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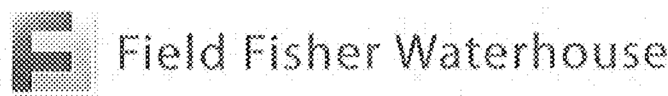


Strictly Private & Confidential

Code A

Our ref: RC2/00492-15579/10194129 v1
Your ref:

By Courier

05 June 2009

Dear Sirs

General Medical Council - Dr Barton

We enclose, by way of service, the following documentation:

1. Signed witness statement of Code A dated 2 June 2009 (an unsigned copy statement, together with exhibit, has previously been provided to you by our letter dated 26 May 2009)

2. Signed witness statement of Lynda Wiles dated 3 June 2009 (an unsigned copy statement, together with exhibit, has previously been provided to you by our letter dated 26 May 2009)

3. Professor Ford's Supplemental Expert Report for Patient G dated 2 June 2009 (signed copy to follow)

4. Letter from Code A to Ms Cooper dated 5 June 2009.

Yours faithfully

Code A

Field Fisher Waterhouse LLP

Field Fisher Waterhouse LLP
Tel Fax
E-mail Web

General Medical Council

Dr Jane Barton

Statement of Code A

I, Code A, will say as follows:

1. I am the Deputy Manager of Langdale Nursing Home, 11 The Avenue, Gosport, PO12 2BQ.

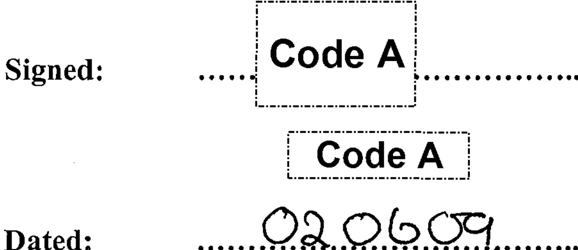
2. Exhibited to this statement and marked **PG/1** is a copy of the witness statement dated 25 July 2005 I made in relation to the care of Arthur Cunningham.

3. I can confirm that I have been given the opportunity to amend this statement and wish to make the following comments.

4. On page two of my statement it states that I have 'total responsibility and accountability to management for all residents within in the Home in addition to all members of staff.' I would like to clarify that I am part of the management team and that this is therefore not my sole responsibility.

5. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true



Signed: ......Code A................

Code A

Dated: ......02.06.09........

General Medical Council

Dr Jane Barton

Statement of Lynda Marion Wiles

I, **Lynda Wiles**, will say as follows:

1. I am the daughter of Leslie Pittock.

2. Exhibited to this statement and marked **LW/1** is a copy of my witness statement dated 8 November 2004.

3. I can confirm that I have been given the opportunity to add to or amend this statement but do not wish to do so.

4. ~~I understand that my statement may be used in evidence for the purposes of a hearing~~ before the General Medical Council's Fitness to Practise ~~Panel and for~~ the purposes of any appeal, including ~~any appeal~~ by the Council for Healthcare Regulatory Excellence. ~~I confirm that I am willing to attend the hearing to give evidence if asked to do so.~~

I believe that the facts stated in this witness statement are true

Signed: Code A

Lynda Marion Wiles

Dated: 3.6.09

Code A

Our Ref; SPD/CAS

Date: 5th June 2009

PRIVATE & CONFIDENTIAL

FAO Rachel Cooper
Field Fisher Waterhouse
27th Floor
City Tower
Piccadilly Plaza
MANCHESTER
M1 4bd

Dear Sirs

RE: MRS LYNDA MARION WILES – Code A
GMC – DR BARTON – CONFIRMED FITNESS TO PRACTISE PANEL HEARING – 8/6/09

Thank you for your letter dated 4th June 2009 regarding our patient Mrs Lynda Wiles and your request for medical details in connection with her attendance at the forthcoming Fitness to Practise Panel Hearing on Monday 8th June 2009 where she is due to give evidence.

I can confirm that she attended the Surgery on Monday 1st June 2009 with [redacted] [redacted] problems for which she is seeking treatment as well as [redacted] [redacted]. She is very adamant that she felt that attending this hearing would be detrimental to her health and really does not wish to do so. Of note I have her permission to write to yourself confirming this.

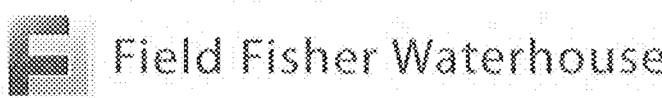
I therefore feel that in my opinion that her attendance to attend the Fitness to Practise Panel Hearing as a witness would be of detriment to her [redacted] and that she is not fit to attend.

I trust this information is helpful.

Yours faithfully

Code A

THE BRIDGE STREET PRACTICE: 21 Bridge Street, Driffield, East Yorkshire YO25 6DB. Tel: (08444) 773361. Fax: (08444) 773368
NAFFERTON BRANCH SURGERY: 22A High Street, Nafferton, Driffield, East Yorkshire YO25 4JR. Tel: (08444) 773363. Fax: (08444) 773369
V.A.T. No.: 878635171



Strictly Private & Confidential

Code A

Our ref: SLE/00492-15579/10252983 v1
Your ref:

By Courier

05 June 2009

Dear Sirs

General Medical Council - Dr Barton

Further to our letter of 1 June and our other recent correspondence we are writing in response to your letter of 22 May.

In your letter you explained that you had visited Waterlooville Police Station and were particularly concerned to have found a receipt from P Code A of the GMC for three boxes received on 10 September 2004.

We have spent some time double checking what happened to that material and confirming that this material has been previously disclosed to you.

We would draw your attention to the IOC/IOP hearing which took place in October 2004 shortly after this material was received. Our review suggests that the documents described as "expert reviews" were the documents at pages 467-507 of the IOP papers. These were consolidated review documents not individual reports (like and in some cases identical to the ones sent to you on 1 June 2009).

There is also material to suggest that you were aware of the records because by 7 October there is an internal GMC communication about getting the photocopying done for you that day (the reprographics team at the GMC were relocating). We have not been able to locate a letter to you disclosing the material once it was copied but we believe it is possible you took it away at the end of the IOP hearing on 13 October 2004.

Field Fisher Waterhouse LLP
Tel Fax
E-mail Web

The medical records were subsequently passed to Eversheds solicitors who in due course provided them to us. We are confident that in the process of disclosing used and unused material we have disclosed everything we received from Eversheds (although we note you would like to pick up some of your queries about the unused material sent in March 2008).

In July 2008 we reviewed all the GMC materials. The material which had been received from the police had either been passed to solicitors (Eversheds then Field Fisher Waterhouse) or was part of the IOP paperwork. For this reason we did not repeat disclosing it during our review in 2008.

We do not accept that you have not been provided with this material and can confirm that we have thoroughly ascertained the nature of the documentation held by our client.

We trust this resolves your concerns on this particular issue.

Yours faithfully

Code A

Field Fisher Waterhouse LLP

Strictly Private & Confidential

Code A

Our ref: TET/GML/00492-15579/8322694 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8322887 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mrs L Wiles
Code A

Our ref: TET/GML/00492-15579/8322786 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mrs Wiles

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Alan Lavender

Code A

Our ref: TET/GML/00492-15579/8322800 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mr Lavender

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

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In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Ms Elizabeth Thomas
Code A

Our ref: TET/GML/00492-15579/8322809 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Ms Thomas

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson (Code A), at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Bernard Page
Code A

Our ref: TET/GML/00492-15579/8322852 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Ms Gillian Mackenzie

Code A

Our ref: TET/GML/00492-15579/8322874 v1
Your ref:

Code A
Assistant Solicitor

Code A (Direct Dial)

23 September 2008

Dear Mrs Mackenzie

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

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Strictly Private & Confidential

Mrs Diane Mussell

Code A

Our ref: TET/GML/00492-15579/8322913 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mrs Mussell

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mrs Pauline Robinson
Code A

Our ref: TET/GML/00492-15579/8322917 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

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Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8322928 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Charles Farthing
Code A

Our ref: TET/GML/00492-15579/8322941 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mr Farthing

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

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Strictly Private & Confidential

Ms Shirley Sellwood
Code A

Our ref: TET/GML/00492-15579/8322955 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Ms Sellwood

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

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Strictly Private & Confidential

Mr Iain Wilson
Code A

Our ref: TET/GML/00492-15579/8322959 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mr Wilson

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

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Strictly Private & Confidential

Mrs Gillian Kimbley
Code A

Our ref: TET/GML/00492-15579/8322970 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Mrs Kimbley

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

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Strictly Private & Confidential

Dr Arumugam Ravindrane

Code A

Our ref: TET/GML/00492-15579/8322981 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Dr Ravindrane

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Carl Jewell

Code A

Our ref: TET/GML/00492-15579/8322995 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Mr Jewell

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Ernest Stevens

Code A

Our ref: TET/GML/00492-15579/8323031 v1
Your ref:

Code A
Assistant Solicitor

Code A

23 September 2008

Dear Mr Stevens

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mrs June Bailey
Code A

Our ref: TET/GML/00492-15579/8323042 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Mrs Bailey

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

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I would be grateful if you could inform my colleague Adele Watson on Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

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I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mrs Betty Packman
Code A

Our ref: TET/GML/00492-15579/8323068 v1
Your ref:

Code A
Assistant Solicitor
Code A ct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

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I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Ms Victoria Packman

Code A

Our ref: TET/GML/00492-15579/8323129 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Packman

General Medical Council - Dr Jane Barton

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Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Dr Ian Reckless

Code A

Our ref: TET/GML/00492-15579/8323167 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Reckless

General Medical Council - Dr Jane Barton

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Yours sincerely

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Strictly Private & Confidential

Ms Carol Ball
Code A

Our ref: TET/GML/00492-15579/8323532 v1
Your ref:
Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Lynne Barrett

Code A

Our ref: TET/GML/00492-15579/8323660 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Barrett

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Margaret Couchman

Code A

Our ref: TET/GML/00492-15579/8323681 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Couchman

General Medical Council - Dr Jane Barton

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Cooper, Rachel

From: Code A
Sent: 05 June 2009 10:11
To: Cooper, Rachel
Subject: Telephone Message - Barton

Hi Rachel

Dr Ian Reid called to say he thinks he has a copy of his final statement the one he has is 50 paragraphs and 8 pages.

If this is not the correct one his numbers are Code A

Code A | **Secretary to** Code A**y, Adele Watson, Katie Henderson and** Code A Code A
for Field Fisher Waterhouse LLP
dd: Code A

Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8323717 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

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Yours sincerely

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Strictly Private & Confidential

Ms Gillian Hamblin

Code A

Our ref: TET/GML/00492-15579/8323729 v1
Your ref:

Code A
Assistant Solicitor

Code A

23 September 2008

Dear Ms Hamblin

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Sheelagh Joines
Code A

Our ref: TET/GML/00492-15579/8323762 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Joines

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Anita Tubbritt
Code A

Our ref: TET/GML/00492-15579/8323808 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Ms Tubbritt

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8323969 v1
Your ref:

Code A
Assistant Solicitor
Code A

Ms Beverley Turnbull
Code A

23 September 2008

Dear Ms Turnbull

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Fiona Walker
Code A

Our ref: TET/GML/00492-15579/8324050 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Walker

General Medical Council - Dr Jane Barton

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Code A

AIRMAIL

Our ref: TET/GML/00492-15579/8324066 v1
Your ref:
Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Dr Richard Reid
Code A

Our ref: TET/GML/00492-15579/8324217 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Reid

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Dr Althea Lord
Code A

AIRMAIL

Our ref: TET/GML/00492-15579/8324237 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Lord

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Dr Jane Tandy

Code A

Our ref: TET/GML/00492-15579/8324269 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Tandy

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8324303 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

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Strictly Private & Confidential

Dr Ewenda Peters

Code A

Our ref: TET/GML/00492-15579/8324426 v1
Your ref:

Code A
Assistant Solicitor

Code A

23 September 2008

Dear Dr Peters

General Medical Council - Dr Jane Barton

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Our ref: TET/GML/00492-15579/8324473 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

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Strictly Private & Confidential

Dr Judith Stevens

Code A

Our ref: TET/GML/00492-15579/8324576 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Stevens

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Dr Tanya Cranfield
Code A

Our ref: TET/GML/00492-15579/8324626 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Dr Cranfield

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Dr J Taylor
Code A

Our ref: TET/GML/00492-15579/8324639 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Dr Taylor

General Medical Council - Dr Jane Barton

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Code A

Our ref: TET/GML/00492-15579/8324665 v1
Your ref:

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Code A

23 September 2008

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Strictly Private & Confidential

Ms Freda Shaw
Code A

Our ref: TET/GML/00492-15579/8324679 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Shaw

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Mr Philip Beed
Code A

Our ref: TET/GML/00492-15579/8324690 v1
Your ref:

Code A
Assistant Solicitor

23 September 2008

Dear Mr Beed

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Margaret Wigfall
Code A

Our ref: TET/GML/00492-15579/8324700 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Ms Wigfall

General Medical Council - Dr Jane Barton

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Strictly Private & Confidential

Ms Shirley Hallman

Code A

Our ref: TET/GML/00492-15579/8324717 v1
Your ref:

Code A
Assistant Solicitor

Code A

23 September 2008

Dear Ms Hallman

General Medical Council - Dr Jane Barton

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Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8324772 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Code A on Code A, at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Alexander Tuffey

Code A

Our ref: TET/GML/00492-15579/8324784 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Mr Tuffey

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A, at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mr Robert Logan
Code A

Our ref: TET/GML/00492-15579/8324802 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Mr Logan

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A, at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Mrs Pauline Gregory
Code A

Our ref: TET/GML/00492-15579/8324818 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Mrs Gregory

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A, at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

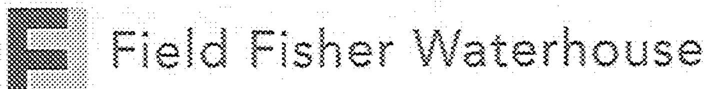
In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).



Strictly Private & Confidential

Code A

Our ref: TET/GML/00492-15579/8324880 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Adele Watson on Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for Field Fisher Waterhouse LLP

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

Field Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
Tel +44 (0)161 233 4000 Fax +44 (0)161 237 5357
E-mail info@ffw.com Web www.ffw.com

Strictly Private & Confidential

Our ref: TET/GML/00492-15579/8324837 v1
Your ref:

Code A
Assistant Solicitor
Code A

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Code A, at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Strictly Private & Confidential

Code A

Our ref: TET/GML/00492-15579/8322858 v1
Your ref:

Code A
Assistant Solicitor
Code A (Direct Dial)

23 September 2008

Dear Code A

General Medical Council - Dr Jane Barton

I write further to my letter of 25 June 2008 regarding the re-listing of the GMC Fitness to Practise hearing.

I have now been informed of the proposed date for the hearing next year. This will be between 8 June 2009 and 21 August 2009 at the GMC in London.

I would be grateful if you could inform my colleague Code A at your earliest convenience, if you have any other unavoidable commitments during this period.

Either myself or one of my colleagues will be in touch with you nearer the hearing date to arrange for you to attend the hearing to give evidence if it is decided that you will be required.

In the meantime if you have any queries, as ever, please do not hesitate to contact me.

I would like to take this opportunity to thank you for your ongoing assistance in this matter.

Yours sincerely

Code A
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750).

Matter: Barton

Date: 1/6/09

Attending: Code A

Telephone call	IN	OUT	In Person	

- Dr recommend doesn't go – send a request to the surgery pls ➔ Code A
  The Br St Practi
  21 Bird St
  Dnffield.
  E' York
  YO25 6DB.

Code A

Action to be taken:

fax:– 0

Time occupied: stress related Code A

Code A

→ Straight across.

Matter: Barton. Date: 4/6/09

Attending: Code A Code A GP)

Telephone call | IN | OUT | In Person

~~[illegible]~~ Call to Code A →
message left calling back.

Action to be taken:

Time occupied: __________ Initials: __________

Matter: Barton

Date: 5/6/09

Attending: L Wiles.

Telephone call | IN | OUT (circled)

In Person

No reply

Action to be taken:

Time occupied: ____________

Initials: ____________

** TRANSMISSION REPORT **

SID : FFW   Number : Code A   Date : 04-06-09 17:24

Date/Time	4-06 17:24
Dialled number	Code A
Subscriber	
Durat.	0'33"
Mode	NORMAL
Pages	2
Status	Correct

Strictly Private & Confidential

Our ref: RC2/GML/00492-15579/10243415 v1
Your ref:
Code A
Solicitor
Code A

By fax only Code A

04 June 2009

Dear Code A

General Medical Council - Dr Jane Barton
Confirmed Fitness to Practise Panel Hearing: 8 June to 28 August 2009

By way of confirmation my firm, Field Fisher Waterhouse LLP, act on behalf of the General Medical Council ("GMC"), the governing body of the medical profession.

The GMC has referred Dr Jane Barton for a hearing before its Fitness to Practise Panel. The Panel will consider whether her fitness to practise is impaired. We have been instructed to prepare the case for the hearing which commences on 8 June 2009.

One of your patients, Mrs Lynda Wiles, has previously provided written witness statements to both my firm and the police in relation to Dr Barton's treatment of her father. In accordance with the rules, Mrs Wiles has been asked to attend the hearing, to give oral evidence before the Fitness to Practise Panel.

I understand from my recent conversations with Mrs Wiles, and her husband, that she is i[redacted] [redacted] which will prevent her from being able to attend and give evidence at the Fitness to Practise Panel hearing. I further understand that Mrs Wiles has recently consulted with you in respect of her [redacted].

I would be most grateful if you could outline, in writing, details of any health problems which may prevent Mrs Wiles from attending and giving evidence at the hearing. Also, please confirm the date on which you last saw Mrs Wiles, in your capacity as her GP, and also your assessment of whether or not Mrs Wiles is fit to attend.

I would be most grateful if your response could be sent to me by fax on Code A

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel +44 (0)161 200 1770 Fax +44 (0)161 200 1777
E-mail info@ffw.com Web www.ffw.com

Strictly Private & Confidential

Code A

Our ref: RC2/GML/00492-15579/10243415 v1
Your ref:

Code A
Solicitor
Code A

By fax only Code A

04 June 2009

Dear Code A

General Medical Council - Dr Jane Barton
Confirmed Fitness to Practise Panel Hearing: 8 June to 28 August 2009

By way of confirmation my firm, Field Fisher Waterhouse LLP, act on behalf of the General Medical Council ("GMC"), the governing body of the medical profession.

The GMC has referred Dr Jane Barton for a hearing before its Fitness to Practise Panel. The Panel will consider whether her fitness to practise is impaired. We have been instructed to prepare the case for the hearing which commences on 8 June 2009.

One of your patients, Mrs Lynda Wiles, has previously provided written witness statements to both my firm and the police in relation to Dr Barton's treatment of her father. In accordance with the rules, Code A has been asked to attend the hearing, to give oral evidence before the Fitness to Practise Panel.

I understand from my recent conversations with Mrs Wiles, and her husband, that she is in [redacted] which will prevent her from being able to attend and give evidence at the Fitness to Practise Panel hearing. I further understand that Mrs Wiles has recently consulted with you in respect of her [redacted]

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I would be most grateful if your response could be sent to me by fax on Code A

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel +44 (0)161 200 1770 **Fax** +44 (0)161 200 1777
E-mail info@ffw.com **Web** www.ffw.com
Field Fisher Waterhouse LLP is a limited liability partnership registered in England and Wales (registered number OC318472) and is regulated by the Solicitors Regulation Authority.
A list of its members and their professional qualifications is available at its registered office, 35 Vine Street, London EC3N 2AA.
We use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with equivalent standing and qualifications.

Should you have any queries, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper Code A.

Yours sincerely

Code A

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Matter: Barton. Date: 3/6/09.

Attending: B. Page.

Telephone call | IN (circled) | OUT | In Person |

- Code A expl hearing going ahead. 8/6/09 - Code A not req to attend + would like to hear matters re mum - Code A to ring when likely - end June expt evidence.

Code A asked if ok to use Code A name - or prefer to anonymise - Code A -

- happy for name to be used.

Code A thanked Code A for time.

Code A - wanted to let Code A that date of birth on death cert wrong - Code A would let court know.

Action to be taken:

Time occupied: .2 Initials: Code A .

Matter: Barton

Date: 28/5/09.

Attending: Bernard Page.

Telephone call | IN | OUT | In Person

Message left Code A to call back.
↳ need to confirm whether okay →

Code A called left message 2/6/09.

Action to be taken:

Time occupied:

Initials: Code A

Matter: Barton

Date: 4/6/09

Attending: Code A

Telephone call	IN (circled)	OUT	In Person	

- Code A to Code A - Code A confirmed Code A on behalf GMC Not calling Code A for FTPH. H/ever def may call Code A - unlikely tho. Code A to provide letter confirm result when H ends.
- Code A thanked Code A help in matter.

Action to be taken:

Time occupied: 0 1 .

Initials: Code A

Matter: Barton

Date: 3/6/09.

Attending: Code A Code A

Telephone call IN OUT (circled) In Person

- Code A exp Code A req to attend GMC H. on 30/6/09. sec said next day better or previous day. Code A expl must be 30/6/09 at this stage sched set. ~~sec~~
- Heather thought ok. wud call Code A back if not.

Action to be taken:

Time occupied: .2

Initials: Code A

Strictly Private & Confidential

Code A

Our ref: RC2/GML/00492-15579/10137246 v1
Your ref:

Code A
Solicitor
Code A

05 June 2009

Dear Code A

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **15 June 2009**. I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The date you have been asked to attend is the date best suited to the proposed order of the evidence in the case. This is the date when it is currently anticipated that your evidence will be heard, but you may be required to attend on subsequent days of the hearing until we are able to release you.

Please could you confirm that you have a copy of your finalised statement that you can use to refresh your memory of events prior to giving evidence. If you have not, please let me know as soon as possible and I will arrange for a copy to be sent to you.

As requested, I enclose rail ticket between Swanick and London (return).

Enclosed is the GMC Guidance for Witnesses on Expense Claims together with an Expenses Claim Form. The GMC Guidance sets out what will and will not be reimbursed and it is therefore important that you read it before making any arrangements for your attendance at the hearing. The claim form should be submitted to us as soon as practicable, preferably within 7 days of the hearing

and certainly no later than one month after the hearing. Claims made later than one month after the conclusion of the hearing will be paid only in exceptional circumstances.

As agreed, I enclose details of the reservation I have made for you in relation to your overnight accommodation, on 14 June 2009, at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161). I also enclose a map for the hotel.

Please do not hesitate to contact me should you have any queries.

For your information, I enclose the following explanatory leaflets entitled:

- Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council; and
- General Medical Council Help for witnesses.

For further information regarding your role as a witness at a GMC hearing, please look at the following link on the GMC's website (www.gmc-uk.org), which provides very helpful information about being a witness at a GMC hearing: http://www.gmc-uk.org/concerns/witnesses/index.asp. This includes information about preparing to give evidence, the actual giving of evidence and what happens once you have given evidence. There are also photographs of what the GMC offices and a typical hearing room look like and later in 2009, a virtual tour facility will be implemented.

For further information regarding the Fitness to Practise Panel and the decisions it can make, please look at the following link:

http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp#4

Should you not have access to the internet, please let me know as soon as possible and I will arrange for a hard copy to be provided to you.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper@ Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Encs:

Map of GMC Offices; GMC Guidance for Witnesses on Expenses Claims; Witness Expenses Claim Form; Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council leaflet; General Medical Council Help for witnesses leaflet; Note regarding

provision of Accommodation.

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Matter: Barton

Date: 4/6/09.

Attending: Charles Farthing.

Telephone call: IN / OUT (circled: OUT)

In Person

- Mr Farthing - 15/6/09. - can attend yes. hotel for 14/6/09.

Code A Stated Code A can't be in (H) before gives evidence, CF asked if could know charges - Code A said no. Not public doc until start of (H) + read out Code A can know them after given evidence. Code A
- asked if Code A and discuss charges - said No. Code A to call Code A if Code A any queries.

Action to be taken:

Time occupied: ·2

Initials: Code A

Cooper, Rachel

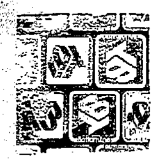
From: Code A
Sent: 05 June 2009 10:11
To: Cooper, Rachel
Subject: Telephone Message - Code A

Hi Rachel

Dr Ian Reid called to say he thinks he has a copy of his final statement the one he has is 50 paragraphs and 8 pages.

If this is not the correct one his numbers are [illegible] 1 ex [illegible]

Code A | Secretary to Code A, Adele Watson, Code A
for Field Fisher Waterhouse LLP
dd: +44 (0)161 200 1772



Field Fisher Waterhouse

Lloyds TSB Bank plc

Fenchurch Street (309323) Branch
72 Fenchurch Street London EC3P 3EH

30-93-23

THIS SECURITY CHEQUE WILL HIGHLIGHT ALTERATIONS MICROTECT BACKGROUND ANTI-COUNTERFEIT

Date: 1st June 2009

Reference	Pay
213499	Code A

GBP125-00X

A/C PAYEE ONLY

£---125.00---

492.15579

For and on behalf of Field Fisher Waterhouse LLP
Office A/C

Code A

Bottomline Technologies/Communisis 9507 03/07

THIS CHEQUE PAPER CONTAINS A CHAIN-MAIL WATERMARK TO VERIFY HOLD TO THE LIGHT RED ALERT UV

⑈213499⑈ 30⑉93 23⑆ 00919405⑈ 10

Strictly Private & Confidential

Mr Carl Jewel

Our ref: RC2/GML/00492-15579/10234891 v1
Your ref:

Rachel Cooper
Solicitor
Code A

4 June 2009

Dear Mr Jewel

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **16 June 2009**. I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The date you have been asked to attend is the date best suited to the proposed order of the evidence in the case. This is the date when it is currently anticipated that your evidence will be heard, but you may be required to attend on subsequent days of the hearing until we are able to release you.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend.

Please could you confirm that you have a copy of your finalised statement that you can use to refresh your memory of events prior to giving evidence. If you have not, please let me know as soon as possible and I will arrange for a copy to be sent to you.

I can confirm that on behalf of the GMC we shall be pleased to reimburse reasonable travel and subsistence expenses which you may incur as a result of your attendance at the hearing. Enclosed is

the GMC Guidance for Witnesses on Expense Claims together with an Expenses Claim Form. The GMC Guidance sets out what will and will not be reimbursed and it is therefore important that you read it before booking your travel or making any other arrangements for your attendance at the hearing. Please note that the GMC will not reimburse you for First Class travel. The claim form should be submitted to us as soon as practicable, preferably within 7 days of the hearing and certainly no later than one month after the hearing. Claims made later than one month after the conclusion of the hearing will be paid only in exceptional circumstances.

We can arrange overnight accommodation for you at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161). Please let me know as soon as possible if you require us to do this.

In terms of your travel arrangements, I would advise that you travel by train to London. As it cannot always be guaranteed that your evidence will finish on the day planned, please book an open return ticket.

For your information, I enclose the following explanatory leaflets entitled:

- Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council; and

- General Medical Council Help for witnesses.

For further information regarding your role as a witness at a GMC hearing, please look at the following link on the GMC's website (www.gmc-uk.org), which provides very helpful information about being a witness at a GMC hearing: http://www.gmc-uk.org/concerns/witnesses/index.asp. This includes information about preparing to give evidence, the actual giving of evidence and what happens once you have given evidence. There are also photographs of what the GMC offices and a typical hearing room look like and later in 2009, a virtual tour facility will be implemented.

For further information regarding the Fitness to Practise Panel and the decisions it can make, please look at the following link:

http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp#4

Should you not have access to the internet, please let me know as soon as possible and I will arrange for a hard copy to be provided to you.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Encs:

Map of GMC Offices; GMC Guidance for Witnesses on Expenses Claims; Witness Expenses Claim Form; Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council leaflet; General Medical Council Help for witnesses leaflet; witness summons.

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

SUPREME COURT OF ENGLAND 29 MAY 2009 ADMINISTRATIVE COURT OFFICE QUEEN'S BENCH DIVISION

To

Mr Carl Jewel

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 125 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Rachel Cooper)

Do not ignore this summons

If you were offered money for travel expenses and compensation for loss of time, at the time it was served on you, you must -

- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

If you wish to set aside or vary this witness summons, you may make an application to the court that issued it.

The court office at 4
is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 125 for the witness's expenses and compensation for loss of time.

Signed ______________________________________

Officer of the Court

Matter: Barton

Date: 4/6/09.

Attending: Code A

Telephone call	IN	OUT	In Person	

- Code A calling re flights to and attendance London / Newcastle flight times discuss Code A - can fly to S/hampton then home from London.
Code A to confirm fare + call back.
→ Code A calling back discussing Sat wknd flight / Mon evening. Code A
- to pay cost of train from S/H to London. GMC cover tube / taxi - reasonable costs.
Code A to forward by email -

Action to be taken:

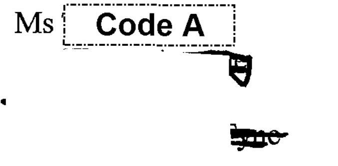
Time occupied: ·3

Initials: Code A

reservation.

Strictly Private & Confidential

Ms Code A



Our ref: RC2/GML/00492-15579/10141953 v1
Your ref:

Code A
Solicitor
Code A

4 June 2009

Dear Code A

General Medical Council - Dr Jane Barton
Confirmed Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **22 June 2009**. I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The date you have been asked to attend is the date best suited to the proposed order of the evidence in the case. This is the date when it is currently anticipated that your evidence will be heard, but you may be required to attend on subsequent days of the hearing until we are able to release you.

Please could you confirm that you have a copy of your finalised statement that you can use to refresh your memory of events prior to giving evidence. If you have not, please let me know as soon as possible and I will arrange for a copy to be sent to you.

I can confirm that on behalf of the GMC we shall be pleased to reimburse reasonable subsistence expenses which you may incur as a result of your attendance at the hearing. Enclosed is the GMC Guidance for Witnesses on Expense Claims together with an Expenses Claim Form. The GMC Guidance sets out what will and will not be reimbursed and it is therefore important that you read it before booking your travel or making any other arrangements for your attendance at the hearing. Please note that the GMC will not reimburse you for First Class travel. The claim form should be submitted to us as soon as practicable, preferably within 7 days of the hearing and certainly no later

than one month after the hearing. Claims made later than one month after the conclusion of the hearing will be paid only in exceptional circumstances.

