FFW/96/05

Dear Mr Rank,

You might like to know that I was Mr Cunningham's N-O-K from the time my mother died (1989) until a few weeks before he passed away (1994).

What happened was that he redesignated this to his house-keeper following a brief spat I had with him due to the frequent changes of Rest / Nursing Home in his last few months. I was still his closest and most concerned relative throughout.

Code A

RESPONSE

Patient G. Pg

PORTSMOUTH HealthCare NHS TRUST

General Information

Surname ..Code A.....	Date of Birth
Forenames ....Code A.....	*Day* *Month* *Year*
Likes to be known as ..Code A.....	Code A
Address Code A	Religion .....
.....	Ethnic Origin ...White.....
Tel No: Code A ..... Post code	Allergies .....

Next of Kin	Carer/Contact/Confidante
Surname ..Code A.....	Surname .....
Forenames ..Code A.....	Forenames .....
Address	Address .....
Code A	.....
Post code	Post code .....
Relationship	Relationship .....
Tel Nos: Home ..Code A.....	Tel Nos: Home .....
Work	Work .....

Code A

Useful Information

Code A

4°6 his from 22/9/99.

Hospital Information	Community Information
Hospital: GWHH Tel No:	District Nurse: Tel No:
Hospital No: Code A	G.P.: Dr Crocock Tel No:
Named nurse: Yvonne Shaw	Bank Holiday Tel No:
Ward: PRYAD Tel No:	Weekends: Tel No:
Consultant: Dr Lord	Twilight Nurse: Tel No:
Manager: Sis Hamilton Tel No:	Manager: Tel No:

CPN Code A

Social Worker Code A

Patient code

Code					

Defence invited us to look at this on 22/07/09 – intend to read this out.

WITNESS STATEMENT

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

This Statement consisting of 6 pages 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.

DATED this 1st day of June 2009

Signed .. Code A

DR JOHN ALBERT HENRY GRUNSTEIN

I am Dr John Albert Henry Grunstein of Beacon House, Crookhorn Lane, Soberton, Hampshire. I was (voluntary erasure) a Registered Medical Practitioner, and was formerly a Consultant Physician specialising in elderly medicine, employed by the Portsmouth District Health Authority and successor Trust organisations. I retired from full time practice in 2000.

As indicated in my statement to the Police of 4th November 2005 I qualified at the London Hospital, Whitechapel in 1963. I hold the qualifications of MBBS, MRCS, and LRCP, together with the further qualifications of MRCP and FRCP (London). Following qualification, I was a Senior Registrar in Geriatric Medicine at Guy's Hospital before being appointed in 1971 as Consultant Physician in Geriatric Medicine in Portsmouth. Although I retired from full time practice in 2000 I continued to work for a time as a part time locum in various capacities until 2006.

Signed..... Code A .. Witnessed.... Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

Again, as I indicated in my Police statement, shortly after I was appointed, I initiated an out-patient service at the Gosport War Memorial Hospital. In addition, I shared responsibility for the continuing care wards in Gosport which were initially sited in the Northcote and Redcliffe Annexes of the Hospital. I believe I shared Consultant responsibilities for these Annexes with Consultant, Dr Bob Logan.

Initially my responsibilities at Gosport included carrying out out-patient clinics, and visiting the GP Wards, when asked to see patients admitted by local General Practitioners. As I have indicated, I shared responsibility for the medical care of the patients on Northcote and Redcliffe Annexes.

GP clinical assistants provided day today clinical care and dealt with emergencies. Elderly medicine consultants and registrars were available for telephone advice and occasional emergency visits. It was more usual to transfer patients with difficult problems back to the DGH.

From my appointment in 1971 I saw a number of Clinical Assistants come and go at the Hospital. In due course, when the post became vacant, Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Hospital – in March 1988. Indeed, I believe that she was the only applicant for the post at the time. I think we were very glad to get someone who had an interest in elderly medicine, who had a liking for frail, elderly patients, and who was competent. Unfortunately, in my experience there were others involved in elderly medicine who were less competent, reliable and dedicated than Dr Barton. For example, when asked to see a patient one might have the impression that they were somewhat reluctant to do so. Dr Barton was certainly in the category of a good Clinical Assistant.

As a consultant in Geriatric Medicine I did not send patients to Gosport whose medical needs were unsorted or where rehabilitation had realistic prospects for discharge from hospital. This was because fundamentally it was a long stay or so called slow stream unit not equipped to deal with patients requiring this type of active management. Thus patients sent to Gosport were in the main those we did not think could be discharged to their own homes or residential homes.

Signed.. Code A ..... Witnessed.. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

Exceptions might be those with large sores requiring lengthy healing and those awaiting transfer to alternative accommodation.

Over the period 1988 to 1992, when I ceased to have responsibilities in relation to Gosport, I think the needs of patients did not alter that much. I, and the other Consultants, chose to send patients to the Hospital who needed care, as opposed to investigation and very active treatment. The patients we admitted there were not those in need of rehabilitation, diagnosis and active medical management. We would have admitted patients there because we had concluded that there was no other place for them to go, and they were unlikely to improve. Geriatricians and other specialists need to keep empty beds in District General Hospitals (DGH) so that it is always possible to admit emergencies. None the less I resisted attempts to fill vacancies in our Gosport beds with unsuitable patients, when there was pressure on DGH beds, for the reasons outlined above.

I recall that when I arrived in 1971, some of the patients had been there for many years, inevitably due to the initial unsuitable selection for the unit.

I believe that in 1988 Dr Barton as Clinical Assistant was not likely to have been required to care for patients with technically demanding medical needs on a day-by-day basis. I felt that Dr Barton was able to do the amount of work required of her at that time within the allocated sessions. (I have been reminded that this was 4 sessions to include out of hours work). I believe the wards were visited daily, new patients were briefly clerked and there were weekly ward rounds with the consultant. I think we alternated both consultants and annexes.

In working with Dr Barton, I felt I was in the presence of someone who knew her stuff. I am conscious that Dr Barton did not write much by way of medical records. However, I felt she was doing a very reasonable job. It is fair to say that in my last years as a Consultant we had much better notes in long stay units because we had doctors there who were expected to create much more detailed notes. However, I believe that by the time I retired we would have effectively had 1.5 doctors to cover what Dr Barton was responsible for at Gosport.

Signed. Code A ..... Witnessed. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

As a comparison Kingsclere Ward at St Mary's Hospital was a double ward with acute rehabilitation patients on one side, and long stay beds on the other. I think there were about 40 beds on the Kingsclere Ward. By comparison with Gosport, I remember being surprised that we were able to fund a full time medical appointment to look after the medical needs of those patients.

Over the period of Dr Barton's appointment until 1992, I thought that in the context of the type of patient coming to the Hospital, the patients were being properly and adequately assessed on admission by Dr Barton. At the same time, I knew that it was impossible to insist on the dotting of Is and the crossing of Ts which might seem to have been required by the job description.

I felt it was extremely important for the referring unit (preferably the consultant) to write usually no more than about a paragraph with essential information for the admitting doctor at Gosport, as I knew how difficult it was for the receiving doctor to go through what would be a very thick set of notes and distil the most pertinent information. I am afraid this did not always happen.

In my view, the writing of a standard (House Physician type) clerking in the notes on the admission of the patient was inessential and more than one should expect of a Clinical Assistant. Although I was not at the War Memorial Hospital after 1992, my understanding was that the Wards there started to be used for patients transferred for rehabilitation. Certainly in the 90s there was a great deal of pressure on District General Hospitals to get patients out of hospital who were perceived to be bed blockers. It would have been patently obvious that the work at the War Memorial Hospital would have become much more onerous, with more patients being taken on for rehabilitation.

When I retired, I was involved in the transformation of the long stay ward in Petersfield to a Rehabilitation Ward. In consequence of this, the GPs who were involved in providing care were given more sessions. None the less there were protests from the GP's, nurses and ancillary staff at the number of admissions. Another difficulty was the tendency for patients to arrive from the DGH late in the day. This causes particular difficulties for GPs.

Signed.... Code A ..... Witnessed.. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

After my close Gosport involvement ceased in 1992, I was not directly aware of acutely ill patients being sent down to Gosport, although it is possible that I might have been made aware of disquiet from Dr Barton that patients were being transferred to the Hospital who were too ill. Certainly I would never countenance the transfer of an ill patient – ie someone in need of active management. The transfer of an ill patient would only be appropriate where everything possible had already been done for them at the District General Hospital. Geriatricians recognise that the act of transferring a frail ill patient often has a deleterious effect on their health. Mortality rates amongst this group are increased.

I have a recollection of being aware of some sort of problem on one of the Annexes with one or two of the nursing sisters there at some point before I ceased working at Gosport in 1992. I do not, recall any Nursing Staff expressing concern about the use of opiate medication and syringe drivers.

I understand that Dr Barton came to employ a method of prescribing for patients on an anticipatory basis – where it was perceived that the patient might require medication at some point in the near future. I can see that from a background in general practice, someone might be concerned to consider provision of medication for example via syringe driver in this way, in anticipation of the development of pain for example, over a weekend when a doctor might not be immediately available.

I have attempted to recall relevant matters once the (often difficult) decision had been made that a patient was dying and suffering and that active treatment with a curative aim should be abandoned in favour of palliative care, or that a patient was suffering. In these circumstances the question of opiate prescription arose. Oft times a dose was arbitrarily prescribed with instructions to repeat it at set intervals or on an as necessary basis. There was a period when rules governing dose titration were much more haphazard than they later became. I cannot recall when dose titration became protocol governed (if ever) in our department. I do recall being concerned that sometimes patients were left without effective analgesic cover.

Signed..... Code A ..... Witnessed. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

In these circumstances the early use of a syringe driver might well be appropriate.

The dose range (Diamorphine 20-200mg by driver has been quoted) appears wide and the starting dose a little high, if the patient had not previously been on a codeine like preparation, but with that proviso if the titration was expertly and carefully supervised I cannot condemn it. Indeed it may have been meritorious.

In any event, knowing Dr Barton, I believe that she would have adopted such a practice only in the best interests of her patients.

I recall that we had policies whereby it was not necessary to call out a doctor from the Surgery or at night in order to confirm death if a patient had died. The nursing staff could then confirm the death. I believe that this was permitted at the War Memorial Hospital. I do not recall a specific phrase being utilised to the effect that the doctor was happy for the Nursing Staff to confirm death, but there would be nothing odd about this. Indeed I do recall that some such instruction was sometimes written in the notes, if the Clinician perceived that the patient might die.

Of Dr Barton, I would say that she was someone in whom one was able to place confidence. She was intelligent and knew her stuff. She could be quite blunt on occasion, but she looked after her elderly patients in a way which I felt was caring and expert. We greeted the allegations which appeared in the media – to the effect that patients were put on drugs effectively as a form of euthanasia, with disbelief. I refused to believe any such allegation of Dr Barton, and any such suggestion does not fit with the person I know.

She was assiduous in attending the educational training sessions provided for her upon her appointment and subsequent sessions described in my statement to the police.

We thought ourselves lucky to have her as a colleague in Gosport.

Signed.... Code A ... Witnessed.. 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: GRUNSTEIN, JOHN ALBERT HENRY

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

This statement (consisting of 2 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: J.A.M Grunstein Date: 02/06/2005

I am a retired Consultant Geriatrician.

From 1990 until January 2000 I was the Consultant Geriatrician for Dickens Ward at the Queen Alexandra Hospital in Portsmouth .

I have been asked to detail my involvement with the patient Robert WILSON Code A Code A who was admitted to Dickens Ward on September 23rd 1998 (23/09/1988).

I had no involvement with this patient between the 19th September 1998 (19/09/1988) and 11th October 1998 (11/10/1988). I was away on holiday between these dates.

I have checked the medical records and I cannot find any entries that I have made relating to this patient.

Whilst I was on leave my ward rounds would have been performed by a Registrar.

There would also have been nominal Consultant cover via the duty Consultant.

Prior to going on leave I would have arranged for a Registrar to cover the wards.

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: GRUNSTEIN, JOHN ALBERT HENRY

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED MEDICAL CONSULTANT

This statement (consisting of 6 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: J GRUNSTEIN Date: 04/11/2005

I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000.

