe themselves accurately as very busy?
A Yes.
G

Q And quite possibly overworked?
A Possibly.

Q And perhaps particularly geriatricians?
A The numbers of patients involved are large.

H

Q And although we know that doctors are taught to make notes about everything that they do, it is not always possible?
A No.

Q Some notes, I expect you would agree, are rather more important than others?
A They are.

Q I am going to run through it, if I may. A note of an assessment when a patient first arrives at a hospital can be fairly critical to give the doctors and nurses a starting baseline?
A It can.

Q Such a note can be critical for the future care of the patient, because without it you do not know where you started from?
A It can.

Q You would expect, would you not, in general terms for major changes in the condition of the patient, or deterioration of a patient, to be made?
A Yes.

Q You would expect in general terms for major changes in the management of a patient to be noted?
A Yes.

Q And when there is a major change in the drug regime, and by way of example, starting opiates where a patient has not been on opiates before, you would expect a careful note to be made about that decision?
A Yes.

Q And the decision to enter into non-curative palliative care is a particularly important decision in a patient's life, is it not?
A It is.

Q And is that something which in your own practice you would either note down yourself, or I expect now you may be too lofty to do so, but you would certainly ensure that doctors under your management would note it?
A Yes.

Q You have spoken about starting doses. I think in your report you say this:

"A range of starting doses between 10 mg to 20 mg"

– and you are referring, I think, to diamorphine?
A I am.

Q

"A range of starting doses between 10 mg to 20 mg subcutaneously delivered by a syringe driver over 24 hours would in my opinion be reasonable."

A Correct.

Q In what circumstances?
A When someone has chronic pain. When someone is chronically agitated and is going into a terminal phase of their illness.

Q Plainly you would not write out such a range unless you felt there was good reason either for believing that the patient was at that time in chronic pain, although perhaps that is a misnomer. Chronic pain means long term pain, does it not?
A Correct.

Q Or very soon to be visited by serious pain?
A Yes.

Q In general terms, and you have been dealing with this sort of patient for a long time, a range of the starting dose between 10 and 20 mg – is that something that you yourself have written in the past?
A Yes, yes.

Q And it is the sort of prescription that you would expect to see among those practising under you?
A Yes.

Q What matters, of course, is the patient, as you said, in front of you?
A Correct.

Q And an attitude of "one size fits all" would be wholly inappropriate, would it not?
A It would.

Q You also said in the course of your evidence, and this was not quite consistent with your report, I think you said, "A starting dose of 20 mg seems a reasonable dose". I did not quite understand in what circumstances you intended that to be read?
A I think in a unit where the doctor cannot return within an hour, and where the staff ratios are relatively low. There it would be reasonable to start at 20 mg rather than 10 mg, for example.

Q But for what sort of patient? What are you referring to?
A For a patient who is either in pain or severe distress, or likely to be in pain.

Q Over what time period? Presumably before the doctor can get back?
A Yes. Twenty-four hours, I would assume in this case.

Q I do not know if you are aware of this, but in relation to this particular hospital, we have heard a number of things about the cover that was available there.
A Right.

Q We have in fact heard that there was effectively – that horrible expression – 24/7, but there was in fact round the clock on-call cover. Were you aware of that?
A I was, but it was clear from some of the statements that that cover was very variable in terms of its actual delivery.

A Q So far as the starting dose is concerned, you have spoken about the WHO, the analgesic ladder. I just want to ask you a little bit about that. Do you still have that binder near you? You have been an adviser to the WHO, although in a different capacity of course, and I do not think you took any role in the devising of these particular guidelines. Indeed, the analgesic ladder, I expect, has been around as long as you have, Professor Sikora?
A Yes. It was there twenty years before I arrived.

B Q It is a very well known basic medical principle, really. Does it go hand in hand with the titration of doses?
A It does. It does, and the ladder itself is about the type of drug, so by the drug, by the route, by the clock and by the patient. These are the four bits in the WHO, but the ladder is specifically about moving from mild pain control to severe pain. One of the problems right across the world is the unwillingness of systems to actually move patients through to the severe pain when it is indicated.

C Q And these guidelines and, indeed, the guidelines in the BNF that you have not looked at, but these guidelines are devised to deal with people potentially in chronic pain?
A That is the case.

Q People dying of cancer and other serious illnesses?
A The guidelines were made for cancer but, as I think I said earlier, the palliative care
D movement across the world is adapting very similar guidelines to other areas of terminal care outside the oncology world.

Q And the guidelines, can we assume, were devised by people on the basis of knowledge built up from dealing with patients in chronic pain?
A And it applies also to acute pain that is not caused by something ---

E Q You are quite right. You are quite right to correct me. I keep using "chronic pain". I mean both chronic and acute pain.
A Yes.

Q So it is to guide those who are dealing with patients at the patient's bedside, perhaps, who are in serious pain?
A Correct.

F Q This is not a purely academic exercise, is it?
A This is not an academic exercise.

Q You do not have the BNF or the *Palliative Care Handbook* in your pocket, as it were, and then you throw them out of the window as soon as you are confronted with a patient?
A Exactly.

G Q These are there to help you prescribe for the patient in front of you in chronic or acute pain?
A They are also there to help health workers, whatever their rank, to give benefit to patients.

Q We have heard quite a lot about the effects of these drugs on the elderly. Again, I do
H not want to spend very much time with you on this issue, but I do not think you have been

A asked to deal with it specifically. Again, we have looked at the BNF. We have looked at the palliative care guidelines. It is a well known principle, is it not, and fact that the elderly are more susceptible, more sensitive, to the use of opiates?
A That is the case.

Q And just by way of example, the sort of half lives that we are looking at in these two documents, that the defence have produced, D7a and b, if one is dealing with an elderly
B patient, possibly with renal impairment, you would not be looking at a two hour half life, would you?
A No. It would be nearer four.

Q Four or above?
A Could be above.

C Q Let us put 7a away, and let us look at 7b. What I think you said was that it demonstrates that there is a plateau at 13 hours and the effectiveness of the drugs goes up a small margin, as it were, beyond 13 hours, but it reaches its effective point – is that fair – at the 13 hour point?
A It probably reaches it in some patients a bit before that, but then it plateaus off slowly.

Q Just looking at the column on the right hand side, and I am focusing on 7b because it
D is much more relevant to elderly patients, is it not than others?
A It is.

Q We can see that after five hours you in fact only reach 2.71 mg?
A I think it is 3.13.

Q I am sorry. Thank you. It is the one below – 3.13. And so 3.13 mg: if you had a
E patient who had what I think is described as breakthrough pain ---
A Yes.

Q --- and you wanted to give them an immediate relief from pain, you might give them – what – a 2.5 mg dose or a 5 mg dose by injection?
A That would be possible, so you get an immediate spurt of plasma level.

F Q And you would hope, would you, that that sort of dose would deal with breakthrough pain?
A It could deal with the breakthrough pain, but then you would have to do it again in four hours.

Q I understand that.
A It may not be possible.
G

Q I entirely understand that. That is the peaks and troughs problem?
A Correct.

Q What this does demonstrate is that a syringe driver is not actually very well equipped to deal with a patient who is suddenly in pain?

H

A A Not a patient that is suddenly in pain, but that is usually not the case. The patients develop pain slowly and the attraction of the syringe driver, once it is there it goes on smoothly for 24 hours a day.

Q In terms of setting your starting dose with a syringe driver, and we have talked about the analgesic ladder and titration, it is important if at all possible to have titrated to the dose which you want to start the syringe driver at. That is very bad English, but does it make
B sense?
A That would be the ideal situation to go for, to have either oral morphine or long-acting morphine or, in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine.

Q Because unless you do that there is a serious danger that you are either going to start too low or too high.
C A That is the case.

Q With your syringe driver.
A Exactly.

Q I have dealt with the *Palliative Care Handbook* and the WHO guidelines but the principle of titration does not go out of the window because you are dealing with a patient in
D pain; it is very relevant, is it not, for a patient in pain?
A It is. One of the reasons the subcutaneous drivers are not mentioned in any WHO book is because they are from low resource environments where you do not have the luxury of them, but they are recognised as a superior form of long term pain control.

Q The principle of titration does not mean, does it, that you need to have a nurse sitting watching the patient for a 24-hour period at the bedside, it means fairly regular review and
E occasional notice, is that fair?
A It does, but it also means variable prescription and, if necessary, injections every four hours.

Q Certainly, but if you were trying to titrate the dose to get to a point where you knew you could control the patient's pain, presumably you would have your nurses observe the patient every hour or two – sorry, you are nodding.
F A Yes, that would be the case.

Q And then make a note of it every four hours perhaps.
A Yes.

Q I think that actually is the guidance given by the Liverpool Care Pathway, is it not?
A It is.
G

Q You spoke about the use of opiates and I think you were talking about for a dying patient.
A Yes.

Q Who is very fearful and agitated.
A Yes.
H

Q Do you yourself use opiates in those circumstances?
A Yes, I have done.

Q You have done.
A I have done.

Q Can you just tell us something about the circumstances in which that occurred?
A Death is very difficult to deal with for all of us, however experienced you are at seeing it, and the specialty of palliative medicine has made it much easier for the broader community of physicians and other health professionals. Sudden declines are very common within a 24-hour period – a patient goes from being relatively stable into a decline – and with older people it is very difficult to work out what the cause of that decline is. If patients are in pain or distressed then some form of medication is necessary, and that can be done in a variety of routes. Ideally one begins with the oral route but often patients cannot take it – they have sickness, they vomit up the drug that is given, and therefore converting to a parenteral route is the next step. The advent of subcutaneous pumps about 20 years ago through palliative medicine really changed the way in which the terminal pathway can be implemented in patients that are estimated to be within three or four days of death. One of the problems is that it is very difficult to make that estimate, it is very difficult to know the true situation, and I have certainly seen that in my patients – that patients have died much more rapidly than I would ever predict and, conversely, people have hung on for weeks.