I enclose details of your flight booking and also details of the reservation I have made for you for overnight accommodation at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161).

For your information, I enclose the following explanatory leaflets entitled:

- Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council; and

- General Medical Council Help for witnesses.

For further information regarding your role as a witness at a GMC hearing, please look at the following link on the GMC's website (www.gmc-uk.org), which provides very helpful information about being a witness at a GMC hearing: http://www.gmc-uk.org/concerns/witnesses/index.asp. This includes information about preparing to give evidence, the actual giving of evidence and what happens once you have given evidence. There are also photographs of what the GMC offices and a typical hearing room look like and later in 2009, a virtual tour facility will be implemented.

For further information regarding the Fitness to Practise Panel and the decisions it can make, please look at the following link:

http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp#4

Should you not have access to the internet, please let me know as soon as possible and I will arrange for a hard copy to be provided to you.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper@ Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Encs:

Map of GMC Offices; GMC Guidance for Witnesses on Expenses Claims; Witness Expenses Claim Form; Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council leaflet; General Medical Council Help for witnesses leaflet; Note regarding provision of Accommodation.

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Reservation - Trip to Southampton 20/06/2009

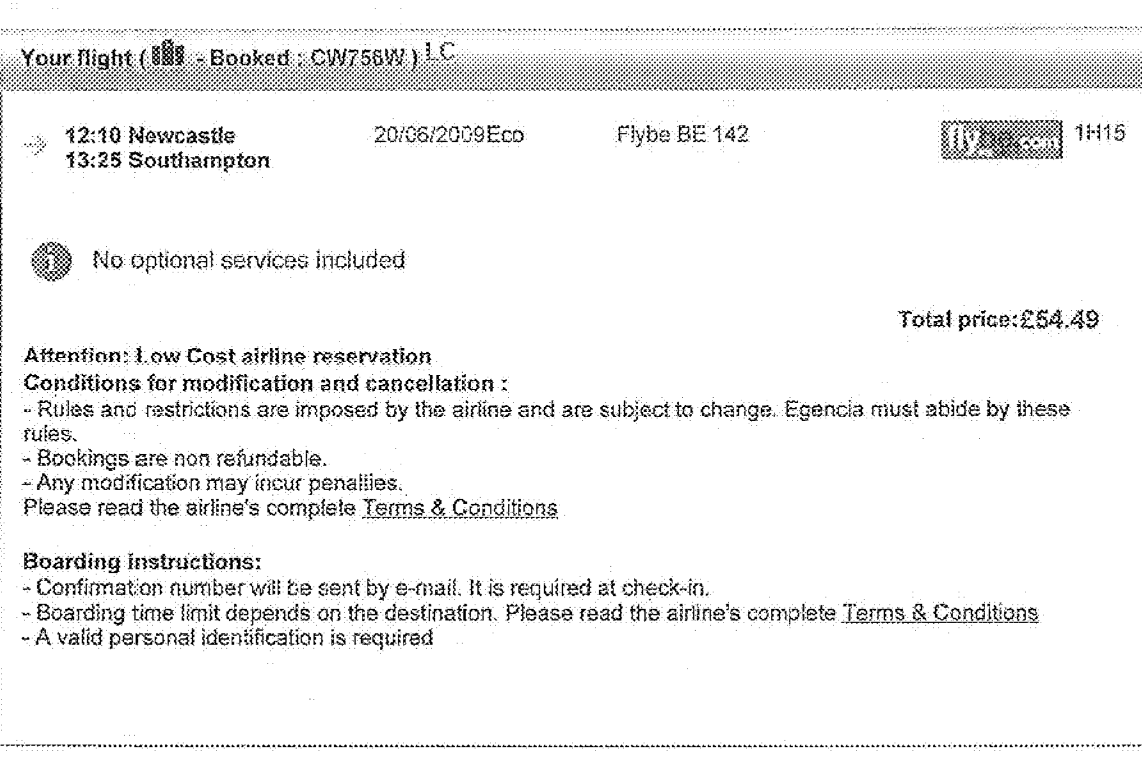
Main traveller

Code A

Section: 7713
Secondary cost centre:

Matter Number / Nominal Code: 00492.15579

Please note the reservation number if you'll need to contact our customer service.



Your flight (- Booked : CW756W) LC

12:10 Newcastle **13:25 Southampton**	20/06/2009Eco	Flybe BE 142	fly...com	1H15

No optional services included

Total price:£54.49

Attention: Low Cost airline reservation
Conditions for modification and cancellation :
- Rules and restrictions are imposed by the airline and are subject to change. Egencia must abide by these rules.
- Bookings are non refundable.
- Any modification may incur penalties.

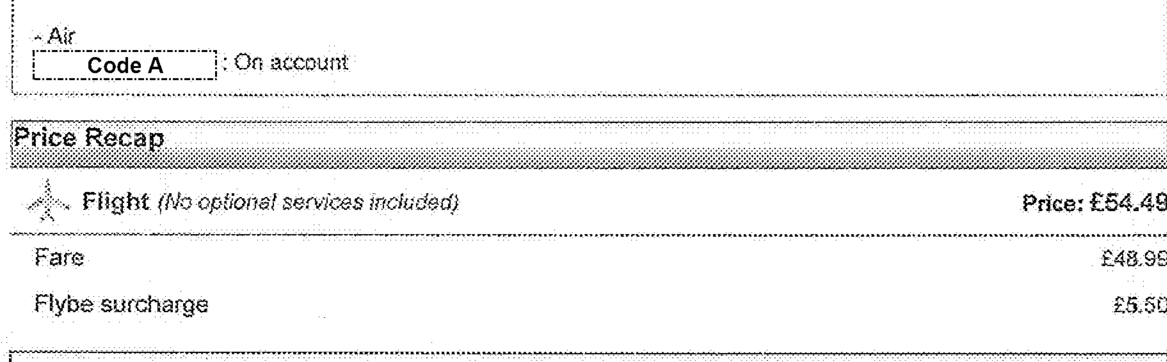
Please read the airline's complete Terms & Conditions

Boarding instructions:
- Confirmation number will be sent by e-mail. It is required at check-in.
- Boarding time limit depends on the destination. Please read the airline's complete Terms & Conditions
- A valid personal identification is required

Payment

- Air

Code A : On account



Price Recap

Flight *(No optional services included)*	**Price: £54.49**
Fare	£48.99
Flybe surcharge	£5.50

Total Price for this trip : £54.49

Code A

From:	Egencia - Customer Service [customer_service@egencia.co.uk]
Sent:	04 June 2009 14:10
To:	Code A
Subject:	Booking air for Code A, SOUTHAMPTON 20/06/2009

The following trip has been booked by Code A on your Egencia web site

Estimated total price : 54.49 GBP

1 Traveller(s) :

Code A
Section : 7713
Secondary cost centre :

Matter Number / Nominal Code : 00492.15579

Fare conditions:

In case of no-show, the airline may allow no modification and/or refund. Please read detailed fare constraints applicable or contact your Customer Service for more information.

FLIGHT : Newcastle - Southampton

Estimated price : 48.99 GBP
Lowest fare proposed : 0.0 GBP (Flybe - flight BE 142 - departing on at)

Booking reference : CW756W

Departure : Newcastle 20/06/09 12:10
Arrival : Southampton 20/06/09 13:25
Flight : Flybe BE142 (operated by Flybe)
Class : Economy

Duration : 01h15
- No optional services included
If you wish to add optional services (baggage, Speedy boarding), please contact Egencia Customer Service

Fare conditions :
- Rules and restrictions are imposed by the airline and are subject to change. Egencia must abide by these rules.
- Bookings are non refundable.
- Any modification may incur penalties.
Please read the airline's complete Terms & Conditions

(http://www.flybe.com/flightInfo/1conditions.htm).

Boarding conditions :
- Confirmation number will be sent by e-mail. It is required at check-in.
- Boarding time limit depends on the destination. Please read the airline''s complete Terms & Conditions (http://www.flybe.com/flightInfo/1conditions.htm)
- A valid personal identification is required

Price Recap

Flight : Price 54.49 GBP
- Fare (No optional services included) : 48.99 GBP
- Flybe surcharge : 5.5 GBP

Total Price for this trip : 54.49 GBP

In case of modification or cancellation, please contact Egencia Customer Service by e-mail at customer_service@egencia.co.uk or by phone at 0871 330 7170 .
Low Cost services are provided to the customer by a third party supplier. Egencia acts as an intermediary agent. Egencia invoices to and receives from the customer payment for the services provided on behalf of the Low Cost carrier.

For assistance from 6 pm to 8.30 am London local time from Monday to Friday, and on Saturdays, Sundays and public holidays, you can contact our 24-hour service on + 44 (0)203 130 9639.

Please ensure that you have all the relevant documents needed for your trip.

If you require assistance or advice obtaining this please consult your Egencia website section "Traveller Tools/Country Watch" or ask one of our consultants.

Please reconfirm onward flights and check reporting times. Failure to do so may result in your reservation being cancelled by the airline.

Note : all timings are quoted locally (as 24 hr clock).

Personal data that has been provided to us in connection with your travel may be passed to government authorities for border control and aviation security purposes.

Security insurance surcharge : the price of your ticket includes a security and/or insurance surcharge. It is shown on your ticket in the tax fee charge area as either YQ or YR or aggregated with other taxes, fees or charges. It is levied by the carrier(s) and is not a tax, fee or charge imposed by a government authority or by a third party.

Ticket price can be modified by the travel provider until ticketed.

Egencia wishes you a pleasant trip.

Reservation - Trip to Newcastle 22/06/2009

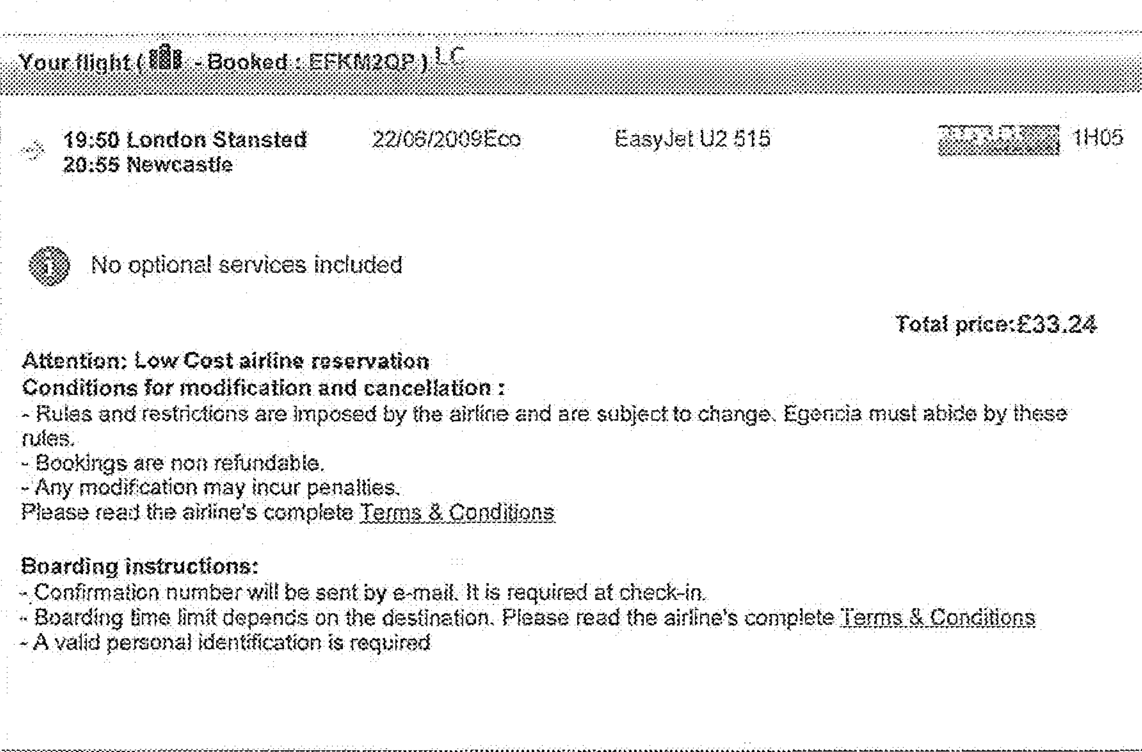
Main traveller

Code A

Section: 7713
Secondary cost centre:

Matter Number / Nominal Code: 00492.15579

Please note the reservation number if you'll need to contact our customer service.



Your flight (- Booked : EFKM2QP) LC

19:50 London Stansted 22/06/2009Eco EasyJet U2 515 1H05
20:55 Newcastle

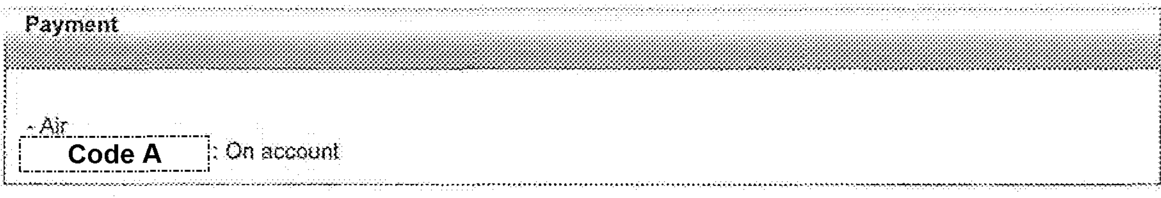
No optional services included

Total price:£33.24

Attention: Low Cost airline reservation
Conditions for modification and cancellation :
- Rules and restrictions are imposed by the airline and are subject to change. Egencia must abide by these rules.
- Bookings are non refundable.
- Any modification may incur penalties.

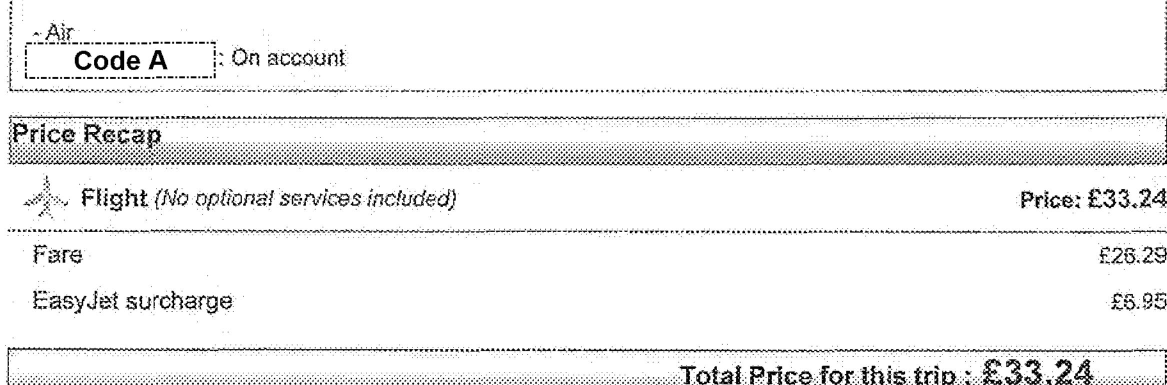
Please read the airline's complete Terms & Conditions

Boarding instructions:
- Confirmation number will be sent by e-mail. It is required at check-in.
- Boarding time limit depends on the destination. Please read the airline's complete Terms & Conditions
- A valid personal identification is required



Payment

- Air
Code A : On account



Price Recap

Flight *(No optional services included)*	**Price: £33.24**
Fare	£26.29
EasyJet surcharge	£6.95

Total Price for this trip : £33.24

Code A

From: Egencia - Customer Service [customer_service@egencia.co.uk]
Sent: 04 June 2009 14:16
To: Code A
Subject: Booking air for Code A, NEWCASTLE 22/06/2009

The following trip has been booked by Code A on your Egencia web site

Estimated total price : 33.24 GBP

1 Traveller(s) :

Code A
Section : 7713
Secondary cost centre :

Matter Number / Nominal Code : 00492.15579

Fare conditions:

In case of no-show, the airline may allow no modification and/or refund. Please read detailed fare constraints applicable or contact your Customer Service for more information.

FLIGHT : London Stansted - Newcastle

Estimated price : 26.29 GBP
Lowest fare proposed : 26.29 GBP (EasyJet - flight U2 515 - departing on 22/06/09 at 19:50)

Booking reference : EFKM2QP

Departure : London Stansted 22/06/09 19:50
Arrival : Newcastle 22/06/09 20:55
Flight : EasyJet U2515 (operated by EasyJet)
Class : Economy

Duration : 01h05
- No optional services included
If you wish to add optional services (baggage, Speedy boarding), please contact Egencia Customer Service

Fare conditions :
- Rules and restrictions are imposed by the airline and are subject to change. Egencia must abide by these rules.
- Bookings are non refundable.
- Any modification may incur penalties.

Please read the airline's complete Terms & Conditions
(https://www.easyjet.com/EN/Book/mom_regulations.html).

Boarding conditions :
- Confirmation number will be sent by e-mail. It is required at check-in.
- Boarding time limit depends on the destination. Please read the airline''s complete Terms & Conditions (https://www.easyjet.com/EN/Book/mom_regulations.html)
- A valid personal identification is required

Price Recap

Flight : Price 33.24 GBP
- Fare (No optional services included) : 26.29 GBP
- EasyJet surcharge : 6.95 GBP

Total Price for this trip : 33.24 GBP

In case of modification or cancellation, please contact Egencia Customer Service by e-mail at customer_service@egencia.co.uk or by phone at 0871 330 7170 .
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For assistance from 6 pm to 8.30 am London local time from Monday to Friday, and on Saturdays, Sundays and public holidays, you can contact our 24-hour service on + 44 (0)203 130 9639.

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Please reconfirm onward flights and check reporting times. Failure to do so may result in your reservation being cancelled by the airline.

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Security insurance surcharge : the price of your ticket includes a security and/or insurance surcharge. It is shown on your ticket in the tax fee charge area as either YQ or YR or aggregated with other taxes, fees or charges. It is levied by the carrier(s) and is not a tax, fee or charge imposed by a government authority or by a third party.

Ticket price can be modified by the travel provider until ticketed.

Egencia wishes you a pleasant trip.

Matter: Barton Date: 3/6/09

Attending: L O'Brien

Telephone call IN OUT In Person

- LO'B rang wanted to ensure mothers admission sheet + drugs book/reg would be considered at FTP
Code A expl expert looked at compt records + commented accordingly
Code A concerned info in her police s'ment not highlighted in her
- FTW s'ment. Code A explained exhibited ∴ all evidence discd + can be Q on if relevant Code A further expl than expert gives

Action to be taken: evidence re drugs admin + quantities ∴ -Ready to do Code A

Time occupied: 3

Initials: Code A

expl Code A may not be asked to comment on everything in her s'ment just the relevant Code A

414616 v1

Unrelated 3rd party information

Strictly Private & Confidential

Mr Iain Wilson

Our ref: RC2/GML/00492-15579/10234865 v1
Your ref:

Code A

Solicitor

Code A

4 June 2009

Dear Mr Wilson

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **15 June 2009**. I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The date you have been asked to attend is the date best suited to the proposed order of the evidence in the case. This is the date when it is currently anticipated that your evidence will be heard, but you may be required to attend on subsequent days of the hearing until we are able to release you.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend.

Please could you confirm that you have a copy of your finalised statement that you can use to refresh your memory of events prior to giving evidence. If you have not, please let me know as soon as possible and I will arrange for a copy to be sent to you.

I can confirm that on behalf of the GMC we shall be pleased to reimburse reasonable travel and subsistence expenses which you may incur as a result of your attendance at the hearing. Enclosed is

the GMC Guidance for Witnesses on Expense Claims together with an Expenses Claim Form. The GMC Guidance sets out what will and will not be reimbursed and it is therefore important that you read it before booking your travel or making any other arrangements for your attendance at the hearing. Please note that the GMC will not reimburse you for First Class travel. The claim form should be submitted to us as soon as practicable, preferably within 7 days of the hearing and certainly no later than one month after the hearing. Claims made later than one month after the conclusion of the hearing will be paid only in exceptional circumstances.

We can arrange overnight accommodation for you at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161). Please let me know as soon as possible if you require us to do this.

In terms of your travel arrangements, I would advise that you travel by train to London. As it cannot always be guaranteed that your evidence will finish on the day planned, please book an open return ticket.

For your information, I enclose the following explanatory leaflets entitled:

- Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council; and

- General Medical Council Help for witnesses.

For further information regarding your role as a witness at a GMC hearing, please look at the following link on the GMC's website (www.gmc-uk.org), which provides very helpful information about being a witness at a GMC hearing: http://www.gmc-uk.org/concerns/witnesses/index.asp. This includes information about preparing to give evidence, the actual giving of evidence and what happens once you have given evidence. There are also photographs of what the GMC offices and a typical hearing room look like and later in 2009, a virtual tour facility will be implemented.

For further information regarding the Fitness to Practise Panel and the decisions it can make, please look at the following link:

http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp#4

Should you not have access to the internet, please let me know as soon as possible and I will arrange for a hard copy to be provided to you.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper(Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Encs:

Map of GMC Offices; GMC Guidance for Witnesses on Expenses Claims; Witness Expenses Claim Form; Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council leaflet; General Medical Council Help for witnesses leaflet; witness summons.

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

To

Mr Iain Wilson

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 135 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Code A

Do not ignore this summons

If you were offered money for travel expenses and compensation for loss of time, at the time it was served on you, you must -

- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

If you wish to set aside or vary this witness summons, you may make an application to the court that issued it.

The court office at 4
is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 135 for the witness's expenses and compensation for loss of time.

Signed ______________________________________

Officer of the Court

Unrelated 3rd party information

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

To

Ms Anita Tubbritt

SUPREME COURT OF ENGLAND & WALES
21 MAY 2009
ADMINISTRATIVE COURT OFFICE
QUEEN'S BENCH DIVISION

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 135 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Code A)

Do not ignore this summons

If you were offered money for travel expenses and compensation for loss of time, at the time it was served on you, you must -

- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

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is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 135 for the witness's expenses and compensation for loss of time.

Signed ______________________________________

Officer of the Court

Cooper, Rachel

From: Lynne Barrett [m]
Sent: 03 June 2009 10:26
To: Cooper, Rachel
Subject: GMC hearing for Dr Jane Barton

Dear Ms Cooper,

My name is Lynne Barrett and you contacted me by phone a few days ago regarding the above matter. Firstly I must apologise for my attitude on that occasion but after what I went through and the toll it took on my health at the Coroners Couirt Hearing doing it all over again filled me with terror and a certain amount of dread.

The other matter which is worrying me almost as much is actually getting to London for the hearing. I'm afraid I no longer use public transport because of my mobility. I've had a couple of falls on buses and I fell on off a train the last time I visited my sister. I go everywhere I need to by taxi or my sister comes to collect me when I visit her in Wiltshire.

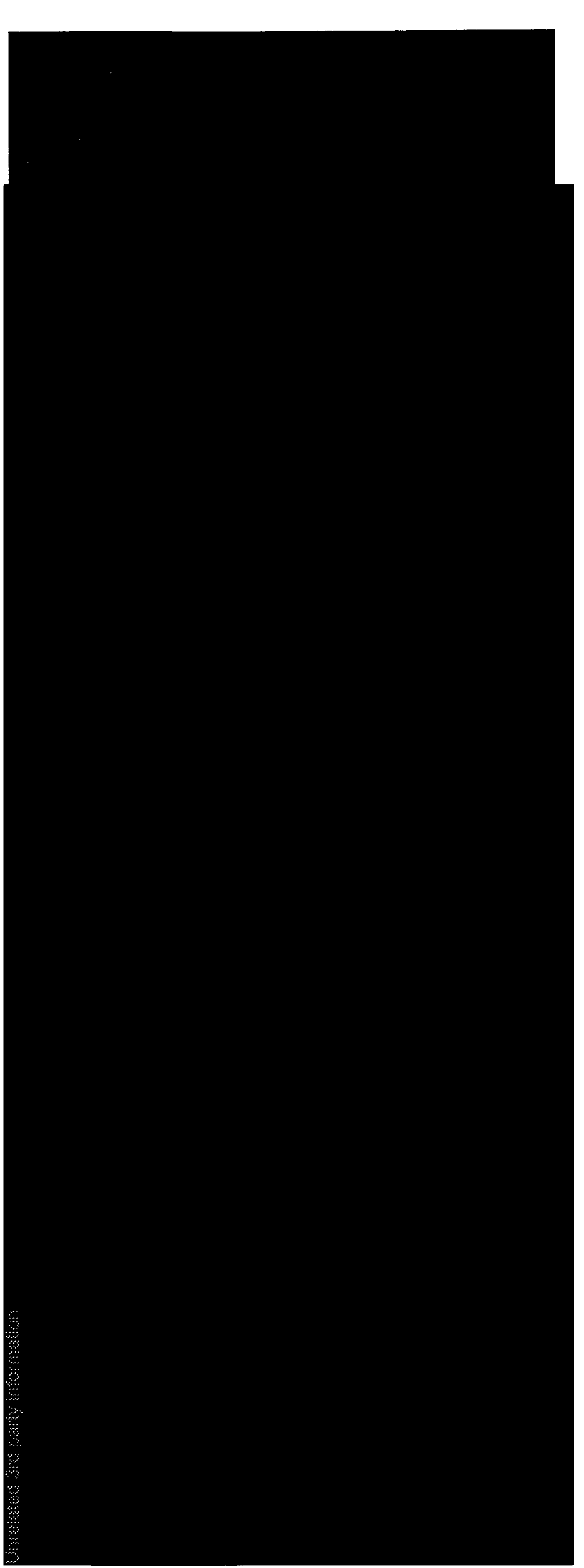
My sister has agreed to come to the hearing with me, despite her own fairly serious health issues, she suffers from [redacted] so as a consequence is not confident enough to drive to and around London, I have discussed this with her. Do I have to pay for my expenses up front and then claim them back? If this is the case then I'm afraid this would be impossible for me as I am receiving disability benefits and have no savings to use. I know that the hotel will be paid by you and that meals are reimbursed after the hearing but what about getting from the hotel to the GMC and back again?

I'm sorry to put all my panic onto you but I am not as strong a person as I used to be but I know I have to try and help resolve this distressing matter. The other thing I would like to clarify is the matter of my finalised statement that you mention in your letter dated 28th May. Does this mean the police statements that I took into the Coroners Court with me? These are the only statements I have. I am a little worried that anything else you have sent me may have been sent to my previous address so I have not received it.

Thank you for your time,

Lynne Barrett

View your Twitter and Flickr updates from one place - Learn more!


Unrelated 3rd party information

Matter: Barton Date: 3/6/09.

Attending: L Barlett

Telephone call (IN) (OUT) In Person

Tc / calling LB – re email. Code A said and attend but v unwell ∴ unable to use pub transport – No one to drive her there. ∴ taxi – Code A asked Code A to check cost + call back.

Also, on disability benefit ∴ no money to pay taxi – Code A expl that were wit sum ∴ conduct monies sent out £135. – if taxi more send further cheq. would need receipt from taxi firm – Code A to get.

Code A accompanying Code A – hotel – twin room. Code A v concerned re giving evidence. inq v difficult

Action to be taken:

Time occupied: Code A Initials: S

Code A offered reassurance – expl process again. confirmed no one in public gallery and ask Code A questions not like inq. –

4145918 v1

Strictly Private & Confidential

Ms L Barrett

Our ref: RC2/00492-15579/10235416 v1
Your ref:

Rachel Cooper
Solicitor
Code A

—

04 June 2009

Dear Ms Barrett

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I write further in the above matter.

I can confirm that the date on which you will be required to attend Dr Barton's Fitness to Practise Panel hearing is **22 June 2009.** I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend.

I also enclose reservation details in relation to your overnight accommodation at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161) on the evening of 21 June 2009.

As requested, I further enclose a copy of your witness statement, dated 28 March 2008, together with exhibits.

Finally, I will arrange for a further cheque to be sent to you shortly to cover the additional travel costs which you have indicated you will incur as a result of your disability and look forward to receiving the travel invoice, as soon as possible.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper@ Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

To

Ms Lynn Barrett

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

SUPREME COURT OF ENGLAND AND WALES 29 MAY 2009 QUEEN'S BENCH DIVISION

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 135 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
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- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

If you wish to set aside or vary this witness summons, you may make an application to the court that issued it.

The court office at 4
is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 135 for the witness's expenses and compensation for loss of time.

Signed ______________________________

Officer of the Court

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

SUPREME COURT OF ENGLAND & WALES
29 MAY 2009
ADMINISTRATIVE COURT OFFICE
QUEEN'S BENCH DIVISION

To
Code A

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 225 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Code A

Do not ignore this summons

If you were offered money for travel expenses and compensation for loss of time, at the time it was served on you, you must -

- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

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The court office at 4
is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________

(the witness) on ______________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 225 for the witness's expenses and compensation for loss of time.

Signed ______________________

Officer of the Court

Unrelated 3rd party information

Strictly Private & Confidential

Ms Beverley Turnbull

Our ref: RC2/GML/00492-15579/10142115 v1
Your ref:

Rachel Cooper
Solicitor
Code A

4 June 2009

Dear Ms Turnbull

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **25 June 2009**. I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The date you have been asked to attend is the date best suited to the proposed order of the evidence in the case. This is the date when it is currently anticipated that your evidence will be heard, but you may be required to attend on subsequent days of the hearing until we are able to release you.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend.

Please could you confirm that you have a copy of your finalised statement that you can use to refresh your memory of events prior to giving evidence. If you have not, please let me know as soon as possible and I will arrange for a copy to be sent to you.

I can confirm that on behalf of the GMC we shall be pleased to reimburse reasonable travel and subsistence expenses which you may incur as a result of your attendance at the hearing. Enclosed is

the GMC Guidance for Witnesses on Expense Claims together with an Expenses Claim Form. The GMC Guidance sets out what will and will not be reimbursed and it is therefore important that you read it before booking your travel or making any other arrangements for your attendance at the hearing. Please note that the GMC will not reimburse you for First Class travel. The claim form should be submitted to us as soon as practicable, preferably within 7 days of the hearing and certainly no later than one month after the hearing. Claims made later than one month after the conclusion of the hearing will be paid only in exceptional circumstances.