My qualifications and CV are as follows:

1. Date of Birth: Code A
2. Place of Birth: London
3. Medical School: London Hospital, Whitechapel 1968-1963
4. Registrable Medical Qualifications:
    a. 1963 MRCS, LRCP
    b. 1963 MB, BS Lond.
5. Higher Registrable Medical Qualifications:
    a. 1968 MRCP Lond.
    b. FRCP Lond.
6. Relevant Appointments:
    a. 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital
    b. 1971 Appointed Consultant Physician in Geriatric Medicine to the Portsmouth Health District and successor organizations.
    c. 2000 Retired.
7. Since retirement I have continued to work as a part time locum in various capacities.
8. *Responsibilities in Gosport:*
    a. Shortly after I was appointed I initiated an outpatient service in Gosport.

b. I shared responsibility for the continuing care wards in Gosport. Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.

c. In 1992, I believe, I gave up all responsibilities in Gosport.

Dr. Jane BARTON applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants . This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment, I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr. BARTON was an experienced doctor with her own general practice in Gosport. I remember her as being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed in similar capacities). She had a liking for these very frail elderly patients. Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attended ward rounds, outpatients and day hospital sessions in order to get "hands on" training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as "in depth".

Dr. BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I recall her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Program - Elderly. (CATPE). This was a series of lectures given in the training of most aspects of elderly medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would also have heard about the

"analgesic ladder" which describes the incremental use of drugs to control pain and distress. The analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

Routine Business Ward Rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients. I would expect my advice to be followed as ultimate responsibility for patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr. BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON. Dr. PETERS and others from her practice worked on the wards while she was unavailable. My department didn't vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.

Admissions to all elderly medicine continuing care wards (long stay wards) were authorized by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

During their time in hospital the patients own General Practitioner had no responsibility or supervisory rights.

During the time that I had specific responsibilities in Gosport (1971-1992). Patients

transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in Gosport.

Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

The bulk of patients transferred to Gosport were considered too incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

The survival time of new admissions was short (on average less than a month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.

I believe that allegations have been made concerning the quality of care given by Dr BARTON. I have never seen any of these in writing, but I have had informal occasional chats with colleagues (no more than gossip) and come across references in the media. To say that I was incredulous is to understate my position.

I considered Dr BARTON to be an outstanding, caring and compassionate Physician.

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: GRUNSTEIN, JOHN ALBERT HENRY

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: RETIRED CONSULTANT

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: J GRUNSTEIN Date: 19/01/2006

I am Dr John Albert Henry GRUNSTEIN, a retired Medical Consultant and previously worked the Queen Alexandra and Gosport War Memorial Hospitals, Hants.

I worked for a time with Dr Jane BARTON.

I produce as exhibit JAHG/1 Dr BARTON's application for the post of Clinical Assistant in Geriatric Medicine dated 17/3/88, a letter from Miss K SOUTHWELL , Portsmouth and South East Hampshire Health Authority of 18th March 1988 to me and my correspondence of 19th April 1991 confirming that Dr BARTON received ten half day sessions from 27th - 31st November 1989.

I cannot recall why she was trained a year and a half after her appointment. The letter is addressed To whom it may concern' so I think there may have been something in the GP contract which required additional formal training.

I do not believe I ever interviewed Dr BARTON formally.

D6

Dr Ian Reid
Clinical Director
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
28th January 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I feel that this is an opportune moment to examine my post for a number or reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration .These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hopsitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago.The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. . There is no such thing as Continuing Care nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.
At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.
In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities.
It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis. In addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I consider appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only serves to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely

Jane Barton

Copy to Dr A Lord
Max Millett

PORTSMOUTH
HealthCare
TRUST

Consultant Geriatricians
Specialist Registrars
Professor Severs
Ward Managers Jersey House/George ward/Jubilee House/Briarwood ward/ Shannon ward/Cedar ward/Daedalus ward/[redacted]
Chrissie Immins & Medical Secs

Our ref
DJ/LB
Your ref
Date
16 February 2000
Ext
Code A

Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post acute patients. A policy offering guidance is enclosed. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help.

Yours sincerely

Code A

DAVID JARRETT FRCP

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY

EMERGENCY USE OF COMMUNITY HOSPITAL BEDS

Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals. Some continuing care beds remain underutilised in Petersfield Community Hospital, Gosport War Memorial Hospital and St Christopher's Hospital Fareham. These beds have no resident medical staff and weekly, or less than weekly, Consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

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

1 Waiting for placement having had a full care management assessment
2 Medically stable with no need for regular medical monitoring
3 No outstanding investigations or need for close medical or nursing monitoring
4 No interventional therapy such as intravenous lines or need for IV medication
5 The patient lives near the community hospital and/or are willing to go there for temporary placement awaiting permanent placement
6 The patient and family consent to the move
7 The patient, family and staff of referring ward clearly understand that the placement is in a post acute bed, not continuing care bed; this placement does not entitle patient to NHS continuing care
8 GP beds in community hospitals are independent of the department's continuing care provision and their flexible use should be negotiated with the patient's general practitioner

This policy will be operational from 16.2.00 and will be reviewed after one month. Linda Butchers in the Elderly Medicine Offices will keep a list of names of patients from referring ward and consultant, discharge destination and any problems encountered.

g:\linda\dj\comm.hosp.beds\9.2.00

Dr David Jarrett
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
22nd February 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

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

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

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

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

As a result I am unable to do the clinical Assistant job to a safe and acceptable standard which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition my staff are subjected to ever increasing pressures from patients and relatives , causing stress and sickness levels to rise.

I would also question the term understilisation in a unit which is handling approximately 40% or the continuing care dontby Elderly Services at this time.

I hope you will give this serious consideration,

Yours Sincerely

PORTSMOUTH
HealthCare
NHS
TRUST

Dr Jane Barton
Clinical Assistant
Elderly Medicine
Gosport War Memorial Hospital
Gosport
Hants

DJ/MW

07 March 2000

Code A

Dear Jane

RE: CLINICAL ASSISTANT ELDERLY MEDICINE GWMH

Thank you for your letter dated from the 22nd February making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues, we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to the move.

I understand that the continuing care workload at Gosport War Memorial Hospital is quite large certainly in comparison with other community hospitals. Gosport is busy in other areas with an ever increasing number of referrals from Haslar hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsula. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns.

Yours sincerely

Code A

David Jarrett

Peter King
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Tel 023 92583333
28th April 2000

References:
a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Dr David Jarrett (copies of both letters attached)

Dear Peter,

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

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

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

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.

Yours sincerely,

Jane Barton

Copies to:
M Millett
Dr I Reid
Dr A Lord

PORTSMOUTH
HealthCare
NHS
TRUST

Private & Confidential

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
Code A

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Peter King has formally responded.

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

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Fiona Cameron
Divisional General Manager

PARACETAMOL

(Acetaminophen)

Indications: mild to moderate pain, pyrexia

Cautions: hepatic and renal impairment, alcohol dependence; **interactions:** Appendix 1 (paracetamol)

Side-effects: side-effects rare, but rashes, blood disorders; acute pancreatitis reported after prolonged use; **important:** liver damage (and less frequently renal damage) following **overdosage**, see Emergency Treatment of Poisoning, p. 20

Dose: *by mouth*, 0.5–1 g every 4–6 hours to a max. of 4 g daily; CHILD 2 months 60 mg for post-immunisation pyrexia; otherwise under 3 months (on doctor's advice only), 10 mg/kg (5 mg/kg if jaundiced); 3 months–1 year 60–120 mg, 1–5 years 120–250 mg, 6–12 years 250–500 mg; these doses may be repeated every 4–6 hours when necessary (max. of 4 doses in 24 hours)

For full Joint Committee on Vaccination and Immunisation recommendation on post-immunisation pyrexia, see section 14.1

Rectal route, see below

Paracetamol (Non-proprietary)

Tablets PoM[1], paracetamol 500 mg. Net price 20 = 11p. Label: 29, 30

Available from APS, Cox, Norton, Sterling Health (*Panadol*[®] DHSS)

Soluble Tablets (= Dispersible tablets) PoM[2], paracetamol 500 mg. Net price 60-tab pack = £2.32. Label: 13, 29, 30

Available from Sterling Health (*Panadol Soluble*[®] DHSS)

Paediatric Soluble Tablets (= Paediatric dispersible tablets), paracetamol 120 mg. Net price 24-tab pack = 82p. Label: 13, 30

Available from R&C (*Disprol*[®] *Soluble Paracetamol* DHSS)

Paediatric Oral Solution (= Paediatric Elixir), paracetamol 120 mg/5 mL. Net price 100 mL = 30p. Label: 30

Note. Sugar-free versions are available and can be ordered by specifying 'sugar-free' on the prescription.

Available from Berk, Norton, Rosemont (*Paldesic*[®] DHSS), Wallace Mfg (*Salzone*[®] DHSS)

Oral Suspension 120 mg/5 mL (= Paediatric Mixture), paracetamol 120 mg/5 mL. Net price 100 mL = 43p. Label: 30

Note. BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol Mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed; sugar-free versions can be ordered by specifying 'sugar-free' on the prescription

Available from Cupal (*Medinol*[®] *Paediatric*, sugar-free), Norton, R&C (*Disprol*[®] *Paediatric*, sugar-free), Rosemont (*Paldesic*[®]), Sterling Health (*Panadol*[®], sugar-free), Warner Lambert (*Calpol*[®] *Paediatric*, *Calpol*[®] *Paediatric* sugar-free)

Oral Suspension 250 mg/5 mL (= Mixture), paracetamol 250 mg/5 mL. Net price 100 mL = 75p. Label: 30

Available from Cupal (*Medinol*[®] *Over 6* DHSS), Hillcross, Rosemont (*Paldesic*[®]), Warner Wellcome (*Calpol*[®] *6 Plus* DHSS)

Suppositories, paracetamol 60 mg, net price 10 = £9.96; 125 mg, 10 = £11.50; 250 mg, 10 = £23.00; 500 mg, 10 = £9.90. Label: 30

Dose: by rectum, ADULT and CHILD over 12 years 0.5–1 g up to 4 times daily, CHILD 1–5 years 125–250 mg, 6–12 years 250–500 mg

Available from Astra (*Alvedon*[®], 60 mg, 125 mg, 250 mg), Aurum (120 mg, 240 mg, 500 mg)

■ Co-codamol 8/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed.

Co-codamol 8/500 PoM[2] (Non-proprietary)

Tablets, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg) Net price 20 = 27p. Label: 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD 6–12 years ½–1 tablet

Available from APS, Cox, CP, Galen, (*Parake*[®] DHSS), Generics, Norton, Sterling Health (*Panadeine*[®] DHSS)

Effervescent or *dispersible tablets*, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 20 = 70p. Label: 13, 29, 30

Dose: 1–2 tablets in water every 4–6 hours, max. 8 tablets daily; CHILD 6–12 years ½–1 tablet, max 4 daily

Available from Roche Consumer Health (*Paracodol*[®] DHSS), Sterwin

Note. The Drug Tariff allows tablets of co-codamol labelled 'dispersible' to be dispensed against an order for 'effervescent' and *vice versa*

Capsules, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 30 = £2.14. Label: 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily

Available from Roche Consumer Health (*Paracodol*[®] DHSS)

■ Co-codamol 30/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed (see preparations above).

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-codamol 30/500 (Non-proprietary) PoM

Tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Available from CP

Kapake® (Galen) PoM

Tablets, scored, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 30-tab pack = £2.26 (hosp. only), 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-cap pack = £7.53. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

1. May be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances; for details see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)
2. May be sold to the public under certain circumstances; for exemptions see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

Sachets (*Kapake Insts*[®]), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-sachet pack = £8.53. Label: 2, 13, 29, 30

Dose: 1–2 sachets every 4 hours; max. 8 sachets daily; CHILD not recommended

Solpadol® (Sanofi Winthrop) PoM

Caplets (= tablets), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-tab pack = £7.90. Label: 2, 29, 30

Dose: 2 tablets every 4 hours; max. 8 daily; CHILD not recommended

Capsules, grey/purple, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £7.90. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 18.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 100-tab pack = £9.48. Label: 2, 13, 29, 30

Dose: 2 tablets in water every 4 hours; max. 8 daily; CHILD not recommended

Tylex® (Schwarz) PoM

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £8.60. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 13.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 90-tab pack = £8.53. Label: 2, 13, 29, 30

Note. Contains aspartame 25 mg/tablet (see section 9.4.1)

Dose: 1–2 tablets in water every 4 hours; max. 8 tablets daily; CHILD not recommended

■ Co-codamol 60/1000

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Kapake® (Galen) PoM

Sachets (*Kapake Insts*[®]), co-codamol 60/1000 (codeine phosphate 60 mg, paracetamol 1 g), net price 50-sachet pack = £8.53. Label: 2, 13, 30

Dose: 1 sachet every 4 hours; max. 4 sachets daily; CHILD not recommended

■ With methionine (co-methiamol)

A mixture of methionine and paracetamol; methionine has no analgesic activity but may prevent paracetamol-induced liver toxicity if overdose taken

Paradote® (Penn)

Tablets, f/c, co-methiamol 100/500 (DL-methionine 100 mg, paracetamol 500 mg). Net price 24-tab pack = £1.05, 96-tab pack = £2.77. Label: 29, 30

Dose: 2 tablets every 4 hours; max. 8 tablets daily; CHILD 12 years and under, not recommended

denotes preparations that are considered to be less suitable for prescribing (see p. vi)

■ With dihydrocodeine tartrate 10 mg

See notes on p. 198

Co-dydramol (Non-proprietary) PoM

Tablets, scored, co-dydramol 10/500 (dihydrocodeine tartrate 10 mg, paracetamol 500 mg). Net price 20 = 31p. Label: 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Available from APS, Cox, CP, Galen (*Galake*[®] DHSS), Generics, Norton, Sterwin

When co-dydramol tablets are prescribed and no strength is stated tablets containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg should be dispensed.