Q It follows from that that if you take the decision that your patient is on a terminal care pathway too early you may get it wrong.
A You might.

Q What I was asking about in fact was the use of opiates in the agitated and distressed dying patient who is not in pain, and I was asking about the circumstances in which you yourself have used opiates in those circumstances.
A Can you just repeat that – the patient in pain or not in pain?

Q Not in pain.
A Okay.

Q Do you use opiates in those circumstances or do you use sedatives?
A No, I use opiates and sedatives.

Q Can you just tell us about the circumstances?
A The most vivid memory is a patient who was in severe distress, a relatively young man, not an old patient, and we just could not get rid of the pain – sorry, we could not get rid of his distress. He was not in any pain.

Q What was his distress arising from?
A A fear of death. He was extremely agitated and it could not be allayed by his family; the nursing care was superb, we were well-staffed. We decided to put a subcutaneous pump in and give diamorphine.

Q That was to give the patient a sense of euphoria and calmness.
A A sense of euphoria and a smooth passage.

A Q Right. Was that a relatively unusual event?
A Unusual in a young person, not so unusual I do not think in older people.

Q You have spoken quite a bit about diamorphine, but of course in this case I think it was invariably used in conjunction with midazolam.
A Correct.

B Q You can confirm, can you not, that midazolam itself has a powerful sedating effect?
A It does.

Q One therefore has to be doubly cautious when using the two together.
A Yes.

Q I am sorry to keep coming back to it, but it is relevant to what you just said, if a
C patient is on a terminal care pathway we can take it that that does not avoid the necessity of using the analgesic ladder or the guidelines so as to ensure you are not over-sedating.
A Correct.

Q Because the danger is otherwise that you can end up with an unconscious patient who does not need to be.
A That is correct.
D

Q Or a dead patient who does not need to be.
A Correct.

Q You spoke about the possibility of stopping a syringe driver completely perhaps in the circumstances we have heard in this case, if a relative wanted that to happen. There would be no difficulty, would there, if there were strong reasons for doing so, good reasons for doing
E so, in reducing the amount of opiate to see if you could find yourself in the position of having a conscious patient but a patient without pain.
A There is a fine balance and it can only be done on an individual patient basis. People do not die from at one moment being completely well and pain-free and not distressed and then at another moment they keel over and that is it. That is not the sort of patients that were at Gosport in any case.

F Q I entirely understand that but if you have a patient who one day has been talking and eating, let us say, and the next day is unrousable and a relative wants to be able to speak to that patient to find out if that is the state in which they wish to be, you would consider, would you not, reducing the dose if you felt it appropriate so that the patient could be roused to speak to?
A It would depend totally on why they had been started on that but just to do it for the relative's wish to speak to them is not reasonable I would have thought.
G

Q It depends on the level that was needed in the first place.
A It depends on the whole clinical circumstance.

Q You spoke about the possibility of having to start at a higher dose than you would otherwise want to if you have inadequate staffing levels, and I just want to ask you a little bit about that. Was it your understanding and the basis for that comment that the nursing levels
H at this hospital were inadequate?

A A They seemed to be inadequate from many of the documents I have read towards the end of the period, in the late nineties, not so much the beginning of the nineties.

Q Can I just read a comment. We have heard from a lot of nurses and I am just taking the words of a nurse that we heard from just yesterday, a sister, who was asked this:

> "Did the nursing notes suffer in any way as a result of the increasing workload?
> B A No. I must point out I had an excellent team of nurses. I am afraid I am a bit old school and I like to think my standards were quite high and my nursing staff knew of this, and if there had been any backlash from this, they would have either come to me or gone to management and it would have been discussed, but I never found that the extra workload affected my nurses' care in any way at all."

That was Sister Joines. If the position was in general terms that the nursing care on these two C wards that we have been dealing with has been described as either very good or excellent, yes? You are nodding and it will not appear on the transcript.
A Yes.

Q Although Dr Barton's time was plainly limited, as we have heard, we have heard from a number of nurses that although the patient type changed and they had to account for that, the patients did not suffer as a result.
D A Right.

Q You are not saying, are you, that in the circumstances in which Dr Barton found herself at this hospital she was entitled to ignore either the *Palliative Care Handbook* or the *BNF* when writing out her prescriptions?
A Well, did she ignore it?

E Q Apparently, yes, she said so.
A Okay.

MR LANGDALE: I am sorry, that is not what her evidence was. She was not saying "I ignored ..." She was well aware of what was in the *Palliative Care Handbook* and the *BNF* and she took her decisions for reasons which she explained to the Panel. She was not ignoring it in the sense that my learned friend is suggesting.

F

MR KARK: We will have to check the transcript. My recollection is – perhaps it does not matter what my recollection is but certainly Dr Barton accepted that she was not following the principles in either the *BNF* or the *Palliative Care Handbook*. I do not know if that is challenged as well.

MR LANGDALE: You say "the principles" – she gave the reasons why she prescribed as G she did and the reasons for them not being according to specific guidelines set out in the *BNF* and the *Palliative Care Handbook*.

THE CHAIRMAN: Can we work on an agreed basis that she made a conscious decision not to adhere to the guidelines. Would that be a reasonable way of proceeding?

MR LANGDALE: Speaking for myself I think that covers it.

H

MR KARK: We have a measure of agreement. Can I just ask you this: are there circumstances in which you yourself have taken the decision not to adhere to the guidelines?
A Yes.

Q What have those circumstances been?
A Relevant to this to give much higher doses of analgesics in certain circumstances.

Q Can I ask you what those circumstances were, please?
A They are all related to cancer and they are all in patients with really severe pain and in one case distress and agitation that was really very distressing for the family.

Q Were you there on the spot?
A I was there on the spot. I was called by the senior registrar who was not able to deal with the situation. It is very unusual but it does happen, even in a very well-staffed environment.

MR KARK: That is all that I ask, thank you very much.

Re-examined by MR LANGDALE

Q Professor Sikora, two matters arising out of the questions you have just been asked by Mr Kark. May I take up the last matter you were asked about when you said what you yourself had done. In terms of the *BNF* is there any guidance in the *BNF* as to the dose that is appropriate in patients who are on a terminal pathway?
A That is avoided in all literature because there is no written dose that is standard, it has to be decided on the spot.

Q Something that you said earlier on when Mr Kark was asking you about the analgesic ladder and so on and asked you to look at the particular passage in the *Palliative Care Handbook*, you said if I have noted it correctly that there was a reluctance – I think you said worldwide – to move to the higher strength or stronger opiates. I may not have got your words down precisely but in broad brush terms is that what that was saying?
A That is correct.

Q Could you just enlarge on that?
A In many countries it is not the availability of the opiates, it is the willingness to use them. Often on cancer wards the patients gain because people are used to it but on non-cancer wards there is much more hesitation. That is changing but it is there. There are also professional differences, so nurses may be much more reticent to use opiates compared to physicians and I guess it is to do with the recognition that the patient really is terminal. Nurses that are there caring for the patient all the time may not wish to acknowledge that inside and therefore are much more hesitant before committing a patient to that, and that may be one of the reasons for the difference.

Q There has been some evidence – I do not know whether you will have picked it up in the transcripts that you yourself have had the opportunity of reading or not – that in the hospitals, the common hospitals that we have been encountering in these cases – the Haslar and also the Queen Alexandra Hospital, the two main local hospitals – there was some evidence to the effect that in the hospitals for patients who had received some kind or surgical

intervention or some kind of acute treatment as it were there was a tendency to tolerate higher levels of pain in patients than you would find, perhaps, elsewhere.
A Absolutely, that is a common phenomenon in all hospitals. When I had my appendectomy I made sure I got my own private bottle of analgesics.

MR LANGDALE: We will not go into that. That is all I need to ask you about that. Sir, that is the last of the questions I need to ask in re-examination. Thank you.

THE CHAIRMAN: Thank you Mr Langdale. Professor, we have reached the point when it is for the Panel to consider whether they have other questions for you. I am afraid we operate in a somewhat lower gear to learned counsel and we are unlikely to be in a position to launch straight into questions. What I suggest, Mr Langdale, Mr Kark, is that we go into camera now for the Panel to consider such questions as they may have and say at this stage not before two. After the luncheon break hopefully we will be in a position to proceed.

Professor, we will rise now. You remain on oath so please do not discuss the case with anybody during this period. You are very free to leave the building and you can have, as a consequence, a somewhat longer lunch than might otherwise have been the case, but please be back here for two, at which time I hope, but cannot guarantee, that the Panel will be in a position to go forward. Thank you very much indeed, ladies and gentlemen.

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

(Luncheon adjournment).

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back everyone. I am sorry we lost an additional half-hour but it just goes to show I was correct when I consoled Mr Jenkins with the observation that my time estimates are no better than his.

Professor, I remind you that you remain on oath. What will happen now is that individual members of the Panel will put their questions to you. When we have done that, there is a final hurdle, which is that counsel themselves have an opportunity to ask you any questions that might arise out of any of the questions that we have asked. Is that clear?

THE WITNESS: Thank you, yes.

Questioned by THE PANEL

THE CHAIRMAN: Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Professor Sikora, much of the evidence you have been giving us is related to terminal care and patients who are on a terminal care pathway. I understand you to say that when moving on to a terminal care pathway, there is an expectation, there is a clearly defined diagnosis, that we have patients for whom there is no further cure for their medical conditions.
A Right.

Q Part of those medical conditions is really around extreme pain so the management of that pain takes the priority. When we are considering the patients we are considering through this hearing, we have patients who have been admitted to the hospital for continuing care and for rehabilitation. They have then speedily moved, seemingly speedily moved, on to a terminal care pathway. What standards would you expect there to be in place as we move into a different pathway?