We can arrange overnight accommodation for you at the Holiday Inn - Regent's Park, Carburton Street, London W1W 5EE (0870 400 9161). Please let me know as soon as possible if you require us to do this.

In terms of your travel arrangements, I would advise that you travel by train to London. As it cannot always be guaranteed that your evidence will finish on the day planned, please book an open return ticket.

For your information, I enclose the following explanatory leaflets entitled:

- Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council; and

- General Medical Council Help for witnesses.

For further information regarding your role as a witness at a GMC hearing, please look at the following link on the GMC's website (www.gmc-uk.org), which provides very helpful information about being a witness at a GMC hearing: http://www.gmc-uk.org/concerns/witnesses/index.asp. This includes information about preparing to give evidence, the actual giving of evidence and what happens once you have given evidence. There are also photographs of what the GMC offices and a typical hearing room look like and later in 2009, a virtual tour facility will be implemented.

For further information regarding the Fitness to Practise Panel and the decisions it can make, please look at the following link:

http://www.gmc-uk.org/concerns/hearings_and_decisions/fitness_to_practise_panels.asp#4

Should you not have access to the internet, please let me know as soon as possible and I will arrange for a hard copy to be provided to you.

Should you have any queries concerning these arrangements, please do not hesitate to contact me on Code A or alternatively via email at rachel.cooper@ Code A

Thank you for your continued assistance in this matter.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Encs:

Map of GMC Offices; GMC Guidance for Witnesses on Expenses Claims; Witness Expenses Claim Form; Information for witnesses appearing before the Fitness to Practise Panel of the General Medical Council leaflet; General Medical Council Help for witnesses leaflet; witness summons

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

To

Ms Beverley Turnbull

SUPREME COURT OF ENGLAND & WALES
29 MAY 2009
ADMINISTRATIVE COURT OFFICE
QUEEN'S BENCH DIVISION

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 125 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Rachel Cooper)

Do not ignore this summons

If you were offered money for travel expenses and compensation for loss of time, at the time it was served on you, you must -

- attend court on the date and time shown and/or produce documents as required by the summons; and
- take an oath or affirm as required for the purposes of answering questions about your evidence or the documents you have been asked to produce.

If you do not comply with this summons you will be liable, in county court proceedings, to a fine. In the High Court, disobedience of a witness summons is a contempt of court and you may be fined or imprisoned for contempt. You may also be liable to pay any wasted costs that arise because of your non-compliance.

If you wish to set aside or vary this witness summons, you may make an application to the court that issued it.

The court office at 4

is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

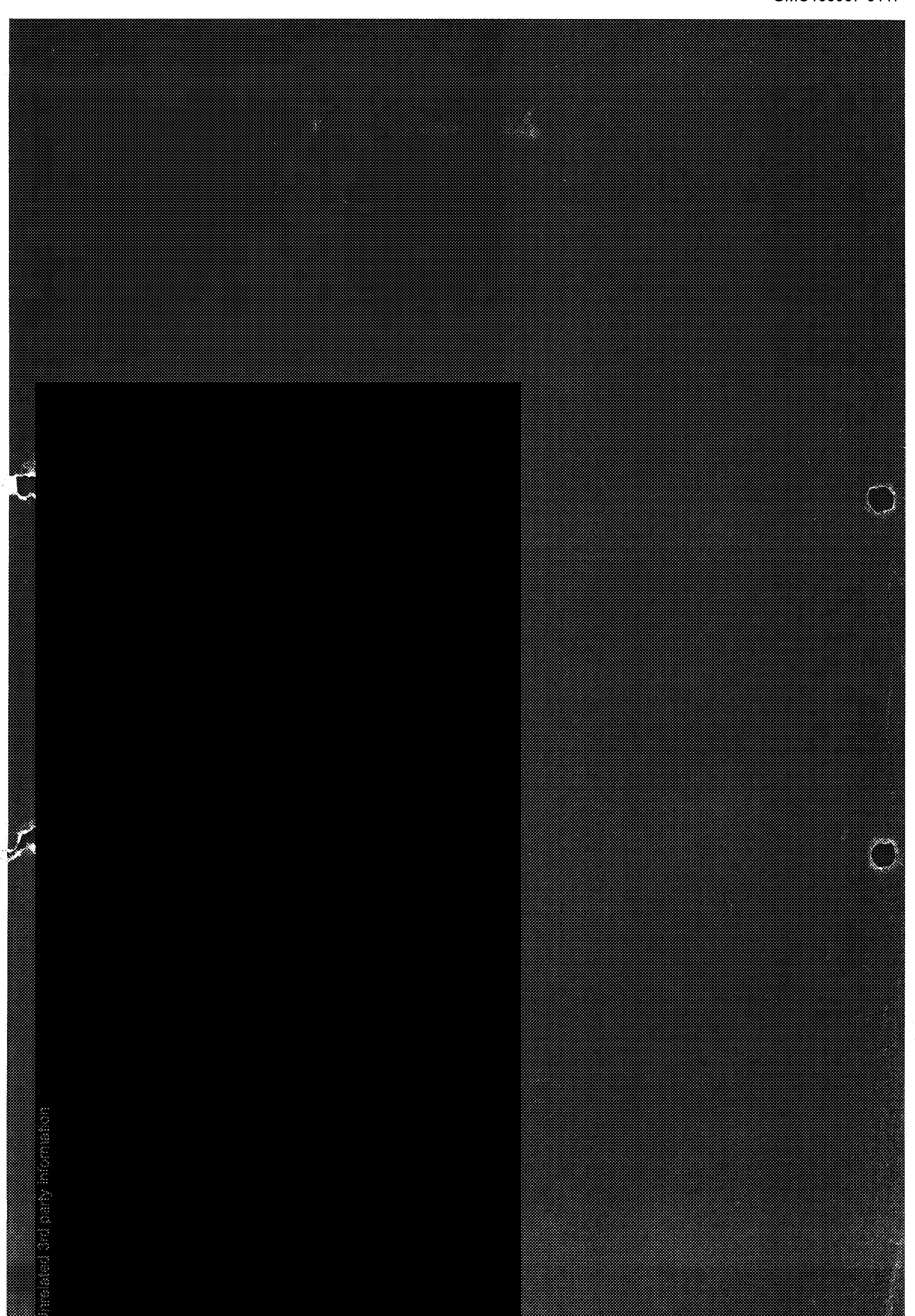
I certify that the summons of which this is a true copy, was served by posting to ______________________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 125 for the witness's expenses and compensation for loss of time.

Signed ______________________________________

Officer of the Court


Unrelated 3rd party information

Strictly Private & Confidential

Ms Margaret Couchman
Flat
ft

Our ref: RC2/GML/00492-15579/10235017 v1
Your ref:

Rachel Cooper
Solicitor

Code A

04 June 2009

Dear Ms Couchman

General Medical Council - Dr Jane Barton
Confirmed Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **Tuesday 16 June 2009**, I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend

I also enclose a copy of your statement, dated 30 January 2008, together with exhibits, as requested.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Strictly Private & Confidential

Ms Anita Tubritt

Our ref: RC2/00492-15579/10177549 v1
Your ref:

Code A
Solicitor
Code A

04 June 2009

Dear Ms Tubbritt

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing: 8 June to 28 August 2009

I am writing to confirm the date that you will be required to attend Dr Barton's Fitness to Practise Panel hearing which commences on 8 June 2009.

The date that you will be required to attend the hearing is **25 June 2009.** I or one of my colleagues will be present at the General Medical Council offices (a map of which is enclosed) which are situated at Regent's Place, 2nd Floor, 350 Euston Road, London, NW1 3NJ to meet you at **9 am** on this date.

The GMC has statutory power to compel witnesses to attend by way of a High Court witness summons – accordingly I enclose, by way of service, your witness summons. The date indicated on the witness summons is the first day of the hearing. This date may differ from the date when you have been asked to attend

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

Solicitors to the General Medical Council. The GMC is a charity registered in England and Wales (1089278) and Scotland (SCO37750)

Witness Summons

In the Matter of an Inquiry by the General Medical Council	
Claim No.	
Claimant (including ref)	General Medical Council
Defendant (including ref)	Dr Jane Barton
Issued on	

To

Ms Margaret Couchman

You are summoned to attend at *(court address)*
The General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN

on Monday, 8th day of June 2009 at 9.30 am

(and each following day of the hearing until the Court tells you that you are no longer required.)

☒ to give evidence in respect of the above claim

☐ to produce the following document(s) *(give details)*

The sum of £ 135 is paid or offered to you with this summons. This is to cover your travelling expenses to and from court and includes an amount by way of compensation for loss of time.

This summons was issued on the application of the claimant or the claimant's solicitor whose name, address and reference number is:

Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

(Ref: Rachel Cooper)

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If you wish to set aside or vary this witness summons, you may make an application to the court that issued it.

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is open between 10am and 4pm Monday to Friday. When corresponding with the court, please address forms or letters to the Court Manager and quote the claim number.

Certificate of service

Claim No.	

I certify that the summons of which this is a true copy, was served by posting to ______________________

(the witness) on ____________________ at the address stated on the summons in accordance with the request of the applicant or his solicitor.

I enclose a P.O. for £ 135 for the witness's expenses and compensation for loss of time.

Signed ______________________________

Officer of the Court

Matter: Barton. Date: 5/6/09.

Attending: C Jewell.

Telephone call IN OUT (OUT circled) In Person

RC speak to CJ expl that instructed to issue summons re his attendance at H. RC again expl importance of him attending to give evidence CJ out of country not able to attend.

RC began to expl that v imp did attend. CJ hung up phone.

RC attempt to call back – no reply

Action to be taken:

Time occupied: 2 Initials: Code A

Matter: Barton. Date: 5/6/09.

Attending: C Jewell

Telephone call | IN (circled) | OUT | In Person | [ ]

- CJ calling 5.30pm - rec'd summons - still not attending will be abroad.
  RC began to expl - summons. CJ - wished her luck but not attending anyway.
- CJ said bye, wished RC luck.

Action to be taken:

Time occupied: 0 1

Initials: **Code A**

Matter: Barton Date: 5/6/09

Attending: Mrs Jewell

Telephone call IN (circled) OUT In Person

RC call Mrs J very annoyed & upset not going to attend GMC - sham like inquest - RC expl'd inq. + GMC separate Mrs J kept speaking over RC.
Mrs J repeatedly said Coroner exclude evidence (key) and had been got at. RC attempted to calm Mrs J down - unsuccessfully
Mrs J said CJ out of country ∴ not attending. K Spurgin died of neglect + drugs - Dr B resp + others

Action to be taken: Mrs J then said CJ clearly loved aunt - all too

Time occupied: RC (?) Initials:

much + too late.
RC again attempted to expl GMC procedure/proceedings

4145818 v1

Cooper, Rachel

From: Code A
Sent: 03 June 2009 02:52
To: Cooper, Rachel
Subject: Re: GMC - Dr Barton

Hi Rachel

Passport details

Code A **Passport number**
Passport number

Address: This is not a postal address, mail here is only delivered to a Post Office Box number.

S— · –

a

, 000

Regards

Code A

On Wed, Jun 3, 2009 at 2:27 AM, Cooper, Rachel <Code A> wrote:

Dear Code A

I refer to the above matter.

In order to book flights and hotels for you and your husband, I will need your full names (including any middle names), your passport numbers, contact details (address only - I already have your telephone numbers). Please can you let me have these as soon as possible.

Many thanks

Rachel

Rachel Cooper | Assistant Solicitor
for Field Fisher Waterhouse LLP
Code A

From: Code A
Sent: Monday, June 01, 2009 10:49 AM
To: Cooper, Rachel
Subject: Re: travel agent in Code A

OK Rachel.

The airport is Code A

When booking the Hotel please can you arrange for the Hotel to collect and return us to the airport. Also concerning our food expenses please can you sort this for me too, hopefully Breakfast comes with the room and an evening Meal.

Can you also let me know where the video link is being held so I can research the area.

Regards

Code A

On Mon, Jun 1, 2009 at 4:32 PM, Cooper, Rachel Code A wrote:

Dear Code A

Many thanks for the information set out below.

By way of confirmation, the GMC have agreed to pay for Code A to flight to and from Code A The GMC are also happy for you to have 2 nights accommodation whilst in Code A

Please can you let me know the name of the airport which you will be flying from and I will make the necessary travel bookings.

Kind regards

Rachel

Rachel Cooper | Assistant Solicitor
for Field Fisher Waterhouse LLP
Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 **Fax**+44 0161 200 1777
E-mail info@ffw.com **Web** www.ffw.com **CDE**823

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This e-mail may contain privileged and confidential information. If you receive it in error please tell the sender and do not copy, distribute or take any action in reliance upon it. You should ensure this e-mail and any attachments are virus free. E-mail is not a 100% virus-free or secure medium. It is your responsibility to ensure that viruses do not adversely affect your system and that your messages to us meet your own security requirements. We reserve the right to read any e-mail or attachment entering or leaving our systems without notice.

Field Fisher Waterhouse LLP is a limited liability partnership registered in England and Wales (registered number OC318472) and is regulated by the Solicitors Regulation Authority. A list of its members and their professional qualifications is available at its registered office, 35 Vine Street, London, EC3N 2AA.
We use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with equivalent standing and qualifications.

From: Code A

Sent: Monday, June 01, 2009 5:09 AM
To: Cooper, Rachel
Subject: travel agent in Code A

HI Code A

Here is a contact in Code A that we have used, today is a Public Holiday so all closed.

First-Classic travel services SND. BHD

Code A

Regards

Code A

Cooper, Rachel

From: Code A
Sent: 01 June 2009 10:49
To: Cooper, Rachel
Subject: Re: travel agent in Code A

OK Rachel.

The airport is Code A

When booking the Hotel please can you arrange for the Hotel to collect and return us to the airport. Also concerning our food expenses please can you sort this for me too, hopefully Breakfast comes with the room and an evening Meal.

Can you also let me know where the video link is being held so I can research the area.

Regards

Code A

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Dear Code A

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Please can you let me know the name of the airport which you will be flying from and I will make the necessary travel bookings.

Kind regards

Rachel

Rachel Cooper | Assistant Solicitor
for Field Fisher Waterhouse LLP
Code A

Consider the environment, think before you print!

Field Fisher Waterhouse LLP 27th Floor City Tower Piccadilly Plaza Manchester M1 4BD
Tel+44 0161 200 1770 **Fax**+44 0161 200 1777
E-mail info@ffw.com **Web** www.ffw.com CDE823

FFW does not accept service of documents by e-mail for Court or other purposes unless expressly agreed in writing beforehand. For service to be effective, the sender must receive an express acknowledgement of receipt from the person intended to be served.

This e-mail may contain privileged and confidential information. If you receive it in error please tell the sender and do not copy, distribute or take any action in reliance upon it. You should ensure this e-mail and any attachments are virus free. E-mail is not a 100% virus-free or secure medium. It is your responsibility to ensure that viruses do not adversely affect your system and that your

REID	That's right.
DC QUADE	Is Petersfield still running?
REID	Yes.
DC QUADE	Yeah. And you've still got the beds at St. Mary's.
REID	Yes.
DC QUADE	Yeah okay.
REID	I mean the configurations changed but...
DC QUADE	Yeah. And did these care trust changes affect your department much or?
REID	One, well (pause) no and, and this is before I, I came to Portsmouth and the decision had been made that elderly medicine would be part of Portsmouth Health Care Trust, so in some ways it was very useful having all the departments, you know, all the beds in Queen Alexandra and St. Mary's plus Gosport all, all being managed by one organisation,...
DC QUADE	Yeah.
REID	...I mean that created some tensions with Portsmouth hospitals because they would like to have run the beds in,...

DC QUADE	Yeah, yeah.
REID	...there are beds in Queen Alexandra Hospital.
DC QUADE	Fine thanks for that. How many doctors were working in your department from 1998?
DC QUADE	Let's say in 1998. Consultants?
REID	I mean, I mean I can't, it, it's changed so often but I mean there'd be I think nine or ten consultants, not often were full time...
DC QUADE	Right, yeah.
REID	... I don't know they might have had, um, (pause) I think they might have had four Registrars or Specialist Registrars (pause), um, I am, you know, I'm guessing, well I'm not it's an inspired guess eight, eight Senior House Officers, two Pre-registration House Officers and we had, um, G.P.'s working for us as Clinical Assistants like Doctor BARTON...
DC QUADE	Yeah.
REID	...at the War Memorial and we had a doctor doing a similar role in Petersfield and we had a practice covering St. Christopher's Hospital.

DC QUADE	So they didn't have their own Clinical Assistant, they had a practice that covered the same role?
REID	Yes and two of them took a lead role if you like.
DC QUADE	Yeah, okay, thanks for that. What's your current role within the department?
REID	Now I'm a straightforward Consultant if you like…
DC QUADE	Okay.
REID	…as of the 1st of June.
DC QUADE	From the 1st of June?
REID	Yeah.
DC QUADE	Is that a job change or?
REID	Yes.
DC QUADE	Oh have you just dropped a title, were you Medical Director?
REID	I was Medical Director …
DC QUADE	Oh right.

General Medical Council

Dr Jane Barton

Statement of Dr Richard Ian Reid

I, Dr **Richard Ian Reid,** will say as follows:

1. I make this statement in relation to the General Medical Council investigation into Dr Barton.

2. Previously I assisted the Hampshire Police with their inquiries and exhibited to this statement and marked as follows are copies of my witness statements and interview transcripts:

   (a) **"RIR/1"** – statement dated 7 June 2000 regarding patient Gladys Richards

   (b) **"RIR/2"** – *statement dated 4 October 2004(1) regarding patient Elsie Devine*

   (c) *"**RIR/3**" – statement dated 4 October 2004(2) regarding patient Elsie Devine*

   (d) **"RIR/4"** – *statement dated 26 November 2004(1) regarding patient Elsie Devine*

   (e) *"**RIR/5**" – statement dated 26 November 2004(2) regarding patient Elsie Devine*

   (f) **"RIR/6"** – statement dated 24 October 2005 regarding patient Code A

   (g) **"RIR/7"** – interview record dated 4 July 2006 (09:21-10:00 hrs)

   (h) **"RIR/8"** – interview record dated 4 July 2006 (10:02-10:42 hrs)

   (i) **"RIR/9"** – interview record dated 4 July 2006 (10:55-11:35 hrs)

   (j) **"RIR/10"** – interview record dated 4 July 2006 (11:42-12:20 hrs)

   (k) **"RIR/11"** – interview record dated 4 July 2006 (13:19-13:59 hrs)

   (l) **"RIR/12"** – interview record dated 4 July 2006 (14:02-14:40 hrs)

   (m) **"RIR/13"** – interview record dated 4 July 2006 (15:00-15:40)

3. I am employed by Portsmouth Hospitals Trust as a Consultant Geriatrician. I commenced working in Portsmouth in 1998 for the then Portsmouth HealthCare Trust. I worked whole-time, spending nominally half my time as Medical Director of Portsmouth HealthCare Trust and the other half of my time as a consultant in geriatric medicine. I relinquished the Medical Director aspect of my role 2 years ago, and since then I have been working as a full-time consultant in geriatric medicine.

4. In February 1999 I was based at the Queen Alexandra Hospital. I also carried out one session a week at the Gosport War Memorial Hospital at the Dolphin Day Hospital. From February 1999 I was the Consultant in charge of Dryad Ward. It would have been very rare for me to admit patients to Dryad Ward but I was the Consultant in charge. Dr Barton was already in post as a Clinical Assistant when I started working in Gosport.

5. I used to carry out a ward round on a Monday afternoon. Dr Barton would attend the ward rounds on Dryad Ward and then Daedalus Ward alternately. At most I would therefore see Dr Barton once a fortnight.

6. I had no concerns at the time about Dr Barton's work. I thought she was a good doctor.

7. "Continuing Care" is the term for a patient whom it was considered would remain in hospital for the rest of their life. That patient would not normally be discharged. The patient was not necessarily terminally ill. . The patient could be in for years. There was no reason why their end of their life should be imminent.

8. "Palliative Care" means administering care to relieve symptoms where there is no cure for the illness. Palliative care patients have an incurable illness, but may not be terminally ill.

9. In relation to my interview of 4 July 2006 exhibited to this statement and marked "**RIR/10**" at page 45 I have stated that "I remember speaking on one occasion to Dr Barton because I observed this sort of large dose range and you know she gave me an explanation as to why she had done that. She stated that her partners were unhelpful at coming out when she was not there and I mean as I remember the dosage range I think was 20-80mg and I accepted that explanation at the time". I would like to clarify that I do not remember when I had a conversation with Dr Barton or which patient it was with regard to. I cannot say, at this time, that it was regarding Sheila Gregory.

10. I remember vaguely that Dr Barton said that over a bank holiday weekend cover was very hard to get from her GP partners and that she said that she had prescribed the range of drugs so that the patient would not have to wait or suffer.

11. I accepted that explanation at time.

12. I do not recollect Dr Barton frequently prescribing drugs in advance.

13. The section of the drugs chart where a variable dose range of drugs would be written was not normally where I would have looked when I carried out my ward round. The drugs chart folds in three and on the back would be where it would be written on so the drugs could be varied from day to day. That part of the drugs chart was very rarely used. I would have had to take out the drugs chart from the blue folder to see that portion of the chart. This is why when I was carrying out the ward rounds I did not used to look at this section of the chart routinely. When I was carrying out the ward rounds I would look at the medical records and speak to the nursing staff. I would also look at the drugs chart to see what the patient was on at that time. However, as I have explained above, I would not have looked at the reverse side of the drugs chart as this was very rarely used in general terms.

14. I have no recollection of seeing drugs charts on which Dr Barton had written up prescriptions for Diamorphine in advance, for patients who were not in pain, or terminally ill at the time.

15. I never had any real cause to use the back sheet of the drugs chart and could only think that it would perhaps be used for a drug such as Warfarin.

16. Around 1999 it was not practise to have any staff reviews or regular supervision. This was not just in Portsmouth but across the board. From time to time Dr Barton would ring me and ask for my advice.

17. I would not expect to be told, as the consultant in charge of the ward, if a patient had died or got better or the position had changed.

18. I have been asked to elaborate regarding anticipatory prescribing. If I was treating my own patients and they were in pain, in normal circumstances I would work through the analgesic ladder. However, there are occasions when patients appear to be in severe pain and it would not then be appropriate to work through the analgesic ladder. In certain circumstances anticipatory prescribing is good practice. For example, if a patient was having an operation and the drugs were written up prior to the operation to be given post-operatively for pain control. Likewise, if a patient were terminally ill and in pain or distress it would be good practice to proactively prescribe medication to relieve pain or distress, particularly where there was no on-site medical cover..

19. On page 15 of exhibit "**RIR/13**" I state that "At the time I felt that Dr Barton, although her notes were brief, did actually record significant changes in either the patient's condition or the significant changes in the management plan at the time". I would

reiterate that I thought that Dr Barton's notes were adequate on most occasions. If there was a significant change in the patient's condition then this would be recorded.

20. I was very conscious that Dr Barton was working very hard at the time and although I knew that her notes weren't entirely adequate I did not want to add to her burden of responsibility by picking up on her note-keeping.

21. In an ideal world then we would have wanted notes to be kept like they would be in an acute hospital where a full-time junior staff member would be making detailed notes. However, this was not practical as Dr Barton was working part-time and had a very busy GP practice.

22. On page 22 of exhibit "**RIR/13**" I recall a conversation with Dr Barton. I would elaborate that I can remember some time in early 2000 having a conversation in passing with Dr Barton. This was an informal conversation rather than her asking to see me specifically. I got the impression that she was finding the pressures of the job very difficult. At this juncture in time I cannot remember the exact details of the conversation.

23. At this time, in early 2000, it was clear that the patient nature had changed. I elaborate on this at page 23 of "**RIR/13**". The patients were more poorly when they came here and as a consequence of pressure to discharge patients from the acute hospital to create beds for admissions to the acute hospital..

24. My colleagues and I were extremely grateful to Dr Barton for the care that she had provided to the patient. She came into the hospital at 7.30 am and in the afternoon and in the evening. Without her I did not see how the Gosport War Memorial Hospital would have been able to function. Not many other GPs would have worked as hard as she had.

25. When I had the conversation with her in early 2000 I was trying to sow the seed that the pressures of the role might be likely to continue to increase, which would make it difficult for the role to be covered on a part-time basis. In the conversation I was informally saying that I thought that it was unlikely the situation would improve so that she would then have a chance to reflect upon whether she was able to fulfil the role, given its apparently increasing demands.

26. My colleagues and I in the Department had come to the view that we probably needed full-time medical cover Monday to Friday 9am – 5pm. I do not recollect this being discussed formally..

27. Subsequently Dr Barton handed in her resignation. She did not hand in her resignation to me and I do not have a copy of her letter.

28. I have been asked if my conversation with Dr Barton in early 2000 was influenced by complaints made regarding her practice at the time. It was not. I met Code A in early 2000 to discuss her complaint about the care of Code A Elsie Devine. During the course of that meeting Mrs Devine complained about Dr Barton's attitude, but I think that this was after my conversation with Dr Barton.

29. There had been a couple of other informal complaints about the treatment and care of patients at that time. I felt that one of these complaints was generated by a certain inflexibility of attitude displayed by Dr Barton and Gill Hamblin, the Ward Sister, at that time. Dr Barton and the Ward Sister had worked closely together for many years. I would like to emphasize that I was not concerned about Dr Barton's practice.

30. I cannot remember the exact details of the complaints at the time but one of them regarded a patient who was on morphine tablets which were then discontinued by Dr Barton who put the patient on less strong medication. The family then complained. The second complaint regards a lady who developed heart failure on a Friday and Dr Barton prescribed morphine, quite appropriately in my opinion, I saw the patient on the Monday and stopped the morphine as the patient was better. On the first occasion, described above, I felt that if I had dealt with the relatives from the outset the complaint might not have arisen.

31. Dr Barton and Gill Hamblin worked very closely together on Dryad Ward for a long time. I observed their way of doing things. If they were challenged I think they found it quite difficult to be flexible, but as the consultant in charge of the ward if I said that I wanted something doing it was done. However, I picked up a sense of this inflexibility from speaking to the patients' relatives.

32. The main concerns that I had about Dr Barton were not to do with the complaints. During the time that I was working there the only complaint that I received about Dr Barton was the one referred to earlier from Code A My main concern was Dr Barton's workload. I felt that in most situations Dr Barton had acted appropriately. I met Mrs McKenzie and her sister, the daughters of Gladys Richards, I think in 2002, when the Health Care Commission produced its report. At that event Mrs Mckenzie and her sister approached me and expressed concerns about the attitude of staff on Daedalus ward. I do not remember any comment about any specific member of staff. After meeting Code A I could understand why Code A felt Dr Barton did not care, as from her description Dr Barton's manner was rather brusque.

33. I am currently employed as a consultant in elderly medicine and based primarily at Gosport War Memorial Hospital. I still however carry out emergency take and on-call duties at the Queen Alexandra Hospital. The policies and practices that had been introduced since these events are very different.

34. On page 20 of the record of interview dated 11 July 2006 (0912-0955 hrs) I state that "Patients were being transferred from other wards and people would over-egg the pudding in terms of what people's capabilities were to persuade us to take the patients". This was a recurrent problem. Staff on acute wards feel that it is their role to deal only with the speciality problem that the patient presents with. For example, on cardiology ward staff would deal with the heart problem but if the patient had had a stroke too not a lot of interest would be shown in this. Generally,staff on acute wards want to get the patient off the speciality ward as soon as the specialty problem had been resolved and might say something like "Your mother has had a stroke but they'll have her up on her feet in no time".

35. The staff on acute wards had little interest in passing on the message that a patient might be ill as they wanted to get them off their ward as soon as possible.

36. A recurrent problem at Gosport War Memorial Hospital was that a patient's relatives had often been told that a patient was going for rehabilitation when the reality was that they were highly unlikely to benefit from rehabilitation..

37. This was very hard to deal with once the patient had arrived at Gosport War Memorial Hospital. The Ward Sister would usually have a dialogue with the family at an early stage to set some more realistic expectations. However this was made more difficult as the doctor was not on site all the time. Some relatives would not take that kind of information from a nurse and would want it from the doctor.

38. However, even when a doctor speaks to a patient's relatives it is hard to undo what medical staff on other wards have already said. This would be particularly difficult if it were a consultant or other senior doctor who had stated that a patient was being transferred for rehabilitation. In these circumstances it would be particularly difficult to undo this impression.

39. On page 2 of 23 of my record of interview dated 11 July 2006 (1004-1048 hrs) I have used the phrase "hopefully remobilisation" in my referral letter regarding Enid Spurgin. I only have the vaguest recollection of Enid Spurgin whom I had seen at Haslar Hospital and about whom I had written a letter. I cannot honestly say that I remember the patient. The phrase "hopefully remobilisation" means that I would have had considerable doubts that she would get back on her feet. The receiving staff would pick up on my doubts from that phrase. If I had been confident about her prospects then I would have used the phrase "for rehabilitation". If I had doubts then I would use a phrase such as "hopefully rehabilitation" or "attempted rehabilitation".

40. I am of the "give everyone a chance" school of thought. My philosophy would be to bring them over to Gosport War Memorial Hospital and have a go and see if anything could be done for the patient.

41. On page 18 of 23 of my record of interview dated 11 July2 006 I mentioned that the notes from the Haslar Hospital were not always transferred over with the patient. This happened very frequently from both Queen Alexandra Hospital, St Mary's Hospital and also Haslar Hospital. I do not remember the fact that Haslar Hospital being a military hospital was an issue (although they do tend to guard their records carefully). It would be reasonable to say that missing records would be a theme of transfer. I do not know how often this happened, but often there would be no notes at all, incomplete notes, missing x-rays and drug charts or other vital information missing. If this were the case then Dr Barton would have had to base her treatment plan on the presentation of the patient.