Note. Tablets containing paracetamol 500 mg and dihydrocodeine 7.46 mg (*Paramol*[®] DHSS) are on sale to the public. The name *Paramol*[®] was formerly applied to a brand of co-dydramol tablets

■ With dihydrocodeine tartrate 20 or 30 mg

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Remedeine® (Napp) PoM

Tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Net price 112-tab pack = £12.21. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £7.39. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Net price 56-tab pack = £7.54. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £9.15. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

■ Other compound preparations

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-proxamol (Non-proprietary) PoM

Tablets, co-proxamol 32.5/325 (dextropropoxyphene hydrochloride 32.5 mg, paracetamol 325 mg). Net price 20 = 23p. Label: 2, 10 patient information leaflet (if available), 29, 30

Dose: 2 tablets 3–4 times daily; max. 8 tablets daily; CHILD not recommended

Available from APS, Berk, Cox (*Cosalgesic*[®] DHSS), Dista (*Distalgesic*[®] DHSS), Norton, Sterwin

When co-proxamol tablets are prescribed and no strength is stated tablets containing dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg should be dispensed.

Fortagesic® (Sanofi Winthrop) DHSS CD

Tablets, pentazocine 15 mg (as hydrochloride), paracetamol 500 mg. Net price 100-tab pack = £7.00. Label: 2, 21, 29, 30

Dose: 2 tablets up to 4 times daily; CHILD 7–12 years 1 tablet every 4 hours, max. 4 tablets daily

Dr Ian Reid
Clinical Director
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
28th January 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I feel that this is an opportune moment to examine my post for a number or reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration .These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hopsitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago.The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. . There is no such thing as Continuing Care nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.
At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.
In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities.
It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis. In addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I consider appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only serves to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely

Jane Barton

Copy to Dr A Lord
Max Millett

PORTSMOUTH
HealthCare
TRUST

Consultant Geriatricians
Specialist Registrars
Professor Severs
Ward Managers Jersey House/George ward/Jubilee House/Briarwood ward/ Shannon ward/Cedar ward/Daedalus ward/[redacted]
Chrissie Immins & Medical Secs

Our ref
DJ/LB
Your ref

Date
16 February 2000
Ext
Code A

Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post acute patients. A policy offering guidance is enclosed. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help.

Yours sincerely

Code A

DAVID JARRETT FRCP

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY

EMERGENCY USE OF COMMUNITY HOSPITAL BEDS

Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals. Some continuing care beds remain underutilised in Petersfield Community Hospital, Gosport War Memorial Hospital and St Christopher's Hospital Fareham. These beds have no resident medical staff and weekly, or less than weekly, Consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

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

1 Waiting for placement having had a full care management assessment
2 Medically stable with no need for regular medical monitoring
3 No outstanding investigations or need for close medical or nursing monitoring
4 No interventional therapy such as intravenous lines or need for IV medication
5 The patient lives near the community hospital and/or are willing to go there for temporary placement awaiting permanent placement
6 The patient and family consent to the move
7 The patient, family and staff of referring ward clearly understand that the placement is in a post acute bed, not continuing care bed; this placement does not entitle patient to NHS continuing care
8 GP beds in community hospitals are independent of the department's continuing care provision and their flexible use should be negotiated with the patient's general practitioner

This policy will be operational from 16.2.00 and will be reviewed after one month. Linda Butchers in the Elderly Medicine Offices will keep a list of names of patients from referring ward and consultant, discharge destination and any problems encountered.

Dr David Jarrett
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
22nd February 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

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

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

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

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

As a result I am unable to do the clinical Assistant job to a safe and acceptable standard which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition my staff are subjected to ever increasing pressures from patients and relatives , causing stress and sickness levels to rise.

I would also question the term understilisation in a unit which is handling approximately 40% or the continuing care donby Elderly Services at this time.

I hope you will give this serious consideration,

Yours Sincerely

PORTSMOUTH
HealthCare
NHS
TRUST

Dr Jane Barton
Clinical Assistant
Elderly Medicine
Gosport War Memorial Hospital
Gosport
Hants

DJ/MW

07 March 2000

Code A

Dear Jane

RE: CLINICAL ASSISTANT ELDERLY MEDICINE GWMH

Thank you for your letter dated from the 22nd February making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues, we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to the move.

I understand that the continuing care workload at Gosport War Memorial Hospital is quite large certainly in comparison with other community hospitals. Gosport is busy in other areas with an ever increasing number of referrals from Haslar hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsula. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns.

Yours sincerely

Code A

David Jarrett

Peter King
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Tel 023 92583333

28th April 2000

References:

a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Dr David Jarrett (copies of both letters attached)

Dear Peter,

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

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

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

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.

Yours sincerely,

Jane Barton

Copies to:
M Millett
Dr I Reid
Dr A Lord

PORTSMOUTH
HealthCare
TRUST

Private & Confidential

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
Code A

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Peter King has formally responded.

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

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Fiona Camero
Divisional General Manager

Legal Assessor's Advice – 6th Aug 2009

Dr Jane Ann Barton

Rule 27(2) Advice

1. You have now reached the stage where, under Rule 27(2), you have to consider which, if any, of the remaining unadmitted facts have been proved to your satisfaction, and whether the proved and admitted facts would be insufficient to support a finding of serious professional misconduct. Although at this stage you will produce one determination, Rule 27(2) clearly requires you to go through 2 separate processes.
2. The first part of Rule 27(3) requires you to record your findings in relation to Rule 27(2): the remainder of Rule 27(3) sets out the procedure you should follow if you conclude, either that none of the facts have been proved [here Dr Barton has, of course, made admissions], or that such facts as have been proved would be insufficient to support a finding of serious professional misconduct.

Rule 27(2)(i): The Facts

3. It is not my role to advise you as to the facts, or express any view in relation to them, and I certainly do not do so. You are the judges of both fact and law.
4. Although it is a matter for you, you will doubtless wish to take into account any concessions made by Mr Kark in relation to the strength of evidence on some of the charges.
5. In relation to any given allegation, it is open to you to find part of that allegation proved, and part not proved. This does not require any amendment. For example, it would be theoretically open to you to find 2bi proved, but only in relation to Diamorphine. Other combinations are possible. This means that, when you are considering whether, for example, Dr Barton's actions or omissions in relation to a certain matter were inappropriate, or not in the best interests of the patient, you must be careful to take into account only those matters in relation to which you have made positive findings, or which are admitted. If you do make partial findings, you should make the fact of the partial finding clear in your determination.
6. Rule 24(4) gives the Panel a qualified discretion, at any stage, to amend a charge. If, during its deliberations, the Panel wishes to consider exercising that power, it should return to open session to allow the parties to make representations, and to receive advice from me.
7. You should not regard a given witness as falling into the GMC camp or the Defence camp, simply on the basis of which side called or read that witness. It is for you to decide whether the evidence of any witness assists you one way or another in deciding the relevant issues. You should consider the evidence of Dr Barton herself in the same fair way as you would consider any other evidence in the case.
8. You may, if you see fit, draw a reasonable inference from evidence. But you must not speculate.
9. You are not bound by the opinion of an expert witness. If you find it of assistance, you are entitled to rely upon it in coming to your conclusions. If you do not find it of assistance, then you are entitled to reject it and not place reliance on it. In the end, what you make of expert evidence is a matter entirely for you.

10. You have heard evidence given by way of TV and indeed telephone link. You must assess the witness concerned in the same way, and with the same care, as you would assess any witness giving evidence in the room before you.
11. You have heard me advise the Chairman to warn witnesses of their right not to give replies which might be used by the Crown to establish guilt or decide whether to prosecute. My advice to give such a warning is no indication whatsoever of my personal view of a witness, and the giving of a warning does not undermine a witness's evidence. As always, the credibility of a witness is a matter for you.
12. You are entitled to take into account the formal, written statements which Dr Barton made to the police. You have heard it said that she made those statements, and that she declined to answer specific police questions. But it has not been suggested to you by Mr Kark that that failure to answer questions should in any way be held against Dr Barton – no doubt she received and followed legal advice on the point - and I advise you that you must not do so.
13. You have had a number of statements read to you. They fall into two categories. The statements in the first category were read to you on the basis that their contents were agreed by the other party. In respect of that category of read statements, you are entitled, but not obliged, to accept the contents of those statements as true, and you should give the evidence in those statements the same weight as you would have given it had it been given orally by the witness in Court. The statements in the second category were read to you on the basis, not that the other party agreed their contents, but on the basis that it was agreed that the statements could be read to you. In respect of that second category of statements, the evidence in the statements is not admitted, and you should not assume that the content of the statements is true. You should look at those statements critically, assessing the maker of the statement as best you can, and comparing the evidence in those statements with other evidence in the case. Unless you are told to the contrary, you should assume that the other side has not had the opportunity to cross-examine that witness – certainly the Panel has not been able to ask that witness questions – and you should bear in mind that your impression both of that witness and of their evidence might be different had cross-examination taken place. Subject to those caveats, it is up to you to make what you will of the content of such a statement. So far as I am aware, the only statements which you have heard read which fall into the second category are those of Ernest Stevens, June Bailey, Jeanette Florio, Sylvia Giffin, Ingrid Lloyd and Gill Hamblin.
14. Mr Langdale QC has referred to a complaint by Nurse Hallmann not being upheld. It is for you to decide whether that affects your view of her credibility. But you have also in the course of this case heard reference made to other more formal inquiries, such as an inquest. Although of course you may take into account what evidence witnesses in our hearing gave in those other formal proceedings, if they have been asked about it, I advise you that the actual decisions of other formal bodies are not relevant to your considerations here, even were you to be aware of them. You do not know precisely what evidence they received, or what their terms of reference were. It is your independent judgement which you have to apply in this case.
15. In considering whether acts or omissions are, for example, inappropriate, potentially hazardous or not in the best interests of the patient concerned, it is proper for you to take into account documents such as Good Medical Practice,

the British National Formulary, the 'Wessex Protocol'/Palliative Care Handbook, and the other items in your Bundle 1, as well as the evidence you have heard from witnesses about those publications, in deciding what the proper standard of reasonable and competent medical practice was at the relevant time, and whether Dr Barton has departed from it.

16. These allegations are all of some age. It has not been suggested by anyone that this means Dr Barton cannot have a fair hearing. But you will no doubt wish to bear in mind the age of these allegations, and the undoubted difficulty that Dr Barton and indeed anyone would experience in recalling the detail of any incident taking place a significant period of time ago. In particular, you should bear in mind, when assessing the weight of their evidence, that a number of people in this case are very largely reliant upon notes made at the time, or at least upon statements made nearer the time, and are able to give relatively little evidence from actual memory now of any individual patient.
17. You should be careful, especially given the age of these allegations, to ensure that you are applying only those standards applicable at the time of the dates specified in the allegations. You should guard against making judgments with the benefit of hindsight. To apply to any acts or omissions the standards of 2009 would be unfair to Dr Barton, because you might be allowing the passage of time to penalise her.
18. In applying the proper standards applicable at the dates specified in the allegations, you are applying an objective test. For example, note-making may, it seems, have been briefer in the 1990's than is the case today. But, if inadequate note-making was prevalent in the 1990's, that does not mean that making very short notes, or none at all, was even then an acceptable practice according to the proper standards of the time. Certainly, by her admissions made in relation to note-making, Dr Barton has accepted that her conduct was, in that respect, inappropriate and not in the best interests of her patients.
19. You have also heard reference made to what is said to be Dr Barton's heavy workload, the issue of resources, the management structure at the GWMH and the premature moving of patients to the GWMH. Professor Sikora, in particular, repeatedly gave evidence as to the differences in various respects between the situation in the 1990's, and the situation now. Clearly, the issue, for example, of the premature moving of patients has relevance to the case as a whole, because it may have a bearing on the reasons for a patient's deterioration. Similarly, any apparent non-intervention by a consultant or pharmacist who knew of Dr Barton's prescribing practices, including her practice of anticipatorily prescribing, may, you think, be potentially relevant to the issue of whether her acts and omissions were a departure from the proper standards of the time. However, in relation to the issue of whether there was any pressure upon Dr Barton affecting her care of patients, I advise you that any such surrounding difficulties, if I may call them that, are not in themselves directly relevant to your fact-finding exercise; they are clearly the background to Dr Barton's work, but you may think that such surrounding difficulties cannot make an inappropriate action or omission appropriate. The same goes for any failings on the part of persons other than Dr Barton. When you are coming to judgments about the quality of Dr Barton's acts or omissions, you are applying an objective test, taking into account as I have said those standards properly applicable at the time of the dates specified in the allegations. If, even taking into account any surrounding difficulties, Dr

Barton's actions or omissions fell below those standards, they fell below them, and it matters not for the purposes of fact-finding that those surrounding difficulties may have contributed to the actions or omissions of Dr Barton.