A In an ideal world, you would want to compare this unit with another unit. You would want to be able to audit. Audit really came in acute NHS facilities around the time of this incident, during the 1990s, but, even to this day, has not come to the chronic long term care environment in the way one would like. What one would really like to see is, using information technology, was there something different going on during different time points and you cannot do that because there is no comparator. You are quite right, it is difficult to know retrospectively. One assumes that patients are going there for chronic rehabilitation and that was something that changed with time, and a certain percentage of those patients will suddenly deteriorate over a week or so and go into a terminal phase. I do not know from the evidence I have seen what the denominator – we know there are 12 patients being considered here – I do not know what that was out of. Was it out of 20 patients in which case it would be a little alarming, or was out of several thousands of patients which would make it not alarming?

Q I accept what you are saying, but I would like to direct your attention not to any particular patient, but if we are thinking around any standard relating to any particular patient as you are moving from one to another, so protecting the patients' interests and all those sorts of processes, what are the sort of standards that you would expect around processes for individual people to protect their interests?

A One would like to see a multidisciplinary team discuss the patient before doing it. However, that, certainly with the staffing structure as alluded in the evidence, would not be possible. I do not believe there was a conventional multidisciplinary team meeting to do just that, certainly not one that can be convened quickly to deal with a patient who is deteriorating over a 24 hour period, for example. To my knowledge there are no written standards of that sort of thing around, certainly in the 80s and 90s. Now people are much more careful about starting a terminal care pathway and document it much more thoroughly, but 10 to 15 years ago this was not the case.

Q Although there was not a disciplinary team, there were consultants around that Dr Barton could consult with, who perhaps were the people who were responsible for those patients when admitted. What would have been your expectations round that?

A My expectation would be that Dr Barton and the nursing team would make the decisions and the consultants would ratify it when they came round. I would not have thought they would come especially to see a patient out of hours. That would be unusual and really not possible. It is clear that the consultant's attendance was not on a regular basis for some of the time, it was not even weekly some of the time, therefore you could not get that ratification, so I think Dr Barton and the team of nurses are acting on their own in many ways with the sort of decision. They would not be able to get advice as to whether to go or not go on a terminal care pathway, they would have to make the decision themselves.

Q You are saying that in a multidisciplinary team meeting everyone would have had to have seen the patient to have made that decision?

A A Not usually, but some of the staff would have seen the patient but they would sit around, discuss the patient, those who had seen would contribute and then an agreed decision would be made, but that takes time.

Q It does, but it is a far cry from it then becoming Dr Barton's decision and the nurses' decision?
A I understand.

B

Q What would have been an intermediate step – phoning the consultant, discussing?
A It would be difficult for the consultant to contribute down the phone. I think he or she would have to come and visit if they were going to make a meaningful contribution. They could be contributing to policy but not to an individual case.

Q Let us look at another standard about the choice for patients. What about patients' C involvement? If a patient is suffering from dementia and is not articulate and cannot contribute, that is one set of circumstances, but when patients are actually articulate, what about their actual involvement in the choice about whether it is going to be terminal care or perhaps more invasive surgery?
A I think it is very rare surgery versus terminal care, it would be very unusual for that to happen. Involving patients is something that, again, there has been a huge change of patient empowerment over the last 15 years. My clinics with new cancer patients take a lot longer D and my colleagues in cardiology say the same thing. All the options are gone through and the patient is then involved in choosing the decision-making. That certainly was not the mode of operation in the 1990s – the challenge in these particular circumstances, the very age of the patients in many cases and the fact that they had multiple comorbidities. Many of the cases, I am sure, reading the evidence would not have been able to take part in the decision-making in a meaningful way. Their families would but they would not.

E Q I will bear in mind within that that you do not actually know the individual patients because you have not looked at their circumstances.
A Exactly.

Q I move on to a slightly different point, because all the time we have to look at how we protect the interests of patients. You said that in terminal care it is open to the discretion of the clinician, the doctor, as to the dosage of opiates that actually may be used. What F safeguards should there be in place to prevent that patient being over dosed?
A Audit and monitoring: in other words, the pharmacy; there should be monitoring in what is going on in real time with good information technology, which was available – local computer programmes were available but not in place; consultants checking protocols and checking that policy is adhered to; nurses who were also involved in this should be the same; and management, who are ultimately responsible for day to day operation and strategic development, should also be involved in the process. There should be checks. The difficulty G is the change in era. Today there are checks everywhere and people are very conscious of this aspect. In the 1990s there was not anywhere.

Q Clinical governance was in place, was it not, in the early 1990s?
A I suspect Gosport was the sort of place where governance reached last because of the nature of it.

H

Q From the perspective of the personal accountability of the doctor, how would you see the standards being managed? You talked about the audit and you have talked about management and overseeing the doctor, from the personal accountability of the doctor when making such critical decisions when to move someone into terminal care, how would you see that doctor making sure that their standards were very transparent and overt?
A I imagine the best way in those days was discussion with the consultant ultimately responsible for that patient – named consultant, named patient – and Dr Barton; obviously, if it cannot be done immediately at the next available opportunity. The problem, again, from the evidence is that the consultants were busy, mainly elsewhere. It is not that they were not working, it was just that were tied up in clinics and ward rounds elsewhere within the Portsmouth system. To them it is relatively low priority.

Q Is that sufficient justification for the doctor not to make that a priority?
A Dr Barton or the consultant?

Q We have heard that the consultants could be available. If Dr Barton wanted the consultants to be available, they could be available. You are saying that a good standard would be for the doctor to discuss the patient's condition with the consultant and then to jointly form a decision, or at least discuss it the next time that the consultants are on the ward. I am looking at the standard for that and you are saying they were busy people, but that cannot overcome what is actually in the interests of the patient, can it?
A Absolutely not, but I would imagine that the patients were discussed with the consultant at the next available visit but, unfortunately, that visit may not be for two weeks after a decision had been made and that is one of the issues. The ideal situation is to have a daily meeting of some form where every patient is discussed, but that would not have been possible for Dr Barton with her plan, or her self constructed job plan, because there was no formal job plan for her.

Q What accountability does the doctor have to make sure that there are certain standards put in place?
A To me it would be the responsibility of the consultants to make sure that they have a system in place that allows their patients to be protected. It was not up to Dr Barton to construct that, she was the part-time clinical assistant who was implementing policy that was the responsibility of the consultants.

Q A final question from me. I understood you to say when you looked at it that you saw that the Gosport had no easy access to x-ray equipment or to acute services, but what you are not saying is that moving to a terminal pathway can be justified because you do not have access to those services?
A No.

Q Have I understood you correctly, or were you saying you might move to a terminal pathway because you do not have those sorts of services?
A No. The only option if you are going to have x-rays and other investigations done, was to transfer the patient over 20 miles. If a patient is near death, that would seem almost cruel to me because the chances are that whatever is causing the symptoms is going to get worse if you start transferring patients. Also acute services, certainly on the south coast during the 1990s, were very over stretched, so you would be moving patients around on a regular basis which would be difficult.

MRS MANSELL: Thank you.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

MS JULIEN: Good afternoon. Some of my questions slightly overlap so, unfortunately, I may need you to go over some ground you have already gone over, but from a different perspective. My first question is in relation to the range of the doses of what you described as a cocktail of opiates, the wide range of the cocktail. I think you had said that the wide range allowed the nurses freedom and flexibility, I do not know your exact words. My question is that, in a situation where there are fewer resources, the nurses using that wide range would be going in straight at the higher rate than they would possibly in another situation. What I am concerned about is, if there is not titration from the beginning, how do you think, under that sort of regime, the risks to the patients could be managed?

A The only way to manage the risk is closer observation. The reassuring factor, looking at the data, is that there was only one patient given at the higher end, at 120 mgs, of the diamorphine. The majority of patients were actually under 80 mgs, so it looks as though, from that evidence, there has been a titration process in place and the nurses were following it. I have not seen the patients, but one assumes the 120 mg patient was had severe problems and that is why the dose was given at that level.

Q The range allowed them to be in a position that they could have gone higher?

A They could have gone to 200 mg, yes.

Q It may be that they did not, but they could have.

A Exactly.

Q That is really my point. In that sort of situation, how would the risk be managed, particularly in terms of adverse effects?

A The way to manage it would be to have the pharmacy monitoring it, producing weekly, monthly reports so you can see any trends in the patters of diamorphine, midazolam and other drug usage.

Q It is the pharmacist who has to manage the risk?

A There was a ward pharmacist, the clinical pharmacist and it would be they who were responsible for patterns of drug use that were changing with time.

Q Would that be sufficient to prevent over sedation of the patient?

A Together with observation by the nursing and medical staff, that should be.

Q If it is a weekend or late at night and it is just the nurses and they are working within that regime, the pharmacist is not necessarily going to be around at that sort of time. Is that sufficient to manage the risk?

A I think all one can do is observation by the staff. What one does retrospectively is to have the pharmacy audit to see if there is a pattern change which happened. That would ring the alarm bells if there was.

Q Would that sort of system be in place at that time in your experience?

A I have seen no evidence that it was in place.

Q You have seen no evidence that that was in place, so the nurses were working under a system where they had quite a lot of discretion?
A They had discretion. The fact that they did not go to the top end immediately and there was a distribution of doses, suggests that they were using that discretion appropriately, although, as you know, I have not seen the individual cases so I cannot comment on that.

Q You accept that there could have been a situation where they may not have done that, it was left open?
A Indeed.

Q Going back to the terminal pathway situation, I think you said that once a patient gets to the point where they are on the terminal pathway, that would not be the time to conduct or to initiate any sort of investigations. I think you said it was a time for good decision making?
A Exactly.

Q What about before you get to that point, would a doctor need to be sure that they had carried out all the investigations before they got to that point?
A I think these patients in many cases had been actively treated not at Gosport but another hospital, and transferred there, so the whole purpose of Gosport was to try and free up space in the acute hospitals, and also to provide a more gentle environment for the management of a patient. If a patient started deteriorating for whatever reason, if there was thought to be a medical problem that could be elucidated, they could be sent for further investigation. On the other hand, if they were beyond that, if they were deteriorating rapidly, there would be no point and a decision would be made just not to further investigate the patient. That would be the normal practice.