42. I do not recall changing the medication of Enid Spurgin although I understand from the medical notes that I did so. I have described this at page 20/21 of 25 of the third part of my record of interview dated 11 July 2006. During the police interview I explained that a Diamorphine infusion by syringe driver had been prescribed by Dr Barton at around 9am on 12 April (1999) for 80 milligrams over 24 hours. During my afternoon ward round I reduced this to 40 milligrams over 24 hours

43. In relation to my statement dated 7 June 2000 regarding the patient Gladys Richards. I have the very vaguest recollection of seeing this patient in the Haslar Hospital that her daughters were with her. I met the daughters at the Commission for Health Improvement meeting.

44. I would like to clarify that once Gladys Richards was transferred to Gosport War Memorial Hospital she went to Daedalus Ward which I was not in charge of and I had no further involvement in her care.

45. With regard to my statement dated 4 October 2004 exhibited at **"RIR/2"** regarding patient Elsie Devine I would like to clarify that I carried out ward rounds on 25 October 1999, 1 November 1999 and 15 November 1999. Mrs Devine was admitted to Gosport War Memorial Hospital on 21 October 1999.

46. On page 5 of this statement I stated that it was not appropriate to prescribe Oramorph in the absence of documented pain. I did not notice this prescription on my ward round of 25 October 1999. I think this is because it was prescribed on an as required (PRN) basis. This might mean that I did not notice it. I would describe myself as being usually meticulous about looking at the drugs sheet. However, as described above, I would not pay attention to the PRN page of the drugs chart, unless it was apparent that a PRN prescription was frequently being administered.

47. It is good practice if a drug has been administered regularly (from a PRN prescription) to re-prescribe it as a regular medication..

48. I have been asked if I think it is reasonable not to have paid much attention to the PRN side of the drug charts. I acknowledge that it was my responsibility to do so and that I should have picked up on it but I can understand how I missed it. On a ward round I would have about ten minutes with each patient and in this time I would need to assess them, see how the patient is, look at their current problems, speak to the nursing staff and I would focus on the drugs that they were actually receiving rather than what they could be receiving.

49. Exhibited to this statement and marked "RIR/?" is an A3 copy of one of the drugs records to illustrate where the prescriptions are written up.

50. I understand that my statement may be used in evidence for the purposes of a hearing before the General Medical Council's Fitness to Practise Panel and for the purposes of any appeal, including any appeal by the Council for Healthcare Regulatory Excellence. I confirm that I am willing to attend the hearing to give evidence if asked to do so.

I believe that the facts stated in this witness statement are true.

Signed: Code A

Dr Richard Ian Reid

Dated: 17th June 2008

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: REID, RICHARD IAN

Age if under 18: OVER 21 (if over 18 insert 'over 18') Occupation: CONSULTANT GERIATRICIAN

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

Signed: R I Reid Date: 07/06/2000

I am the above named and I reside at the overleaf address. My qualifications are MB, ChB, FRCP (Glasgow), FRCP (London). I am a consultant in care of the elderly. I am employed by Portsmouth Healthcare Trust . Although I am based at the Queen Alexander Hospital I am often asked to give advice on the treatment of elderly patients in other wards and hospitals. I frequently attend the Royal Hospital Haslar to give such advice. I can see up to 10 patients a week in outside wards and hospitals.

I have been asked to comment about my involvement with one particular patient Gladys RICHARDS who was admitted to the Haslar Hospital in August 1998. I saw her after she had received a hernia-anthroplasty of her right hip following a fall at Glen Heathers nursing home . In laymans terms this was a semi-hip replacement.

I cannot remember Mrs RICHARDS as an individual patient but by referring to my letter dated 8th August 1998 (8/8/1998) (RIR/1) to Code A I can say the following.

When I saw Mrs RICHARDS on the 3rd August 1998 (3/8/1998) it was likely that she was physically well enough to be transferred to Gosport War Memorial Hospital for attempted rehabilitation.

Having re-read the above letter I believe there is an error on page two line 5. The word 'a' prior to little discomfort should be deleted.

Signed: R I Reid Signature Witnessed by:

2004(1)

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: REID, RICHARD IAN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: CONSULTANT GERIATRIC MEDICINE

This statement (consisting of 41 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signed: R Ian REID Date: 04/10/2004

I am Doctor Richard Ian REID MB, ChB. I reside at the address detailed overleaf. I qualified at Glasgow in 1974.

I became a Member of the Royal College of Physicians (United Kingdom) in 1978.
A Fellow of the Royal College of Physicians (Glasgow) in about 1988 and a Fellow of the Royal College of Physicians (London) in about 1990.

My General Medical Council registered number is Code A

Experience

1. House Officer (Medicine) at Royal Alexandra Infirmary, Paisley, Scotland from August 1974 to January 1975.
2. House Officer (Surgery) at Stirling Royal Infirmary, Stirling, Scotland from February 1975 to July 1975.
3. Senior House Officer)Obstetrics and Gynaecology) at Paisley Maternity Hospital, Paisley, Scotland from August 1975 to January 1976.
4. Senior House Officer (Geriatric Medicine) at the Victoria Geriatric Unit, Glasgow from February 1976 to July 1976.
5. Senior House Officer (Cardiology) at the Glasgow royal Infirmary, Scotland from august 1976 to April 1977.

6. Registrar in General Medicine at the Kilmarnock Infirmary, Kilmarnock, Scotland from May 1977 to July 1979.
7. Senior Registrar in Geriatric Medicine at Portsmouth and Southampton Hospitals from August 1979 to July 1982.
8. Consultant in Geriatric medicine at Southampton General Hospital from August 1982 to March 1998.

My current role which I began in April 1998 is as Consultant in Geriatric Medicine and Medical Director of East Hampshire Primary Care Trust (formerly Portsmouth Health Care Trust). I am based at the Queen Alexandra Hospital, Cosham.

I have a full time National Health Service contract which consists of 11 (eleven) sessions per week. One session is 3½ hours. I have an 'On Call' responsibility and work weekends (Saturday and Sunday on roughly one weekend in ten basis).

I began the responsibility of looking after 'In Patients' at Gosport War Memorial Hospital in either February or April of 1999.

This continued for a period of about 12 months until about March 2000.
As Consultant to Gosport War Memorial Hospital I had a responsibility for the in patients on Dryad Ward of the hospital.

In this role I supervised the work of Doctor Jane BARTON , a local General Practitioner who, in addition to her work in general practice, worked as 'Clinical Assistant' at Gosport War Memorial Hospital.

In the absence of Dr BARTON I supervised the work of any 'locum' or partners at her general practice who covered her responsibilities for her.

It was also my role to supervise the work of any Specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital.

I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

During the ward round I would visit each of the in patients on Dryad Ward.
I was accompanied on my ward round by the clinical assistant, Dr Jane BARTON, every two weeks, if she was available to do so.

I also provided consultant cover to Daedalus Ward the other consultant led ward at the Gosport War Memorial Hospital, when my colleague Dr A LORD was on leave or unavailable. This was a reciprocal arrangement with Dr LORD who would normally cover my leave periods or unavailability. In the event of myself and Dr LORD being unavailable for long periods of time then locum consultant cover would be sought, however for short periods of absence then no locum cover was arranged.
If the Clinical Assistant, Dr BARTON was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice or to ask me to attend Dryad Ward to carry out an examination of the patient or see relatives who were concerned.

If my advice was sought by the Clinical Assistant then I would expect a note to be made on that patient's clinical notes by the Clinical Assistant. Dr Jane BARTON is a very experienced doctor and as such it would be a serious clinical problem relating to the treatment of a patient that would require her to seek such advice.
If a problem arose requiring a Consultant input during any short term unavailability of both myself and Dr LORD then I would expect the Clinical Assistant to contact the Elderly Medicine Office at the Queen Alexandra Hospital, Portsmouth to obtain the required consultant input.
The clinical notes of a patient are where a record is kept of the clinical treatment of a patient.

I would expect a note to be made on the clinical notes on a patients admission to the

hospital, giving a brief history and the results of any examination and treatment.

I would also expect a prescription sheet to be commenced detailing any drugs prescribed on admission (see separate statement).

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as Consultant, with entries from other clinical staff when consulted regarding the management of a patient.
A nursing record is also commenced on admission of a patient which is maintained by the nursing staff.
During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff, provided from the nursing records. This information is usually verbally provided and it would be unusual for me to read the nursing record of a patient.

This information together with information I have obtained myself as a result of any examination I have made of the patient, would form the basis of any note that I made on a patients clinical notes.

If there is no marked change in a patients condition, treatment or management then I would not expect any entry to be made on a patients clinical notes by the Clinical Assistant.

However I would make a note on the clinical notes of each patient I saw during my ward round.

Included in my notes on the clinical notes would be any instructions regarding the clinical care of a patient to the Clinical Assistant.

I have been asked to detail my involvement and the care and treatment of Mrs Elsie DEVINE , born on Code A who was admitted to Dryad Ward of the Gosport War Memorial Hospital on Thursday 21st October 1999 (21/10/1999), having been

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transferred from the Queen Alexandra Hospital, Portsmouth.

Mrs DEVINE was a patient on Dryad Ward until her death on Sunday 21st November 1999 (21/11/1999) at the age of 88.

During this period I was the Consultant for Dryad Ward, Gosport War Memorial Hospital.

I first wish to state that I have no personal recollection of Mrs Elsie DEVINE herself and therefore this statement has been provided by referring to certain entries made by myself and others on Mrs DEVINE's medical notes. In particular entries made on her clinical notes and prescription sheets.

By referring to Mrs DEVINE's medical notes I can state that I saw her on three occasions, between 21st October 1999 (21/10/1999) and 21st November 1999 (21/11/1999).

On each of the three occasions that I saw Mrs DEVINE it was as a result of my weekly ward round of Dryad Ward, Gosport War Memorial Hospital.

The three occasions were as follows:

1. Monday 25th October 1999 (25/10/1999)
2. Monday 1st November 1999 (01/11/1999)
3. Monday 15th November 1999 (15/11/1999)

I have been shown a document bearing an exhibit label BJC/16/PG/154&155. This document I recognised as a speciality history sheet on which doctors record clinical notes in relation to a particular patient. The patient in the case of this document was Elsie DEVINE.

This document is double sided, notes therefore are recorded on both sides. My attention has been directed to an entry on the lower part of page 154 which commences with the date 25th October 1999 (25/10/1999).

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I recognise this writing as mine and that the note ends with a signature that I recognise as my own.

My note is proceeded by a note dated 21st October 1999 (21/10/1999). The handwriting and the signature at the end I recognise as that of Dr Jane BARTON, Clinical Assistant at the Gosport War Memorial Hospital.

These are the only two notes that appear on page 154.

My note of 25th October 1999 (25/10/1999) would have been made during the course of my weekly visit to Gosport War Memorial Hospital (GWMH) and during my ward round at Dryad Ward.

My note reads as follows:-

'25th October 1999 (25/10/1999), mobile unaided

Washes with supervision - dresses herself

Continent - mildly confused

Blood pressure 110/70

Normochromic anaemia

Chronic renal failure'

'Was living with daughter and son-in-law, believed son-in-law awaiting bone marrow transplant.

Need to find out more regarding son-in-law etc'.

The entry has then been signed by me using my normal signature.

This note should be interpreted as follows:

On Monday 25th October 1999 (25/10/1999) I saw and had contact with patient Elsie DEVINE. It is possible that Dr Jane BARTON was present, it is also possible that I carried out a physical examination of Elsie DEVINE. The main content would have been noted by me from reports made to me by the nursing staff, and/or Dr BARTON, if present.

'Mobile unaided'. This probably meant that Elsie DEVINE was at that time walking without

support and that she, at that time, was probably safe walking on her own.

'Washes with supervision', this probably meant that Elsie DEVINE was physically able to wash herself but due to her confusion required some guidance and prompting to wash.

'Dresses herself', this probably meant that Elsie DEVINE was, at this time, physically capable of dressing herself. I have made no record of if she required any guidance with her dressing.

'Continent', this probably meant that Elsie DEVINE was at this time, continent, regarding 'urine' and was aware of the need and recognised the need to pass urine, also able to control her bladder until she passed urine.

'Mildly confused', this probably meant that, at this time, Elsie DEVINE's short term memory was mildly impaired. She was confused as to time and recent events but was probably aware of her surroundings, ie that she was in hospital.

'Blood pressure 110/70', this blood pressure I would regard as being on the low side, however provided that patient had appeared to be well in themselves it would not be a cause for concern.

'Normochromic anaemia', means that at that time Elsie DEVINE's red blood cells were low in number and that these cells were normal in colour when examined under the microscope.

'Chronic Renal Failure', this is a reference to Chronic Renal Failure being one of a number of causes of Normochromic Anaemia.

These notes would have been completed by me during my afternoon ward round of Dryad Ward, Gosport War Memorial Hospital. This would have been the first occasion that I would have seen Elsie DEVINE as she was admitted to this hospital on Thursday 21st October 1999 (21/10/1999).

The note is then completed with a brief social background which is self explanatory and related to me by the nursing staff, that prior to her admittance to hospital. Mrs DEVINE was living with her daughter and son-in-law, in a home environment.

That it was believed that her son-in-law was himself in hospital [redacted]

The note of:-
'Need to find out more re son-in-law etc'.

This is an indication that more had to be found out about Mrs DEVINE's current home circumstances and if daughter would be able to care for her mother, following her husband's illness, or if a residential or nursing home needed to be considered.

All the above, would have been obtained from verbal reports of the nursing staff and from Mrs DEVINE's notes.

I would not have relied on a patient in a 'confused state' to provide such information.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 1/11/99 (01/11/1999) and has been written on the reverse side of this document (page 155).

This note has been written on by me and would have been written by me during my weekly ward round of Dryad Ward at the Gosport War Memorial Hospital.
I do not regard it as unusual that no note has been made on the clinical notes since 25/10/99 (25/10/1999) as there had been no major change in Mrs DEVINE's condition and treatment since that date. I would have had access to all medical notes relating to Elsie DEVINE's condition and treatment and in addition could possibly have had Dr Jane BARTON in attendance as well as the nursing staff from all of whom I would have taken verbal reports on which my note would have been based. This should read as follows:

'1st November 1999 (01/11/1999) physically independent but needs supervision with washing and dressing and help with bathing.

Continent.

Quite confused and disorientated.

For example, undresses during the day.

Is unlikely to get much social support at home.

Therefore try home visit to see if functions better in own home'.

This entry is then signed by me with my normal signature.

This note could be interpreted as follows:

'Physically independent', probably means that Mrs DEVINE, at that time, was physically able to walk, at least short distances, unaided by either staff or walking aides.

'But needs supervision with washing and dressing and help with bathing', this probably means that at this time due to Elsie DEVINE's confusion she needed guidance and direction but that she was physically capable of both dressing and washing. However if Mrs DEVINE was taking a bath, then she needed physical help to do so.

'Continent', this is a further reference to Elsie DEVINE's passing of urine and a reference to the fact that with regard to this, there had been no change in Mrs DEVINE's status, since the last occasion on which I saw her. Namely she was still aware of any need to pass urine and was able to control that need and was not 'wetting herself'.

Had Mrs DEVINE suffered from any incontinence of the bowel then this would have been separately noted.

'Quite confused and disorientated', this would probably mean that at that time Mrs DEVINE may not have been aware that she was in hospital or of the time of day, day in the week etc.

This information would have been obtained from verbal reports given by the nursing staff of

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Dryad Ward. The note is supported by the following example:'
'Undressing during the day'

This part of the note is self explanatory and has been entered on the notes as an example of Mrs DEVINE's confusion at that time.

As previously stated this information would have been provided in the form of verbal reports provided by the nursing staff from their nursing notes.

'Is unlikely to get much social support at home'.
This sentence is a reference to earlier and current reports of Elsie DEVINE's home circumstances provided by the nursing staff namely that prior to her admittance to hospital Mrs DEVINE was living with her daughter and son-in-law. However her son-in-law was in hospital himself Sensitive personal data. Mrs DEVINE's daughter was staying with her husband in London. There was not anyone at home to provide care, support or supervision to Elsie DEVINE at that time.

'Therefore try home visit to see if functions better in own home'.
This note is a suggestion made by me in order to assess Mrs DEVINE's level of 'confusion'. Elsie DEVINE appeared to be suffering from 'Dementia'. Persons suffering from Dementia (confusion) often function worse in unfamiliar surroundings for example:- within hospital, changing hospital, changing ward within a hospital.

It appeared to me that Mrs DEVINE's condition with regard to her confusion had worsened since my visit of 25th October 1999 (25/10/1999). It is often the case that a person suffering this condition can improve if returned to more familiar circumstances.

The suggestion was therefore to try a supervised part of a day at home with an occupational therapist to see how Mrs DEVINE functioned in her 'activities of daily living' within familiar surroundings and circumstances.

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At the same time an assessment could be made of what support would be required for her to return home, or whether Mrs DEVINE would require a position in a residential home or a nursing home. In addition what support she would require in these circumstances. This home visit would be dependent on Mrs DEVINE's physical condition, which appears from my note of the 1st November 1999 (01/11/1999) to be stable.

The main focus of my note of 1st November 1999 (01/11/1999) appears to be Mrs DEVINE's confusion. Had there been any concerns regarding her physical condition at that time then I would have made a note of it. I note from the prescription sheets that on 1st November 1999 (01/11/1999) Dr BARTON prescribed to Elsie DEVINE the drug 'Amiloride' in the form of 5mg tablets, one tablet daily. It is possible that the prescription of the drug 'Amiloride' to Mrs Elsie DEVINE was discussed by myself and Dr BARTON during my ward round.

However I have not made any mention of this in my note of 1st November 1999 (01/11/1999) and do not have any personal recollection of such a discussion.

The drug 'Amiloride' is used to treat fluid retention and heart failure. The drug is entirely compatible with the other drugs prescribed to Elsie DEVINE at that time.

I have provided a further statement regarding drugs prescribed to Elsie DEVINE.

In my further statement I have detailed the dosage and two possible reasons for its prescription.

I note from the prescription sheets that Mrs DEVINE was first administered 'Amiloride' on 2nd November 1999 (02/11/1999) and continued to be given the drug until 18th November 1999 (18/11/1999). The dosage remained the same throughout this period.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 15/11/99 (15/11/1999). This note has been written by me and should be read as follows:

'15th November 1999 (15/11/1999)

Very aggressive at times.

Very restless.

Has needed 'Thioridazine'

*On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine.
On examination pulse rate 100 per minute.
Regular temperature 36.4°C
Jugular venous pulse not seen
Hepato-jugular reflux negative
Oedema gross extending to thighs
Heart sounds - nil added
Chest clear
Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty
But good bowel action since
(* mid stream specimen urine - no growth)
Ask Doctor LUSZNAT to see'

My interpretation of this note is as follows:-
On Monday 15th November 1999 (15/11/1999) I saw Mrs Elsie DEVINE as part of my weekly visit to Dryad Ward at Gosport War Memorial Hospital.

This is two weeks since my last visit to Dryad Ward as I had been on leave. No note has been made on Mrs DEVINE's clinical notes since my note dated 1/11/99 (01/11/1999). It was reported to me as a result of face to face contact and verbal reports from the nursing staff and possibly Dr Jane BARTON that Mrs DEVINE had been:-

'Very aggressive at times'.

This could mean her having been either verbally or physically aggressive, or both, towards either staff or other patients or both.

'Very restless'
This probably meant that Mrs DEVINE was continually moving about whilst sitting or lying in bed. In addition she may have been pacing around the ward.

Both the above symptoms can be brought on by a deterioration in a persons physical state which causes anxiety and further confusion, which in turn can cause the person to become aggressive and restless.

The above comments on the notes have been bracketed by the words 'Has needed Thioridazine'.

Thioridazine is a major tranquillizer. The fact that this drug had been administered to Mrs DEVINE would have been obtained from my face to face contact with the nursing staff, Dr BARTON if present and from my examination of the drug/prescription chart.

I would not necessarily expect the administration of this drug to have been entered onto the clinical notes although it would be good practise to do so. In my opinion this was the correct drug to be given for the reported behaviour displayed by Mrs DEVINE. The dosage given at that time in my opinion was low.

'* On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine'.

This information would have also been gleaned from reports (verbal) made to me by staff and also from Mrs DEVINE's medical notes that since I had last seen Mrs DEVINE on 1/11/99 (01/11/1999) a mid stream urine specimen had been taken from Mrs DEVINE which had been subjected to a 'Dipstix' check which had shown the presence of blood and protein in Mrs DEVINE's urine. This is a simple test carried out by the nursing staff which involves the use of a reactive strip which indicates the presence of blood and protein within urine.
Having identified this presence the staff have then sent Mrs DEVINE's mid stream urine sample for further examination to the Microbiology Laboratory at St Mary's Hospital.

The nursing staff could have carried out this test and submission of the sample on their own initiative or on the instruction of the Clinical Assistant, Dr BARTON.

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It appears that there was concern regarding Mrs DEVINE having developed a urinary tract infection and that steps had been taken to treat this.
It would have been best practise that a note of this had been made on Mrs DEVINE's clinical notes recording the start of any new treatment.

Beside this entry on the notes, I have entered an asterisk.

This indicates to me that at the time of making this entry I had questioned the staff, as to the result of the urine sample being sent to St Mary's Hospital for examination.

Later in the note made by me on 15/11/99 (15/11/1999) the following appears:
(*MSU - no growth).

This indicates that whilst still engaged in my examination and/or making my note of the examination of Mrs DEVINE the result of the mid stream urine samples examination by the laboratory at St Mary's had been obtained and that it showed:
'- no growth'.

Which indicated to me that there was no infection in Mrs DEVINE's urine.

'On examination pulse rate 100 per minute and regular, temperature 36.4°C'
On examination is a note by me that indicates that I carried out a physical examination of Mrs DEVINE.

A pulse rate of 100 per minute and regular would be regarded on the 'upper limit' of normal. The normal pulse rate being 60 to 100 per minute.

A pulse rate of 100 per minute and regular would not cause any undue concern.

A temperature of 36.4°C would be regarded as normal, normal temperature range being 35 to 37°C.

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'Jugular venous pulse not seen. Hepato- jugular reflux negative'
This indicates that when examining Mrs DEVINE's jugular veins in her neck I saw that they were not distended (sticking out) and that the pulse in the vein was not visible.

When I applied pressure to Mrs DEVINE's liver this also failed to produce any neck vein distension.

Applying pressure to the liver is to cause the increased return of blood to the heart. At this stage Mrs DEVINE's veins remained undistended which indicated to me the absence of heart failure in Mrs DEVINE's case.

'Oedema - gross extending to thighs'
This means that on examination of Mrs DEVINE I found that her legs were very badly swollen to the thighs due to fluid retention. This condition can be caused by heart failure or renal failure and is also a symptom of other conditions. The above examinations were carried out in order to eliminate heart failure as a cause of Mrs DEVINE's very bad 'oedema'.

'Heart sounds - nil added'
This indicates that I listened to Mrs DEVINE's heart sounds and found them to be normal, with no murmurs or abnormal beats.

'Chest clear'
This is a note that during the course of my examination of Mrs DEVINE I listened to her chest and found her breathing sounds to be normal.

Both these examinations gave no indication of any significant chest or heart problems.

'Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty but good bowel action since'.

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This would have been reported verbally to me by the nursing staff as a result of enquiries made by me regarding Mrs DEVINE's bowel movements and formed part of my investigation into Mrs DEVINE's increased aggression and confused state.
The nursing staff would be expected to carry out a rectal examination of a patient if a period of time had elapsed without a patient having any significant bowel movement (passing of solid waste). It was reported to me by the nursing staff that such an examination had been carried out by them on 13th November 1999 (13/11/1999) and that the result of that examination showed that Mrs DEVINE's bowel was empty.
This was an indication that Mrs DEVINE was very unlikely at this time to be suffering from constipation.

The further note of 'But good bowel action since' is a result of further reports by the nursing staff that since their rectal examination on 13th November 1999 (13/11/1999) it had been noted that Mrs DEVINE had passed solid waste normally. This provided a further indication that she was not suffering from being constipated.

Constipation can be a cause of increased 'confusion, aggression and anxiety in an elderly patient'.

The final note made by me on Mrs DEVINE's clinical notes (after the mid stream urine result) was:

'Ask Doctor Code A to see'.
This note is an instruction that Mrs DEVINE be referred to Doctor R M Code A I believe that this doctor's initials (RM) stand for Rose Marie but I'm not sure of this. She is however known as 'Rosie'. Dr Code A is a Consultant in 'Old Age Psychiatry'.

Due to Mrs DEVINE's increasingly, 'confused', 'aggressive' and 'restless' condition and having found 'no apparent' physical reason for this from my physical examination of Mrs DEVINE I have written the instruction:

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'Ask Doctor Code A to see'
This instruction would be for Dr Jane BARTON or the doctor covering her responsibilities to carry out.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 16th November 1999 (16/11/1999) the note begins 'Dear Rosie' and ends with the words 'Can you help? Many thanks' this note is then signed. I recognise the writing and the signature of this note to be that of Dr Jane BARTON. This indicates to me that the notes of my examination of Elsie DEVINE on Monday 15th November 1999 (15/11/1999) made during my weekly ward round of 'Dryad Ward', Gosport War Memorial Hospital have been read by Dr Jane BARTON and a referral has been made to Dr Code A as instructed.

I have been shown a document bearing the exhibit reference of BJC/16/PG156&157. This is the next page of the 'clinical notes' of 'Elsie DEVINE'.

The first note on this document (page 156) APPEARS to be dated 18th November 1999 (18/11/1999) and is headed 'Elderly Mental Health'. This note appears to have been signed off by a 'a locum staff psychiatrist'. This indicates to me that Elsie DEVINE was seen by someone from Dr Code A team on 18th November 1999 (18/11/1999) following my instruction of 15th November 1999 (15/11/1999).

My next ward round of 'Dryad Ward', Gosport War Memorial Hospital would have been on Monday 22nd November 1999 (22/11/1999). From my examination of exhibit BJC/16/PG156&157 I note that Mrs Elsie DEVINE died at some time during the evening of Sunday 21st November 1999 (21/11/1999).

It appears from the 'clinical notes' that I had no further dealings in the care of Elsie DEVINE after Monday 15th November 1999 (15/11/1999).

I have been asked to comment on the lack of notes made on the 'clinical notes' between the following dates:

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21/10/99 (21/10/1999) note - Dr BARTON on admission (exhibit BJC/16/PG/154&155) and
25/10/99 (25/10/1999) my note -ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and
1/11/99 (01/1//1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and
15/11/99 (15/11/1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155).

As previously stated if there is 'no marked' change in a patient's 'condition', 'treatment' or management then I would not expect an entry to be made on a patients medical notes.

Between 21st October 1999 (21/10/1999) and 25th October 1999 (25/10/1999) there appears to be no marked change in the condition, treatment or management of Elsie DEVINE. Therefore I would not necessarily expect any note to be made.

Between 25th October 1999 (25/10/1999) and 1st November 1999 (01/11/1999) other than Mrs DEVINE appearing to be slightly more 'confused' there again appears to be NO marked change in Mrs DEVINE's condition and management., The drug 'Amiloride' was prescribed that day and was first administered on 2nd November 1999 (02/11/1999). I am unable to recall if I discussed the prescription of this drug with Dr BARTON.
It would have been 'best practice' for an entry to have been made on Mrs DEVINE's clinical notes.

Between 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/1999) a period of 14 days no entry has been made on the 'clinical notes'. During this period I took a period of leave which included my weekly ward round which would have been due on Monday 8th November 1999 (08/11/1999). I am unable to say if this responsibility was covered by another consultant in my absence.

However, as previously stated, had the 'Clinical Assistant' required any 'consultant input' regarding a patients treatment or management then I would expect the 'Clinical Assistant' to contact the Elderly Medicine Office at the Queen Alexandra Hospital and a note to be made on the patients 'clinical notes'.

Signed: R Ian REID Signature Witnessed by: Code A
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From my review of the 'clinical notes' and 'prescription sheets' of Elsie DEVINE for the period of 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/999) it appears that Mrs DEVINE's condition and treatment had undergone a 'marked change'.

On 11th November 1999 (11/11/1999) Mrs DEVINE began a course of the antibiotic Trimethoprim for 5 days to treat a urinary tract infection.

In the early hours of the morning of 11th November 1999 (11/11/1999) at 0115 hours Mrs DEVINE was administered one 10mg 'Temazepam' tablet.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required basis' the drug 'Thioridazine', a drug used in the treatment of 'agitation', 'restlessness' and 'confusion' which has a sedating and tranquilizing effect.

'Thioridazine' was first administered at 0830 hours on 11th November 1999 (11/11/1999) (see further statement).

Whilst in my opinion, the prescription of both 'Trimethoprim' and 'Thioridazine' in the case of Elsie DEVINE and the above drugs administration to her was wholly appropriate, at that time, I would have expected a note to have been made on Elsie DEVINE's 'clinical notes' regarding this. It would have been 'Best Practice' to do this as clearly on 11th November 1999 (11/11/1999) there had been a 'marked change' in Mrs Elsie DEVINE's 'condition', 'treatment' and 'management'.

The treatment of the 'urinary tract infection' and the administering of the drug 'Thioridazine' are both mentioned in my 'ward round' note of 15th November 1999 (15/11/1999).

My next ward round of Dryad Ward, Gosport War Memorial Hospital would have been during the afternoon of Monday 22nd November 1999 (22/11/1999).

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Mrs DEVINE died during the evening of Sunday 21st November 1999 (21/11/1999).
Having seen Mrs DEVINE on three occasions I am almost certain that I would have enquired as to her whereabouts on my subsequent visit to Dryad Ward.

This is mainly because the 'turnover' of patients on 'Dryad Ward' was relatively low and therefore I could usually remember from the previous week which patients had been there. In addition when last seen by me Mrs DEVINE had been 'very agitated' and I had made a full note on her 'clinical notes' which included an instruction for her to be seen by Code A

I would normally make an enquiry of Dr BARTON and/or the nursing staff as to what had happened to any patient I noticed was no longer on the ward.

There would not normally be any requirement for me to take any further action after the death of a patient, unless there were suspicious or unexplained circumstances or that the death required discussion with the 'Coroner'.

I do not recall there being any such discussion of any concern regarding the death of Elsie DEVINE at the time.

I have been asked what contact I have had with Mrs Elsie DEVINE's family since Mrs DEVINE's death on 21st November 1999 (21/11/1999).