20. However, issues such as management, staffing and premature patient transfers may be relevant when you come on to consider serious professional misconduct.
21. This case as charged concerns only the 12 specified patients. You have heard some evidence as to how Dr Barton treated other patients at the GWMH; for example, in relation to advance prescribing and the institution of syringe drivers. I advise that you can take into account any such evidence you have heard concerning the treatment of patients at the GWMH other than the 12, but only in so far as it assists you to decide whether the allegations in relation to the 12 patients are proved. In respect of evidence concerning Dr Barton's assessment of GWMH patients other than the 12 before you, I advise you that that evidence is capable of lending support to Dr Barton's contention that, whether she made a note of it or not, she did assess each of the 12 patients before you. Of course, the weight to be given to such evidence is entirely a matter for you. But what you should not do is draw any inferences from the fact itself that you only have these 12 patients to consider. You certainly should not assume, for example, that the GMC chose these allegations relating to these 12 patients as 'specimen' charges; that is to say, as a manageable number of samples of a wider picture of wrongdoing. There are a number of possible reasons as to why you only have these 12 before you, and you must not speculate as to why that is the case. The position is that you have to make findings only in relation to these 12.
22. Dr Barton's good character is not in doubt. She is a doctor of many years' standing, and there are no previous adverse findings against her. The allegations raise in themselves no issue as to character; they don't allege motives; they allege facts. But that is not the end of the matter. I advise that the doctor's good character is relevant to your considerations. The reason for this is that, you may think, there are, at least potentially, particular disputes between the GMC and the doctor which may bring into issue, either whether or not this doctor has behaved in a specifically discreditable way (as opposed to making, for example, an error of judgement), or whether she has been telling you the truth. You may think that an example of such an area of dispute directly relevant to a charge is whether or not Dr Barton performed an assessment on a given patient. Where you are of the view that such a specific issue arises, you should take her good character into account in two ways. Firstly: she is entitled to have taken into account on her behalf the fact of her good character, and to argue that her good character makes it less likely that she would act in a discreditable way. Secondly: if there are issues upon which her credibility and truthfulness have in your view been called into question, you should, again, take her good character into account: she is entitled to argue that her good character makes it more likely that she has been telling you the truth on any specific issue in relation to which her credibility has been called into question.
23. I have advised as to how you may take into account specific evidence as to how Dr Barton treated patients at the GWMH other than the 12 before you. I have also just advised that you should take into account Dr Barton's good character. But you have also heard, for reasons I have outlined in an earlier

advice, what is effectively general testimonial evidence as to what is said to be Dr Barton's pleasant and approachable personality, and general medical skills in relation to non-GWMH patients. I advise you that you are entitled to take into account any evidence you have heard as to Dr Barton being a caring or committed doctor, because this you may think is capable of being relevant to the factual issues of whether Dr Barton assessed the 12 patients in this case. But I advise you also that general testimonial evidence as to a doctor's personality or as to her general medical skills is not relevant at this particular stage of the proceedings.

Rule 27(2)(i): Proof of the Unadmitted Facts

24. Because of the age of this matter it is, as you are well aware, the old rules that apply. As is still the case under the new rules, the burden of proof in respect of any disputed fact rests throughout upon the Council; there is no burden here upon Dr Barton to prove anything. However, as regards the standard of proof, you must apply the criminal standard, not the civil standard which applies under the new rules: in other words, in this case, the Council must satisfy you so that you are sure before you find any fact proved against Dr Barton. Anything less, and Dr Barton is entitled to a finding of not proved. It may help if I give an example; one also posited by Mr Langdale QC; the issue of whether Dr Barton assessed a given patient. The fact that she did not, as she accepts, make adequate notes does not mean for one moment that it is up to her to prove to you by other means that she did assess the patient. It is for the GMC to make you sure that she did not.
25. When you have come to your decision as to the facts not admitted, you should then go on to consider Rule 27(2)(ii), on the basis of both the facts admitted, and those not admitted, but found proved.

Rule 27(2)(ii): Whether the Proven or Admitted Facts would be Insufficient to Support a Finding of Serious Professional Misconduct

26. Although you are not now making a formal finding as to serious professional misconduct, you do at this stage have to go on to consider and determine whether the proven or admitted facts would be insufficient to support a finding of serious professional misconduct. This means that I do have to advise you on this in some detail now. Should this case proceed to the next stage, there may be much of this part of my advice that I will not need to repeat.
27. The application of Rule 27(2)(ii) is a matter for your judgement, rather than for the application of any burden or standard of proof [CRHCP v. GMC & Biswas [2006]].
28. At this stage, you should consider the cumulative effect of the facts admitted or found proved. In other words, you will ask yourselves: would all the facts admitted or found proved, taken together, be insufficient to support a finding of serious professional misconduct?
29. What does 'serious professional misconduct' mean? As was pointed out in the case of Roylance v. General Medical Council, referred to in more detail below, the phrase is not defined in the legislation, and it is not an area in which an absolute precision can be looked for.
30. Even a single incident can amount to serious professional misconduct (McCoan v. General Medical Council [1964] 3 All ER 143).
31. In the 1987 case of Doughty v. General Dental Council [Privy Council], in relation to the phrase 'serious professional misconduct', it was stated that the Council had to establish that there was conduct connected with the profession

in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that such falling short as is established should be serious.

32. In the 1999 case of Roylance v. General Medical Council [Privy Council], assistance was given as follows [at page 21]:
    - 'Serious professional misconduct is presented as a distinct matter from a conviction in the British Islands of a criminal offence, which is dealt with as a separate basis for a direction by the committee in section 36(1) of the Medical Act 1983. Analysis of what is essentially a single concept requires to be undertaken with caution, but it may be useful at least to recognise the elements which the respective words contribute to it. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. Firstly, it is qualified by the word 'professional' which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious.'
33. "It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence" (per Lord Cooke of Thorndon in Preiss v. General Dental Council [2001] 1 WLR 1926, 1936C [28]).
34. In deciding whether the facts proved or admitted would be insufficient to support a finding of serious professional misconduct, what evidence can you take into account? As I have already pointed out, it is not the case that you can take into account any evidence that you have heard up to now.
35. Assistance was given in the 2005 case of Campbell v. GMC [Court of Appeal], which I quote or summarise as follows:
    - [Paragraphs 19-20.] The character and previous history of the practitioner may be relevant to the issue of whether the practitioner is guilty of serious professional misconduct. There may be an overlap, in that evidence may be relevant, both to that issue and to the later issue, if relevant, of mitigation. Thus, the professional history of the practitioner may support a finding of serious professional misconduct on the basis that he has previously been found to have committed an identical professional error. This may not have been regarded as serious professional misconduct on the first or previous occasion, but the 'history' may lead the Committee to conclude that that on this occasion it does, just because the conduct in question was repeated. Without the previous history an acquittal would be appropriate. In a different context, the error under consideration may need to be examined in the context of a dedicated practitioner working in isolation and under huge pressure, say, of an epidemic. Such circumstances may be relevant to the question whether he should be found guilty of serious professional misconduct. It may indeed provide mitigation of

circumstances, unrelated to penalty. If notwithstanding this evidence the case is proved, then precisely the same circumstances may also be relevant to mitigation of penalty. In short, the same facts may on occasion impact both on the question whether the practitioner's conduct amounted to serious professional misconduct, and on the appropriate consequential sanction. Nevertheless, although the same evidence may be relevant on both questions, it does not follow that they cease to be distinct issues requiring separate determination.

- [Paragraph 46.] Although the committee can, if it thinks it right to do so, consider the circumstances in which the practitioner found himself when committing the relevant misconduct, it should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty rather than to the question of whether the professional misconduct was serious; in particular committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct. At this stage, the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty.

36. I advise as follows.
    (i) As I have advised you in relation to fact-finding, any general testimonial evidence you have heard in relation to Dr Barton's personality or general medical skills is not relevant to the issue of serious professional misconduct, either.
    (ii) But the context and circumstances in which Dr Barton was working at the relevant time, including any pressure upon her, are capable of being relevant to the issue of serious professional misconduct. It is for you to decide, for example, whether there was such pressure in this case and, if so, whether it goes to the issue of serious professional misconduct in the particular circumstances of this case. The issue of whether any proven or admitted lapse is an isolated one may also be relevant to the issue of serious professional misconduct.
    (iii) It is important that you look carefully at the evidence you have heard, and that you decide at what stage or stages of your deliberations it is relevant.
37. However, I emphasise that, at this stage, you are not making any substantive finding as to serious professional misconduct. All that you are doing is deciding whether the proven and/or admitted facts would at this stage be insufficient to support a finding of serious professional misconduct and that, therefore, the case should proceed no further.

6th August 2009

Francis Chamberlain

Legal Assessor

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Fitness to Practise Panel
Session beginning 8 June 2009
Dr Jane Ann BARTON
Determination of application to admit evidence of witnesses
30 July 2009

Mr Jenkins

Before the end of proceedings yesterday, you made an application to adduce evidence on behalf of Dr Barton from three witnesses, two of whom are patients of Dr Barton, and all of whom have had a parent treated by Dr Barton during her time at the Gosport War Memorial Hospital (GWMH). You stated that their evidence will give the Panel some insight into Dr Barton's general disposition and patient care practices at the time. It is your submission that their evidence is relevant to certain aspects of the fact-finding exercise that the Panel has shortly to perform.

Mr Kark, Counsel for the GMC, opposed your application on the basis that any evidence given by these witnesses would be either character evidence, or evidence not specifically relating to the allegations in the case. Mr Kark submitted that the GMC's case relates only to the care received by the twelve patients that have been considered during this hearing.

The Panel has considered your application. It has had regard to your submissions and those of Mr Kark. It has also noted the advice of the Legal Assessor in relation to relevant evidence at the fact-finding stage. The Legal Assessor has advised that it may be helpful to consider separately the proposed evidence as to good character and general medical skills on the one hand, and Dr Barton's examination practices on the other.

Dealing with Dr Barton's examination practices, the Panel notes that there are specific allegations as to failures in her examination and assessment of twelve patients. It appears that the proposed evidence does, in part, concern the issue of patient examination by Dr Barton at GWMH during the period under consideration.

It is not in dispute that Dr Barton assessed patients other than the twelve with whom we are directly concerned. The Panel notes that the fact that Dr Barton assessed other patients does not however, mean that she necessarily assessed these twelve.

The Panel recognises that a large number of witnesses have already been asked general background questions by all Counsel and by members of the Panel. As you pointed out, there were questions for example, as to the safety of the wards and Dr Barton's interaction with relatives. It would appear to be inconsistent if evidence on such issues were now to be excluded. If adduced, the proposed evidence might or might not assist the Panel in determining the factual issues before it. The Panel will only be in a position to make such a judgement, if it permits the evidence to be adduced.

As to evidence concerning the Doctor's good character and general medical skills, the Panel recognises that such evidence can have no relevance to the fact-finding process, and the Panel notes your concession that such evidence is not for the Panel to consider in relation to serious professional misconduct under Rule 27(2)(ii). However, the Panel recognises that, for the reasons given by the Legal Assessor, such evidence has already been elicited from many witnesses. The Panel takes the view that it is well able to set aside consideration of such evidence until the appropriate stage is reached, and that it would be wrong and unnecessary to require witnesses to return on a second occasion to give such evidence.

It is on this basis that the Panel has determined to accede to your application.