Q The doctor would have to be sure in herself that she had carried out all the investigations, because you are saying there would be no point once they were on the terminal pathway?
A It would be based on the history. It would be based on the medical details of that individual patient. Over the last few months, why have they come to that point? If there are factors that are essentially irredeemable – renal failure, cardiac problems, chest problems and so on – you make the decision there is no active treatment that can be done. In cancer it is slightly easier because you have good ways of monitoring the cancer. In general medicine, it is a bit more difficult. In post-surgical procedures such as hip surgery, and so on, it is a bit more difficult, and in patients that cannot give you a history, it is doubly difficult but I think you can come to a point where you say, "No more active treatment. Tender loving care only," and you put the patient into that pathway. You deal with the symptoms as they arise.

Q And that pathway can take quite a lot time to get to the end of?
A It is extremely variable. It can be 24 hours or it can be 24 days.

Q Let us suppose in the event that it is 24 days, under no circumstances would you consider it would be appropriate to conduct any sort of investigation or another opinion?
A Unless the investigation was going to lead to a change in treatment, and that seemed very unlikely in this group of patients, even a simple chest X-ray – what would it do? Would you really start patients like this on antibiotics, for example? So why do the chest X-ray? We always teach students that diagnosis is only a guide to treatment.

Q Possibly you could consider it. You may not actually carry it out but it does not mean you close the door and you do not consider it?
A You could consider it. I am sure there were patients transferred back to the acute sector over the years from Gosport.

Q Just moving on to the syringe drivers in general, there was a point where you were talking about the possibility of reducing, or taking someone completely off a syringe driver, I think you said that it could be seen as unethical to do so. My question is this: in a situation where a patient could be taken off and a level of consciousness could come up to a level but they have not actually started to experience pain – maybe just before that pain threshold if you understand what I am talking about?
A Yes, I do.

Q Surely that would not be unethical at that stage, would it?
A It would require close monitoring because otherwise the patient could be in pain for several hours before anything is done about it. It is possible to do that.

Q The hospital could do it. And if they were experiencing some pain but not intense pain, but some pain that they could communicate?
A If they could communicate, you could then increase the dose again. They go back to a higher dose.

Q And it would not be unethical to do that, but I think to stop everything would be unethical, which is really the only way to find out what is going on – to stop all medication and see what happens to the patient.

Q So stopping would, but a reduction would not?
A The problem with a reduction is, you would have to do it stepwise and monitor the whole thing. It may take several days before you knew what was going on. There are circumstances in medicine where we do stop everything where we are not sure if it is the drugs that are actually contributing to the medical problem. We stop everything and see, but in a very controlled and monitored environment.

Q And that could be seen to be in the best interests of the patient, would you say?
A It the environment is properly monitored it can be, but it depends on the type of patient. I would have thought with this group of patients, to me, it does not seem likely that you are really going to get any benefit. The idea is to make these people comfortable.

Q Does the reason for not stopping its impact and reducing, whether you think it would be ethical or not, the reason for doing it? I am thinking of, let us suppose, the next of kin want to speak to the patient, or want to make necessary arrangements, what would be your take on that?
A I think that would be difficult. I think if the patient had had severe symptoms, I would try and persuade the relative that it would be unkind to do that sort of thing if they wanted to. Patients do surprising things in the terminal phase. Sometimes people suddenly wake up and suddenly have a lucid moment. They talk for ten or fifteen minutes, and they express their wishes – and this does happen – but on the whole the terminal event tends to be a progressive downward spiral as the organs shut down. So it is really unkind to suddenly stop everything and try to get the patient to... We have ways of counteracting diamorphine with drugs. If someone takes an overdose we have an antidote that we can give, and is given

A across the road but it would be unethical, I would have thought unethical, to do this in this group of patients where the illness trajectory is definitely downhill.

Q So in those particular circumstances unethical, but you are not saying it is a blanket situation?
A No. There are circumstances where we do do it, and it would not be unethical.

B Q My other question is about the options available to Dr Barton. You had said at one point that you considered the various options or alternatives would have been available to her once she found herself in that particular situation. I think you had started to talk about her resigning being an option, but you were not able to pursue that. I just wanted you to elaborate on that?
A One option for her is walk away from the whole issue – just say, "This is no good. I cannot stand it." The other option would be to discuss the issues with the consultants, which
C ---

Q Yes. I think you did talk about that. I was specifically interested in her resigning.
A Right.

Q Just what your view is about that.
A I think morally it would be difficult to do. She would be leaving. The next person
D would come along to the same circumstances, so changing the system would seem better than just walking away from the system, to get the whole thing better. I think the difficulty is, there was no clear leadership amongst management, both general management and medical management, that she could go to so far as I can see from reading the evidence.

Q We do know that after Dr Barton resigned there was an improvement in terms of resources.
E A Right.

Q Do you have any different take on the matter, knowing that?
A I think the public outcry at the time was great and the health authority had to do something. They funded a full time position permanently based at the hospital, not offsite at all, afterwards.

F Q And my last question relates to note-taking. You would accept that keeping clear and accurate records. It is part of good clinical practice?
A Yes.

Q It is part and parcel of clinical practice in general?
A Yes.

G Q Would you say it is an integral part?
A It is an integral part.

Q Would you say it has equal weighting to actually providing treatment and care?
A I think if you had to chose or the other, you would choose the care first and the notes afterwards. There is no doubt that is the way. The other thing is doctors in different specialties and different levels of experience tend to write less and less as they get older.
H Certainly comparing my notes in outpatient clinic to the registrar's notes – the registrar fills a

page and I put two lines down. I like to think that there is enough information in those two lines. And the medical student fills three pages, and that has always been the case in my experience.

Q In principle they have the same weighting though? The treatment and the ---
A To me the treatment and care are more important than the note-taking, but the note-taking is important because it decides future treatment.

Q But according to *Good Medical Practice*, when you look at it, there is not a hierarchy. It has equal status?
A I did not write *Good Medical Practice* but I would have thought, if you had the choice, if you were lying on the street and you had a man with a notebook or a man with a stethoscope, you would choose the man with a stethoscope.

Q But you do accept that it is an integral part of clinical practice?
A I accept fully it is an integral part.

Q And do you accept that if a doctor does not give sufficient weight to note-taking, that he or she does that at her peril?
A I think, again, it is difficult for an individual. My notes last week, because I was in a hurry for a variety of reasons, were brief. No one has told me that my notes were too brief. I had no feedback. I had the feeling from the papers I read that Dr Barton had no feedback about this.

MS JULIEN: Thank you very much.

THE CHAIRMAN: Thank you. Mr William Payne is a lay member of the Panel.

MR PAYNE: I am going to take you back right to the first part of your evidence that you gave because I want to be refreshed. I do not expect you for one minute to be critical of any colleagues, but I want to discuss the input that you said that you first made when you were first asked questions by Mr Langdale with regard to the consultants that were looking after the ward. I think you said – and you have also just said it to my colleague – there was insufficient leadership, no clear guidance and you did not say "insufficient input" but you went on to be very kind, and say they were obviously very busy people, but there was not a lot of input from the consultants above. Can you tell me how you came to that conclusion, to start with?
A A combination of reading the papers before and then the transcripts of this, and listening to them talking. There is no doubt that management in hospitals and health care facilities is best if there is one person that is clearly responsible, a single person that is clearly the place where things get solved. That one person has to be available and approachable and willing to be approached, not just by his medical colleagues but also nursing colleagues, even the cleaning ladies if there is some problem. There has to be that in good management. That was clearly not the case here, and that was the impression I got from the transcripts and the notes.

Q I think you said that the name above the patient's bed was the person who was in charge, and that was the consultant?
A Yes. That is the tradition in British hospital. It is the consultant's name, not the patient's name.

A

Q Thank you. I believe that you also said that Dr Barton had had inadequate training for the role that she was expected to do as the nature of the work changed. Am I correct in that?
A She was a GP, and she was trained as a GP. She had done no specialist training in internal medicine or palliative medicine or, indeed, care of the elderly as far as I know.

Q Right, thank you.
B A She was competent, I would have thought, from her training to be a clinical assistant but by its title "clinical assistant" implies there is someone that is not the assistant who is looking after her.

Q Right. If you have someone in that situation that you identified as not necessarily having the adequate training, and you have a consultant who obviously had the adequate training, who should be responsible for making the decision to put someone on a terminal
C pathway or an end of life pathway?
A Ultimately it is the consultant's responsibility, definitely, but having said that they can delegate that to people on the spot, and they did delegate it to people on the spot.

Q How did you come to that conclusion, that they had delegated it?
A They were not there. Without seeing the patient, it would be difficult. Even if they knew the patient, and the patient had changed, and they did not come to see the patient, and
D they were not running the place on that basis – they were not available to come on a Tuesday afternoon, for example, suddenly to see one patient, it would disrupt their normal clinical patterns of work, then they would have to delegate, and that is what they did.

Q You went on to speak about the best way to assess the needs and requirements of a patient is to be by the bedside and see them?
A Correct.
E

Q And if you were going to have to make a decision with regards to, say, pain relief, then the best decision would be after you had seen the patient?
A Yes.

QBut would you agree with me that it is also – I have to use the word – "guesswork", but there has to be some form of working it out, and a stab in the dark to start with perhaps.
F Would you agree with that?
A I would, and that is the purpose of the sliding scale: that you start off at one end and you can go higher if necessary, so getting started is a stab in the dark.

Q Would that be more difficult if you have not had adequate training for the specific area that you are working in?
A It is a difficult question because a lot of my generation of doctors were trained by
G observation in the work place, and no formal training programmes. I do not mean in cancer medicine, but in things like palliative care. I had to do palliative care as a registrar without any training whatsoever. We did it. The consultants were not interested in talking about it and that sometimes happens.