I am unable to remember the specific dates but I do recall that Mrs DEVINE's daughter, Mrs Anne REAVES made a formal complaint regarding her mother's treatment. This complaint resulted in two or three meetings taking place with Code A from either the Portsmouth Health Care Trust or Fareham and Gosport Primary Care Trust. I believe on one or more occasions Mrs DEVINE's grand daughter (Mrs REAVES daughter) was also present.

I recall that at times Mrs REAVES was angry and had a number of legitimate complaints/concerns regarding poor communication between Gosport War Memorial Hospital and herself, despite her having made it very clear at the time that she wished to be kept fully

Signed: R Ian REID
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Signature Witnessed by: Code A

informed of her mother's condition. This it appeared had not been done until a late stage.

Mrs REAVES was concerned regarding her mother's treatment and I recall spending a long time going through the whole medical picture, concerning her mother, with Mrs REAVES trying to explain fully the circumstances leading up to her mother's death.

I recall that one of Mrs REAVES questions was:-
"Was it Dr BARTON's decision alone to terminate my mother's life?"

I recall that Mrs REAVES was very upset by her perception of Dr BARTON's attitude and by Dr BARTON's explanation of what was happening in the last few days of her mother's life.

It was apparent to me as a result of the first meeting I had with Mrs REAVES, after her mother's death that Mrs REAVES intensely disliked Dr BARTON.

I felt that as a result of my meetings with Mrs REAVES on the two or three occasions in May or June 2000 that I developed a 'rapport' with Mrs REAVES which at one stage led to her making a comment that indicated that she felt her concerns would have been addressed had she had myself to deal with at that time, as opposed to Dr BARTON and that this would possibly have negated the need for her to make any complaint. It was unusual for me to have any involvement on any level with relatives, after the death of a patient, unless requested by the relatives. Had Mrs REAVES or any relative asked to see me at any stage then I would have seen them.

I am aware that there were other issues raised by Mrs REAVES concerning her mother's treatment, medication and care. However I am not able to recall these in any detail without access to the minutes of these meetings.

Taken by: Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: REID, RICHARD IAN

Age if under 18: o.21 (if over 18 insert 'over 18') Occupation: CONSULTANT ELDERLY MEDICINE

This statement (consisting of 31 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signed: R Ian REID Date: 04/10/2004

I am Doctor Richard Ian REID and I reside at the address detailed overleaf.

Further to my earlier statement regarding Elsie DEVINE , I wish to add the following:-

I have been shown the below listed documents by Detective Constable 1019 LEE.

1. Exhibit BJC/16/PG/274&275
2. Exhibit BJC/16/PG/276
3. Exhibit BJC/16/PG/277&278
4. Exhibit BJC/16/PG/279&280

The above four documents form the prescription sheet of Mrs Elsie DEVINE whilst she was an inpatient on Dryad Ward of Gosport War Memorial Hospital .

I have been allowed by Code A to properly examine these documents and to reassemble them into their original format.

Exhibit BJC/PG/277&278 forms the basis of the document.
Exhibit BJC/PG/279&280 would have originally been attached to the edge of the previous document creating one long folding card or booklet.
Exhibit BJC/16/PG/276 is a stick on extension to the above documents which would have been

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affixed to exhibit BJC/16/PG/277&278 on page 278.
Exhibit BJC/16/PG/274&275 is a further extension of the document which would have originally been affixed above exhibit BJC/16/PG/276.

I have been asked to explain the content of the above documents and provide an explanation of each drug detailed on them. Also to give an account from these documents of what the dose rate of each drug was as shown on the prescription sheet. Finally to comment on the use of each drug prescribed.
I first wish to state that I am not the author of any of the notes or writing on these documents.

My name appears at the top of page 277 beside the word 'Consultant'. From my examination of these documents, together with my examination of the clinical notes as referred to in my earlier statement, I am able to say that none of the drugs listed on the prescription sheets was prescribed by me or prescribed on my advice or instruction. There is however one possible exception to this, that being the drug 'Amiloride' - a drug used to treat fluid retention or heart failure.

This drug was prescribed on 1st November 1999 (01/11/1999) by Dr BARTON. It is possible that Dr BARTON consulted me regarding the prescribing of this drug in Mrs DEVINE's case or that Dr BARTON prescribed it on my instruction.

These documents would have been available to me and would almost certainly have been examined by me on each of the occasions that I conducted a ward round of Dryad Ward during the period that Mrs DEVINE was on the ward. Namely on 25th October 1999 (25/10/1999), the 1st November 1999 (01/11/1999) and finally on 15th November 1999 (15/11/1999).

I feel that these documents are best explained by detailing each drug in turn by date order.

As previously stated Mrs DEVINE was admitted to Dryad Ward, Gosport War Memorial Hospital on 21st October 1999 (21/10/1999) from the Queen Alexandra Hospital.

Signed: R Ian REID
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On 21st October 1999 (21/10/1999) Dr BARTON has prescribed a regular dose of:-
Thyroxine 100 micrograms daily.

This drug is for the treatment of hypo-thyroidism which is an under active thyroid gland which if severe and untreated could cause confusion.

In my experience I would say that this would be a very common treatment dose for persons suffering from this complaint. This dosage is monitored by carrying out blood tests.

Mrs DEVINE would have taken this drug in tablet form. There are no major side effects of this drug.

I note from the prescription charts that Mrs DEVINE took this drug from 22nd October 1999 (22/10/1999) until 17th November 1999 (17/11/1999). I can only assume that Mrs DEVINE's condition after this time had become such that she was no longer able to take this drug orally or was refusing to take drugs orally.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed a regular dose of Frusemide 40 mg tablets, one daily. This drug is used in the treatment of fluid retention and heart failure and also other conditions. The dosage prescribed is the most usual starting dose of this drug. This drug was administered from 22nd October 1999 (21/10/1999) until 17th November 1999 (17/11/1999). The use of these two drugs together is quite compatible.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed on an 'as required' basis the drug Temazepam 10mg tablets, one at night.

This drug is a 'sleeping tablet' and one 10mg tablet is the normal starting dose for this drug.

The drug was administered on one occasion only to Elsie DEVINE. This was at 0115 hours on 11th November 1999 (11/11/1999).

Signed: R Ian REID

Signature Witnessed by: Code A

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Given the history on admission to Dryad Ward of 'confusion' and the fact that changes of environment/hospitals can increase 'confusion', particularly at night. I do not feel it was unreasonable to have prescribed this drug on an 'as required' basis on her admission to Gosport War Memorial Hospital.

It must be borne in mind that nursing staff at not permitted to administer drugs without them first being prescribed by a doctor.

Gosport War Memorial Hospital operated with only a 'Clinical Assistant', Dr Jane BARTON and therefore there was no resident medical cover in the form of a doctor available on site 24 hrs a day.

It was therefore in my opinion good practice to prescribe on an 'as required' basis a sleeping pill for this patient.

This would allow the nursing staff to administer the drug if required without consulting a doctor.

On 21st October 1999 (21/10/1999) on admission to the Gosport War Memorial Hospital I note that Dr BARTON has also prescribed in the 'as required' section the drug 'Oramorph ' at a strength of 10mgs in 5mls in a dose of 2.5 - 5mls 4 hourly as required. This drug is an oral morphine drug in solution and the dose prescribed in milligrams is 5-10mg.

This is the usual recommended starting dose for this drug.

This drug is usually used in the treatment of pain.

This drug, according to the prescription sheets was never administered to Elsie DEVINE.

Given that there is no resident doctor at Gosport War Memorial Hospital I feel that it would be entirely reasonable to prescribe on an 'as required' basis a simple 'analgesic' (painkiller) which

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the nursing staff could then administer if required.

In the absence of any documented pain being reported in the case of Elsie DEVINE I feel that this prescription was inappropriate at this stage. This is because 'analgesics' can be divided into 3 levels/groups of which 'Oramorph' falls into the strongest level/group.

On 1st November 1999 (01/11/1999) I note that Dr BARTON has prescribed the drug 'Amiloride' 5mg tablets, one daily. This drug is used to treat fluid retention or heart failure.

This is the usual recommended starting dose of the drug and is at the lower end of the starting range.

This drug was administered from 2nd November 1999 (02/11/1999) to the 18th November 1999 (18/11/1999).

The use of this drug is entirely compatible with 'Frusemide' and Thyroxine.

This drug was possibly discussed with me prior to prescription as stated earlier in this statement.

There are two reasons that possibly led to the prescription of this drug. The first being that Mrs DEVINE's fluid retention was increasing namely her legs were swelling.
The second being that 'Frusemide' can have the effect of lowering potassium levels in the blood whereas 'Amiloride' can have the effect of raising potassium levels in the blood. Therefore it can be useful to use these two drugs in combination 'Amiloride' can, in some cases, cause a worsening of kidney function and requires monitoring if given. This can be achieved by blood tests.

On 11th November 1999 (11/11/1999) I note that Dr BARTON prescribed 'Trimethoprim' 200mg tablets, one daily for a period of 5 days.

'Trimethoprim' is an antibiotic which is commonly used for the treatment of urinary tract

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infections. This is in my opinion an entirely correct dose and length of treatment.

This drug is compatible with the other prescriptions taken daily by Mrs DEVINE at this time.

I note that Mrs DEVINE completed the course of treatment involving this drug on the 15th November 1999 (15/11/1999).

Caution should be taken when administering this drug to patients suffering from impaired kidney function.

However failing to treat a urinary tract infection can also have adverse consequences on kidney function. Therefore there is a need to monitor.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required' basis 'Thioridazine' 10 mg tablets, one three times daily.

'Thioridazine' is a drug used in the treatment of 'restlessness', 'agitation' and 'confusion'.
The drug has a tranquilizing and sedative effect.
The dose prescribed in Mrs DEVINE's case was at the very bottom end of the dosage range.

This drug was administered on ten occasions between 11th November 1999 (11/11/1999) and 17th November 1999 (17/11/1999) to Mrs DEVINE. She received the prescribed dose on each occasion. These were as follows:-

1. 0830 hrs on 11th November 1999 (11/11/1999)
2. 1330 hrs on 12th November 1999 (12/11/1999)
3. 0825 hrs on 13th November 1999 (13/11/1999)
4. 1800 hrs on 13th November 1999 (13/11/1999)
5. 0825 hrs on 14th November 1999 (14/11/1999)
6. 1945 hrs on 14th November 1999 (14/11/1999)

7. 0830 hrs on 15th November 1999 (15/11/1999)

8. 2130 hrs on 15th November 1999 (15/11/1999)

9. 0845 hrs on 16th November 1999 (16/11/1999)

10. 1740 hrs on 17th November 1999 (17/11/1999)

No more than 2 tablets were given in any one day. The prescribed limit being three tablets.

This drug is compatible with the other prescribed drugs that Mrs DEVINE was taking on a daily basis.

On 15th November 1999 (15/11/1999) I carried out a ward round at Dryad Ward, Gosport War Memorial Hospital. On Mrs DEVINE's clinical notes of that day I noted the use of this drug to treat Mrs DEVINE's 'aggression' and 'restlessness' (see exhibit BJC/16/PG/154&155). I have also referred to its use in my earlier statement and mentioned that I felt it was important that, when a new drug was prescribed, that the reasons for this were recorded on the medical notes.

This does not appear to have been done in this case.

I would consider that the dose prescribed of 'Thioridazine' was wholly appropriate at that time in the treatment of Mrs Elsie DEVINE's 'aggression' and 'restlessness'.

On 18th November 1999 (18/11/1999) Dr BARTON prescribed 'Fentanyl TTS', 25 micrograms as a self adhesive skin patch on a 'regular basis'- every third day. 'Fentanyl' is a drug used in the treatment of pain.

This drug was administered in 'patch' form at 0915 hours on 18th November 1999 (18/11/1999).

The drug once administered in 'patch' form does take a period of time before it is fully effective.

This period can be up to 24 hours.

According to the prescription sheet the Fentanyl patch was removed at 1230 hours on 19th November 1999 (19/11/1999). The recommended sites to place Fentanyl patch are on dry healthy hairless skin on the chest, back or upper arm. I have not seen on the medical notes of Elsie DEVINE where the Fentanyl patch was sited in her case.

I have been asked why an 'analgesic' (painkiller) of the strength of Fentanyl has been prescribed and administered to a patient who according to their medical record have not made any complaint of pain.

This is best explained as follows:-

It is often the case that an elderly patient who is very confused and/or distressed may not be able to communicate that they are in pain and may also not display any symptoms or signs of pain other than their confusion, restlessness and aggression.

In the first instance these symptoms are treated with a sedative drug which in this case had been commenced on 11th November 1999 (11/11/1999) by administering Thioridazine' in tablet form.

On 18th November 1999 (18/11/1999) it has been noted on Mrs DEVINE's clinical notes by the locum staff psychiatrist that despite taking Thioridazine Mrs DEVINE had become more restless and aggressive and that she was also refusing to take medication.

In my opinion the continued distress, restlessness and aggression being displayed by Mrs DEVINE could be an indication of pain that she was suffering and was unable to communicate.

At this stage, in my opinion, there would be three possible courses of action:-

1. To increase the dosage of 'sedative'.
2. Cease sedative and place on analgesic (painkiller).
3. Administer a combination of both sedative and painkiller.

From my reading of the prescription sheet, Dr BARTON appears to have taken the second

option of prescribing the analgesic (painkiller) in the form of a 'Fentanyl patch'.
I also note that Mrs DEVINE on 18th November 1999 (15/11/1999) was refusing to take her oral medication which would explain the use of the Fentanyl patch as opposed to an orally taken analgesic (painkiller).

To have continued with sedation in Mrs DEVINE's case would have involved, increased dosages of sedation which would probably have involved having to receive several injections daily which in turn could cause Mrs DEVINE to suffer further distress.

With regard to the decision by Dr BARTON to apply a 'Fentanyl patch' on 18th November 1999 (18/11/1999) I would not have expected Dr BARTON to consult me prior to making that decision unless she had concerns herself about doing it.

Dr BARTON is a very experienced doctor who has considerable experience in the treatment of elderly patients and elderly patients who are dying.

The primary concern in these circumstances would be the comfort of the patient and in particular to relieve any distress and pain they were suffering.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed 'Chlorpromazine', 50mg to be given by intramuscular injection.

This prescription was made in the 'once only' section and was administered at 0830 hours on 19th November 1999 (19/11/1999) by a member of the nursing staff. Chlorpromazine is a sedative/tranquiliser. The dosage of 50mgs given to Mrs Elsie DEVINE is at the upper end of the normal range of dosage.

This dosage and drug is compatible with the 'Fentanyl patch' that Mrs DEVINE was wearing at the time. The administering of Chlorpromazine is consistent with Mrs DEVINE's continued 'confused' and 'aggressive state'.

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On 19th November 1999 (19/11/1999) I note from Mrs DEVINE's clinical notes exhibit BJC/16/PG/156/157 that Dr BARTON has made an entry in which she refers to a marked deterioration of Mrs DEVINE's condition overnight with confusion and aggression and a marked decline in her kidney function. She also notes a further deterioration of Mrs DEVINE's condition that morning.

In this note Dr BARTON mentions the application of the Fentanyl patch the previous day.

She notes that despite its use Mrs DEVINE's condition was continuing to deteriorate.

She notes:
'Needs sub-cutaneous analgesia with Midazolam'.

In my opinion this may be translated as follows:-
'In Dr BARTON's opinion Mrs DEVINE needed a sub-cutaneous infusion of a painkiller and a sedative'. A sub-cutaneous infusion would probably be a reference to the drugs being administered by means of a syringe driver.

The note then reads:
'Son seen and aware of condition and diagnosis'.
'Please make comfortable'
'I am happy for nursing staff to confirm death'.

In my opinion the last section of this note indicates that Dr BARTON had formed the opinion that Mrs Elsie DEVINE was terminally ill and that the overriding priority was to relive symptoms and therefore her instructions were to ensure Mrs DEVINE was comfortable and free from distress.

It is my opinion that Dr BARTON should have made entries on Mrs DEVINE's clinical notes regarding the prescription of:
1. Fentanyl patch on 18/11/99 (18/11/1999)

2. The Chlorpromazine on 19/11/99 (19/11/1999)

Both are powerful drugs and also represent an important change in Mrs DEVINE's condition and treatment. It would therefore have been best practice to have noted these changes and reasons for the changes on Mrs DEVINE's clinical notes at the time of prescription.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed Diamorphine 40-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver).

Together with;
Midazolam 20-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver). These two drugs would have been mixed together, both drugs being in a liquid form, both drugs are completely compatible with being mixed together and administered over a 24 hour period by means of syringe driver.
Diamorphine is an opiate drug used in the treatment of pain.

It is a very strong analgesic (painkiller) which is frequently used in the care of terminally ill patients who are in pain or are distressed or both.

The dose of Diamorphine prescribed by Dr BARTON was 40-80mgs in a 24 hour period.

Mrs DEVINE had been wearing a 25 microgram Fentanyl patch for the previous 24 hours.

A 25 microgram Fentanyl patch is probably the equivalent to between 30 mgs and 60mgs of Diamorphine over a 4 hour period. Both Fentanyl and Diamorphine are opiates.

The prescription of 40mg of Diamorphine over a 24 hour period was therefore the correct replacement dose for the Fentanyl patch.

However the Fentanyl patch was not removed from Elsie DEVINE until 1230 hours on 19th November 1999 (19/11/1999). Fentanyl remains in the system of a patient for between 12 to 24

hours after the patch is removed.

Mrs DEVINE's treatment with Diamorphine began at 0925 hours on 19th November 1999 (19/11/1999) whilst she was still wearing the Fentanyl patch. Therefore Mrs DEVINE is likely to have received more than the equivalent of 40mgs in the first 24 hours of her treatment with Diamorphine.

However it should be noted that Fentanyl had not relieved Mrs DEVINE's distress and that the prescribed Diamorphine dosage was 40-80mgs. It is extremely unlikely that this dosage was exceeded.

The drug Midazolam is a sedative in liquid form which is completely compatible for use with Diamorphine. It is prescribed to treat restlessness in patients who are terminally ill and who are unable to take sedation by mouth or are refusing to do so.

The dose prescribed by Dr BARTON was 20-80mgs in a 24 hour period.

The normal starting dose for Midazolam is 10-20 mgs in a 24 hour period.

From my examination of the prescription sheets I note that sub-cutaneous infusion commenced at 0925 hours on 19th November 1999 (19/11/1999).

This would have been set up by a senior member of the nursing staff. I note that the starting dose of Diamorphine administered was 40mgs in a 24 hour period.

This was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

In the case of the drug Midazolam a dose of 40mgs was administered at 0925 hours 19th November 1999 (19/11/1999) over a 24 hour period and was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

A sub-cutaneous infusion usually refers to the continuous administration of a drug through a needle inserted just under the skin and involves the use of a syringe driver.
A syringe driver is a medical device which in simple terms is an electrically powered syringe that has a motor which depresses the plunger of the syringe very slowly. This enables a patient to be administered an even dose of the drug throughout a 24 hour period. Other than the first insertion of a needle this equipment avoids the need for a patient to be given multiple injections. This therefore avoids causing the patient distress. In the case of Elsie DEVINE it is my opinion that the use of a syringe driver to administer the drugs Diamorphine and Midazolam was appropriate in the circumstances. This is because Mrs DEVINE had already received Fentanyl (an opiate) sub-cutaneously in the form of a skin patch and because Mrs DEVINE was refusing oral medication. Mrs DEVINE at the time required two nurses to be solely looking after her because of her agitation and distress.

With regard to the doses of the drugs Diamorphine and Midazolam the administering of the Fentanyl patch and the 50mgs of chlorpromazine I have the following observations:

Regarding the Fentanyl patch in my opinion it may have been a more appropriate alternative to have administered individual sub-cutaneous injections of small doses of Diamorphine over 24 hours to assess its effect on Mrs DEVINE so that a clearer idea could be obtained of the dose of Diamorphine to be administered over a period of 24 hours via a syringe driver in order to relieve Mrs DEVINE's symptoms.

This however would involve multiple injections that may have caused further distress and may not have led to a relief of her symptoms.

Regarding the starting dose of 40mgs of Diamorphine over a 24 hour period in my opinion this is unlikely to have taken account of the application of the Fentanyl patch 24 hours before. It would probably have been more prudent to have started with a dose of 20-30 mgs of Diamorphine.

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The administering of 40mgs of Diamorphine in the first 24 hours could have led to over sedation but the administration of 20-30mgs might well not have relieved Mrs DEVINE's distress.

Regarding the sedatives administered to Elsie DEVINE on 19th November 1999 (19/11/1999) I have the following observations.

At 0830 hours on 19th November 1999 (19/11/1999) Mrs DEVINE received an intramuscular injection of 50mgs of Chlorpromazine. This dose is at the upper limit of the dosage range for an initial injection.

I would expect to see some effect on a patient administered this drug, in a period of half to one hour.

The effect of this drug I would expect to last from anything from three to six hours.
(However I have limited expertise in this field).

It is of some concern that when Mrs DEVINE was administered Midazolam at 0925 hours on 19th November 1999 (19/11/1999) via syringe driver the Chlorpromazine may not have reached its maximum effect.

It should however be borne in mind that the Midazolam was being administered as a slow infusion over a 24 hour period.

This could also have led to some over sedation of Mrs DEVINE during the first few hours of the Midazolam infusion.

With regard to the dose of 40mgs of Midazolam over a 24 hour period I have concerns that the administered starting dose was of 40mgs when the prescription sheet shows that Dr BARTON prescribed a dose of 20-80 mgs over a 24 hour period.

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In my opinion 20mgs of Midazolam over a 24 hour period would have been a more appropriate starting dose.

I can see nothing on the medical notes of Elsie DEVINE to show the reason for administering 40mgs of Midazolam. The drugs Diamorphine and Midazolam were administered together by syringe driver by a member of the nursing staff.

In the main drugs are administered to a patient by the nursing staff following prescription by a doctor.

When writing a prescription with a range of 20mg - 80mg of a drug I would expect that, initially the lowest dose would be administered to assess its effect on the patient unless there were very good reasons for giving a higher dose.

In that instance I would expect a note to be made on the medical record of the patient giving the reasons for administering the higher dose.

I can see 'no note' on the medical records of Elsie DEVINE explaining the reason for her being administered the higher starting dose of 40mg of Midazolam on 19th November 1999 (19/11/1999).

In my opinion Dr BARTON's note of 19th November 1999 (19/11/1999) on Mrs DEVINE's clinical notes exhibit BJC/16/PG/156&157 together with the prescription sheets is an indication of a change in course of treatment of Elsie DEVINE to palliative care.

I would not expect DR BARTON to consult me prior to making this decision, unless, she had concerns about doing so.

Palliative care in this case would mean relieving Mrs DEVINE symptoms of confusion, restlessness, aggression and distress on a background of rapidly declining renal function by using a combination of analgesia (painkillers) and sedatives.

Signed: R Ian REID

Signature Witnessed by: Code A

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It is well recognised that administering strong analgesics and sedatives in this situation may hasten death in the course of relieving suffering and making a patient comfortable.

The most common side effects of administering Diamorphine to a patient are:-
Nausea, vomiting, constipation and drowsiness.

Large doses produce:
Respiratory depression - slow and shallow breathing.
Hypotension - low blood pressure
The most common side effects of the drug Midazolam are:-
Drowsiness and respiratory depression.
These side effects may hasten death.

In my opinion the variable dose on prescription by Dr BARTON of the drugs Diamorphine and Midazolam was to allow the nursing staff the discretion to increase the dosage of each drug should the initial dose not control or relieve the symptoms displayed by Mrs DEVINE, particularly as there was no on site 24 hour doctor cover. No increase of dosage of either Diamorphine or Midazolam from the initial starting doses was made in the case of Mrs DEVINE.

Mrs DEVINE died at Dryad Ward, Gosport War Memorial Hospital during the evening of 21st November 1999 (21/11/1999).

Taken by Code A

RESTRICTED

Form MG11(T)

WITNESS STATEMENT

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

Statement of: REID, RICHARD IAN

Age if under 18: O.18 (if over 18 insert 'over 18') Occupation: CONSULTANT GERIATRIC MEDICINE

This statement (consisting of 41 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signed: R L REID Date: 26/11/2004

I am Doctor Richard Ian REID MB, ChB. I reside at the address detailed overleaf. I qualified at Glasgow in 1974.

I became a Member of the Royal College of Physicians (United Kingdom) in 1978 and a Fellow of the Royal College of Physicians (Glasgow) in about 1988 and a Fellow of the Royal College of Physicians (London) in about 1990.

My General Medical Council registered number is Code A

Experience

1. House Officer (Medicine) at Royal Alexandra Infirmary, Paisley, Scotland from August 1974 to January 1975.
2. House Officer (Surgery) at Stirling Royal Infirmary, Stirling, Scotland from February 1975 to July 1975.
3. Senior House Officer (Obstetrics and Gynaecology) at Paisley Maternity Hospital, Paisley, Scotland from August 1975 to January 1976.
4. Senior House Officer (Geriatric Medicine) at the Victoria Geriatric Unit, Glasgow from February 1976 to July 1976.
5. Senior House Officer (Cardiology) at the Glasgow royal Infirmary, Scotland from August 1976 to April 1977.

6. Registrar in General Medicine at the Kilmarnock Infirmary, Kilmarnock, Scotland from May 1977 to July 1979.
7. Senior Registrar in Geriatric Medicine at Portsmouth and Southampton Hospitals from August 1979 to July 1982.
8. Consultant in Geriatric medicine at Southampton General Hospital from August 1982 to March 1998.

My current role which I began in April 1998 is as Consultant in Geriatric Medicine and Medical Director of East Hampshire Primary Care Trust (formerly Portsmouth Health Care Trust). I am based at the Queen Alexandra Hospital, Cosham.

I have a full time National Health Service contract which consists of 11 (eleven) sessions per week. One session is 3½ hours. I have an 'On Call' responsibility and work weekends (Saturday and Sunday on roughly one weekend in ten basis).

I began the responsibility of looking after 'In Patients' at Gosport War Memorial Hospital in either February or April of 1999.

This continued for a period of about 12 months until about March 2000.
As Consultant to Gosport War Memorial Hospital I had a responsibility for the in patients on Dryad Ward of the hospital.

In this role I supervised the work of Doctor Jane BARTON , a local General Practitioner who, in addition to her work in general practice, worked as 'Clinical Assistant' at Gosport War Memorial Hospital.

In the absence of Dr BARTON I supervised the work of any 'locum' or partners at her general practice who covered her responsibilities for her.

It was also my role to supervise the work of any Specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital.

I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

During the ward round I would visit each of the in patients on Dryad Ward.
I was accompanied on my ward round by the clinical assistant, Dr Jane BARTON, every two weeks, if she was available to do so.

I also provided consultant cover to Daedalus Ward, the other consultant led ward at the Gosport War Memorial Hospital, when my colleague Dr A LORD was on leave or unavailable. This was a reciprocal arrangement with Dr LORD who would normally cover my leave periods or unavailability. In the event of myself and Dr LORD being unavailable for long periods of time then locum consultant cover would be sought, however for short periods of absence then no locum cover was arranged.
If the Clinical Assistant, Dr BARTON was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice or to ask me to attend Dryad Ward to carry out an examination of the patient or see relatives who were concerned.

If my advice was sought by the Clinical Assistant then I would expect a note to be made on that patient's clinical notes by the Clinical Assistant. Dr Jane BARTON is a very experienced doctor and as such it would be a serious clinical problem relating to the treatment of a patient that would require her to seek such advice.
If a problem arose requiring a Consultant input during any short term unavailability of both myself and Dr LORD then I would expect the Clinical Assistant to contact the Elderly Medicine Office at the Queen Alexandra Hospital, Portsmouth to obtain the required consultant input.
The clinical notes of a patient are where a record is kept of the clinical treatment of a patient.

I would expect a note to be made on the clinical notes on a patient's admission to the

hospital, giving a brief history and the results of any examination and treatment.

I would also expect a prescription sheet to be commenced detailing any drugs prescribed on admission (see separate statement).

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as Consultant, with entries from other clinical staff when consulted regarding the management of a patient.
A nursing record is also commenced on admission of a patient which is maintained by the nursing staff.
During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff, provided from the nursing records. This information is usually verbally provided and it would be unusual for me to read the nursing record of a patient.

This information, together with information I have obtained myself as a result of any examination I have made of the patient, would form the basis of any note that I made on a patient's clinical notes.

If there is no marked change in a patients condition, treatment or management then I would not expect any entry to be made on a patients clinical notes by the Clinical Assistant.

However I would make a note on the clinical notes of each patient I saw during my ward round.

Included in my notes on the clinical notes would be any instructions regarding the clinical care of a patient to the Clinical Assistant.

I have been asked to detail my involvement and the care and treatment of Mrs Elsie DEVINE , born on Code A who was admitted to Dryad Ward of the Gosport War Memorial Hospital on Thursday 21st October 1999 (21/10/1999), having been

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transferred from the Queen Alexandra Hospital, Portsmouth.

Mrs DEVINE was a patient on Dryad Ward until her death on Sunday 21st November 1999 (21/11/1999) at the age of 88.

During this period I was the Consultant for Dryad Ward, Gosport War Memorial Hospital.

I first wish to state that I have no personal recollection of Mrs Elsie DEVINE herself and therefore this statement has been provided by referring to certain entries made by myself and others on Mrs DEVINE's medical notes and in particular entries made on her clinical notes and prescription sheets.

By referring to Mrs DEVINE's medical notes I can state that I saw her on three occasions, between 21st October 1999 (21/10/1999) and 21st November 1999 (21/11/1999).

On each of the three occasions that I saw Mrs DEVINE it was as a result of my weekly ward round of Dryad Ward, Gosport War Memorial Hospital.

The three occasions were as follows:

1. Monday 25th October 1999 (25/10/1999)
2. Monday 1st November 1999 (01/11/1999)
3. Monday 15th November 1999 (15/11/1999)

I have been shown a document bearing an exhibit label BJC/16/PG/154&155. This document I recognised as a speciality history sheet on which doctors record clinical notes in relation to a particular patient. The patient in the case of this document was Elsie DEVINE.