76

Diamorphine Blood Levels – 20mgs SC over 24 hours – 4 hour half life

1	.83																				0.83
2	.73	.83																			1.56
3	.63	.73	.83																		2.19
4	.52	.63	.73	.83																	2.71
5	.42	.52	.63	.73	.83																3.13
6	.37	.42	.52	.63	.73	.83															3.50
7	.32	.37	.42	.52	.63	.73	.83														3.82
8	.26	.32	.37	.42	.52	.63	.73	.83													4.08
9	.21	.26	.32	.37	.42	.52	.63	.73	.83												4.29
10	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83											4.48
11	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83										4.64
12	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83									4.77
13	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83								4.88
14	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83							4.97
15	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83						5.05
16	.07	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83					5.12
17	.06	.07	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83				5.18
18	.05	.06	.07	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83			5.23
19	.04	.05	.06	.07	.08	.09	.11	.13	16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83		5.27
20	.03	.04	.05	.06	.07	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83	5.30
21	.02	.03	.04	.05	.06	.07	.08	.09	.11	.13	.16	.19	.21	.26	.32	.37	.42	.52	.63	.73	.83	5.32

79

Diamorphine Blood Levels – 20mgs SC over 24 hours – 2 hour half life

1	.83											0.83
2	.63	.83										1.46
3	.42	.63	.83									1.88
4	.32	.42	.63	.83								2.20
5	.21	.32	.42	.63	.83							2.41
6	.16	.21	.32	.42	.63	.83						2.57
7	.11	.16	.21	.32	.42	.63	.83					2.68
8	.08	.11	.16	.21	.32	.42	.63	.83				2.76
9	.05	.08	.11	.16	.21	.32	.42	.63	.83			2.81
10	.03	05	.08	.11	.16	.21	.32	.42	.63	.83		2.84
11	.02	.03	05	.08	.11	.16	.21	.32	.42	.63	.83	2.86

ack = £26.13. Label: 2

IDOL

s: see under Dose

Contra-indications; Side-effects: Haloperidol

nouth, tranquillisation and emergency
i mania, 5–20 mg repeated every 4–8
necessary (elderly, initially half adult
ILD, 0.5–1 mg daily

scular injection, up to 10 mg repeated
5 hours if necessary (elderly, initially
dose); CHILD, 0.5–1 mg daily

ous injection, 5–15 mg repeated every
if necessary (elderly, initially half adult

iemotherapy-induced nausea and vomi-
ntramuscular or intravenous injection,
30 minutes before starting therapy, fol-
continuous intravenous infusion of 1–
or 1–5 mg *by intramuscular or intra-*
jection every 1–6 hours as necessary;
intramuscular or intravenous injection,
:rograms/kg

ation, *by intramuscular injection*, up to
ites before operation; CHILD 200–
grams/kg

® (Janssen-Cilag) PoM

llow, scored, droperidol 10 mg. Net
ab pack = £12.30. Label: 2

l, sugar-free, droperidol 1 mg/mL. Net
mL pack (with graduated cap) = £4.47;
ack = £21.25. Label: 2

lroperidol 5 mg/mL. Net price 2-mL
p

TIXOL

ol)

s: schizophrenia and other psychoses,
ly with apathy and withdrawal but not
psychomotor hyperactivity; depression,
3.4

Contra-indications; Side-effects: Cf promazine Hydrochloride but less
extrapyramidal symptoms more fre-
% of patients); avoid in senile confu-
ites, excitable and overactive patients;
(section 9.8.2)

chosis, initially 3–9 mg twice daily
according to the response; max. 18 mg
ERLY (or debilitated) initially quarter to
dose; CHILD not recommended
n, see section 4.3.4

Lundbeck) PoM

llow, s/c, flupentixol 3 mg (as dihydro-
Net price 20 = £3.14. Label: 2

ction (flupentixol decanoate): section

particularly dystonic reactions and akathisia, are more frequent; avoid in depression

Dose: schizophrenia and other psychoses, mania, initially 2.5–10 mg daily in 2–3 divided doses, adjusted according to response to 20 mg daily; doses above 20 mg daily (10 mg in elderly) only with special caution; CHILD not recommended

Short-term adjunctive management of severe anxiety, psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 1 mg twice daily, increased as necessary to 2 mg twice daily; CHILD not recommended

Moditen® (Sanofi Winthrop) PoM

Tablets, all s/c, fluphenazine hydrochloride 1 mg (pink), net price 20 = £1.06; 2.5 mg (yellow), 20 = £1.33; 5 mg, 20 = £1.77. Label: 2

Modecate® PoM

Section 4.2.2

HALOPERIDOL

Indications: see under Dose; motor tics, section 4.9.3

Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride but less sedating, and fewer antimuscarinic or hypotensive symptoms; pigmentation and photosensitivity reactions rare. Extrapyramidal symptoms, particularly dystonic reactions and akathisia are more frequent especially in thyrotoxic patients. Rarely weight loss. Avoid in basal ganglia disease

Dose: *by mouth*,

Schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 1.5–3 mg 2–3 times daily *or* 3–5 mg 2–3 times daily in severely affected or resistant patients; in resistant schizophrenia up to 100 mg (rarely 120 mg) daily may be needed; adjusted according to response to lowest effective maintenance dose (as low as 5–10 mg daily); ELDERLY (or debilitated) initially half adult dose; CHILD initially 25–50 micrograms/kg daily (in 2 divided doses) to a max. of 10 mg; adolescents up to 30 mg daily (exceptionally 60 mg)

Short-term adjunctive management of severe anxiety, adults 500 micrograms twice daily; CHILD not recommended

Intractable hiccup, 1.5 mg 3 times daily adjusted according to response; CHILD not recommended

By intramuscular injection, 2–10 mg, subsequent doses being given every 4–8 hours according to response (up to every hour if necessary) to total max. 60 mg; severely disturbed patients may require initial dose of up to 30 mg; CHILD not recommended

Nausea and vomiting, 0.5–2 mg

Haloperidol (Non-proprietary) PoM

Tablets, haloperidol 1.5 mg, net price 20 = 84p; 5 mg, 20 = £2.48; 10 mg, 20 = £4.73; 20 mg, 20 = £8.66. Label: 2

Dozic® (Rosemont) PoM
Oral liquid, sugar-free, haloperidol 1 mg/mL. Net price 100-mL pack = £7.65. Label: 2

Haldol® (Janssen-Cilag) PoM
Tablets, both scored, haloperidol 5 mg (blue), net price 20 = £1.65; 10 mg (yellow), 20 = £3.21. Label: 2
Oral liquid, sugar-free, haloperidol 2 mg/mL. Net price 100-mL pack (with pipette) = £5.08. Label: 2
Injection, haloperidol 5 mg/mL. Net price 1-mL amp = 33p
Depot injection (haloperidol decanoate): section 4.2.2

Serenace® (Baker Norton) PoM
Capsules, green, haloperidol 500 micrograms. Net price 20 = 65p. Label: 2
Tablets, haloperidol 1.5 mg, net price 20 = £1.16; 5 mg (pink), 20 = £3.27; 10 mg (pale pink), 20 = £5.87; 20 mg (dark pink), 20 = £10.58. Label: 2
Oral liquid, sugar-free, haloperidol 2 mg/mL. Net price 100-mL pack = £8.77. Label: 2
Injection, haloperidol 5 mg/mL, net price 1-mL amp = 59p; 10 mg/mL, 2-mL amp = £2.03

LOXAPINE

Indications: acute and chronic psychoses
Cautions; Contra-indications: see under Chlorpromazine Hydrochloride; porphyria (section 9.8.2)
Side-effects: see under Chlorpromazine Hydrochloride; nausea and vomiting, weight gain or loss, dyspnoea, ptosis, hyperpyrexia, flushing and headache, paraesthesia, and polydipsia also reported
Dose: initially 20–50 mg daily in 2 divided doses, increased as necessary over 7–10 days to 60–100 mg daily (max. 250 mg) in 2–4 divided doses, then adjusted to usual maintenance dose of 20–100 mg daily; CHILD not recommended

Loxapac® (Lederle) PoM
Capsules, loxapine (as succinate) 10 mg (yellow/green), net price 100-cap pack = £9.52; 25 mg (light green/dark green), 56-cap pack = £10.67; 50 mg (blue/dark green), 100-cap pack = £34.27. Label: 2

METHOTRIMEPRAZINE

(Levomepromazine)
Indications: see under Dose
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride but more sedating
ELDERLY. Risk of postural hypotension particularly in patients over 50 years—not recommended for ambulant patients over 50 years unless risk of hypotensive reaction has been assessed
Dose: *by mouth*, schizophrenia, initially 25–50 mg daily in divided doses increased as necessary; bedpatients initially 100–200 mg daily usually in 3 divided doses, increased if necessary to 1 g daily; ELDERLY, see Cautions
Adjunctive treatment in palliative care (including management of pain and associated restlessness, distress, or vomiting), 12.5–50 mg every 4–8 hours
By intramuscular injection or by intravenous injection (by intravenous injection after dilution with an equal volume of sodium chloride 0.9% injection), adjunct in palliative care, 12.5–25 mg (severe agitation up to 50 mg) every 6–8 hours if necessary
By continuous subcutaneous infusion, adjunct in palliative care (via syringe driver), diluted in a suitable volume of sodium chloride 0.9% injection, see Prescribing in Palliative Care, p. 13; CHILD (experience limited), 0.35–3 mg/kg daily

Nozinan® (Link) PoM
Tablets, scored, methotrimeprazine maleate 25 mg. Net price 20 = £3.57. Label: 2
Injection, methotrimeprazine hydrochloride 25 mg/mL. Net price 1-mL amp = £1.94

OXYPERTINE

Indications: see under Dose
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride, but extrapyramidal symptoms may occur less frequently. With low doses agitation and hyperactivity occur and with high doses sedation. Occasionally photophobia may occur
Dose: schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 80–120 mg daily in divided doses adjusted according to the response; max. 300 mg daily; CHILD not recommended
Short-term adjunctive management of severe anxiety, initially 10 mg 3–4 times daily preferably after food; max. 60 mg daily; CHILD not recommended

Oxypertine (Sanofi Winthrop) PoM
Capsules, oxypertine 10 mg. Net price 20 = £2.12. Label: 2
Tablets, scored, oxypertine 40 mg. Net price 20 = £6.64. Label: 2

PERICYAZINE

(Periciazine)
Indications: see under Dose
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride, but more sedating; hypotension commonly occurs when treatment initiated
Dose: schizophrenia and other psychoses, initially 75 mg daily in divided doses increased at weekly intervals by steps of 25 mg according to response; usual max. 300 mg daily (elderly initially 15–30 mg daily)
Short-term adjunctive management of severe anxiety, psychomotor agitation, and violent or dangerously impulsive behaviour, initially 15–30 mg (elderly 5–10 mg) daily divided into 2 doses, taking the larger dose at bedtime, adjusted according to response
CHILD (severe mental or behavioural disorders only), initially, 500 micrograms daily for 10-kg child, increased by 1 mg for each additional 5 kg to max. total daily dose of 10 mg; dose may be gradually increased according to response but maintenance should not exceed twice initial dose
INFANT under 1 year not recommended

Dose: 0.25–1.5 mg daily in divided doses, adjusted according to the response; ELDERLY (or debilitated) initially half adult dose; CHILD not recommended

Anquil® (Janssen-Cilag) PoM
Tablets, benperidol 250 micrograms. Net price 100-tab pack = £26.13. Label: 2

DROPERIDOL

Indications: see under Dose
Cautions; Contra-indications; Side-effects: see under Haloperidol
Dose: *by mouth*, tranquillisation and emergency control in mania, 5–20 mg repeated every 4–8 hours if necessary (elderly, initially half adult dose); CHILD, 0.5–1 mg daily
By intramuscular injection, up to 10 mg repeated every 4–6 hours if necessary (elderly, initially half adult dose); CHILD, 0.5–1 mg daily
By intravenous injection, 5–15 mg repeated every 4–6 hours if necessary (elderly, initially half adult dose)
Cancer chemotherapy-induced nausea and vomiting, *by intramuscular or intravenous injection*, 1–10 mg 30 minutes before starting therapy, followed by *continuous intravenous infusion* of 1–3 mg/hour *or* 1–5 mg *by intramuscular or intravenous injection* every 1–6 hours as necessary; CHILD *by intramuscular or intravenous injection*, 20–75 micrograms/kg
Premedication, *by intramuscular injection*, up to 10 mg 60 minutes before operation; CHILD 200–500 micrograms/kg