Q Can I just take that slightly further with you? We have listened to your C.V., and you are very eminent in your field, you are a leader of your field probably, but if you were being
H

taken out of that scenario and placed into a different field, you would not feel too comfortable about making the decisions for someone else, would you?
A No. I thought long and hard what I would do if I had been in Dr Barton's shoes in Gosport. I cannot see any other way out as to what happened. She was delegated. The consultants were there. They knew they were responsible. They could not get more hours at Gosport. Whatever they did there was no way they could spend more time there. The ward seemed to run well and the system worked as far as I could see.

Q But if you were in that situation, Professor, and you were having to make a decision, and you are not adequately trained and you are having to use opiates, for instance, would you not rely to some degree on the use of knowledge that is available to you, like the BNF or the Wessex Protocol, for guidance with regard to the size and the width of the drugs you are going to prescribe?
A Unfortunately the BNF does not have that. It recommends 10 to 20 mg as a start dose, but it does not have an upper limit of the range in it. It does not have a range, in fact, so I think that will be very difficult. A competent GP is trained to give opiates, is trained to give palliative care in patients' homes. This is an extension of that primary care role.

Q Correct me if I am wrong, but the BNF does give a guide to the conversion from, say for instance, Oramorph onto diamorphine?
A It does.

Q By subcutaneous ---
A Exactly.

Q Would it be for someone who, as you have described it, has not had the adequate training to use that as a guide to move forward, initially at least?
A The conversions at two-thirds of the dose of oral morphine – that is presumably what you are alluding to – a patient on 60 mg of morphine ---

Q A third to a half.
A A third to a half, morphine to diamorphine, continuous over 24 hours, that is at two-thirds of the dose to diamorphine. The evidence I have looked at – I agree I have not looked at all the notes – suggest that that was adhered to essentially when the patients had been on opiates before.

Q So you would not be aware that perhaps those doses were maybe twice and three times higher than the recommendations from the BNF?
A The reason for starting the subcutaneous pump was that some event had happened to require a change in the management from oral dose. It may be that the patient was being sick, but in most cases it was because, as far as I can see from Dr Barton's statements, there had been a deterioration in the patient requiring more analgesic and therefore the conversion may not be quite correct. It may not be exactly the same. It would be at a higher level basically.

Q Can I just press you a little more on that? If someone comes to you, let us say, who has been on step one – paracetamol perhaps – would it be appropriate then to write out, even as an anticipatory prescription, a prescription for diamorphine that is three times higher than, say, the minimum start?

A A It depends on the clinical circumstances. If that patient is in severe pain we may go to a very high level and then maybe come back. Lots of things depend completely on the clinical situation.

Q What would be the situation where you would come back?
A If the pain disappeared or if the symptom, whatever the symptom of the distress or anxiety, also disappeared.

B Q If a patient is heavily sedated with, say, midazolam, if you have introduced that as well which leads to heavy sedation, how will you know that you have over-prescribed the diamorphine?
A It is an educated guess, as I think you said earlier, and clinical skill that you realise that the symptoms have now gone and the patient is comfortable. That is the level at which you continue.

C Q You think that the system was working acceptably here.
A I think for that decade it was working in an acceptable way. I could find no evidence of huge, inappropriate doses being given of any of the drugs in the syringes.

MR PAYNE: Thank you very much indeed for answering my questions.

D THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: Good afternoon, Professor. Let us go back to the terminal pathway. The terminal care pathway is predicated on knowledge that the patient is in the terminal stage. In your world of cancer that is pretty well defined, is it not, it is a chronic process that is pretty much predictable.
A Yes.

E Q Apart from one patient in our bundle, 12, there is not a patient with cancer, so I want to ask you this really. First of all, if you are dealing with pain does the object have to be to render the patient pain-free or is it a reasonable alternative to get the patient to a position where they are in a degree of pain that is acceptable to them?
A I would prefer to be pain-free and usually it is achievable, to get pain-free without troubles from the side effects of the medication including over-sedation side effects by
F judicious use of the drugs in most patients. I would certainly rather be pain-free.

Q I think you suggested that in the terminal phase it is reasonable to have a patient drowsy or even unconscious if you know what the course of their illness has been.
A Yes.

Q That is fine for chronic pain.
G A Yes.

Q And you have said that it would be unethical perhaps to withdraw some or all of the treatment to see what they are like, except in exceptional circumstances.
A Yes.

Q What if the pain, as part of a chronic decline in an old person, with many
H comorbidities, was an acute pain and because of the acute pain a syringe driver was started

A with the full knowledge and intention that it would not be stopped. that the terminal pathway had now been entered?
A I think the implication in that question is that the syringe driver was the termination event. and I do not think that was the case. I do not think anyone would consider that in this country. The syringe driver was there ---

Q Explain to me what you mean by that, nobody would consider that.
B A You are suggesting that the syringe driver was used to bring about a terminal event.

Q I did not suggest that.
A I am sorry, I misunderstood. Basically if a patient is in acute pain and one agrees that the patient has no way of coming back to a normal existence the symptoms are treated in the most appropriate way. In some patients a syringe driver is the most appropriate way.

C Q If he was in acute pain how do you know if the pain has gone? It is a silly question.
A Death is a mysterious business, as you know, and the events that put a patient into the decline and the timing of the physiological events are really completely unknown and under-researched – for obvious reasons it is a very difficult area to research. To me a doctor's duty is to get rid of symptoms. Sure, if a patient has no other disease and they are in some short term problem – say acute post-operative recovery – things may be different. But that was not this class of patients here; these patients had chronic disease, long term illnesses, that were
D gradually going down, and some of them exhibited a sudden deterioration which involved symptoms, so getting rid of those symptoms when the patients are deteriorating in the most appropriate way seems reasonable.

Q But would you still apply the adjective "unethical" in that situation if you were to pull back on the dose to see?
A Unethical only in the sense that patients are suffering and have suffered. You have
E got them out of suffering with the medication and now you are going to make them suffer again to satisfy the curiosity of seeing the effects of the drug versus the effects of the disease.

Q What if that change of tack and that treatment were applied in a situation where there was not pain?
A That is more tricky but distress and anxiety are well-known pre-terminal events and seeing a patient is distressed, often shouting, often very disturbed and very disturbing to
F families, sometimes with death rattles and so on, is a very disturbing experience for everybody including the patient, so stopping the drugs under those circumstances would not make much sense.

Q With your expertise would you be prepared to answer a question about a patient with very advanced dementia who did not have cancer?
A If they have got symptoms – whatever they are, not symptoms of dementia but
G symptoms of anxiety, distress or pain – they should be treated like anybody else. The difficulty of course is getting the response.

Q Are you happy to answer a question if I put it to you about such a patient?
A Yes.

Q Do you have experience of looking after elderly demented patients who do not have
H cancer?

A A Only as a registrar in medicine.

Q I will ask it because it is pertinent to our inquiry. Would you agree, from that experience as a registrar, that elderly demented patients in hospital, because of inter-current illnesses or events, can become extremely agitated?
A Yes.

B Q As an acute event.
A Yes.

Q And that such episodes can be well-defined episodes – that is to say they occur and they resolve.
A Yes.

C Q So then if such an event occurred and to that patient was applied a terminal pathway because of that event, what would you expect to be the justification for such a decision?
A Starting a patient on terminal pathway would require more than just having dementia, there would have to be some other underlying problem that was going on that was basically pointing out the fact that this patient was coming to the end phase of their life, so that would trigger the terminal pathway, not the dementia as such.

D Q Such a treatment renders the patient unconscious. This is not pain: would it be unethical to pull back on the treatment or stop the treatment to see if the agitation had gone away?
A It is possible to do that but, as you know, it would require adequate monitoring to do that sort of procedure.

E Q Just in relation to old people you drew attention to the distress of a fear of dying, and I think you talked about a young man with cancer. You may not be able to answer this but you may through your experience. Is the fear of dying a prominent problem in the elderly or the very old or does it tend to wane with age?
A I certainly do not know of any information on that or any data that it does that. One would like to think it wanes and older people have a much more realistic approach about death generally when you talk to them, even people that have not got serious, life-threatening illnesses, but it depends completely on the circumstances around the terminal event whether
F people get frightened or not.

Q Thank you. You said that titration is the ideal but what if I put it to you that it is the norm?
A I would say that it may be the norm under certain circumstances but not everywhere.

G Q I am not into semantics so I will not go further than that. This is a side issue because you said in a certain context that the consultant cannot make the decision – it was a decision about terminal care over the telephone. I wonder how different that is to you being phoned by a registrar in the night when you are on call and given the full details of a patient's situation and then being able to make a decision that helps that registrar.
A There is a similarity but then we have 24/7 cover by registrars, 24/7 cover by SHOs or foundation year doctors, which was not present in Gosport. Occasionally even now I do get phoned up by the registrar to say do you want to resuscitate the patient, for example; if I
H know the patient it is usually quite easy, if I do not know the patient – and these consultants

A in Portsmouth had a lot of patients under their overall care and they could not possibly remember the details of all the patients I would have thought – it would be very difficult to know what to do.

Q Even with a very experienced clinical assistant who had been there for ten years or 20 years.
A Exactly.

B

Q Right. Can we turn to guidelines? You have said that you stepped out of guidelines.
A Yes.

Q I am sure we all have. When you step out of guidelines what do you do?
A You write it down.

C Q Why?
A So you do not come to the GMC I guess. No, so that people can understand, so that other staff members understand the rationale for you diverting from guidelines.

Q To justify it.
A Justify it, yes.

D Q Would you expect to do that on an individual patient basis every time you do it?
A I do not do it every time, it depends how unusual the event I am doing and how far I am going from the guidelines.

Q Some doctors – indeed quite a lot of doctors – when you mention the word "guidelines" groan.
A They do.