This document is double sided, notes therefore are recorded on both sides. My attention has been directed to an entry on the lower part of page 154 which commences with the date 25th October 1999 (25/10/1999).

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I recognise this writing as mine and that the note ends with a signature that I recognise as my own.

My note is proceeded by a note dated 21st October 1999 (21/10/1999). The handwriting and the signature at the end I recognise as that of Dr Jane BARTON, Clinical Assistant at the Gosport War Memorial Hospital.

These are the only two notes that appear on page 154.

My note of 25th October 1999 (25/10/1999) would have been made during the course of my weekly visit to Gosport War Memorial Hospital (GWMH) and during my ward round at Dryad Ward.

My note reads as follows:-

'25th October 1999 (25/10/1999), mobile unaided
Washes with supervision - dresses herself
Continent - mildly confused
Blood pressure 110/70
Normochromic anaemia
Chronic renal failure'
'Was living with daughter and son-in-law, believed son-in-law awaiting bone marrow transplant.
Need to find out more regarding son-in-law etc'.
The entry has then been signed by me using my normal signature.
This note should be interpreted as follows:
On Monday 25th October 1999 (25/10/1999) I saw and had contact with patient Elsie DEVINE. It is possible that Dr Jane BARTON was present, it is also possible that I carried out a physical examination of Elsie DEVINE. The main content would have been noted by me from reports made to me by the nursing staff, and/or Dr BARTON, if present.

'Mobile unaided'. This probably meant that Elsie DEVINE was at that time walking without

support and that she, at that time, was probably safe walking on her own.

'Washes with supervision', this probably meant that Elsie DEVINE was physically able to wash herself but due to her confusion required some guidance and prompting to wash.

'Dresses herself', this probably meant that Elsie DEVINE was, at this time, physically capable of dressing herself. I have made no record of if she required any guidance with her dressing.

'Continent', this probably meant that Elsie DEVINE was at this time, continent, regarding 'urine' and was aware of the need and recognised the need to pass urine, also able to control her bladder until she passed urine.

'Mildly confused', this probably meant that, at this time, Elsie DEVINE's short term memory was mildly impaired and that she was confused as to time and recent events but was probably aware of her surroundings, ie that she was in hospital.

'Blood pressure 110/70'. This blood pressure I would regard as being on the low side, however provided that patient had appeared to be well in themselves it would not be a cause for concern.

'Normochromic anaemia', means that at that time Elsie DEVINE's red blood cells were low in number and that these cells were normal in colour when examined under the microscope.

'Chronic Renal Failure', this is a reference to Chronic Renal Failure being one of a number of causes of Normochromic Anaemia.

These notes would have been completed by me during my afternoon ward round of Dryad Ward, Gosport War Memorial Hospital. This would have been the first occasion that I would have seen Elsie DEVINE as she was admitted to this hospital on Thursday 21st October 1999 (21/10/1999).

The note is then completed with a brief social background which is self explanatory and related to me by the nursing staff, that prior to her admittance to hospital. Mrs DEVINE was living with her daughter and son-in-law, in a home environment.

That it was believed that her son-in-law was himself in hospital awaiting a bone marrow transplant.

The note of:-
'Need to find out more re son-in-law etc'.

This is an indication that more had to be found out about Mrs DEVINE's current home circumstances and if daughter would be able to care for her mother, following her husband's illness, or if a residential or nursing home needed to be considered.

All the above, would have been obtained from verbal reports of the nursing staff and from Mrs DEVINE's notes.

I would not have relied on a patient in a 'confused state' to provide such information.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 1/11/99 (01/11/1999) and has been written on the reverse side of this document (page 155).

This note has been written on by me and would have been written by me during my weekly ward round of Dryad Ward at the Gosport War Memorial Hospital.
I do not regard it as unusual that no note has been made on the clinical notes since 25/10/99 (25/10/1999) as there had been no major change in Mrs DEVINE's condition and treatment since that date. I would have had access to all medical notes relating to Elsie DEVINE's condition and treatment and in addition could possibly have had Dr Jane BARTON in attendance as well as the nursing staff from all of whom I would have taken verbal reports on which my note would have been based. This should read as follows:

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'1st November 1999 (01/11/1999) physically independent but needs supervision with washing and dressing and help with bathing.
Continent.
Quite confused and disorientated.
For example, undresses during the day.
Is unlikely to get much social support at home.
Therefore try home visit to see if functions better in own home'.
This entry is then signed by me with my normal signature.

This note could be interpreted as follows:
'Physically independent', probably means that Mrs DEVINE, at that time, was physically able to walk, at least short distances, unaided by either staff or walking aides.

'But needs supervision with washing and dressing and help with bathing', this probably means that at this time due to Elsie DEVINE's confusion she needed guidance and direction but that she was physically capable of both dressing and washing. However if Mrs DEVINE was taking a bath, then she needed physical help to do so.

'Continent', this is a further reference to Elsie DEVINE's passing of urine and a reference to the fact that with regard to this, there had been no change in Mrs DEVINE's status, since the last occasion on which I saw her. Namely she was still aware of any need to pass urine and was able to control that need and was not 'wetting herself'.

Had Mrs DEVINE suffered from any incontinence of the bowel then this would have been separately noted.

'Quite confused and disorientated', this would probably mean that at that time Mrs DEVINE may not have been aware that she was in hospital or of the time of day, day in the week etc.

This information would have been obtained from verbal reports given by the nursing staff of

Dryad Ward. The note is supported by the following example:'
'Undressing during the day'

This part of the note is self explanatory and has been entered on the notes as an example of Mrs DEVINE's confusion at that time.

As previously stated this information would have been provided in the form of verbal reports provided by the nursing staff from their nursing notes.

'Is unlikely to get much social support at home'.
This sentence is a reference to earlier and current reports of Elsie DEVINE's home circumstances provided by the nursing staff namely that prior to her admittance to hospital Mrs DEVINE was living with her daughter and son-in-law. However her son-in-law was in hospital himself [Sensitive personal data]. Mrs DEVINE's daughter was staying with her husband in London. There was not anyone at home to provide care, support or supervision to Elsie DEVINE at that time.

'Therefore try home visit to see if functions better in own home'.
This note is a suggestion made by me in order to assess Mrs DEVINE's level of 'confusion'. Elsie DEVINE appeared to be suffering from 'Dementia'. Persons suffering from Dementia (confusion) often function worse in unfamiliar surroundings for example:- within hospital, changing hospitals, changing ward within a hospital.

It appeared to me that Mrs DEVINE's condition with regard to her confusion had worsened since my visit of 25th October 1999 (25/10/1999). It is often the case that a person suffering this condition can improve if returned to more familiar circumstances.

The suggestion was therefore to try a supervised part of a day at home with an occupational therapist to see how Mrs DEVINE functioned in her 'activities of daily living' within familiar surroundings and circumstances.

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At the same time an assessment could be made of what support would be required for her to return home, or whether Mrs DEVINE would require a position in a residential home or a nursing home and in addition what support she would require in these circumstances. This home visit would be dependent on Mrs DEVINE's physical condition, which appears from my note of the 1st November 1999 (01/11/1999) to be stable.

The main focus of my note of 1st November 1999 (01/11/1999) appears to be Mrs DEVINE's confusion. Had there been any concerns regarding her physical condition at that time then I would have made a note of it. I note from the prescription sheets that on 1st November 1999 (01/11/1999) Dr BARTON prescribed to Elsie DEVINE the drug 'Amiloride' in the form of 5mg tablets, one tablet daily. It is possible that the prescription of the drug 'Amiloride' to Mrs Elsie DEVINE was discussed by myself and Dr BARTON during my ward round.

However I have not made any mention of this in my note of 1st November 1999 (01/11/1999) and do not have any personal recollection of such a discussion.

The drug 'Amiloride' is used to treat fluid retention and heart failure. The drug is entirely compatible with the other drugs prescribed to Elsie DEVINE at that time.

I have provided a further statement regarding drugs prescribed to Elsie DEVINE.

In my further statement I have detailed the dosage and two possible reasons for its prescription.

I note from the prescription sheets that Mrs DEVINE was first administered 'Amiloride' on 2nd November 1999 (02/11/1999) and continued to be given the drug until 18th November 1999 (18/11/1999). The dosage remained the same throughout this period.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 15/11/99 (15/11/1999). This note has been written by me and should be read as follows:

'15th November 1999 (15/11/1999)

Very aggressive at times.

Very restless.

Has needed 'Thioridazine'

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*On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine.
On examination pulse rate 100 per minute.
Regular temperature 36.4°C
Jugular venous pulse not seen
Hepato-jugular reflux negative
Oedema gross extending to thighs
Heart sounds - nil added
Chest clear
Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty
But good bowel action since
(* mid stream specimen urine - no growth)
Ask Doctor LUSZNAT to see'

My interpretation of this note is as follows:-
On Monday 15th November 1999 (15/11/1999) I saw Mrs Elsie DEVINE as part of my weekly visit to Dryad Ward at Gosport War Memorial Hospital.

This is two weeks since my last visit to Dryad Ward as I had been on leave. No note has been made on Mrs DEVINE's clinical notes since my note dated 1/11/99 (01/11/1999). It was reported to me as a result of face to face contact and verbal reports from the nursing staff and possibly Dr Jane BARTON that Mrs DEVINE had been:-

'Very aggressive at times'.

This could mean her having been either verbally or physically aggressive, or both, towards either staff or other patients or both.

'Very restless'
This probably meant that Mrs DEVINE was continually moving about whilst sitting or lying in bed. In addition she may have been pacing around the ward.

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Both the above symptoms can be brought on by a deterioration in a person's physical state which causes anxiety and further confusion, which in turn can cause the person to become aggressive and restless.

The above comments on the notes have been bracketed by the words 'Has needed Thioridazine'.

Thioridazine is a major tranquillizer. The fact that this drug had been administered to Mrs DEVINE would have been obtained from my face to face contact with the nursing staff, Dr BARTON if present, and from my examination of the drug/prescription chart.

I would not necessarily expect the administration of this drug to have been entered onto the clinical notes although it would be good practice to do so. In my opinion this was the correct drug to be given for the reported behaviour displayed by Mrs DEVINE. The dosage given at that time in my opinion was low.

'* On treatment for urinary tract infection - mid stream specimen sent because blood and protein in urine'.

This information would have also been gleaned from reports (verbal) made to me by staff and also from Mrs DEVINE's medical notes that since I had last seen Mrs DEVINE on 1/11/99 (01/11/1999) a mid stream urine specimen had been taken from Mrs DEVINE which had been subjected to a 'Dipstix' check which had shown the presence of blood and protein in Mrs DEVINE's urine. This is a simple test carried out by the nursing staff which involves the use of a reactive strip which indicates the presence of blood and protein within urine.
Having identified this presence the staff have then sent Mrs DEVINE's mid stream urine sample for further examination to the Microbiology Laboratory at St Mary's Hospital.

The nursing staff could have carried out this test and submission of the sample on their own initiative or on the instruction of the Clinical Assistant, Dr BARTON.

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It appears that there was concern regarding Mrs DEVINE having possibly developed a urinary tract infection and that steps had been taken to treat this.
It would have been best practice that a note of this had been made on Mrs DEVINE's clinical notes, recording the start of any new treatment.

Beside this entry on the notes, I have entered an asterisk.

This indicates to me that at the time of making this entry I had questioned the staff, as to the result of the urine sample being sent to St Mary's Hospital for examination.

Later in the note made by me on 15/11/99 (15/11/1999) the following appears:
(*MSU - no growth).

This indicates that whilst still engaged in my examination and/or making my note of the examination of Mrs DEVINE the result of the mid stream urine samples examination by the laboratory at St Mary's had been obtained and that it showed:
'- no growth'.

Which indicated to me that there was no infection in Mrs DEVINE's urine.

'On examination pulse rate 100 per minute and regular, temperature 36.4°C'
On examination is a note by me that indicates that I carried out a physical examination of Mrs DEVINE.

A pulse rate of 100 per minute and regular would be regarded on the 'upper limit' of normal. The normal pulse rate being 60 to 100 per minute.

A pulse rate of 100 per minute and regular would not cause any undue concern.

A temperature of 36.4°C would be regarded as normal, normal temperature range being 35 to 37°C.

Signed: R L REID
2003(1)

Signature Witnessed by:

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'Jugular venous pulse not seen. Hepato- jugular reflux negative'
This indicates that when examining Mrs DEVINE's jugular veins in her neck I saw that they were not distended (sticking out) and that the pulse in the vein was not visible.

When I applied pressure to Mrs DEVINE's liver this also failed to produce any neck vein distension.

Applying pressure to the liver is to cause the increased return of blood to the heart. At this stage Mrs DEVINE's veins remained undistended which indicated to me the absence of heart failure in Mrs DEVINE's case.

'Oedema - gross extending to thighs'
This means that on examination of Mrs DEVINE I found that her legs were very badly swollen to the thighs due to fluid retention. This condition can be caused by heart failure or renal failure and is also a symptom of other conditions. The above examinations were carried out in order to eliminate heart failure as a cause of Mrs DEVINE's severe 'oedema'.

'Heart sounds - nil added'
This indicates that I listened to Mrs DEVINE's heart sounds and found them to be normal, with no murmurs or abnormal beats.

'Chest clear'
This is a note that during the course of my examination of Mrs DEVINE I listened to her chest and found her breathing sounds to be normal.

Both these examinations gave no indication of any significant chest or heart problems.

'Bowels regular - rectal examination on 13/11/99 (13/11/1999) revealed rectum empty but good bowel action since'.

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This would have been reported verbally to me by the nursing staff as a result of enquiries made by me regarding Mrs DEVINE's bowel movements and formed part of my investigation into Mrs DEVINE's increased aggression and confused state.
The nursing staff would be expected to carry out a rectal examination of a patient if a period of time had elapsed without a patient having any significant bowel movement (passing of solid waste). It was reported to me by the nursing staff that such an examination had been carried out by them on 13th November 1999 (13/11/1999) and that the result of that examination showed that Mrs DEVINE's bowel was empty.
This was an indication that Mrs DEVINE was very unlikely at this time to be suffering from constipation.

The further note of 'But good bowel action since' is a result of further reports by the nursing staff that since their rectal examination on 13th November 1999 (13/11/1999) it had been noted that Mrs DEVINE had passed solid waste normally. This provided a further indication that she was not suffering from being constipated.

Constipation can be a cause of increased 'confusion, aggression and anxiety in an elderly patient'.

The final note made by me on Mrs DEVINE's clinical notes (after the mid stream urine result) was:

'Ask Doctor Code A to see'.
This note is an instruction that Mrs DEVINE be referred to Doctor R M Code A. I believe that this doctor's initials (RM) stand for Rose Marie but I'm not sure of this. She is however known as 'Rosie'. Code A is a Consultant in 'Old Age Psychiatry'.

Due to Mrs DEVINE's increasingly, 'confused', 'aggressive' and 'restless' condition and having found 'no apparent' physical reason for this from my physical examination of Mrs DEVINE I have written the instruction:

Signed: R L REID

Signature Witnessed by:

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'Ask Doctor LUSZNAT to see'
This instruction would be for Dr Jane BARTON or the doctor covering her responsibilities to carry out.

The next note on this same document (exhibit BJC/16/PG154&155) is dated 16th November 1999 (16/11/1999) the note begins 'Dear Rosie' and ends with the words 'Can you help? Many thanks' this note is then signed. I recognise the writing and the signature of this note to be that of Dr Jane BARTON. This indicates to me that the notes of my examination of Elsie DEVINE on Monday 15th November 1999 (15/11/1999) made during my weekly ward round of 'Dryad Ward', Gosport War Memorial Hospital have been read by Dr Jane BARTON and a referral has been made to Dr Code A as instructed.

I have been shown a document bearing the exhibit reference of BJC/16/PG156&157. This is the next page of the 'clinical notes' of 'Elsie DEVINE'.

The first note on this document (page 156) APPEARS to be dated 18th November 1999 (18/11/1999) and is headed 'Elderly Mental Health'. This note appears to have been signed off by a 'a locum staff psychiatrist'. This indicates to me that Elsie DEVINE was seen by someone. from Dr Code A team on 18th November 1999 (18/11/1999) following my instruction of 15th November 1999 (15/11/1999).

My next ward round of 'Dryad Ward', Gosport War Memorial Hospital would have been on Monday 22nd November 1999 (22/11/1999). From my examination of exhibit BJC/16/PG156&157 I note that Mrs Elsie DEVINE died at some time during the evening of Sunday 21st November 1999 (21/11/1999).

It appears from the 'clinical notes' that I had no further dealings in the care of Elsie DEVINE after Monday 15th November 1999 (15/11/1999).

I have been asked to comment on the lack of notes made on the 'clinical notes' between the following dates:

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21/10/99 (21/10/1999) note - Dr BARTON on admission (exhibit BJC/16/PG/154&155) and
25/10/99 (25/10/1999) my note -ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and
1/11/99 (01/1//1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155) and
15/11/99 (15/11/1999) my note - ward round, Dryad Ward (exhibit BJC/16/PG/154&155).

As previously stated if there is 'no marked' change in a patient's 'condition', 'treatment' or management then I would not expect an entry to be made on a patients medical notes.

Between 21st October 1999 (21/10/1999) and 25th October 1999 (25/10/1999) there appears to be no marked change in the condition, treatment or management of Elsie DEVINE. Therefore I would not necessarily expect any note to be made.

Between 25th October 1999 (25/10/1999) and 1st November 1999 (01/11/1999) other than Mrs DEVINE appearing to be slightly more 'confused' there again appears to be NO marked change in Mrs DEVINE's condition and management., The drug 'Amiloride' was prescribed that day and was first administered on 2nd November 1999 (02/11/1999). I am unable to recall if I discussed the prescription of this drug with Dr BARTON.
It would have been 'best practice' for an entry to have been made on Mrs DEVINE's clinical notes.

Between 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/1999) a period of 14 days no entry has been made on the 'clinical notes'. During this period I took a period of leave which included my weekly ward round which would have been due on Monday 8th November 1999 (08/11/1999). I am unable to say if this responsibility was covered by another consultant in my absence.

However, as previously stated, had the 'Clinical Assistant' required any 'consultant input' regarding a patient's treatment or management then I would expect the 'Clinical Assistant' to contact the Elderly Medicine Office at the Queen Alexandra Hospital and a note to be made on the patients 'clinical notes'.

Signed: R L REID

Signature Witnessed by:

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From my review of the 'clinical notes' and 'prescription sheets' of Elsie DEVINE for the period of 1st November 1999 (01/11/1999) and 15th November 1999 (15/11/999) it appears that Mrs DEVINE's condition and treatment had undergone a 'marked change'.

On 11th November 1999 (11/11/1999) Mrs DEVINE began a course of the antibiotic Trimethoprim for 5 days to treat a urinary tract infection.

In the early hours of the morning of 11th November 1999 (11/11/1999) at 0115 hours Mrs DEVINE was administered one 10mg 'Temazepam' tablet.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required basis' the drug 'Thioridazine', a drug used in the treatment of 'agitation', 'restlessness' and 'confusion' which has a sedating and tranquillising effect.

'Thioridazine' was first administered at 0830 hours on 11th November 1999 (11/11/1999) (see further statement).

Whilst in my opinion, the prescription of both 'Trimethoprim' and 'Thioridazine' in the case of Elsie DEVINE and the above drugs administration to her was wholly appropriate, at that time, I would have expected a note to have been made on Elsie DEVINE's 'clinical notes' regarding this. It would have been 'Best Practice' to do this as clearly on 11th November 1999 (11/11/1999) there had been a 'marked change' in Mrs Elsie DEVINE's 'condition', 'treatment' and 'management'.

The treatment of the 'urinary tract infection' and the administering of the drug 'Thioridazine' are both mentioned in my 'ward round' note of 15th November 1999 (15/11/1999).

My next ward round of Dryad Ward, Gosport War Memorial Hospital would have been during the afternoon of Monday 22nd November 1999 (22/11/1999).

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Mrs DEVINE died during the evening of Sunday 21st November 1999 (21/11/1999).
Having seen Mrs DEVINE on three occasions I am almost certain that I would have enquired as to her whereabouts on my subsequent visit to Dryad Ward.

This is mainly because the 'turnover' of patients on 'Dryad Ward' was relatively low and therefore I could usually remember from the previous week which patients had been there. In addition when last seen by me Mrs DEVINE had been 'very agitated' and I had made a full note on her 'clinical notes' which included an instruction for her to be seen by Dr Code A

I would normally make an enquiry of Dr BARTON and/or the nursing staff as to what had happened to any patient I noticed was no longer on the ward.

There would not normally be any requirement for me to take any further action after the death of a patient, unless there were suspicious or unexplained circumstances or that the death required discussion with the 'Coroner'.

I do not recall there being any such discussion of any concern regarding the death of Elsie DEVINE at the time.

I have been asked what contact I have had with Mrs Elsie DEVINE's family since Mrs DEVINE's death on 21st November 1999 (21/11/1999).

I am unable to remember the specific dates but I do recall that Mrs DEVINE's daughter, Mrs Anne REAVES made a formal complaint regarding her mother's treatment. This complaint resulted in two or three meetings taking place with Fiona CAMERON from either the Portsmouth Health Care Trust or Fareham and Gosport Primary Care Trust. I believe on one or more occasions Mrs DEVINE's grand daughter (Mrs REAVES daughter) was also present.

I recall that at times Mrs REAVES was angry and had a number of legitimate complaints/concerns regarding poor communication between Gosport War Memorial Hospital and herself. Despite her having made it very clear at the time that she wished to be kept fully

informed of her mother's condition, this, it appeared, had not been done until a late stage.

Mrs REAVES was concerned regarding her mother's treatment and I recall spending a long time going through the whole medical picture, concerning her mother, with Mrs REAVES trying to explain fully the circumstances leading up to her mother's death.

I recall that one of Mrs REAVES questions was:-
"Was it Dr BARTON's decision alone to terminate my mother's life?"

I recall that Mrs REAVES was very upset by her perception of Dr BARTON's attitude and by Dr BARTON's explanation of what was happening in the last few days of her mother's life.

It was apparent to me as a result of the first meeting I had with Mrs REAVES, after her mother's death that Mrs REAVES intensely disliked Dr BARTON.

I felt that as a result of my meetings with Mrs REAVES on the two or three occasions in May or June 2000 that I developed a 'rapport' with Mrs REAVES which at one stage led to her making a comment that indicated that she felt her concerns would have been addressed had she had myself to deal with at that time, as opposed to Dr BARTON and that this would possibly have negated the need for her to make any complaint. It was unusual for me to have any involvement on any level with relatives, after the death of a patient, unless requested by the relatives. Had Mrs REAVES or any relative asked to see me at any stage then I would have seen them.

I am aware that there were other issues raised by Mrs REAVES concerning her mother's treatment, medication and care. However I am not able to recall these in any detail without access to the minutes of these meetings.

Taken by Code A

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Form MG11(T)

WITNESS STATEMENT

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

Statement of: REID, RICHARD IAN

Age if under 18: O.21 (if over 18 insert 'over 18') Occupation: CONSULTANT ELDERLY MEDICINE

This statement (consisting of 31 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signed: R I REID Date: 26/11/2004

I am Doctor Richard Ian REID and I reside at the address detailed overleaf.

Further to my earlier statement regarding Elsie DEVINE , I wish to add the following:-

I have been shown the below listed documents by Detective Constable 1019 LEE.

1. Exhibit BJC/16/PG/274&275
2. Exhibit BJC/16/PG/276
3. Exhibit BJC/16/PG/277&278
4. Exhibit BJC/16/PG/279&280

The above four documents form the prescription sheet of Mrs Elsie DEVINE whilst she was an inpatient on Dryad Ward of Gosport War Memorial Hospital .

I have been allowed by Code A to properly examine these documents and to reassemble them into their original format.

Exhibit BJC/PG/277&278 forms the basis of the document.

Exhibit BJC/PG/279&280 would have originally been attached to the edge of the previous document creating one long folding card or booklet.

Exhibit BJC/16/PG/276 is a stick on extension to the above documents which would have been

affixed to exhibit BJC/16/PG/277&278 on page 278.
Exhibit BJC/16/PG/274&275 is a further extension of the document which would have originally been affixed above exhibit BJC/16/PG/276.

I have been asked to explain the content of the above documents and provide an explanation of each drug detailed on them, to give an account from these documents of what the dose rate of each drug was, as shown on the prescription sheet and finally to comment on the use of each drug prescribed.
I first wish to state that I am not the author of any of the notes or writing on these documents.

My name appears at the top of page 277 beside the word 'Consultant'. From my examination of these documents, together with my examination of the clinical notes as referred to in my earlier statement, I am able to say that none of the drugs listed on the prescription sheets was prescribed by me or prescribed on my advice or instruction. There is however one possible exception to this, that being the drug 'Amiloride' - a drug used to treat fluid retention or heart failure.

This drug was prescribed on 1st November 1999 (01/11/1999) by Dr BARTON. It is possible that Dr BARTON consulted me regarding the prescribing of this drug in Mrs DEVINE's case or that Dr BARTON prescribed it on my instruction.

These documents would have been available to me and would almost certainly have been examined by me on each of the occasions that I conducted a ward round of Dryad Ward during the period that Mrs DEVINE was on the ward. Namely on 25th October 1999 (25/10/1999), the 1st November 1999 (01/11/1999) and finally on 15th November 1999 (15/11/1999).

I feel that these documents are best explained by detailing each drug in turn by date order.

As previously stated Mrs DEVINE was admitted to Dryad Ward, Gosport War Memorial Hospital on 21st October 1999 (21/10/1999) from the Queen Alexandra Hospital.

On 21st October 1999 (21/10/1999) Dr BARTON has prescribed a regular dose of:-
Thyroxine 100 micrograms daily.

This drug is for the treatment of hypo-thyroidism which is an under active thyroid gland which if severe and untreated could cause confusion.

In my experience I would say that this would be a very common treatment dose for persons suffering from this complaint. This dosage is monitored by carrying out blood tests.

Mrs DEVINE would have taken this drug in tablet form. There are no major side effects of this drug.

I note from the prescription charts that Mrs DEVINE took this drug from 22nd October 1999 (22/10/1999) until 17th November 1999 (17/11/1999). I can only assume that Mrs DEVINE's condition after this time had become such that she was no longer able to take this drug orally or was refusing to take drugs orally.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed a regular dose of Frusemide 40 mg tablets, one daily. This drug is used in the treatment of fluid retention and heart failure and also other conditions. The dosage prescribed is the most usual starting dose of this drug. This drug was administered from 22nd October 1999 (21/10/1999) until 17th November 1999 (17/11/1999). The use of these two drugs together is quite compatible.

On 21st October 1999 (21/10/1999) Dr BARTON also prescribed on an 'as required' basis the drug Temazepam 10mg tablets, one at night.

This drug is a 'sleeping tablet' and one 10mg tablet is the normal starting dose for this drug.

The drug was administered on one occasion only to Elsie DEVINE. This was at 0115 hours on 11th November 1999 (11/11/1999).

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Given the history on admission to Dryad Ward of 'confusion' and the fact that changes of environment/hospitals can increase 'confusion', particularly at night, I do not feel it was unreasonable to have prescribed this drug on an 'as required' basis on her admission to Gosport War Memorial Hospital.

It must be borne in mind that nursing staff at not permitted to administer drugs without them first being prescribed by a doctor.

Gosport War Memorial Hospital operated with only a 'Clinical Assistant', Dr Jane BARTON and therefore there was no resident medical cover in the form of a doctor available on site 24 hrs a day.

It was therefore in my opinion good practice to prescribe on an 'as required' basis a sleeping pill for this patient.

This would allow the nursing staff to administer the drug if required without consulting a doctor.

On 21st October 1999 (21/10/1999) on admission to the Gosport War Memorial Hospital I note that Dr BARTON has also prescribed in the 'as required' section the drug 'Oramorph ' at a strength of 10mgs in 5mls in a dose of 2.5 - 5mls 4 hourly as required. This drug is an oral morphine drug in solution and the dose prescribed in milligrams is 5-10mg.

This is the usual recommended starting dose for this drug.

This drug is usually used in the treatment of pain.

This drug, according to the prescription sheets was never administered to Elsie DEVINE.

Given that there is no resident doctor at Gosport War Memorial Hospital I feel that it would be entirely reasonable to prescribe on an 'as required' basis a simple 'analgesic' (painkiller) which

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the nursing staff could then administer if required.

In the absence of any documented pain being reported in the case of Elsie DEVINE I feel that this prescription was inappropriate at this stage. This is because 'analgesics' can be divided into 3 levels/groups of which 'Oramorph' falls into the strongest level/group.

On 1st November 1999 (01/11/1999) I note that Dr BARTON has prescribed the drug 'Amiloride' 5mg tablets, one daily. This drug is used to treat fluid retention or heart failure.

This is the usual recommended starting dose of the drug and is at the lower end of the starting range.

This drug was administered from 2nd November 1999 (02/11/1999) to the 18th November 1999 (18/11/1999).

The use of this drug is entirely compatible with 'Frusemide' and Thyroxine.

This drug was possibly discussed with me prior to prescription as stated earlier in this statement.

There are two reasons that possibly led to the prescription of this drug. The first being that Mrs DEVINE's fluid retention was increasing namely her legs were swelling.
The second being that 'Frusemide' can have the effect of lowering potassium levels in the blood whereas 'Amiloride' can have the effect of raising potassium levels in the blood. Therefore it can be useful to use these two drugs in combination. 'Amiloride' can, in some cases, cause a worsening of kidney function and requires monitoring if given. This can be achieved by blood tests.

On 11th November 1999 (11/11/1999) I note that Dr BARTON prescribed 'Trimethoprim' 200mg tablets, one daily for a period of 5 days.

'Trimethoprim' is an antibiotic which is commonly used for the treatment of urinary tract

infections. This is in my opinion an entirely correct dose and length of treatment.

This drug is compatible with the other prescriptions taken daily by Mrs DEVINE at this time.

I note that Mrs DEVINE completed the course of treatment involving this drug on the 15th November 1999 (15/11/1999).

Caution should be taken when administering this drug to patients suffering from impaired kidney function.