Droleptan® (Janssen-Cilag) PoM
Tablets, yellow, scored, droperidol 10 mg. Net price 50-tab pack = £12.30. Label: 2
Oral liquid, sugar-free, droperidol 1 mg/mL. Net price 100-mL pack (with graduated cap) = £4.47; 500-mL pack = £21.25. Label: 2
Injection, droperidol 5 mg/mL. Net price 2-mL amp = 90p

FLUPENTHIXOL

(Flupentixol)
Indications: schizophrenia and other psychoses, particularly with apathy and withdrawal but not mania or psychomotor hyperactivity; depression, section 4.3.4
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride but less sedating; extrapyramidal symptoms more frequent (25% of patients); avoid in senile confusional states, excitable and overactive patients; porphyria (see section 9.8.2)
Dose: psychosis, initially 3–9 mg twice daily adjusted according to the response; max. 18 mg daily; ELDERLY (or debilitated) initially quarter to half adult dose; CHILD not recommended
Depression, see section 4.3.4

Depixol® (Lundbeck) PoM
Tablets, yellow, s/c, flupenthixol 3 mg (as dihydrochloride). Net price 20 = £2.85. Label: 2
Depot injection (flupenthixol decanoate): section 4.2.2

Fluanxol® PoM (depression), see section 4.3.4

FLUPHENAZINE HYDROCHLORIDE

Indications: see under Dose
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride, but less sedating and fewer antimuscarinic or hypotensive symptoms; extrapyramidal symptoms, particularly dystonic reactions and akathisia, are more frequent; avoid in depression
Dose: schizophrenia and other psychoses, mania, initially 2.5–10 mg daily in 2–3 divided doses, adjusted according to response to 20 mg daily; doses above 20 mg daily (10 mg in elderly) only with special caution; CHILD not recommended
Short-term adjunctive management of severe anxiety, psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 1 mg twice daily, increased as necessary to 2 mg twice daily; CHILD not recommended

Moditen® (Sanofi Winthrop) PoM
Tablets, all s/c, fluphenazine hydrochloride 1 mg (pink), net price 20 = £1.06; 2.5 mg (yellow), 20 = £1.33; 5 mg, 20 = £1.77. Label: 2
Depot injections (fluphenazine decanoate): section 4.2.2

HALOPERIDOL

Indications: see under Dose; motor tics, section 4.9.3
Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride but less sedating, and fewer antimuscarinic or hypotensive symptoms; pigmentation and photosensitivity reactions rare. Extrapyramidal symptoms, particularly dystonic reactions and akathisia are more frequent especially in thyrotoxic patients. Rarely weight loss. Avoid in basal ganglia disease
Dose: *by mouth*,
Schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 1.5–3 mg 2–3 times daily *or* 3–5 mg 2–3 times daily in severely affected or resistant patients; in resistant schizophrenia up to 100 mg (rarely 120 mg) daily may be needed; adjusted according to response to lowest effective maintenance dose (as low as 5–10 mg daily); ELDERLY (or debilitated) initially half adult dose; CHILD initially 25–50 micrograms/kg daily (in 2 divided doses) to a max. of 10 mg; adolescents up to 30 mg daily (exceptionally 60 mg)
Short-term adjunctive management of severe anxiety, adults 500 micrograms twice daily; CHILD not recommended
Intractable hiccup, 1.5 mg 3 times daily adjusted according to response; CHILD not recommended
By intramuscular injection, 2–10 mg, subsequent doses being given every 4–8 hours according to response (up to every hour if necessary) to total max. 60 mg; severely disturbed patients may require initial dose of up to 30 mg; CHILD not recommended
Nausea and vomiting, 0.5–2 mg

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Fitness to Practise Panel
Session beginning 8 June 2009
Dr Jane Ann BARTON
Determination of application to admit evidence of a witness who has been present during the proceedings
17 July 2009

Mr Jenkins

The Panel has considered your application to adduce evidence on behalf of Dr Barton which relates principally to the credibility of an earlier witness called by the GMC, Mrs Shirley Hallmann. You stated that "She is the nurse and the only one who has suggested that she had concerns about the use of syringe drivers and diamorphine during the time with which you are concerned."

You seek to bring contradictory evidence before the Panel in the form of testimony from Ms Betty Woodland, the nurse representative, who has been present in the public gallery for a large number of days of this hearing. In addition, you also propose to adduce evidence from Ms Woodland as to the general character and skills of Dr Barton, what Ms Woodland knew of the 1991 debate over the use of opiates, and finally evidence concerning unrelated dealings Ms Woodland had with Nurse Hallmann and which you say would go to Nurse Hallmann's credibility.

The Panel has in mind Rule 50(5) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 which states:

> "Without leave of the Committee no person (other than a party to the proceedings) shall be called as a witness by either party in proceedings before the Professional Conduct Committee unless he has been excluded from the proceedings until he is called to give evidence".

The Panel has had regard to the evidence of Nurse Hallmann in relation to her claimed concern over the use of opiates, in particular the use of syringe drivers. The Panel has also had regard to exhibit D3 'Notes of the meeting between Dr Jane Barton and Rosemary Salmond, Investigating Officer, on Friday 7 April' and to Dr Barton's own evidence in chief.

The Panel notes that this additional evidence is corroborative of Nurse Hallmann's testimony as to her concern over the use of opiates at the time in question.

Accordingly, it appears to the Panel that this is a settled issue. In the circumstances, the Panel does not find that it would be helped by hearing from Ms Woodland as to what issues had or had not been discussed by her and Nurse Hallmann when preparing the harassment complaint and the Panel does not find that the reception of such evidence is desirable in the face of Rule 50(5).

So far as the other matters of evidence which you wished to adduce are concerned, the Panel has considered whether those are collateral to the real issues of the case or whether they have an importance which would make it desirable to admit them at this stage regardless of Rule 50(5).

So far as testimony to the general skills and character of Dr Barton are concerned, the Panel has already received considerable evidence and may well hear more from other witnesses who have not been present during the proceedings. The significance of this evidence is not such as to make it desirable for the Panel to receive it regardless of Rule 50(5).

Similarly, the Panel has received a great deal of evidence, both oral and written, as to the circumstances of the 1991 debate. The recollection of Ms Woodland is not something which the Panel feel would be likely to add to its understanding of the matter. It follows that the Panel does not take the view that such evidence is of sufficient significance to make its reception desirable in the face of Rule 50(5).

Finally, you alluded to testimony connected with an unrelated collateral matter which it is said would reflect on the credibility of Nurse Hallmann. The Panel sees no value in

receiving this testimony since Nurse Hallmann's evidence on the subject of opiate concerns is already corroborated by other evidence.

In all the circumstances, this application is denied.

Haloperidol (Non-proprietary) PoM
Tablets, haloperidol 1.5 mg, net price 20 = 84p; 5 mg, 20 = £2.62; 10 mg, 20 = £4.82; 20 mg, 20 = £8.76. Label: 2

Dozic® (Rosemont) PoM
Oral liquid, sugar-free, haloperidol 1 mg/mL. Net price 100-mL pack = £7.65. Label: 2

Haldol® (Janssen-Cilag) PoM
Tablets, both scored, haloperidol 5 mg (blue), net price 20 = £1.65; 10 mg (yellow), 20 = £3.21. Label: 2
Oral liquid, sugar-free, haloperidol 2 mg/mL. Net price 100-mL pack (with pipette) = £5.08. Label: 2
Injection, haloperidol 5 mg/mL. Net price 1-mL amp = 33p; 2-mL amp = 62p
Depot injection (haloperidol decanoate): section 4.2.2

Serenace® (Baker Norton) PoM
Capsules, green, haloperidol 500 micrograms. Net price 20 = 65p. Label: 2
Tablets, haloperidol 1.5 mg, net price 20 = £1.16; 5 mg (pink), 20 = £3.27; 10 mg (pale pink), 20 = £5.87; 20 mg (dark pink), 20 = £10.58. Label: 2
Oral liquid, sugar-free, haloperidol 2 mg/mL. Net price 100-mL pack = £8.77. Label: 2
Injection, haloperidol 5 mg/mL, net price 1-mL amp = 59p; 10 mg/mL, 2-mL amp = £2.03

LOXAPINE

Indications: acute and chronic psychoses

Cautions; Contra-indications: see under Chlorpromazine Hydrochloride; porphyria (section 9.8.2)

Side-effects: see under Chlorpromazine Hydrochloride; nausea and vomiting, weight gain or loss, dyspnoea, ptosis, hyperpyrexia, flushing and headache, paraesthesia, and polydipsia also reported

Dose: initially 20–50 mg daily in 2 divided doses, increased as necessary over 7–10 days to 60–100 mg daily (max. 250 mg) in 2–4 divided doses, then adjusted to usual maintenance dose of 20–100 mg daily; CHILD not recommended

Loxapac® (Lederle) PoM
Capsules, loxapine (as succinate) 10 mg (yellow/green), net price 100-cap pack = £9.52; 25 mg (light green/dark green), 100-cap pack = £19.05; 50 mg (blue/dark green), 100-cap pack = £34.27. Label: 2

METHOTRIMEPRAZINE

(Levomepromazine)

Indications: see under Dose

Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride but more sedating

ELDERLY. Risk of postural hypotension particularly in patients over 50 years—not recommended for ambulant patients over 50 years unless risk of hypotensive reaction has been assessed

Dose: *by mouth*, schizophrenia, initially 25–50 mg daily in divided doses increased as necessary; bedpatients initially 100–200 mg daily usually in 3 divided doses, increased if necessary to 1 g daily; ELDERLY, see Cautions

Adjunctive treatment in palliative care (including management of pain and associated restlessness, distress, or vomiting), 12.5–50 mg every 4–8 hours

By intramuscular injection or by intravenous injection (by intravenous injection after dilution with an equal volume of sodium chloride 0.9% injection), adjunct in palliative care, 12.5–25 mg (severe agitation up to 50 mg) every 6–8 hours if necessary

By continuous subcutaneous infusion, adjunct in palliative care (via syringe driver), 25–200 mg daily (over 24-hour period), diluted in a suitable volume of sodium chloride 0.9% injection; CHILD (experience limited), 0.35–3 mg/kg daily

Nozinan® (Link) PoM
Tablets, scored, methotrimeprazine maleate 25 mg. Net price 20 = £3.57. Label: 2
Injection, methotrimeprazine hydrochloride 25 mg/mL. Net price 1-mL amp = £1.94

OXYPERTINE

Indications: see under Dose

Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride, but extrapyramidal symptoms may occur less frequently. With low doses agitation and hyperactivity occur and with high doses sedation. Occasionally photophobia may occur

Dose: schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement, and violent or dangerously impulsive behaviour, initially 80–120 mg daily in divided doses adjusted according to the response; max. 300 mg daily; CHILD not recommended

Short-term adjunctive management of severe anxiety, initially 10 mg 3–4 times daily preferably after food; max. 60 mg daily; CHILD not recommended

Oxypertine (Sanofi Winthrop) PoM
Capsules, oxypertine 10 mg. Net price 20 = £2.12. Label: 2
Tablets, scored, oxypertine 40 mg. Net price 20 = £6.64. Label: 2

PERICYAZINE

(Periciazine)

Indications: see under Dose

Cautions; Contra-indications; Side-effects: see under Chlorpromazine Hydrochloride, but more sedating; hypotension commonly occurs when treatment initiated

Dose: schizophrenia and other psychoses, initially 75 mg daily in divided doses increased at weekly intervals by steps of 25 mg according to response; usual max. 300 mg daily (elderly initially 15–30 mg daily)

Short-term adjunctive management of severe anxiety, psychomotor agitation, and violent or dangerously impulsive behaviour, initially 15–30 mg (elderly 5–10 mg) daily divided into 2 doses, taking the larger dose at bedtime, adjusted according to response

CHILD (severe mental or behavioural disorders only), initially, 500 micrograms daily for 10-kg

PARACETAMOL

(Acetaminophen)

Indications: mild to moderate pain, pyrexia

Cautions: hepatic and renal impairment, alcohol dependence; **interactions:** Appendix 1 (paracetamol)

Side-effects: side-effects rare, but rashes, blood disorders; acute pancreatitis reported after prolonged use; **important:** liver damage (and less frequently renal damage) following **overdosage**, see Emergency Treatment of Poisoning, p. 20

Dose: *by mouth*, 0.5–1 g every 4–6 hours to a max. of 4 g daily; CHILD 2 months 60 mg for post-immunisation pyrexia; otherwise under 3 months (on doctor's advice only), 10 mg/kg (5 mg/kg if jaundiced); 3 months–1 year 60–120 mg, 1–5 years 120–250 mg, 6–12 years 250–500 mg; these doses may be repeated every 4–6 hours when necessary (max. of 4 doses in 24 hours)

For full Joint Committee on Vaccination and Immunisation recommendation on post-immunisation pyrexia, see section 14.1

Rectal route, see below

Paracetamol (Non-proprietary)

Tablets PoM[1], paracetamol 500 mg. Net price 20 = 11p. Label: 29, 30

Available from APS, Cox, Norton, Sterling Health (*Panadol*® DHSS)

Soluble Tablets (= Dispersible tablets) PoM[2], paracetamol 500 mg. Net price 60-tab pack = £2.32. Label: 13, 29, 30

Available from Sterling Health (*Panadol Soluble*® DHSS)

Paediatric Soluble Tablets (= Paediatric dispersible tablets), paracetamol 120 mg. Net price 24-tab pack = 82p. Label: 13, 30

Available from R&C (*Disprol*® *Soluble Paracetamol* DHSS)

Paediatric Oral Solution (= Paediatric Elixir), paracetamol 120 mg/5 mL. Net price 100 mL = 30p. Label: 30

Note. Sugar-free versions are available and can be ordered by specifying 'sugar-free' on the prescription.