E

Q We have even heard one doctor here say that they are tramlines, but guidelines are there for a purpose are they not? They are there to guide us as to what to do. Dr Barton has made, in her evidence, a number of references to not taking account of or ignoring guidelines in the form of either the little green book, the *Palliative Care Handbook* or the *BNF* when writing prescriptions for syringe drivers. She cites as her justification her long experience, and indeed Mr Kark on one of those occasions asked her about writing such a prescription F that was called anticipatory, some days before it was started. He asked her what the justification was for making that decision about that level in anticipation that something would happen and she said that it was based on "knowledge of the patient, having seen him the previous week, and long experience of starting doses of subcutaneous analgesia when needed, faced with a particular patient." I wonder if you would find that an acceptable thing if that was applied to one or two patients.
A Yes.

G

Q If it was applied to a large number of patients is that acceptable?
A The number of patients flowing through Gosport during Dr Barton's period working there must have been several thousand so one would imagine that a handful of patients where she had experience, she knew the patient, she could predict what was likely to happen seems reasonable in an experienced GP.

H

A Q Does it become reasonable that the norm is rejecting guidelines on the basis of your own experience?
A I think we all do it, all doctors do it.

Q You said in certain circumstances.
A Yes, in certain circumstances where one's experience is that this patient is going to suffer if we do not do something then we go away from guidelines.

B Q What if you have had no training?
A One of the difficulties now is we are comparing practice 15 years ago with practice today. Why tramlines comes out is that guidelines are a relatively recent invention and certainly in the 1990s there were very few guidelines.

Q The *BNF* has been around for 300 years or more.
C A Okay, but the guidelines in the *BNF* are about analgesics mainly – and other drugs obviously – they are not about patient management. Now there are guidelines everywhere for every aspect of patient management as you know and we do frequently divert from them.

Q You alluded to the fact that, like me, you were not trained, you got experience, but if your experience is gained in a place where there are no checks and balances how valid is that experience?
D A The checks and balances are relatively recent additions to modern medicine. Certainly when I trained as a medical student and then as a registrar there were really no checks on what I was doing, it is just that things have changed.

Q Do you think you got there by luck?
A No, I think I did not have any disasters by luck but I did not get there by luck.

E Q Just one other question. You said that it was perfectly reasonable to start at 20 mg of diamorphine in a syringe driver and you have gone through a number of discussions about that. But if I tell you that the *BNF* cautions that the elderly should receive one-third of the dose of an adult then would you agree that that 20 mg becomes 60 mg equivalent?
A I am not sure it does say that but it tells you to be careful of the doses in elderly patients: I do not think it had any specific – I could look it up for you.

F Q We will, just to be sure that I am on the right track. It is in bundle 1 again, I have in mind half to a third. If you look at page 7, this is from September 1997. This is "Prescribing for the Elderly" and it says "Guidelines" on the left. It starts "First always question"?

A No, I am looking at the wrong --

G Q It is behind tab 3, page 7.
A Fifty per cent of the adult, not a third of the adult.

Q Let us take that. That becomes the equivalent of 40 mgs in an adult, otherwise called an adult.
A Right.

H Q Is 40 mgs, as a norm, in anticipation that pain may occur, a reasonable starting dose?

A A It might be depending on the clinical circumstance.

Q I did not ask about that, I asked about the norm in anticipation in case something happened.
A I reply again that it totally depends on the clinical circumstances, not just the patient but what the clinical background is that is leading to the clinical situation and how reversible it is, or non reversible it is, and the speed of deterioration. A lot of this is like watching a
B ballet where what you are seeing is a series of still shots, you are not seeing the movements and, therefore, you cannot predict what is going to happen. You have to do it looking at the stills.

Q Is that not the point?
A If you need that sort of evidence, if you need to see the ballet, you will not relieve the symptoms, you will be watching what is happening all the time and not actually taking
C effective action.

Q You are describing something of an unpredictability in these patients.
A Death and life is unpredictable and these patients are unpredictable.

DR SMITH: Thank you.

D THE CHAIRMAN: You are down to me. I am a lay member, as I am sure will become very apparent. I would like to pick up very quickly on one of the points raised by Ms Julien when she was talking about note-taking. Note-taking is an integral part of clinical care, is it not?
A It is.

Q Any suggestion that, on the one hand you will take care of the patient and then you will do the notes, is by definition inappropriate?
E A Yes.

Q You talked earlier about the delegation of some fairly important functions. One of them is the whole issue of when that decision that the change over is occurring and that the patient is now moving from general care or general palliative care into that terminal pathway. Who do you perceive the delegation extended to in the making of the decision as to when you move from one to the other?
F A To me, the consultant is responsible and the delegation was to Dr Barton to make the decision. In an ideal world that decision would be reviewed at some point in the future but not at the time. It was not necessary at the time.

Q You would be quite happy that Dr Barton was more than competent to make such a decision?
A Yes.
G

Q What about the nursing staff?
A They were not making the decision to start a terminal pathway, they were involved in the decision about the dose escalation.

Q With respect, not just that. You have talked about anticipatory prescribing and I think you have dealt, very specifically, with instances where there would be an absence of
H consultation with Dr Barton because she was not available and an absence of consultation

A with any other doctor because they were not available. One of the consequences of anticipatory prescribing of a syringe driver where there is no start date on it, inevitably is that there is at least the risk that nursing staff, of their own volition, will make that judgment, no doubt with the best of intentions, but that is a risk, is it not?
A It is.

Q Is that in your view an acceptable risk?
B A I think for the period of time and the location in terms of the structure, it was an acceptable risk. I cannot see any other way of getting appropriate symptom control. These are not well patients, the ones who are being written up for the syringe driver. They are not people who are ever likely to go out of hospital, so the decision is made to give them the best palliative care as quickly as possible if they do develop symptoms and the person on the spot, in this case the nurses, make the final decision and then it is reviewed the next day by the doctor.

C

Q They do that in the presence of an open ended prescription which takes the patient directly on to what you describe as the cocktail of opiates and the syringe driver. You also discussed with Mr Kark, and indeed with Dr Smith, what you had indicated was the ideal approach, which was, I think you said, to spend up to a couple of days defining, through titration, the appropriate dose for the patient to start on the syringe driver?
A Yes.

D

Q The reason why in the ideal world you would want to do that rather than go directly on to the syringe driver, or the reasons, is what?
A So that you give an accurate dose, no more than is needed and no less than is needed, and the patient's comfort is assured for the next few days.

Q No more than is needed; what are some of the effects of that, of not over sedating?
E A All drugs have side effects and, therefore, one wants to avoid those side effects, including sedation.

Q I will come to the side effects, but just the sedation itself to be less obscure about it. Is it that, if you do not over sedate, you are going to have an alert patient?
A An alert patient that has no symptoms is great, but, sadly, that cannot often be achieved. You have to get a certain level of sedation to get rid of certain symptoms.

F

Q Absolutely right and I think you said to us a few moments ago that usually it is possible to get pain free without side effects and over sedation by judicious use of the opiates?
A Yes.

Q What I am suggesting is that when you said, "In the ideal world what we would do is
G titration over a period of up to two days", that would indeed be a judicious use of opiates?
A It would.

Q Its consequence, if it was done properly, would be that a patient would be able to remain pain free whilst at the same time sufficiently alert to spend his or her last hours or last days, at least part of the time, in the company of their family in a meaningful way.
A I think death is, what one reads about it, from the practicality there is a great
H difference. It is very difficult. When you actually have patients dying, the vagaries of the

process are tremendous. The only way to ensure comfort in any environment, even when you have doctors on call all the time and so on, is to make sure that the patient's symptoms are treated, and that was the reason for the WHO Guidelines on Pain Control, but it also applies to other symptoms than pain.

Q I am sure we have all taken on board very clearly that in the terminal situation a patient can, for perfectly natural reasons, become drowsy, become unrousable and so on. What I am concerned about is your phrase, "judicious use of opiates to best effect". It seemed to me that what you were saying was that, if one were to have this judicious use of opiates through a period of titration, it would reduce the risk of a patient being treated for what appeared to be symptoms, such as agitation and restlessness, as a result of the terminal process, but which were actually created as a consequence, as a side effect, of the over use of the opiate. By titrating you make that much less likely to happen. Was that your point?
A Yes, but the titration is far more labour intensive than just putting up the syringe driver.

Q You said that to us and you said one of the reasons for not going down that particular route was that a doctor would have to keep coming back every four hours or so. I did not quite understand that because the system that Dr Barton had developed of anticipatory prescribing with a range of doses, surely would allow for that. If, before one reached a prescription for the syringe driver one had a prescription, in effect for this up to 48 hour period of titration whereby the nurses themselves are able to monitor the patient, and indeed they are there to do just that, then they will go and administer because they have a prescription for it an increased individual dose if there is a need for it, but if there is not, then they would not do it. As a consequence, the patient could not become over sedated and, as a consequence, there would be less likelihood of the patient exhibiting symptoms as a result of the overdose of opiates that might be mistaken for end of life restlessness or agitation?
A I think if the patient was titrated orally with oral morphine, either slow release morphine or soluble morphine which acts quickly, one could get the 24-hour need. The difficulty is that if you start giving it intramuscularly or subcutaneously by bolus injection and you want to change that dose, that requires much closer monitoring to get the 24-hour level. It also allows variable prescriptions. I have never seen a practice where people, other than oral morphine, write variable prescriptions of intramuscular morphine in advance, whereas with the subcutaneous pump it is common practice to have a range of doses.

Q Aside from breaking a new path, because I do not think that is something that this doctor has been accused of not doing, you say that there would be a need for a greater degree of – I forget your words exactly – supervision and monitoring.
A Exactly.

Q How would that be more so than every four hours going to see how the patient is, making a determination as to whether you were (a) going to give any further sedation of opiate or diamorphine intramuscularly at all; or whether you were going to give the same as the previous dose; or whether you were going to give more?
A Intramuscular prescriptions are one at a time. It would be difficult to see how you would give a variable dose and know what was going on because you could have a different person every four hours – it has to be given every four hours – coming along and drawing up a different size of injection and then the kinetics would be all over the place. With subcutaneous pump the kinetics are smooth, with the oral medication the kinetics are smoothing out because of the time taken to absorb the dose.