However failing to treat a urinary tract infection can also have adverse consequences on kidney function. Therefore there is a need to monitor.

On 11th November 1999 (11/11/1999) Dr BARTON prescribed on an 'as required' basis 'Thioridazine' 10 mg tablets, one three times daily.

'Thioridazine' is a drug used in the treatment of 'restlessness', 'agitation' and 'confusion'.
The drug has a tranquillizing and sedative effect.
The dose prescribed in Mrs DEVINE's case was at the very bottom end of the dosage range.

This drug was administered on ten occasions between 11th November 1999 (11/11/1999) and 17th November 1999 (17/11/1999) to Mrs DEVINE. She received the prescribed dose on each occasion. These were as follows:-

1. 0830 hrs on 11th November 1999 (11/11/1999)
2. 1330 hrs on 12th November 1999 (12/11/1999)
3. 0825 hrs on 13th November 1999 (13/11/1999)
4. 1800 hrs on 13th November 1999 (13/11/1999)
5. 0825 hrs on 14th November 1999 (14/11/1999)
6. 1945 hrs on 14th November 1999 (14/11/1999)

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7. 0830 hrs on 15th November 1999 (15/11/1999)
8. 2130 hrs on 15th November 1999 (15/11/1999)
9. 0845 hrs on 16th November 1999 (16/11/1999)
10. 1740 hrs on 17th November 1999 (17/11/1999)

No more than 2 tablets were given in any one day. The prescribed limit being three tablets.

This drug is compatible with the other prescribed drugs that Mrs DEVINE was taking on a daily basis.

On 15th November 1999 (15/11/1999) I carried out a ward round at Dryad Ward, Gosport War Memorial Hospital. On Mrs DEVINE's clinical notes of that day I noted the use of this drug to treat Mrs DEVINE's 'aggression' and 'restlessness' (see exhibit BJC/16/PG/154&155). I have also referred to its use in my earlier statement and mentioned that I felt it was important that, when a new drug was prescribed, that the reasons for this were recorded on the medical notes.

This does not appear to have been done in this case.

I would consider that the dose prescribed of 'Thioridazine' was wholly appropriate at that time in the treatment of Mrs Elsie DEVINE's 'aggression' and 'restlessness'.

On 18th November 1999 (18/11/1999) Dr BARTON prescribed 'Fentanyl TTS', 25 micrograms as a self adhesive skin patch on a 'regular basis'- every third day. 'Fentanyl' is a drug used in the treatment of pain.

This drug was administered in 'patch' form at 0915 hours on 18th November 1999 (18/11/1999).

The drug once administered in 'patch' form does take a period of time before it is fully effective.

This period can be up to 24 hours.

Signed: R I REID
2003(1)

Signature Witnessed by:

According to the prescription sheet the Fentanyl patch was removed at 1230 hours on 19th November 1999 (19/11/1999). The recommended sites to place Fentanyl patch are on dry healthy hairless skin on the chest, back or upper arm. I have not seen on the medical notes of Elsie DEVINE where the Fentanyl patch was sited in her case.
I have been asked why an 'analgesic' (painkiller) of the strength of Fentanyl has been prescribed and administered to a patient who according to their medical record have not made any complaint of pain.

This is best explained as follows:-

It is often the case that an elderly patient who is very confused and/or distressed may not be able to communicate that they are in pain and may also not display any symptoms or signs of pain other than their confusion, restlessness and aggression.
In the first instance these symptoms are treated with a sedative drug which in this case had been commenced on 11th November 1999 (11/11/1999) by administering 'Thioridazine' in tablet form.

On 18th November 1999 (18/11/1999) it has been noted on Mrs DEVINE's clinical notes by the locum staff psychiatrist that despite taking Thioridazine Mrs DEVINE had become more restless and aggressive and that she was also refusing to take medication.

In my opinion the continued distress, restlessness and aggression being displayed by Mrs DEVINE could be an indication of pain that she was suffering and was unable to communicate.

At this stage, in my opinion, there would be three possible courses of action:-

1. To increase the dosage of 'sedative'.
2. Cease sedative and place on analgesic (painkiller).
3. Administer a combination of both sedative and painkiller.

From my reading of the prescription sheet, Dr BARTON appears to have taken the second

option of prescribing the analgesic (painkiller) in the form of a 'Fentanyl patch'.

I also note that Mrs DEVINE on 18th November 1999 (15/11/1999) was refusing to take her oral medication which would explain the use of the Fentanyl patch as opposed to an orally taken analgesic (painkiller).

To have continued with sedation in Mrs DEVINE's case would have involved, increased dosages of sedation which would probably have involved having to receive several injections daily which in turn could cause Mrs DEVINE to suffer further distress.

With regard to the decision by Dr BARTON to apply a 'Fentanyl patch' on 18th November 1999 (18/11/1999) I would not have expected Dr BARTON to consult me prior to making that decision unless she had concerns herself about doing it.

Dr BARTON is a very experienced doctor who has considerable experience in the treatment of elderly patients and elderly patients who are dying.

The primary concern in these circumstances would be the comfort of the patient and in particular to relieve any distress and pain they were suffering.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed 'Chlorpromazine', 50mg to be given by intramuscular injection.

This prescription was made in the 'once only' section and was administered at 0830 hours on 19th November 1999 (19/11/1999) by a member of the nursing staff. Chlorpromazine is a sedative/tranquiliser. The dosage of 50mgs given to Mrs Elsie DEVINE is at the upper end of the normal range of dosage.

This dosage and drug is compatible with the 'Fentanyl patch' that Mrs DEVINE was wearing at the time. The administering of Chlorpromazine is consistent with Mrs DEVINE's continued 'confused' and 'aggressive state'.

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On 19th November 1999 (19/11/1999) I note from Mrs DEVINE's clinical notes exhibit BJC/16/PG/156/157 that Dr BARTON has made an entry in which she refers to a marked deterioration of Mrs DEVINE's condition overnight with confusion and aggression and a marked decline in her kidney function. She also notes a further deterioration of Mrs DEVINE's condition that morning.

In this note Dr BARTON mentions the application of the Fentanyl patch the previous day.

She notes that despite its use Mrs DEVINE's condition was continuing to deteriorate.

She notes:
'Needs sub-cutaneous analgesia with Midazolam'.

In my opinion this may be translated as follows:-
'In Dr BARTON's opinion Mrs DEVINE needed a sub-cutaneous infusion of a painkiller and a sedative'. A sub-cutaneous infusion would probably be a reference to the drugs being administered by means of a syringe driver.

The note then reads:
'Son seen and aware of condition and diagnosis'.
'Please make comfortable'
'I am happy for nursing staff to confirm death'.

In my opinion the last section of this note indicates that Dr BARTON had formed the opinion that Mrs Elsie DEVINE was terminally ill and that the overriding priority was to relive symptoms and therefore her instructions were to ensure Mrs DEVINE was comfortable and free from distress.

It is my opinion that Dr BARTON should have made entries on Mrs DEVINE's clinical notes regarding the prescription of:
1. Fentanyl patch on 18/11/99 (18/11/1999)

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2. The Chlorpromazine on 19/11/99 (19/11/1999)

Both are powerful drugs and also represent an important change in Mrs DEVINE's condition and treatment. It would therefore have been best practice to have noted these changes and reasons for the changes on Mrs DEVINE's clinical notes at the time of prescription.

On 19th November 1999 (19/11/1999) Dr BARTON prescribed Diamorphine 40-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver).

Together with;
Midazolam 20-80mgs every 24 hours on a regular basis by sub-cutaneous infusion (via syringe driver). These two drugs would have been mixed together, both drugs being in a liquid form, both drugs are completely compatible with being mixed together and administered over a 24 hour period by means of syringe driver.
Diamorphine is an opiate drug used in the treatment of pain.

It is a very strong analgesic (painkiller) which is frequently used in the care of terminally ill patients who are in pain or are distressed or both.

The dose of Diamorphine prescribed by Dr BARTON was 40-80mgs in a 24 hour period.

Mrs DEVINE had been wearing a 25 microgram Fentanyl patch for the previous 24 hours.

A 25 microgram Fentanyl patch is probably the equivalent to between 30 mgs and 60mgs of Diamorphine over a 4 hour period. Both Fentanyl and Diamorphine are opiates.

The prescription of 40mg of Diamorphine over a 24 hour period was therefore the correct replacement dose for the Fentanyl patch.

However the Fentanyl patch was not removed from Elsie DEVINE until 1230 hours on 19th November 1999 (19/11/1999). Fentanyl remains in the system of a patient for between 12 to 24

hours after the patch is removed.

Mrs DEVINE's treatment with Diamorphine began at 0925 hours on 19th November 1999 (19/11/1999) whilst she was still wearing the Fentanyl patch. Therefore Mrs DEVINE is likely to have received more than the equivalent of 40mgs in the first 24 hours of her treatment with Diamorphine.

However it should be noted that Fentanyl had not relieved Mrs DEVINE's distress and that the prescribed Diamorphine dosage was 40-80mgs. It is extremely unlikely that this dosage was exceeded.

The drug Midazolam is a sedative in liquid form which is completely compatible for use with Diamorphine. It is prescribed to treat restlessness in patients who are terminally ill and who are unable to take sedation by mouth or are refusing to do so.

The dose prescribed by Dr BARTON was 20-80mgs in a 24 hour period.

The normal starting dose for Midazolam is 10-20 mgs in a 24 hour period.

From my examination of the prescription sheets I note that sub-cutaneous infusion commenced at 0925 hours on 19th November 1999 (19/11/1999).

This would have been set up by a senior member of the nursing staff. I note that the starting dose of Diamorphine administered was 40mgs in a 24 hour period.

This was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

In the case of the drug Midazolam a dose of 40mgs was administered at 0925 hours 19th November 1999 (19/11/1999) over a 24 hour period and was repeated at 0735 hours on 20th November 1999 (20/11/1999) and again at 0715 hours on 21st November 1999 (21/11/1999).

A sub-cutaneous infusion usually refers to the continuous administration of a drug through a needle inserted just under the skin and involves the use of a syringe driver.
A syringe driver is a medical device which in simple terms is an electrically powered syringe that has a motor which depresses the plunger of the syringe very slowly. This enables a patient to be administered an even dose of the drug throughout a 24 hour period. Other than the first insertion of a needle this equipment avoids the need for a patient to be given multiple injections. This therefore avoids causing the patient distress. In the case of Elsie DEVINE it is my opinion that the use of a syringe driver to administer the drugs Diamorphine and Midazolam was appropriate in the circumstances. This is because Mrs DEVINE had already received Fentanyl (an opiate) sub-cutaneously in the form of a skin patch and because Mrs DEVINE was refusing oral medication. Mrs DEVINE at the time required two nurses to be solely looking after her because of her agitation and distress.

With regard to the doses of the drugs Diamorphine and Midazolam the administering of the Fentanyl patch and the 50mgs of chlorpromazine I have the following observations:

Regarding the Fentanyl patch in my opinion it may have been a more appropriate alternative to have administered individual sub-cutaneous injections of small doses of Diamorphine over 24 hours to assess its effect on Mrs DEVINE so that a clearer idea could be obtained of the dose of Diamorphine to be administered over a period of 24 hours via a syringe driver in order to relieve Mrs DEVINE's symptoms.

This however would involve multiple injections that may have caused further distress and may not have led to a relief of her symptoms.

Regarding the starting dose of 40mgs of Diamorphine over a 24 hour period in my opinion this is unlikely to have taken account of the application of the Fentanyl patch 24 hours before. It would probably have been more prudent to have started with a dose of 20-30 mgs of Diamorphine.

The administering of 40mgs of Diamorphine in the first 24 hours could have led to over sedation but the administration of 20-30mgs might well not have relieved Mrs DEVINE's distress.

Regarding the sedatives administered to Elsie DEVINE on 19th November 1999 (19/11/1999) I have the following observations.

At 0830 hours on 19th November 1999 (19/11/1999) Mrs DEVINE received an intramuscular injection of 50mgs of Chlorpromazine. This dose is at the upper limit of the dosage range for an initial injection.

I would expect to see some effect on a patient administered this drug, in a period of half to one hour.

The effect of this drug I would expect to last from anything from three to six hours.
(However I have limited expertise in this field).

It is of some concern that when Mrs DEVINE was administered Midazolam at 0925 hours on 19th November 1999 (19/11/1999) via syringe driver the Chlorpromazine may not have reached its maximum effect.

It should however be borne in mind that the Midazolam was being administered as a slow infusion over a 24 hour period.

This could also have led to some over sedation of Mrs DEVINE during the first few hours of the Midazolam infusion.

With regard to the dose of 40mgs of Midazolam over a 24 hour period I have concerns that the administered starting dose was of 40mgs when the prescription sheet shows that Dr BARTON prescribed a dose of 20-80 mgs over a 24 hour period.

In my opinion 20mgs of Midazolam over a 24 hour period would have been a more appropriate starting dose.

I can see nothing on the medical notes of Elsie DEVINE to show the reason for administering 40mgs of Midazolam. The drugs Diamorphine and Midazolam were administered together by syringe driver by a member of the nursing staff.

In the main drugs are administered to a patient by the nursing staff following prescription by a doctor.

When writing a prescription with a range of 20mg - 80mg of a drug I would expect that, initially the lowest dose would be administered to assess its effect on the patient unless there were very good reasons for giving a higher dose.

In that instance I would expect a note to be made on the medical record of the patient giving the reasons for administering the higher dose.

I can see 'no note' on the medical records of Elsie DEVINE explaining the reason for her being administered the higher starting dose of 40mg of Midazolam on 19th November 1999 (19/11/1999).

In my opinion Dr BARTON's note of 19th November 1999 (19/11/1999) on Mrs DEVINE's clinical notes exhibit BJC/16/PG/156&157 together with the prescription sheets is an indication of a change in course of treatment of Elsie DEVINE to palliative care.

I would not expect DR BARTON to consult me prior to making this decision, unless, she had concerns about doing so.

Palliative care in this case would mean relieving Mrs DEVINE symptoms of confusion, restlessness, aggression and distress on a background of rapidly declining renal function by using a combination of analgesia (painkillers) and sedatives.

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It is well recognised that administering strong analgesics and sedatives in this situation may hasten death in the course of relieving suffering and making a patient comfortable.

The most common side effects of administering Diamorphine to a patient are:-
Nausea, vomiting, constipation and drowsiness.

Large doses produce:
Respiratory depression - slow and shallow breathing.
Hypotension - low blood pressure
The most common side effects of the drug Midazolam are:-
Drowsiness and respiratory depression.
These side effects may hasten death.

In my opinion the variable dose on prescription by Dr BARTON of the drugs Diamorphine and Midazolam was to allow the nursing staff the discretion to increase the dosage of each drug should the initial dose not control or relieve the symptoms displayed by Mrs DEVINE, particularly as there was no on site 24 hour doctor cover. No increase of dosage of either Diamorphine or Midazolam from the initial starting doses was made in the case of Mrs DEVINE.

Mrs DEVINE died at Dryad Ward, Gosport War Memorial Hospital during the evening of 21st November 1999 (21/11/1999).

Taken by:DC1019 LEE

Signed: R I REID

Signature Witnessed by:

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RECORD OF INTERVIEW

Number: Y25

Enter type: ROTI
(SDN / ROTI / Contemporaneous Notes / Index of Interview with VIW / Visually recorded interview)

Person interviewed: REID, RICHARD IAN

Place of interview: FAREHAM POLICE STATION

Date of interview: 04/07/2006

Time commenced: 0921 Time concluded: 1000

Duration of interview: 39 MINUTES Tape reference nos.
(→)

Interviewer(s): DC Code A Geoff QUADE / DC Code A Chris YATES

Other persons present: Mr CHILDS - Solicitor

Police Exhibit No: Number of Pages: 22

Signature of interviewer producing exhibit

Person speaking	Text
DC QUADE	This interview is being tape recorded, I am Detective Constable Code A Geoff QUADE and my colleague is?
DC YATES	DC Code A Chris YATES.
DC QUADE	Right. We are interviewing Doctor Ian REID. Doctor REID would you give me your full name and date of birth please?
REID	It's Richard Ian REID, and my date-of-birth is Code A.

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DC QUADE	Thank you very much. And also present is Mr CHILDS who is Mr REID's solicitor. Can you pleas introduce yourself Mr CHILDS?
CHILDS	Oh yes it's Will CHILDS for Radcliffes Le Brasseur Solicitors in Westminster.
DC QUADE	Thank you very much. This interview is being conducted in an interview room at Fareham Police Station in Hampshire. The time by my watch is 0921, and the date is the 4th of July 2006 (04/07/2006). At the conclusion of the interview we will give you a notice explaining what will happen to all the tapes. Okay?
REID	Yeah.
DC QUADE	I will remind you Doctor REID that you are still entitled to free legal advice, Mr CHILDS is here as your legal advisor. Can you confirm, or not, that you have had enough time to consult with Mr CHILDS in private, or would you like further time before we start the interview?
REID	I mean, I mean I've had enough time, but obviously I don't know what's...
DC QUADE	Sure, yeah.
REID	What you've got.

DC QUADE	Yeah fine. So the next bit is, I'll explain that if, at any time, you wish to stop the interview and take further legal advice from Mr CHILDS just let us know that and we will do that. Okay?
REID	Okay.
DC QUADE	Yeah?
REID	Yeah.
DC QUADE	Now it's already been pointed out to you twice already this morning that you've attended voluntarily,...
REID	Yeah.
DC QUADE	...you're not under arrest, you've come here of your own free will. If at any time you wish to leave the police station, leave the interview room and leave the police station you're entitled to do that, we can't stop you and we won't stop you.
REID	Right.
DC QUADE	Okay?
REID	(Silent)
DC QUADE	Now I have to caution you,...

REID	Right.
DC QUADE	...and the caution says you do not have to say anything but it may harm your defence if you fail to mention, when questioned, something which you later rely on in court and anything you do say may be given in evidence. Do you understand that caution?
REID	Yes.
DC QUADE	Would it help you if I sort of did a sort of layman's...
REID	Yes.
DC QUADE	Yeah, okay. It can be broken down into three bits. The first part is that you've got a right not to say anything and we respect that and so anything we ask you you don't have to answer. Okay?
REID	(Silent.)
DC QUADE	The second part is a little bit more confusing, but if this matter should go to court if you should be charged, or reported for offences and you go to court it might harm your defence if you wish to rely on something as part of your evidence that you haven't told us, but you've had the opportunity to tell us.
REID	Right.

DC QUADE	Yeah. So if we ask you questions today and you choose not to tell us an answer to those questions, but then come out with answers in court it may harm your defence.
REID	Right.
DC QUADE	Right, okay. And so in other words a court might draw what they call an 'adverse inference'...
REID	Right.
DC QUADE	...wondering why you didn't mention it during the entire process.
REID	Yeah.
DC QUADE	And the third part is that it is being recorded and if it goes to court the transcript of this interview may be available to the court. Okay?
REID	(Silence)
DC QUADE	On this occasion the room that we are using is equipped with a monitoring facility and there's a red light that's on which tells us that someone is monitoring at the moment and that will be DI GROCOTT the chap you met just now. ...
REID	Right.

DC QUADE	...The reason he's doing that is that it enables us to carry out any enquiries that may come about as a result of anything you say to us today expeditiously. No person can hear anything via the equipment when the machine isn't running, so if this tape recorder isn't running that microphone doesn't work. Okay?
REID	Right. So what you're saying is that, is it D?
DC QUADE	DI GROCOTT.
REID	DI GROCOTT is listening into this....
DC QUADE	Yes. I will do most of the talking today, but DC YATES will almost certainly be taking notes as we go along...
REID	Right.
DC QUADE	...and he will be asking you some questions as well at some stage I should think.
REID	Right.
DC QUADE	Operation Rochester is an investigation being conducted by Hampshire Constabulary and it started in September of 2002, so it's already been running for the best part of four years now. It's an investigation into allegations of the unlawful killing of a number of patients at the Gosport War Memorial Hospital between 1990 and 2000. Now no decision has yet been made as to whether any offence, or

	offences have been committed, but it's important to be aware that the offence range that we're investigating run from potential murder right the way down to assault. Okay?
REID	(Silence)
DC QUADE	Part of the ongoing enquiry is to interview witnesses who were involved in the care and treatment of the patients during that period. Now you were the Consultant Geriatrician for the Gosport War Memorial Hospital during part of the time that these deaths occurred, so your knowledge of the working of the hospital, the care and the treatment of the patients is very central to our enquiry. The interview today will be what we term as a 'generic interview' in that we wish to talk about yourself, your qualifications, your training as well as the policies and procedures pertinent to the Gosport War Memorial Hospital during this time period. Now the groups of questions will come under particular topic headings and we will endeavour to try and explain the topics at the start of each stage. Okay?
REID	(Silence)
DC QUADE	And do you think you are quite comfortable with,
REID	Yeah.
DC YATES	As comfortable as can be

DC QUADE	(Pause) So the interview, as I just said will be generic and it's not patient specific. Okay?
REID	(Silence)
DC QUADE	During the interview we will ask you questions about several topics such as your qualifications and the role of the consultant, that sort of thing.
REID	Uh-huh.
DC QUADE	When we start on your topic area we will tell you what it is and the reasons why we want to ask those questions about that particular subject. Now the first topic area to cover is about your qualifications. ...
REID	Right.
DC QUADE	...The reason we want to speak about these now is that it's not only, it's a good point to start off with but we need to establish exactly what your qualifications are as a doctor and how experienced you are etcetera. Okay?
REID	Yeah.
DC QUADE	Can you tell us when you qualified as a doctor?
REID	1974.

DC QUADE	Thank you. And where was that?
REID	Glasgow.
DC QUADE	And where did you do your pre-registration training?
REID	Um I did six months in a town called, well the Royal Alexandra Infirmary in Paisley, Scotland. Yes that's the first six months, and the second six months was at Stirling Royal Infirmary, Stirling, Scotland.
DC QUADE	Yeah. And that's Junior House Officer as well then yeah?
REID	These are both what are called the 'Pre-registration House Officer'. Yeah.
DC QUADE	Yeah. And where did you train as a Senior House Officer?
REID	Um I did, um, there were several posts, um, the first one was, can I just look back to...
DC QUADE	Yeah sure.
REID	...(inaudible) over here. There's the Senior House Officer in Obstetrics and Gynaecology at Paisley Maternity Hospital, Paisley, Scotland and that was from August 1975 to January 1976, and then following that, um, I did training as a Senior House Officer in Geriatric medicine at the Victoria Geriatric Unit in Glasgow from February 1976 to July 1976, and following that I was a Senior House Officer

	in Cardiology at the Glasgow Royal Infirmary in Scotland from August 1976 to April 1977. Um so that covers the Senior House Officer.
DC QUADE	Uh-huh. And where were you the Registrar, where did you train as a Registrar?
REID	Uh yeah in Kilmarnock Infirmary, Kilmarnock, Scotland and that was from May 1977 to to July 1979.
DC QUADE	Thank you. And then Senior Registrar?
REID	Yeah, um, I became a Senior, well it's, one was appointed to what was called a Wessex Rotation, um, which involves spending different periods of time in different hospitals...
DC QUADE	Yeah, yeah.
REID	...and for me it was Portsmouth and Southampton...
DC QUADE	Yes.
REID	...and that was from August '79 to July 1982.
DC QUADE	And then the next stage of your career was to become a Consultant?
REID	A Consultant in Geriatric Medicine at Southampton General Hospital and that was from August 1982 to March 1998.

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DC QUADE	And from '98 to present?
REID	Yeah from, in April 1998 I was appointed as Consultant in Geriatric Medicine and along with that I was the Medical Director of, well at that time was Portsmouth Health Care Trust.
DC QUADE	Uh-huh. And so that's covered all your hospital appointments really hasn't it...
REID	Yes.
DC QUADE	...from when your career starts?
REID	Yeah.
DC QUADE	Why did you want to become a Consultant then?
REID	(Pause) Um, (laughs)...
DC QUADE	(Laughs) It's forty-five minutes the tape.
REID	Um, well I mean the choice one's faced with is either, either becoming a, in general terms becoming a G.P. or become a Consultant. I mean in fact I had been going to, um, become a G.P.,...
DC QUADE	Oh right.

REID	...um, but, um, for sort of personal reasons, um, when I was sort of a Senior Registrar, um, I was sort of married before that, my marriage broke up and I thought, you know, 'I don't want to go into a sort of small town and be a G.P. I'd rather sort of have a bit of a social life (laughs)', um, so I stayed in hospital and I'd really quite enjoyed my time in Geriatric Medicine,...
DC QUADE	Yeah.
REID	...um, at the Victoria Geriatric Unit and so that was when I applied to, um, become a sort of Senior Registrar in Geriatric Medicine down here, and I also felt I wanted a change from the West of Scotland.
DC QUADE	Yeah.
REID	(Pause) And in kind of some ways General Practice and Geriastrics is sort of quite similar; they're very sort of broad based.
DC QUADE	Okay. And how did you get the, you answered a role; there was an advert in the papers, or in the magazines, or something like that?
REID	Yes I mean the medical journal carries advertisements.
DC QUADE	As the Consultant what was your first position that you were initially employed in?

REID	In Southampton in Geriatric Medicine.
DC QUADE	In Southampton?
REID	Yes.
DC QUADE	Okay and then when did you come over to the Queen Alexandra then?
REID	That was in April 1998.
DC QUADE	That's nicely covered your career background. Doctor REID what is the organisational set up of the hospital, the Queen Alexandra?
REID	You mean which organisation does it belong to?
DC QUADE	Yeah go on, because we know that it changes over the years...
REID	(Laughs)
DC QUADE	...doesn't it?
REID	When I came to Portsmouth in 1998, um, the non primary care / community care was covered, in Portsmouth was covered by two organisations the Portsmouth Hospital's, um, NHS Trust as it was called and Portsmouth Health Care Trust. Now Portsmouth Hospital Trust ran most of the, um, beds, if not all of the beds at St. Mary's Hospital

	and most of the beds in Queen Alexandra Hospital other than the beds which are used for the Department of Elderly Medicine. The Department of Elderly Medicine, um, was part of Portsmouth Health Care Trust, which, um, was responsible for running St. James's Hospital, mental health services, um, community paediatrics, um, district nursing, health visiting, school nursing, um, so it was almost everything that was sort of not acute hospital and not strictly G.P.
DC QUADE	Yeah, okay. So when did all that, and when did all that change then? Because what they called, what does it come under, what does it come under now?
REID	It's East, it's East Hampshire Primary Care Trust,...
DC QUADE	Yeah.
REID	...um, now run, um, elderly, the elderly medicine beds at Queen Alexandra Hospital. I mean I should also have said that, um, Portsmouth Health Care Trust ran all the community hospitals so that was Havant War Memorial, Petersfield, Gosport War Memorial, um, I'm sorry I can't remember your last question you asked me.
DC QUADE	We were just trying to find out when it all changed over ...
REID	When it changed?
DC QUADE	...to its current positioning.

REID	Uh I can't remember when the last reorganisation was whether it was 2002 maybe. So I went to Portsmouth, Portsmouth Health Care Trust was dissolved and basically split into three organisations Portsmouth City Primary Care Trust, Fareham and Gosport Primary Care Trust and East Hampshire Primary Care Trust.
DC QUADE	Yeah so that's covered that, so it's covered, that's how it's changed since 1998 basically then?
REID	Yes.
DC QUADE	Yeah okay. And what about your department.
REID	Elderly Medicine?
DC QUADE	Yeah.
REID	Well the Elderly Medicine Department had beds, um, in Petersfield Hospital, at that time St. Christopher's Hospital in Fareham, which is no longer there and Gosport War Memorial Hospital as well as St. Mary's Hospital and Queen Alexandra Hospital. Um we also had, you know, day hospitals at Petersfield Hospital, at Gosport and both at Queen Alexandra Hospital and St. Mary's Hospital.
DC QUADE	Okay, yeah. And you say 'St. Christopher's isn't there anymore' is it?

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. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service. I undertake research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

4. This report is based on my review of the following documents; medical records of Patient A; statement of Dr Jane Barton re Patient A; witness statements of Lynda Wiles, Dr Jane Tandy, Code A 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 Code A 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 Code A 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 Code A

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 Code A 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 Code A 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
Prescription date not marked — None administered

Midazolam subcut via syringe driver 20-40mg/24hr
Prescription date not marked — None administered

Page 203

Drug	Administered		
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

Drug	Administered	
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	17 Jan	?h
1200ucg/24hr	18 Jan	1615h
Prescribed 18 Jan	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	17 Jan	?h
20mg/24hr	18 Jan	1605h
Prescribed 18 Jan	19 Jan	1800h
	20 Jan	Entry crossed out. Discontinued
Nozinan subcut	23 Jan	1500h
100mg/24hr		
Prescribed 22 Jan		

As required prescriptions

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Diamorphine subcut via syringe driver	15 Jan	?h	80mg/24hr
80-120mg/24hr	16 Jan	?h	80mg/24hr
Prescribed 11 Jan	17 Jan	?h	80mg/24hr
Hyoscine subcut via syringe driver	15 Jan	0825h	400 ucg/24hr
200-400 ucg/24hr	16 Jan	0825h	400 ucg/24hr
Prescribed 11 Jan	17 Jan	?h	400 ucg/24hr
Midazolam subcut via syringe driver	15 Jan	?h	60mg/24hr
40-80mg/24hr	16 Jan	?h	60mg/24hr
Prescribed 11 Jan	17 Jan	?h	60 mg/24hr
	18 Jan	0825h	60 mg/24hr
Midazolam subcut via syringe driver	None administered		
80mg/24hr			
Prescribed 16 Jan			

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Nozinan subcut via syringe driver	18 Jan	?h
50mg/24hr	19 Jan	?h
Prescribed 18 Jan		
Nozinan subcut via syringe driver	20 Jan	?h
100mg/24hr	21 Jan	1745h
Prescribed verbal order Dr Brigg 1720h	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.