Available from Berk, Norton, Rosemont (*Paldesic*® DHSS), Wallace Mfg (*Salzone*® DHSS)

Oral Suspension 120 mg/5 mL (= Paediatric Mixture), paracetamol 120 mg/5 mL. Net price 100 mL = 43p. Label: 30

Note. BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol Mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed; sugar-free versions can be ordered by specifying 'sugar-free' on the prescription

Available from Cupal (*Medinol*® *Paediatric*, sugar-free), Norton, R&C (*Disprol*® *Paediatric*, sugar-free), Rosemont (*Paldesic*®), Sterling Health (*Panadol*®, sugar-free), Warner Lambert (*Calpol*® *Paediatric*, *Calpol*® *Paediatric* sugar-free)

Oral Suspension 250 mg/5 mL (= Mixture), paracetamol 250 mg/5 mL. Net price 100 mL = 75p. Label: 30

Available from Cupal (*Medinol*® *Over 6* DHSS), Hillcross, Rosemont (*Paldesic*®), Warner Wellcome (*Calpol*® *6 Plus* DHSS)

Suppositories, paracetamol 60 mg, net price 10 = £9.96; 125 mg, 10 = £11.50; 250 mg, 10 = £23.00; 500 mg, 10 = £9.90. Label: 30

Dose: by rectum, ADULT and CHILD over 12 years 0.5–1 g up to 4 times daily, CHILD 1–5 years 125–250 mg, 6–12 years 250–500 mg

Available from Astra (*Alvedon*®, 60 mg, 125 mg, 250 mg), Aurum (120 mg, 240 mg, 500 mg)

■ Co-codamol 8/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed.

Co-codamol 8/500 PoM[2] (Non-proprietary)

Tablets, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg) Net price 20 = 27p. Label: 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD 6–12 years ½–1 tablet

Available from APS, Cox, CP, Galen, (*Parake*® DHSS), Generics, Norton, Sterling Health (*Panadeine*® DHSS)

Effervescent or *dispersible tablets*, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 20 = 70p. Label: 13, 29, 30

Dose: 1–2 tablets in water every 4–6 hours, max. 8 tablets daily; CHILD 6–12 years ½–1 tablet, max 4 daily

Available from Roche Consumer Health (*Paracodol*® DHSS), Sterwin

Note. The Drug Tariff allows tablets of co-codamol labelled 'dispersible' to be dispensed against an order for 'effervescent' and *vice versa*

Capsules, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 30 = £2.14. Label: 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily

Available from Roche Consumer Health (*Paracodol*® DHSS)

■ Co-codamol 30/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed (see preparations above).

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-codamol 30/500 (Non-proprietary) PoM

Tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Available from CP

Kapake® (Galen) PoM

Tablets, scored, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 30-tab pack = £2.26 (hosp. only), 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-cap pack = £7.53. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

1. May be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances; for details see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)
2. May be sold to the public under certain circumstances; for exemptions see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

Sachets (*Kapake Insts*®), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-sachet pack = £8.53. Label: 2, 13, 29, 30

Dose: 1–2 sachets every 4 hours; max. 8 sachets daily; CHILD not recommended

Solpadol® (Sanofi Winthrop) PoM

Caplets (= tablets), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-tab pack = £7.90. Label: 2, 29, 30

Dose: 2 tablets every 4 hours; max. 8 daily; CHILD not recommended

Capsules, grey/purple, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £7.90. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 18.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 100-tab pack = £9.48. Label: 2, 13, 29, 30

Dose: 2 tablets in water every 4 hours; max. 8 daily; CHILD not recommended

Tylex® (Schwarz) PoM

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £8.60. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 13.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 90-tab pack = £8.53. Label: 2, 13, 29, 30

Note. Contains aspartame 25 mg/tablet (see section 9.4.1)

Dose: 1–2 tablets in water every 4 hours; max. 8 tablets daily; CHILD not recommended

■ Co-codamol 60/1000

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Kapake® (Galen) PoM

Sachets (*Kapake Insts*®), co-codamol 60/1000 (codeine phosphate 60 mg, paracetamol 1 g), net price 50-sachet pack = £8.53. Label: 2, 13, 30

Dose: 1 sachet every 4 hours; max. 4 sachets daily; CHILD not recommended

■ With methionine (co-methiamol)

A mixture of methionine and paracetamol; methionine has no analgesic activity but may prevent paracetamol-induced liver toxicity if overdose taken

Paradote® (Penn)

Tablets, f/c, co-methiamol 100/500 (DL-methionine 100 mg, paracetamol 500 mg). Net price 24-tab pack = £1.05, 96-tab pack = £2.77. Label: 29, 30

Dose: 2 tablets every 4 hours; max. 8 tablets daily; CHILD 12 years and under, not recommended

denotes preparations that are considered to be less suitable for prescribing (see p. vi)

■ With dihydrocodeine tartrate 10 mg

See notes on p. 198

Co-dydramol (Non-proprietary) PoM

Tablets, scored, co-dydramol 10/500 (dihydrocodeine tartrate 10 mg, paracetamol 500 mg). Net price 20 = 31p. Label: 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Available from APS, Cox, CP, Galen (*Galake*® DHSS), Generics, Norton, Sterwin

When co-dydramol tablets are prescribed and no strength is stated tablets containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg should be dispensed.

Note. Tablets containing paracetamol 500 mg and dihydrocodeine 7.46 mg (*Paramol*® DHSS) are on sale to the public. The name *Paramol*® was formerly applied to a brand of co-dydramol tablets

■ With dihydrocodeine tartrate 20 or 30 mg

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Remedeine® (Napp) PoM

Tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Net price 112-tab pack = £12.21. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £7.39. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Net price 56-tab pack = £7.54. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £9.15. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

■ Other compound preparations

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-proxamol (Non-proprietary) PoM

Tablets, co-proxamol 32.5/325 (dextropropoxyphene hydrochloride 32.5 mg, paracetamol 325 mg). Net price 20 = 23p. Label: 2, 10 patient information leaflet (if available), 29, 30

Dose: 2 tablets 3–4 times daily; max. 8 tablets daily; CHILD not recommended

Available from APS, Berk, Cox (*Cosalgesic*® DHSS), Dista (*Distalgesic*® DHSS), Norton, Sterwin

When co-proxamol tablets are prescribed and no strength is stated tablets containing dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg should be dispensed.

Fortagesic® (Sanofi Winthrop) DHSS CD

Tablets, pentazocine 15 mg (as hydrochloride), paracetamol 500 mg. Net price 100-tab pack = £7.00. Label: 2, 21, 29, 30

Dose: 2 tablets up to 4 times daily; CHILD 7–12 years 1 tablet every 4 hours, max. 4 tablets daily

PARACETAMOL

(Acetaminophen)

Indications: mild to moderate pain, pyrexia

Cautions: hepatic and renal impairment, alcohol dependence; **interactions:** Appendix 1 (paracetamol)

Side-effects: side-effects rare, but rashes, blood disorders; acute pancreatitis reported after prolonged use; **important:** liver damage (and less frequently renal damage) following **overdosage**, see Emergency Treatment of Poisoning, p. 20

Dose: *by mouth*, 0.5–1 g every 4–6 hours to a max. of 4 g daily; CHILD 2 months 60 mg for post-immunisation pyrexia; otherwise under 3 months (on doctor's advice only), 10 mg/kg (5 mg/kg if jaundiced); 3 months–1 year 60–120 mg, 1–5 years 120–250 mg, 6–12 years 250–500 mg; these doses may be repeated every 4–6 hours when necessary (max. of 4 doses in 24 hours)

For full Joint Committee on Vaccination and Immunisation recommendation on post-immunisation pyrexia, see section 14.1

Rectal route, see below

Paracetamol (Non-proprietary)

Tablets PoM[1], paracetamol 500 mg. Net price 20 = 11p. Label: 29, 30

Available from APS, Cox, Norton, Sterling Health (*Panadol*® DHSS)

Soluble Tablets (= Dispersible tablets) PoM[2], paracetamol 500 mg. Net price 60-tab pack = £2.32. Label: 13, 29, 30

Available from Sterling Health (*Panadol Soluble*® DHSS)

Paediatric Soluble Tablets (= Paediatric dispersible tablets), paracetamol 120 mg. Net price 24-tab pack = 82p. Label: 13, 30

Available from R&C (*Disprol*® *Soluble Paracetamol* DHSS)

Paediatric Oral Solution (= Paediatric Elixir), paracetamol 120 mg/5 mL. Net price 100 mL = 30p. Label: 30

Note. Sugar-free versions are available and can be ordered by specifying 'sugar-free' on the prescription.

Available from Berk, Norton, Rosemont (*Paldesic*® DHSS), Wallace Mfg (*Salzone*® DHSS)

Oral Suspension 120 mg/5 mL (= Paediatric Mixture), paracetamol 120 mg/5 mL. Net price 100 mL = 43p. Label: 30

Note. BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol Mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed; sugar-free versions can be ordered by specifying 'sugar-free' on the prescription

Available from Cupal (*Medinol*® *Paediatric*, sugar-free), Norton, R&C (*Disprol*® *Paediatric*, sugar-free), Rosemont (*Paldesic*®), Sterling Health (*Panadol*®, sugar-free), Warner Lambert (*Calpol*® *Paediatric*, *Calpol*® *Paediatric* sugar-free)

Oral Suspension 250 mg/5 mL (= Mixture), paracetamol 250 mg/5 mL. Net price 100 mL = 75p. Label: 30

Available from Cupal (*Medinol*® *Over 6* DHSS), Hillcross, Rosemont (*Paldesic*®), Warner Wellcome (*Calpol*® *6 Plus* DHSS)

Suppositories, paracetamol 60 mg, net price 10 = £9.96; 125 mg, 10 = £11.50; 250 mg, 10 = £23.00; 500 mg, 10 = £9.90. Label: 30

Dose: by rectum, ADULT and CHILD over 12 years 0.5–1 g up to 4 times daily, CHILD 1–5 years 125–250 mg, 6–12 years 250–500 mg

Available from Astra (*Alvedon*®, 60 mg, 125 mg, 250 mg), Aurum (120 mg, 240 mg, 500 mg)

■ Co-codamol 8/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed.

Co-codamol 8/500 PoM[2] (Non-proprietary)

Tablets, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg) Net price 20 = 27p. Label: 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD 6–12 years ½–1 tablet

Available from APS, Cox, CP, Galen, (*Parake*® DHSS), Generics, Norton, Sterling Health (*Panadeine*® DHSS)

Effervescent or *dispersible tablets*, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 20 = 70p. Label: 13, 29, 30

Dose: 1–2 tablets in water every 4–6 hours, max. 8 tablets daily; CHILD 6–12 years ½–1 tablet, max 4 daily

Available from Roche Consumer Health (*Paracodol*® DHSS), Sterwin

Note. The Drug Tariff allows tablets of co-codamol labelled 'dispersible' to be dispensed against an order for 'effervescent' and *vice versa*

Capsules, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 30 = £2.14. Label: 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily

Available from Roche Consumer Health (*Paracodol*® DHSS)

■ Co-codamol 30/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed (see preparations above).