Q Your clear evidence is that it would be in impractical to adapt that course?
A It would be.

Q The risk of not taking that difficult course, of course, is that you are going to therefore go straight to the syringe driver. Is that right?
A Yes.

Q That, without titration, carries with it the risk that you get the dose wrong and over sedate the patient.
A You begin at a low dose and work up with the syringe driver.

Q There has been a considerable discussion about whether a dose is low or not, but the risk would be in the abstract that, whatever dose you chose, you would run the risk of over sedating the patient?
A That is always the case with any form of analgesic.

Q The particular danger when that analgesic is an opiate is what?
A Respiratory depression, sedation.

Q Both of which lead ultimately to?
A To death.

Q What we are looking at here, it appears, is a regime where the single, most important element is to keep a patient pain free at all times?
A Yes.

Q You have discussed the potential for discussing with the patient, prior to putting them on to a syringe driver, whether that is a course that they would want to take and you rightly point out that in many cases that would not be something that elderly patients, with the sort of comorbidities we have been looking at, might be able to participate in?
A That is right.

Q In the cases where – and there may only be a few – they would be able to do that, would you regard that as an essential prerequisite before putting them on to that particular path?
A I would certainly try and explain what was going on and get their views on it, but that may not be possible in this group of patients.

Q I am specifically referring to those for whom it might be possible.
A In my experience it is pretty rare because people who are either in severe pain or very distressed just want the distress and the pain to end, they do not want to enter into an intellectual discussion about it or, indeed, have the existentialist thought about death with you.

Q Even in those very rare circumstances, do you think it should be for you to decide whether or not the patient wants to enter into that discussion, or would you feel it appropriate to at least give them the opportunity to do so?
A It may be that this group of patients could not get involved in the discussion.

A Q If they could not, what would have been lost?
A Their consent to it, but I would go ahead.

Q If they could not consent, then you would not have lost the consent. You have only lost the consent, have you not, when they could have given it and you did not ask them?
A Yes, that is the case.

B Q The whole business of keeping the patient pain free, is not automatically achieved by placing them on to a syringe driver with this combination of opiates, is it?
A Absolutely not.

Q Because breakthrough pain, at some stage there is the potential they are going to require more opiates?
A Yes.

C Q The only way to be absolutely sure that your patient never again experiences pain is to keep increasing the dosage on a daily basis?
A That is the case, or not, to reduce it, to keep it steady and make sure they are still pain free or symptom free.

Q If you are doing either, but particularly if you are increasing it every day, the end
D result is obvious, is it not?
A Not having studied the patient, I am not sure it was increased every day.

Q I am talking in the abstract?
A In the abstract yes.

E THE CHAIRMAN: Thank you, that completes my questions and, therefore, all the questions from the Panel. I am conscious that you have been grilled by us since 2.30. We normally reckon an hour is about enough. You have had coming up to an hour and a half. We will take a break now, because I am sure counsel will have more than one or two questions for you. Am I right in that, I think so, yes.

MR LANGDALE: I think I saw Mr Kark nodding, so I will be guided by him.

F THE CHAIRMAN: We will return at ten past four.

(The Panel adjourned for a short time).

THE CHAIRMAN: Welcome back everyone. I hope you have had a chance to refresh yourself a little, Professor Sikora. I am going to pass you now to Mr Kark.

G Further cross-examined by MR KARK

Q Professor Sikora, I am going to work backwards, as it were, from the Chairman's questions round. I just want to deal with the topic that you were dealing with shortly before the break. That is the issue of titration. I want to make sure that I understand it. First of all, is it right that it is easier to titrate before you start a syringe driver?
A Both are possible, and it depends on the clinical circumstances. If things are very
H slowly changing, then normally what happens, you begin at a low dose of an oral analgesic,

A often a mild one, and go up the ladder, get to the opiate, titrate the opiate and then convert to a syringe driver. That is if there is a slow progress of the symptoms. If the progress is more rapid, which does occur, you may decide to just go straight into the subcutaneous pump.

Q If you are trying to deal with pain immediately, I think we have already established that a syringe driver is not actually the way to do it. To deal with acute immediate pain, you do not start the syringe driver, do you?

B A Very few patients get the sudden onset – one minute they are pain-free, the next minute they get sudden onset severe pain. It is usually a build-up that comes.

Q But the best way of titrating, as you said, I think, is you start with oral doses. You find out what the level is that will deal with the patient's pain and then, if necessary, you can convert to a syringe driver?

A Correct.

C

Q I just want to understand how titration works with a syringe driver. Have you still got this schedule that was produce, D7b?

A Yes.

Q From what you told us, the patient is not going to get to the plateau that you have described until about 13 hours into the medication?

D A Pretty close to the plateau, much sooner than that, but I agree they do not get into the final end of the plateau till then.

Q So it might take ten hours, not thirteen hours, but it takes a good while?

A It does.

Q You may then find that you need to increase the dose because the patient is still in

E pain, and you are going to increase it incrementally. Just using this table for a moment, let us imagine that we do not follow the guidelines and we double up, and you add another 20 mg to the syringe driver. If we go to hour 13, just to see if I can follow this, what will be in the patient's system before the new dose is put in is around, is it, 4.88?

A Yes.

Q And then, when the second dose of 20 mg is put in, so the patient is now receiving 40,

F they are going to still be receiving 4.88 but additionally to that, in the first hour, another 0.83?

A Correct.

Q That increased dose itself, of course, takes a long time to work up to the system?

A It does.

G Q If you are trying to deal with immediate pain, I suppose there is a danger that you increase the syringe driver by too much in order to deal with that immediate pain, but in hour 12-13 you are going to hit a problem, are you not?

A There is. The aim of the syringe driver is to reach a steady state over a 24 hour period, and just keep repeating that. Now, what one does if one doubles from 20 to 40, one has the plateau for 20, and if at any time you add another 20, you gradually go up to a new plateau.

H

A Q Yes.
A Within 12 hours.

Q And there is a danger, is there not, if you do that too quickly that you are not just dealing with a patient's pain, but you are going to over-sedate them in ten hours' time?
A Certainly these drugs have side effects and, as you mentioned, that is one of the side effects. When you add an incremental dose to a syringe driver, you have to be thinking
B forward, as it were, to what that is going to peak to in ten or eleven hours' time?
A Yes.

Q That is very helpful. And so does it follow from that, that your responsibility for monitoring the patient is obviously that much greater?
A It is.

C Q You told the Chairman when he was asking you questions about delegation, that nurses were not taking the decision to move to palliative care, and that may or may not be wrong. I just want to know on what basis you said that. Is that because you have taken that from Dr Barton's statements? Where have you got that from?
A Because only a doctor can write these drugs up, and therefore the doctor has to be involved in the decision. The nurses cannot write them up.

D Q No, I am sorry. Okay. I might have misunderstood you. When we have an anticipatory prescription, we have a prescription sitting on the sheet - yes?
A Yes.

Q For a syringe driver to be started?
A Yes.

E Q That can be started by nurses, can it not?
A Indeed, that can, but the doctor has made that decision that if the pain gets to a certain level, as judged by the nursing staff, they are empowered to start it.

Q Of course, it is difficult for the doctor to make that decision if the patient does not have any pain at that time – at the time she or he writes a prescription?
A But if they know the patient, and they can assess the progress of the disease, rather
F like ballet, they get the moving picture, then it may reasonable to do that.

Q I understand that. If they had known the patient for a good period of time, and they see how things progress ---
A Yes.

Q --- is that what you are talking about?
G A Exactly so.

Q You spoke on a number of occasions about "this group of patients", and you said, for instance, "These patients have chronic diseases and long-term illnesses". You said earlier, "I cannot see the benefit of reducing the drugs to this group of patients". How are you grouping this?
A I was reading ---
H

Q They are twelve individuals.
A After the denominator that is unknown to me or presumably to us here, simply by reading the statements from Dr Barton on these patients, which I have read.

Q I am not criticising you for this, but which you accepted?
A Yes.

Q Because, of course, it is dangerous, is it not, to look at this as a group of patients because these are twelve individuals?
A Yes.

Q Some had hip fractures, one had a broken arm, some had sacral sores, some had dementia. It is dangerous if you start grouping ---
A It is. All had distress in common, and most had pain in common.

Q On the basis of Dr Barton's statements?
A Yes.

Q I see. Dealing with Dr Barton, you were being asked questions by Mr Payne about the issue of training, and I think your view. We have heard a bit of evidence about some training that Dr Barton had, but your view was that Dr Barton did not have specific training in palliative care, and obviously she was not a geriatrician, as it were, although she dealt with old patients?
A Yes.

Q For a doctor in that position, the guidelines, the Wessex protocol, which I expect you have heard of ---
A I have.

Q --- and the BNF take on an even greater significance, do they not?
A Yes.

Q The guidelines are there to guide the average doctor?
A Yes.

Q Is that fair?
A That is the case.

Q And of course there are circumstances, as you have told us, where a doctor can step outside the guidelines, but they have to exercise considerable caution when doing so?
A Yes.

Q And note it?
A Yes.

Q You said in your answers to Ms Julien that the fact that the nurses did not go to the top end demonstrates that the nurses were using their discretion appropriately. That is my précis; that is not by any means an exact note of your comments, but does that properly reflect an observation that you made?
A The twelve doses and the twelve patients was a wide range, the top dose given.

A

Q Yes.
A Which would imply that there is some form of titration going on.

Q I just want to examine how you feel able to say that, not having seen the notes?
A Simply that if all patients had been put onto 100 mg, for example, every one of the twelve patients, that would imply that that is what they are using as standard, and they are not
B really using a sliding scale. The fact they vary from 20 to 120, with the average between 60 and 80, that suggests the sliding scale is being used appropriately.

Q It certainly suggests that a scale is being used, does it not?
A Yes.