Code A

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient B

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. **Course of events**

5.1 Patient B was 83 years of age when she was admitted to the Royal Hospital Haslar on 5 February 1996 following a fall, was transferred to Daedalus Ward, Gosport War Memorial Hospital on 22 February 1996. Patient B died on Daedalus Ward, Gosport War Memorial Hospital on 6 March 1996. Prior to her fall and admission on 5 February 1996, Patient B lived alone at home with her bed downstairs. She had a history of long-standing insulin dependent diabetes and was registered blind due to cataracts (page 79). The admission clerking notes (page 127) record she could walk about 10 yards with a stick, that her son did

her shopping and she was supported with daily home help and nurse visits to administer her insulin.

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

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

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

5.5 On 7 February the notes record that she still had left shoulder and upper arm pain and her hands were a problem (p145). On 8 February she was seen by 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	23 Feb – 4 Mar then discontinued
Prescribed 22 Feb	
Digoxin 125ug od	5 Mar no further doses
Prescribed 4 Mar	
Co-amilofruse 1 tablet once daily	23 Feb – 4 Mar then discontinued
Prescribed 22 Feb	
Co-amilofruse 1 tablet once daily	4 Mar then no further doses
Prescribed 4 Mar	
Ferrous sulphate 200mg bd	23 Feb – 4 Mar then discontinued
Prescribed 22 Feb and further continuation prescription 4 Mar	
Beclomethasone inhaler 2 puffs twice daily	
Prescribed 22 Feb	22 Feb – 4 Mar then discontinued
Salbutamol inhaler 2 puffs four times daily	
Prescribed 22 Feb	22 Feb – 4 Mar then discontinued
Insulin mixtard 50 units once daily 0730h	
Prescribed 22 February 1996	23-26 Feb
Insulin mixtard 50 units once daily 1800h	
Prescribed 22 February 1996	22-25 Feb
Insulin mixtard dose unclear	23 Feb – 4 Mar (omitted 28 Feb)
Insulin mixtard dose unclear	
Insulin mixtard 30 units morning	4-5 March
Prescribed 4 March	
Insulin mixtard 20 units evening	No doses administered
Prescribed 4 March	
Trimethoprim 200mg bd	23-27 Feb then discontinued.
Prescribed 23 Feb	
MST 10mg bd 0600h, 1800h	24-26 Feb discontinued after morning dose
Prescribed 24 Feb	

MST 20mg bd 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.

Code A

GARY A FORD

REID	...um, of, um, what are called Secondary Care Services within East Hampshire Primary Care Trust and Fareham and Gosport Primary Care Trust. Well I'd actually did it for Portsmouth City Primary Care Trust for a year, or a couple of years, this is when Portsmouth Heath Care Trust was dissolved...
DC QUADE	Uh-huh.
REID	...and then Portsmouth, I think after a couple of years Portsmouth City P.C.T. appointed their own Medical Director and I was left as Medical Director for what we call 'secondary care', in other words I had no, my role didn't cover general practice but, um, it covered the sort of community hospitals which were Fareham and Gosport P.C.T. and East Hampshire P.C.T.
DC QUADE	You decided to cease that role or?
REID	Yeah, yeah, well I was asked to cease it (laughs)...
DC QUADE	Oh right (laughs).
REID	...because there's another re-organisation, um, well it's happening, we're in the midst of that happening now because Fareham and Gosport P.C.T's will no longer exist from the end of, um, September I think it is...
DC QUADE	Another change?

REID ...I was going to be a Hampshire wide P.C.T. excluding Portsmouth City and Southampton City.

DC YATES So there will be just the three Health Care Trusts in the future Hampshire, Portsmouth and Southampton?

REID Um not quite, um,...

DC YATES No. I didn't think it would be that simple.

REID ...as of the 1st of October there will be Portsmouth Hospital Trust,...

DC QUADE Yeah.

REID ...there will be the Hampshire P.C.T., there will be Portsmouth City P.C.T., but what I didn't also say was that, um, Mental Health Services, um, are now run by Hampshire, what's called Hampshire Partnership Trust and that was established when Portsmouth Health Care Trust was dissolved, so around about 2002 / 2003. It used to be called West Hampshire NHS Trust, but it's changed its name to Hampshire Partnership and over the past year there's been sort of, um, fits of service from both Fareham and Gosport and East Hampshire PCT which have gone to Hampshire Partnership Trust or, I don't think anything's going to Portsmouth Hospital Trust yet, but we are about to be taken over by Portsmouth Hospital Trust the elderly medicine service.

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DC QYATES	But within the department when you were a Consultant, were you the head of the department?
REID	No I wasn't head of the department. The head of the department in 1998 was Doctor Code A (pause) and he was head of the department until about a year ago.
DC QUADE	Okay. Would that have been his title as well?
REID	He was, um, Lead Consultant,...
DC QUADE	Lead Consultant.
REID	...Lead Consultant for Elderly Medicines was his title. Now I was the Medical Director for the Trust, which covered elderly medicines, psychiatry, the whole works and he was the Lead Consultant for the department.
DC YATES	With that title a layman just assumes that you were the headman.
REID	No. So I was not the Medical Director of Gosport War Memorial Hospital,...
DC QUADE	No.
REID	...I was like any other consultant at Gosport Memorial Hospital.

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

Professor Gary A Ford, FRCP
Consultant Physician

22 May 2009

GMC and Dr Jane Barton
Patient B

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

3.

Section 5.1	line 6 (page 79) corrected to (page 81)
	line 7 (page 127) corrected to (page 139)
Section 5.2	line 7 (page 130) corrected to (page 132)
Section 5.3	line 4 (now sutured) changed to (sutured)
Section 5.4	line 4 'Examination reports chest and abdomen were normal and there was no obvious source of infection' changed to 'Chest and abdomen examination were reported to be normal and there was no obvious source of infection'.
Section 5.6	line 1 (page 146) corrected to (page 148)
Section 5.10	line 3 (page 175) corrected to (page 975)
Section 5.14	line 1 " ..patient B was complaining of pain and of having extra as required doses of analgesia' changed to '..patient B was complaining of pain and was receiving extra 'as required' doses of analgesia'.
	line 7 ' .. patient B was not unrousable.' corrected to ' .. patient B was unrousable.'
Section 7	line 6 '..the clinical evidence does not support this diagnosis.' changed to '... the information recorded in the notes does not support this diagnosis.'
Section 8	line 13 '... significantly reduced to that prior to her fall.' changed to '.. significantly reduced compared to that prior to her fall.'

4. 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. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. **Course of events**

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

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

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

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

   Once only prescription
   Diamorphine im 5mg — administered twice. First date unclear, 0800 h
   Second date unclear, 1500 h

As required prescriptions

Thioridazine 25mg 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 28 Feb 29 Feb	1 dose 2 doses 1 dose
Thioridazine dose unclear tds Prescribed 28 Feb	1 Mar 2 Mar	2 doses 1 dose then discontinued
Heminevrin dose unclear nocte Prescribed 28 Feb	28 Feb 1 Mar	1 dose 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.

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

23 May 2009

General Medical Council and Dr Barton
Patient C

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 1 line 7 "...too wide a dose range and were there inappropriate..." corrected to "....too wide a dose range and were therefore inappropriate.....

3. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

4. Section 6 lines 5/6. I stated the date of administration of two diamorphine doses were unclear. The nursing notes (p170) indicate this must have been 2 Mar 1999.

   Section 6 Regular prescriptions.
   The thioridazine prescription on 28 Feb was not written by Dr Barton. The signature is unclear but not that of Dr Barton
   The Hemineverin (cholormethiazole) prescription on 28 Feb was not written by Dr Barton. The signature is unclear but not that of Dr Barton.

   Section 9 line 3. "Patient C ha d..' corrected to "Patient C had..."

   Section 9 In view of the clarification of the timing of the diamorphine dose administrations on 2 March the following section is changed from

   "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." to

   "Patient C had received substantially less than the equivalent of 90mg oral morphine in the previous 24 hours as she had only received one 5mg dose of morphine. Dr Barton therefore prescribed a ten fold higher dose of opioid with the fentanyl patch prescribed at 0800h on 2 March with further opioid prescribed and administered with the two 5mg doses of diamorphine at 0800h and 1500h the same day. There was a very high risk of adverse effects from the combination of the fentanyl patch and the diamorphine and this was the most likely cause of Patient C developing drowsiness."

   Section 10 line 1. "The notes record Mrs Page's son.." corrected to " The notes record Patient C's son..."

   Section 11 line 3. "..do not indicate patient was... corrected to "...do not indicate patient C had..."

5. 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.

Code A

GARY A FORD

GMC100987-0267

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient D

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. Course of events

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

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

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

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

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

As required prescriptions

Promazine syrup 25mg Prescribed 31 Jul 1998 by Code A	None administered
Haloperidol subcut 2.5-10mg maximum 60mg in 24 hours Prescribed 1 Aug 1998 by Code A	1 Aug 2045h 2.5mg
Magnesium hydroxide 10mls Prescribed 4 Aug 1998 Code A	None administered

Regular prescriptions

Fluoxetine (Prozac) 20mg od Prescribed 31 Jul 1998 Code A	1-9 Aug then discontinued
Co-danthramer 5-10mls Prescribed 31 Jul 1998 Code A	31 Jul – 19 Aug
Zopiclone 3.75mg Prescribed 31 Jul 1998 Code A	3-19 Aug
Lactulose 10mls Prescribed 31 Jul 1998 Code A	1 - 4 Aug then discontinued
Promazine 25mg od Prescribed 31 Jul 1998 Code A	None administered
Augmentin1.2 g iv tds Prescribed 1 Aug 1998 Code A	1 Aug 2 doses Discontinued 2 August
Augmentin elixir 250-62 500mg tds Prescribed 2 Aug 1998 Code A	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

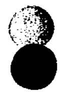
7. I have already provided my opinion on patient management in my report to Hampshire Constabulary. I am making additional comments which relate specifically to the allegations made to the Fitness to Practice Panel with respect to Dr Barton's prescribing.

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.

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

General Medical Council and Dr Barton
Report on Patient D

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I <u>undertake</u> research into the effects of drugs in older people."

3. Section 10 line 2. (p635) corrected to (p206)

4. 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 Gladys Richards (Patient E)

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient E

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. **Course of events**

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

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

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

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

As required prescriptions

Oramorphine 10mg/5ml	11 Aug	1115h	10mg
2.5-5ml		1145h	10mg
Prescribed 11 Aug	12 Aug	0615h	10mg
	13 Aug	2050h	10mg
	14 Aug	1150h	10mg
	17 Aug	1300h	5mg
		?	5mg
		1645h	5mg
		2030h	10mg
	18 Aug	0230h	10mg
		?	10mg

Diamorphine subcut via syringe driver — None administered
20-200mg/24hr
Prescribed 11 Aug

Hyoscine subcut via syringe driver	19 Aug 1120h	200ucg/24hr *? 400*
200-800 ucg/24hr	20 Aug 1045h	400ucg/24hr
Prescribed 11 Aug	21 Aug 1155h	40ucg/24hr

Midazolam subcut via syringe driver	18 Aug 1145h	20mg/24hr
20-80mg / 24 hr	19 Aug 1120h	20mg/24hr
Prescribed 11 Aug	20 Aug 1045h	20mg/24hr
	21 Aug 1155h	20mg/24hr

Regular prescriptions

Haloperidol 2mg/ml oral — 13 Aug One dose administered
0.5ml 'If noisy'
Heading 'REGULAR PRESCRIPTION' crossed out and replaced with 'PRN' for this prescription

Haloperidol 2mg/ml, I mg twice daily — 11 -14 Aug
Prescribed 11 Aug — 17 Aug then none administered

Oramorphine 10mg/5ml — None administered
2.5 ml four time daily
Prescribed 12 Aug. Marked 'PRN'
Oramorphine 10mg/5ml — None administered
5ml nocte
Prescribed 12 Aug. Marked 'PRN'

Diamorphine subcut via syringe driver	18 Aug 1145h	40mg/24hr
40-200mg/24hr	19 Aug 1120h	40mg/24hr
Prescribed 17 Aug	20 Aug 1045h	40mg/24hr
	21 Aug 1155h	40mg/24hr

Haloperidol subcut via syringe driver	18 Aug 1145h	5mg/24hr
5-10mg/24hr	19 Aug 1120h	5mg/24hr
Prescribed 17 Aug	20 Aug 1045h	5mg/24hr
	21 Aug 1155h	5mg/24hr

Lactulose 10ml twice daily Prescribed 11 Aug	11-14 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.

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

GMC and Dr Barton
Supplementary Report on Patient E

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

Section 12 line 5	"..in the Wessex Protocol'..." corrected to " ... in the "Wessex Protocols"...".
Section 18 line 8	"..Constabulary II consider the prescription..." corrected to '..Constabulary I consider the prescription..."
Section 20 line 3	". ..required palliative care following her and was..." corrected to "required palliative care and was...".

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient F

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. **Course of events**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hyoscine sc via syringe driver 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

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

General Medical Council and Dr Jane Barton
Supplementary Report on Patient F

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

3.

Section 5.1 line 3	"Patient Fdied..." corrected to "Patient F died...".
Section 5.1 line 8	"...gout, hypertension, renal impairment which.." corrected to " ..gout, hypertension and renal impairment which..."."
Section 5.1 line 11	"..for a treatment of leg ulcers." Corrected to "...for treatment of leg ulcers."
Section 5.3 line 11	"A further note (p511) states by Surgeon Captain ..." corrected to "A further note (p511) by Surgeon Captain...".
Section 5.5 line 3	"..which was improving sick, sinus syndrome/atrial fibrillation,.." corrected to ".. which was improving, sick sinus syndrome/atrial fibrillation..."
Section 7 line 2	" Investigation into these .." corrected to "Investigation of these..."
Section 7 line 5	".. appeared to be stable the assessment by.." corrected to "..appeared to be stable. The assessment by..."
Section 7 line 6	".. leading to Dr Lord to include that..." corrected to "..leading Dr Lord to conclude that ..."
Section 7 line 11	"...with a view as to assessing.." corrected to "..with a view to assessing..."
Section 11 line 1	"The prescription of diamorphine and midazolam and hyoscine (undated).." changed to "The prescription of diamorphine and midazolam (undated) ..."
Section 11 line 4	"It is possible this was prescribed as treatment..." changed to "It is possible that diamorphine was prescribed as treatment..."
Section 13 line 5	"..requiring further sedative and drugs.." corrected to "..requiring further sedative drugs..."
Section 14 line 7	"... midazolam by subcutaneous." corrected to ".. midazolam by subcutaneous infusion."
Section 14 line10	".. chest pain there should.." corrected to "..chest pain when there should.."

have been a physical examination and investigations undertaken and recorded in medical notes.

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient G

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

4. This report is based on my review of the following documents; medical records of Patient G; witness statements of Charles Farthing, Code A, 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

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

As required prescription

Prescription	Administered
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)

Prescription	Administered
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.

Code A

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

2 June 2009

GMC and Dr Jane Barton
Patient G

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors.

2. | | |
|---|---|
| Section 2 line 4" | ... service I undertook research into the effects of drugs in older people." changed to "....service. I <u>undertake</u> research into the effects of drugs in older people." |
| Section 5 line 1 | "I have no major changes to make.." corrected to " I have <u>two</u> changes to make.." |
| Section 6 | *As required prescription* "Oramorph 2.5-10mg" corrected to "Oramorph 5-10mg" |
| Section 9 line 1 | "Although review of the notes suggests it was clear that Patient G.." corrected to "Although review of the notes suggests Patient G.." |
| Section 14 line 4 | "...of the Responsible Consultant,.." corrected to "... of the responsible Consultant, .." |
| Section 17 line 5 | "I consider the prescription and administration of." changed to "I consider the prescription of...." |

3. I have reviewed the witness statement of Dr Hamid (dated 25 April 2005) in which he recorded the cause of death as bilateral bronchopneumonia and his opinion that Patient G's death was due to natural causes. No post mortem drug analyses were reported as being undertaken. I have not changed my opinion stated in section 16 of my report dated 21 April 2009 which was as follows: *"In my view it is likely that Patient G died from midazolam and diamorphine induced respiratory depression in combination with bronchopneumonia. In my opinion it is very likely that the administration of midazolam and diamorphine at the doses used led to him dying earlier than would have been the case had he not received these drugs."*

4. I have been asked to comment on the appropriateness of the prescriptions by Dr Barton on 25 September 1998 of diamorphine 40-200mg/24hr and midazolam 20-200mg/24hr. A previous prescription by Dr Barton had written a prn (as required) prescription for diamorphine 20-200mg/24hr and midazolam 20-80mg/24hr on 21 September. This prescription on 25 September did not change the maximum dose of diamorphine that could be administered but set a lower dose of 40mg/24hr to be administered by nursing staff. The prescription on 25 September set a lower dose of 20mg/24hr midazolam to be administered by nursing staff and increased the maximum dose of midazolam that could be administered from 80mg/24hr to 200mg/24hr.

5. The medical records do not record the reasons why Dr Barton made these changes to the prescription, and it is difficult to understand why the original prescription was changed by Dr Barton. Dr Barton recorded in the notes on 24 September that Patient G's pain was *"just controlled"* when receiving 20mg/24 hr diamorphine. I consider the prescription of diamorphine on 25 September was in too wide a dose range and hazardous. I consider the prescription of midazolam on 25 September was inappropriate, in too wide a dose range and excessively high. The medical and nursing notes do not record that Patient G had uncontrolled restlessness on 24 or 25 September and no justification is recorded in the medical notes for increasing the administered dose of midazolam from 60mg/24hr to 80mg/24hr and then 100mg/24hr. The Wessex Protocols recommended a dose range of 10-

60mg/24hr for terminal restlessness. The prescription of midazolam up to a dose of 200mg/24hr was inappropriate and excessively high and not indicated by the information recorded in the medical records. If Patient G was deteriorating and experiencing increasing pain and restlessness this should have led to Dr Barton examining Patient G and recording in the medical notes the cause of any deterioration and the rationale for increasing the dose of diamorphine and midazolam administered by nursing staff. The information in the medical notes does not contain any record of such assessment taking place on 25 or 26 September.

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

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

Code A

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Barton
Report on Patient H

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

2. I am Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics, and General Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service. I undertake research into the effects of drugs in older people. I am editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

4. This report is based on my review of the following documents; medical records of Patient H; statements of Dr Code A, Dr Ewenda Peters, Code A 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

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

Regular prescriptions

Prescription	Administered
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"

Prescription	Administered
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

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

GMC and Dr Barton
Supplementary Report on Patient H

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 6. The comment in my report "Illegible prescription by another doctor" is written below the prescription for Oramorph 10mg/5ml 20mg nocte prescribed 15 Oct. I wish to clarify that this refers to a separate prescription not the Oramorph prescription.

3. Section 12 line 9 "...who has only received two.." corrected to "..who had only received two.."

4. 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

H

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Barton
Report on Patient I

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people. I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. Course of events

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

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

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

5.3 She underwent surgery under spinal anaesthesia on 20 March 1999 with insertion of a right dynamic hip screw. An entry by an SHO post-operative review on 20 March 1999 at 2130 hours (page 359) notes *"oozing from the wound with swelling of the right thigh."* The impression was of a potential bleeding vessel in the wound with risk of a compartment syndrome and hypovolaemia developing. She was monitored and received a blood transfusion. On 21 March 1999 at 2300h(page 371) the notes record a review by 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 2 tablets 11/12 April	 Not administered

Opinion on Patient Management

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

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

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

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

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

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

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

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

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

Summary of Conclusions

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

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

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

General Medical Council and Dr Barton
Supplementary Report on Patient I

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2.

Section 2 line 4	"... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."
Section 5.1 line 2	"..transferred to Dryad Ward, Gosport War Memorial Hospital on 20 March 1999." Corrected to "..transferred to Dryad Ward, Gosport War Memorial Hospital on 26 March 1999."
Section 5.6 line 1	"An entry in the notes by Dr Reid Consultant in Elderly Medicine is dated 23 March..". This note entry by Dr Reid was written on 24 March as it comes after the referral dated 14 March 1999 and Dr Reid confirms that he assessed Patient I on 24 March (p301).
Section 5.6 line 3	"...Patient I received.... three doses of 5mg morphine on 20 March and two doses of 5mg morphine on 21 March." changed to "...Patient I received.... two doses of 5mg morphine on 20 March and one dose of 5mg morphine on 21 March." This does not affect any the opinions or conclusions in my report.
Section 5.9 line 1	"... admission to Dryad Ward note on 20 March.." corrected to " ...admissions to Dryad Ward on 26 March...".
Section 6	*As required prescriptions* "Oramorph 10mg/5ml sc 2.5-5mg 31 Mar 2.5mg Prescribed 26 March 11 Apr 2.5mg" Corrected to "Oramorph 10mg/5ml 2.5-5ml 31 Mar 5mg Prescribed 26 March 11 Apr 5mg"
Section 10 line 4	"It would not be usual for a patient.. corrected to " It would be unusual for a patient..."
Section 12 line 2	"....dose of oral morphine (40mg daily) that she was receiving" corrected to "..dose of oral morphine (45mg; daily 40mg MST, one 5mg as required Oramorph dose) that she was receiving..."
Section 12 line 5	"The 40mg or oral morphine.." corrected to "The 45mg of oral morphine...."
Section 12 line 6	".. approximately 15-20 mg diamorphine.." corrected to "approximately 15-23 mg diamorphine..."
Section 12 line 11	"..have been 20-30mg/24hr." corrected to "..have been 20-35mg/24hr."
Section 12 line 12	".. dose greater than 30mg/24 hr.." corrected to "..dose greater than 35mg/24hr..."
Section 12 line 14	".. 80mg/24hr four times greater .." corrected to "..80mg/24hr two and a half to four times greater..."
Section 13 line 6	".. reduction in dose by Dr Reid on 12 March.." corrected to "..reduction in dose by Dr Reid on 12 April..".

3. 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

b

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

General Medical Council and Dr Jane Barton
Report on Patient J

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. **Course of Events**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug therapy received at Gosport War Memorial Hospital

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

Once only drugs

Diamorphine im 10mg	26 Aug 1800h
Verbal message, subsequent prescription by Dr Barton date unclear	

As required prescriptions

Gaviscon 10ml	25 Aug 12 00h
Prescription date unclear (Doctor other than Dr Barton)	
Temazepam 10-20mg	24 Aug 22 10h 10mg
Prescribed 24 Aug	25 Aug 22 05h 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 dos es 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 dos es administered unclear if 10 or 20 mg
Diamorphine sc via syringe driver	30 Aug 1445h 40mg/24hr
40-200mg/24hr	31 Aug 1545h 40mg/24hr
Prescription date not written	1 Sep 1545h 40mg/24hr
	1915h increased to 60mg/24hr
	2 Sep 1540h 90mg/24hr

Midazolam subcut via syringe driver	30 Aug 14 45h	20 mg/24hr
20-80mg/24hr	31 Aug 1540h	20 mg/24hr
Prescription date not written	1 Sep 1545h	40 mg/24hr
	1915h	increased to 60 mg/24hr
	2 Sep 1540h	80mg/24hr
Hyoscine subcut via syringe driver 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 duties as an expert, as set out at paragraph 57 of my Generic Report.

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

General Medical Council and Dr Jane Barton
Supplementary Report on Patient J

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 1 line 7 "...too wide a dose range and were there inappropriate..." corrected to "....too wide a dose range and were therefore inappropriate.....

3. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

4. Section 5.1 line 4 (p30) corrected to (p31)
   Section 5.3 line 2 (p44) corrected to (p45)
   Section 5.5 line 5 *"In view of premorbid sate.."* corrected to *"In view of premorbid state.."*
   Section 10 line 8 "..should not be undertaken in cardiac.." corrected to "..should not be undertaken if cardiac..."
   Section 18 line 7 "..between 31 and 2 September." corrected to ".. between 31 August and 2 September"

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient K

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

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

5. Course of events

5.1 Patient K was an 88 year old lady who was admitted to Queen Alexandra Hospital, Ward 3 on 9 October 1999 with an episode of acute confusion. Some of the medical records relating to this admission appear not to be in the copy of medical notes provided to me but a letter by Dr Taylor, Clinical Assistant in Old Age Psychiatry summarises Patient K's problems at this time (page 29, 30). Dr Taylor saw Patient K on behalf of Code A 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 Code A to review Patient K.

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

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

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

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

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

Once only drugs

Chlorpromazine 50mg im	Date unclear November 0830h

Regular prescriptions

Thyroxine 100ug od Prescribed 21 Oct	22 Oct-17 Nov. Not administered 2 Nov or 18 Nov onwards
Frusemide 40mg od Prescribed 21 Oct	22 Oct – 17 Nov. Not administered 18 Nov onwards
Amiloride 5 mg od Prescribed 1 Nov	2 Nov-18 Nov. Not administered 19 Nov onwards
Trimethoprim 200mg bd Prescribed 11 Nov	11 Nov – 15 Nov. Then discontinued
Fentanyl 25ug skin (every three days) Prescribed 18 Nov	18 Nov 0915h

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

Opinion on Patient Management

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

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

9. Patient K was intermittently aggressive on the ward. Aggression is a well recognised and troublesome symptom in some patients with dementia and is often worse when patients are in a new environment such as a hospital ward. It can also be precipitated or worsened by other medical problems particularly chest or urinary tract infections. Thiordiazine had been prescribed on 11 November. Neuroleptic drugs such as thioridazine are commonly used to

try and improve symptoms of aggressions in people with dementia. I would consider this was an appropriate treatment approach.

10. When her aggressive behaviour persisted a request for consultation was sent to Code A Consultant Old Age Psychiatrist who had previously assessed Patient K. This was appropriate and good medical practice. Dr Taylor, a member of Code A 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 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.

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

GMC and Dr Jane Barton
Patient K

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

3. Section 5.2 line 8 "..evidence to make diagnosis of myeloma.2 corrected to "..evidence to make a diagnosis of myeloma."

   Section 5.4 line 5. "...rehabilitation and had arranged a transfer to.." corrected to "..rehabilitation and that he had arranged a transfer to..."

   Section 5.6 line 6 *"..supervision with W and D help with.."* corrected to *"..supervision with W* (washing*) and D* (dressing) *help with.."*

   Section 5.7 line 2 ".. and that needed thioridazine." Corrected to "..and had been treated with thioridazine."

   Section 5.7 lines 2/3 "She was on treatment.." corrected to "She was receiving treatment ..'

4. I have been asked to comment on the prescription of as required Oramorph on 21 October 1999 by Dr Barton which I did not comment on in my previous report. Oramorph was not administered by nursing staff from this prescription. The medical and nursing notes contain no evidence that Patient K was in pain on admission to Dryad ward. Dr Barton did not record the indication for prescribing opiates to patient K. Patient K had symptoms of confusion and agitation but morphine was not an appropriate treatment for these symptoms. Dr Barton did not record the symptoms for which the Oramorph should have been administered by nursing staff. There was therefore a risk that the Oramorph could have been administered by nursing staff for inappropriate reasons such as insomnia, agitation or restlessness. In my opinion the prescription of oral morphine by Dr Barton on 21 October was not consistent with good medical practice as the prescription did not serve patient K's needs.

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

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

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

21 April 2009

GMC and Dr Jane Barton
Patient L

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

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

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

4. This report is based on my review of the following documents; medical records of Patient L; statements of Code A 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 Code A Code A spoke to patient L's family and explained her poor prognosis and the rationale for making her not for resuscitation or care on an intensive care unit if she deteriorated (p200). On 14 May she was reviewed by an orthopaedic specialist as it was thought she might have dislocated her left shoulder. This was found to be subluxation of the shoulder and no active intervention was needed (page 202). On 18 May the notes record the medical team liaised with Gosport War Memorial Hospital (page 204) and that she was tolerating her nasogastric feeding, was recovering from her aspiration pneumonia and showing improvement in her orientation, speech and strength, but was faecally incontinent

and had a urinary catheter in place. The transfer note states that patient L was for rehabilitation (p70). On transfer she was taking prescribed aspirin, enalapril, digoxin, isosorbide mononitrate (Imdur) and "as required" subcutaneous diamorphine 5mg.

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

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

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

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

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

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

Regular prescriptions

Digoxin elixir 1.2 ml od 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 Code A 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.

Code A

GARY A FORD

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

Professor Gary A Ford, FRCP
Consultant Physician

25 May 2009

GMC and Dr Jane Barton
Patient L

1. This report is supplementary to my previous report dated 21 April 2009 and is made for the purpose of correcting drafting errors. All page number references in the report refer to the -123- format.

2. Section 2 line 4 "... service I undertook research into the effects of drugs in older people." changed to " ....service. I undertake research into the effects of drugs in older people."

Section 6	As required prescriptions		
	"Oramorphine 10mg/5ml	20 May 1430h	5mg
	2.5-5ml	1830h	2.5mg
	Prescribed 20 May	2245h	2.5mg
		21 May 0735h	2.5mg"
	Corrected to		
	"Oramorphine 10mg/5ml	20 May 1430h	5mg
	2.5-5ml	1830h	5mg
	Prescribed 20 May	2245h	5mg
		21 May 0735h	5mg"

Section 16 line 10	"..patient L, as the oramorphine was administered for abdominal pain and there had not been an adequate..." changed to "..patient L, as there had not been an adequate..."
Section 19 line 1	"In the preceding 24 hours patient L had received 27.5 mg oramorphine (2.5+2.5+25+10+10)." corrected to "In the preceding 24 hours Patient L had received 35mg Oramorphine (5+5+5+10+10)."
Section 19 line 2	".. one third to a half of the dose of morphine received i.e. 9mg-14mg over 24 hours." corrected to ".. one third to a half of the dose of morphine received i.e. 12-18mg over 24 hours."
Section 19 line	"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." changed to "The diamorphine infusion was commenced at 20mg/24hr and this was an acceptable starting dose if continuing opioid drugs by using subcutaneous infusion was appropriate and Patient L's pain was uncontrolled on Oramorphine. This diamorphine dose was about 40% greater than the equivalent dose of oramorphine that Patient L had received."
Section 27 line 1	"..very likely shorten Patient L's.." corrected to ".. very likely shortened Patient L's.."

3. I have been asked to comment on whether the entry in the medical records made by Dr Barton on 20 May 2008 (section 5.8 of my report) could have been made without her seeing Patient L. In my opinion it would have been possible for Dr Barton to write the information in the notes without seeing Patient L through review of the previous medical records and information obtained from nursing staff if they had recorded a Barthel assessment.

4. 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