Q Whether or not it is being used appropriately depends entirely on what the nurses
C were actually reacting to when they either started the syringe driver, or when they increased it, does it not?
A That is correct.

Q If it was inappropriate at the start, or that the increases were inappropriate, then the fact they did not get up to 100 mg does not matter ---?
A No.
D

Q --- at all, does it?
A Absolutely.

Q You were asked by Mrs Mansell about checks and balances, and Dr Barton was in a particular position at this hospital. She had the check, as it were, of the consultants?
A Yes.
E

Q But they were coming in less frequently than perhaps one might hope. They came in apparently on a weekly or fortnightly basis?
A Yes.

Q And she was not working in a hospital environment – an acute hospital environment – when she was surrounded by other doctors doing a similar sort of thing. But she did have, as
F we understand it, those consultants on the end of a telephone, did she not?
A Right.

Q Of course, for a doctor in Dr Barton's position, it takes a certain insight, I suppose, to say to yourself as the doctor, "I think I had better pick up the phone and speak to a consultant about whether I am going to start a terminal path with this patient." That requires the doctor to think about what she or he is doing?
G A Yes, but I assume she did that on ward rounds. Patients were discussed on ward rounds.

Q With whom?
A With the consultant, when the consultant came round.

Q I think you said it was the responsibility of the consultants to adopt the role, to take
H the role of checking?

A A Yes.

Q But again, there is a personal responsibility, is there not, on the doctor who writes the prescription, to ensure that their practice is appropriate?
A Yes.

Q Just finally this on the issue of notes – again, you were asked about this by Mrs
B Mansell, and I think you said, now, before a patient is started on a terminal pathway or even a palliative pathway, you would expect there to be a multi-disciplinary team decision. Yes?
A Yes.

Q And you said that that should be noted, and the reasons should be noted now, but were you saying that was not the case ten or fifteen years ago? Are you saying that even ten or fifteen years ago a doctor should not have made a note that a patient was being put on a
C terminal pathway?
A In a sense, the prescription could serve as the indication that that has started – the very prescription is a note. But in an ideal world certainly you would expect to see at least a one line note saying this has happened, and maybe an annotation of the reasons.

Q It is not just an ideal world, is it, the cake with frosting on the top? It is pretty basic, is it not, ten or fifteen years ago to make a note that you are entering a patient on a terminal
D pathway?
A I have not seen the notes, so I do not know what notes were made.

Q But that would be a pretty basic note to make?
A Some sort of annotation would be optimal.

MR KARK: Thank you.
E

THE CHAIRMAN: Mr Langdale.

Further re-examined by MR LANGDALE

Q Professor Sikora, I am only going to take about half a dozen matters arising out of questions you were asked by the Panel. I am going to take them more or less in the order in
F which the Panel members dealt with them. The question of – my words – Dr Barton consulting the consultant before concluding that a patient's condition was such that they were in a state of terminal decline – again, my words. Did you realise that the evidence from the consultants was that they did not expect Dr Barton to consult them about that? Did you realise that that was the evidence?
A I did not realise.

G Q So in relation to a clinical assistant in the position of Dr Barton, with the consultants not expecting her to consult with them, and not expecting her to consult with them about whether a syringe driver should be started or not, what do you say about the clinical assistant's position?
A She or he has to do the best they can within their capacity, within the system and the constraints of it, and I have done the same. When I was first a consultant, I consulted on many patients by telephone with a senior colleague at another hospital before making a
H

clinical decision. In the end he told me politely not to bother him. "You are now on your own. Just do it. You make the decision," and I suspect that may have happened here.

Q In relation to the question of nurses, as it was put to you, the risk of nurses going in at a higher rate, I am not going to trouble you with the detail that we have heard in this case about whether nurses started at the bottom of the range prescribed, or did not, but just so we can consider this in relation to the case of the patient who, when he died, was receiving 120 mg of diamorphine in 24 hours, I think you indicated it would depend on how it was built up.
A Yes.

Q This particular patient had been on Oramorph for something like four or five days before diamorphine at 80 mg was started. He was on that for two days, and then the dose had 50 per cent added to it, so it became 120, and he was being treated with medication in terms of the diamorphine at 120 mg per day for six days. Is that something which would appear to you to be a consistent kind of build-up, or not?
A Yes, yes.

Q In terms of Dr Barton as clinical assistant, matters were raised with you about her training. It is not suggested in this case, and has never been suggested by the GMC, that she was not properly, adequately trained to be a clinical assistant.
A Absolutely not.

Q And I think it follows from what you have told us that that was the view you had formed?
A Yes.

Q In relation to a clinical assistant being somebody who was a competent and experienced GP, would there be anything to cause anyone concern in relation to such a person being entitled to make a decision as to what was an appropriate amount of opiate to prescribe to a patient in this elderly type of patient group?
A I would imagine that is perfectly within the capability of an experienced GP.

Q Similarly, in relation to whether it was appropriate to commence the administration of opiates by means of a syringe driver?
A Yes, again, within the capability of a GP.

Q We have heard evidence about GPs being responsible, not only in general, but also in Dr Barton's case, for people who are on a syringe driver, say, at home?
A Yes.

Q It was suggested to you that the significance of the experience of a clinical assistant like Dr Barton would be affected by whether their experience had been or had not been subject to any checks and balances in the sense of other people having some input into what they did. Were you aware that before Dr Lord and before Dr Reid were consultants, there were also consultants – I think Dr Wilkie was one name, Dr Grunstein may have been another, although I may not be remembering them correctly – who were in place right from the time that Dr Barton started as a clinical assistant?
A I was unaware of that.

Q Were you aware that we have an example in this case in 1991 of Dr Logan, another consultant who was in post at the time, giving clear indications as to what he thought was appropriate with regard to the administration in particular of diamorphine?
A No, I did not have that information.

Q In terms of the *BNF* I think it was put to you that it had been in existence for 300 years – unless I misheard the evidence. What was the position with regard to the length of time the *BNF* has been in existence so far as you are aware?
A Certainly not more than 40 years.

Q We can check on that. You were also asked about the question of acceptable risk with regard to anticipatory prescriptions. Obviously this is clear, there is no dispute about it, that with an anticipatory prescription which has a range there is a dose range, quite a wide dose range, there is a risk that a member of the nursing staff might administer to a patient an unacceptably high dose of analgesic, within the range but unacceptable because it did not meet the patient's condition. You indicated that of course there is a risk; does the nature of the risk, the degree of the risk, depend on the trust the prescribing doctor has in her nursing staff?
A Yes, a nurse under these circumstances is perfectly entitled to give a patient a pump with 200 mg for 24 hours because they have made the assessment that that patient needs it. So there is a degree of trust and there is no evidence from the 12 cases that that was happening.

Q Would the degree of trust placed by a doctor in her nursing staff depend on her experience of their actions over a period of time?
A It would.

MR LANGDALE: A question was asked by a member of the Panel about the issue of dementia. Sir, the reason I am not going to pursue this with Professor Sikora is because I think I know which patient may have been in the Panel member's mind but I do not think it is appropriate to ask Professor Sikora about it because I shall immediately go into what were the other features of the patient's case, so I am going to specifically avoid going into a specific patient. That concludes what I have to ask; thank you very much.

THE CHAIRMAN: Thank you, Professor. That then completes your testimony. We are most grateful to you for coming to assist us today. As you will have gathered there are a lot of issues that at the end of the day the Panel are going to have to wrestle with and reach a conclusion on; your expert assistance in that area is of course greatly appreciated and we thank you very much indeed for coming. You are free to go.

(The witness withdrew).

MR JENKINS: Sir, you will recall that at the start of the day I was intending to call a witness but after some discussion with Mr Kark and your learned Legal Assessor we delayed that witness and sent them home. I would like nonetheless to call that witness and a couple of others tomorrow. I know that there is objection from Mr Kark.

THE CHAIRMAN: Just that witness or the other couple as well?

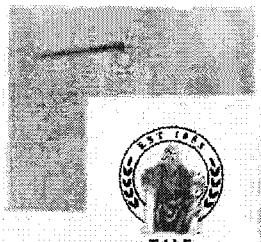
Confidential
Addendum (III)
BARTON

General Medical Council

Regulating doctors
Ensuring good medical practice

Interim Orders Panel
12 November 2009

Information: Further correspondence from the MDU.



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BY COURIER

Please quote our reference in your reply
Our ref:
Your ref: Code A
Date: 30th October 2009

Dear Mr Elliott

DR JANE BARTON – INTERIM ORDERS PANEL HEARING – 12 NOVEMBER 2009

I believe that I may have inadvertently failed to enclose a copy of the letter from the Head of Medicines Management at NHS Hampshire when writing to you the other day. Please accept my apologies for the oversight.

I have pleasure in enclosing a copy of the letter now to assist in preparation for the IOP hearing.

Yours sincerely,

Code A

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Our Ref: NH/CS

Date: 20 October 2009

Mr I Barker
The Medical Defence Union
230 Blackfriars Road
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Dear Ian

Re: **Dr Jane Barton**

As requested I am happy to confirm that the PCT continues to monitor Dr Barton's prescribing using data from the Prescription Pricing Division of the NHS Business Services Agency. This monitoring includes regular analysis of prescribing data, both for Dr Barton as an individual prescriber and for the Practice. Where appropriate, individual prescriptions are recalled for confirmation of the prescriber's signature.

I am happy to confirm that Dr Barton has maintained her compliance with the agreement which has been in place with this, and predecessor, PCTs since October 2002. The agreement with the PCT is that Dr Barton will not prescribe Diamorphine and will restrict her prescribing of Diazepam in line with BNF guidance. I appreciate that this mirrors a condition imposed upon Dr Barton by the General Medical Council in July 2008. I have continued to monitor the position with reference to Dr Barton's prescribing and I am happy that she has complied with the condition and PCT agreement.

If you would like to discuss this further please do not hesitate to contact me.

Best wishes.

Yours sincerely

Code A
Neil Hardy
Head of Medicines Management

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