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-codamol 30/500 (Non-proprietary) PoM

Tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Available from CP

Kapake® (Galen) PoM

Tablets, scored, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 30-tab pack = £2.26 (hosp. only), 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-cap pack = £7.53. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

1. May be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances; for details see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)
2. May be sold to the public under certain circumstances; for exemptions see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

Sachets (*Kapake Insts*®), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-sachet pack = £8.53. Label: 2, 13, 29, 30

Dose: 1–2 sachets every 4 hours; max. 8 sachets daily; CHILD not recommended

Solpadol® (Sanofi Winthrop) PoM

Caplets (= tablets), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-tab pack = £7.90. Label: 2, 29, 30

Dose: 2 tablets every 4 hours; max. 8 daily; CHILD not recommended

Capsules, grey/purple, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £7.90. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 18.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 100-tab pack = £9.48. Label: 2, 13, 29, 30

Dose: 2 tablets in water every 4 hours; max. 8 daily; CHILD not recommended

Tylex® (Schwarz) PoM

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £8.60. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 13.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 90-tab pack = £8.53. Label: 2, 13, 29, 30

Note. Contains aspartame 25 mg/tablet (see section 9.4.1)

Dose: 1–2 tablets in water every 4 hours; max. 8 tablets daily; CHILD not recommended

■ Co-codamol 60/1000

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Kapake® (Galen) PoM

Sachets (*Kapake Insts*®), co-codamol 60/1000 (codeine phosphate 60 mg, paracetamol 1 g), net price 50-sachet pack = £8.53. Label: 2, 13, 30

Dose: 1 sachet every 4 hours; max. 4 sachets daily; CHILD not recommended

■ With methionine (co-methiamol)

A mixture of methionine and paracetamol; methionine has no analgesic activity but may prevent paracetamol-induced liver toxicity if overdose taken

Paradote® (Penn)

Tablets, f/c, co-methiamol 100/500 (DL-methionine 100 mg, paracetamol 500 mg). Net price 24-tab pack = £1.05, 96-tab pack = £2.77. Label: 29, 30

Dose: 2 tablets every 4 hours; max. 8 tablets daily; CHILD 12 years and under, not recommended

denotes preparations that are considered to be less suitable for prescribing (see p. vi)

■ With dihydrocodeine tartrate 10 mg

See notes on p. 198

Co-dydramol (Non-proprietary) PoM

Tablets, scored, co-dydramol 10/500 (dihydrocodeine tartrate 10 mg, paracetamol 500 mg). Net price 20 = 31p. Label: 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Available from APS, Cox, CP, Galen (*Galake*® DHSS), Generics, Norton, Sterwin

When co-dydramol tablets are prescribed and no strength is stated tablets containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg should be dispensed.

Note. Tablets containing paracetamol 500 mg and dihydrocodeine 7.46 mg (*Paramol*® DHSS) are on sale to the public. The name *Paramol*® was formerly applied to a brand of co-dydramol tablets

■ With dihydrocodeine tartrate 20 or 30 mg

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Remedeine® (Napp) PoM

Tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Net price 112-tab pack = £12.21. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £7.39. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Net price 56-tab pack = £7.54. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Contains 15.2mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £9.15. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

■ Other compound preparations

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-proxamol (Non-proprietary) PoM

Tablets, co-proxamol 32.5/325 (dextropropoxyphene hydrochloride 32.5 mg, paracetamol 325 mg). Net price 20 = 23p. Label: 2, 10 patient information leaflet (if available), 29, 30

Dose: 2 tablets 3–4 times daily; max. 8 tablets daily; CHILD not recommended

Available from APS, Berk, Cox (*Cosalgesic*® DHSS), Dista (*Distalgesic*® DHSS), Norton, Sterwin

When co-proxamol tablets are prescribed and no strength is stated tablets containing dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg should be dispensed.

Fortagesic® (Sanofi Winthrop) DHSS CD

Tablets, pentazocine 15 mg (as hydrochloride), paracetamol 500 mg. Net price 100-tab pack = £7.00. Label: 2, 21, 29, 30

Dose: 2 tablets up to 4 times daily; CHILD 7–12 years 1 tablet every 4 hours, max. 4 tablets daily

PARACETAMOL

(Acetaminophen)

Indications: mild to moderate pain, pyrexia

Cautions: hepatic and renal impairment, alcohol dependence; **interactions:** Appendix 1 (paracetamol)

Side-effects: side-effects rare, but rashes, blood disorders; acute pancreatitis reported after prolonged use; **important:** liver damage (and less frequently renal damage) following **overdosage**, see Emergency Treatment of Poisoning, p. 20

Dose: *by mouth*, 0.5–1 g every 4–6 hours to a max. of 4 g daily; CHILD 2 months 60 mg for post-immunisation pyrexia; otherwise under 3 months (on doctor's advice only), 10 mg/kg (5 mg/kg if jaundiced); 3 months–1 year 60–120 mg, 1–5 years 120–250 mg, 6–12 years 250–500 mg; these doses may be repeated every 4–6 hours when necessary (max. of 4 doses in 24 hours)

For full Joint Committee on Vaccination and Immunisation recommendation on post-immunisation pyrexia, see section 14.1

Rectal route, see below

Paracetamol (Non-proprietary)

Tablets PoM[1], paracetamol 500 mg. Net price 20 = 11p. Label: 29, 30

Available from APS, Cox, Norton, Sterling Health (*Panadol*® DHSS)

Soluble Tablets (= Dispersible tablets) PoM[2], paracetamol 500 mg. Net price 60-tab pack = £2.32. Label: 13, 29, 30

Available from Sterling Health (*Panadol Soluble*® DHSS)

Paediatric Soluble Tablets (= Paediatric dispersible tablets), paracetamol 120 mg. Net price 24-tab pack = 82p. Label: 13, 30

Available from R&C (*Disprol*® *Soluble Paracetamol* DHSS)

Paediatric Oral Solution (= Paediatric Elixir), paracetamol 120 mg/5 mL. Net price 100 mL = 30p. Label: 30

Note. Sugar-free versions are available and can be ordered by specifying 'sugar-free' on the prescription.

Available from Berk, Norton, Rosemont (*Paldesic*® DHSS), Wallace Mfg (*Salzone*® DHSS)

Oral Suspension 120 mg/5 mL (= Paediatric Mixture), paracetamol 120 mg/5 mL. Net price 100 mL = 43p. Label: 30

Note. BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol Mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed; sugar-free versions can be ordered by specifying 'sugar-free' on the prescription

Available from Cupal (*Medinol*® *Paediatric*, sugar-free), Norton, R&C (*Disprol*® *Paediatric*, sugar-free), Rosemont (*Paldesic*®), Sterling Health (*Panadol*®, sugar-free), Warner Lambert (*Calpol*® *Paediatric*, *Calpol*® *Paediatric* sugar-free)

Oral Suspension 250 mg/5 mL (= Mixture), paracetamol 250 mg/5 mL. Net price 100 mL = 75p. Label: 30

Available from Cupal (*Medinol*® *Over 6* DHSS), Hillcross, Rosemont (*Paldesic*®), Warner Wellcome (*Calpol*® *6 Plus* DHSS)

Suppositories, paracetamol 60 mg, net price 10 = £9.96; 125 mg, 10 = £11.50; 250 mg, 10 = £23.00; 500 mg, 10 = £9.90. Label: 30

Dose: by rectum, ADULT and CHILD over 12 years 0.5–1 g up to 4 times daily, CHILD 1–5 years 125–250 mg, 6–12 years 250–500 mg

Available from Astra (*Alvedon*®, 60 mg, 125 mg, 250 mg), Aurum (120 mg, 240 mg, 500 mg)

■ Co-codamol 8/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed.

Co-codamol 8/500 PoM[2] (Non-proprietary)

Tablets, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg) Net price 20 = 27p. Label: 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD 6–12 years ½–1 tablet

Available from APS, Cox, CP, Galen, (*Parake*® DHSS), Generics, Norton, Sterling Health (*Panadeine*® DHSS)

Effervescent or *dispersible tablets*, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 20 = 70p. Label: 13, 29, 30

Dose: 1–2 tablets in water every 4–6 hours, max. 8 tablets daily; CHILD 6–12 years ½–1 tablet, max 4 daily

Available from Roche Consumer Health (*Paracodol*® DHSS), Sterwin

Note. The Drug Tariff allows tablets of co-codamol labelled 'dispersible' to be dispensed against an order for 'effervescent' and *vice versa*

Capsules, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 30 = £2.14. Label: 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily

Available from Roche Consumer Health (*Paracodol*® DHSS)

■ Co-codamol 30/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed (see preparations above).

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-codamol 30/500 (Non-proprietary) PoM

Tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Available from CP

Kapake® (Galen) PoM

Tablets, scored, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 30-tab pack = £2.26 (hosp. only), 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-cap pack = £7.53. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

1. May be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances; for details see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

2. May be sold to the public under certain circumstances; for exemptions see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

Sachets (*Kapake Insts*®), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-sachet pack = £8.53. Label: 2, 13, 29, 30

Dose: 1–2 sachets every 4 hours; max. 8 sachets daily; CHILD not recommended

Solpadol® (Sanofi Winthrop) PoM

Caplets (= tablets), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-tab pack = £7.90. Label: 2, 29, 30

Dose: 2 tablets every 4 hours; max. 8 daily; CHILD not recommended

Capsules, grey/purple, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £7.90. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 18.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 100-tab pack = £9.48. Label: 2, 13, 29, 30

Dose: 2 tablets in water every 4 hours; max. 8 daily; CHILD not recommended

Tylex® (Schwarz) PoM

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £8.60. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 13.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 90-tab pack = £8.53. Label: 2, 13, 29, 30

Note. Contains aspartame 25 mg/tablet (see section 9.4.1)

Dose: 1–2 tablets in water every 4 hours; max. 8 tablets daily; CHILD not recommended

■ Co-codamol 60/1000

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Kapake® (Galen) PoM

Sachets (*Kapake Insts*®), co-codamol 60/1000 (codeine phosphate 60 mg, paracetamol 1 g), net price 50-sachet pack = £8.53. Label: 2, 13, 30

Dose: 1 sachet every 4 hours; max. 4 sachets daily; CHILD not recommended

■ With methionine (co-methiamol)

A mixture of methionine and paracetamol; methionine has no analgesic activity but may prevent paracetamol-induced liver toxicity if overdose taken

Paradote® (Penn)

Tablets, f/c, co-methiamol 100/500 (DL-methionine 100 mg, paracetamol 500 mg). Net price 24-tab pack = £1.05, 96-tab pack = £2.77. Label: 29, 30

Dose: 2 tablets every 4 hours; max. 8 tablets daily; CHILD 12 years and under, not recommended

▬ denotes preparations that are considered to be less suitable for prescribing (see p. vi)

■ With dihydrocodeine tartrate 10 mg

See notes on p. 198

Co-dydramol (Non-proprietary) PoM ▬

Tablets, scored, co-dydramol 10/500 (dihydrocodeine tartrate 10 mg, paracetamol 500 mg). Net price 20 = 31p. Label: 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Available from APS, Cox, CP, Galen (*Galake*® DHSS), Generics, Norton, Sterwin

When co-dydramol tablets are prescribed and no strength is stated tablets containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg should be dispensed.

Note. Tablets containing paracetamol 500 mg and dihydrocodeine 7.46 mg (*Paramol*® DHSS) are on sale to the public. The name *Paramol*® was formerly applied to a brand of co-dydramol tablets

■ With dihydrocodeine tartrate 20 or 30 mg

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Remedeine® (Napp) PoM ▬

Tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Net price 112-tab pack = £12.21. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £7.39. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Net price 56-tab pack = £7.54. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £9.15. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

■ Other compound preparations

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-proxamol (Non-proprietary) PoM ▬

Tablets, co-proxamol 32.5/325 (dextropropoxyphene hydrochloride 32.5 mg, paracetamol 325 mg). Net price 20 = 23p. Label: 2, 10 patient information leaflet (if available), 29, 30

Dose: 2 tablets 3–4 times daily; max. 8 tablets daily; CHILD not recommended

Available from APS, Berk, Cox (*Cosalgesic*® DHSS), Dista (*Distalgesic*® DHSS), Norton, Sterwin

When co-proxamol tablets are prescribed and no strength is stated tablets containing dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg should be dispensed.

Fortagesic® (Sanofi Winthrop) DHSS CD ▬

Tablets, pentazocine 15 mg (as hydrochloride), paracetamol 500 mg. Net price 100-tab pack = £7.00. Label: 2, 21, 29, 30

Dose: 2 tablets up to 4 times daily; CHILD 7–12 years 1 tablet every 4 hours, max. 4 tablets daily

PARACETAMOL

(Acetaminophen)

Indications: mild to moderate pain, pyrexia

Cautions: hepatic and renal impairment, alcohol dependence; **interactions:** Appendix 1 (paracetamol)

Side-effects: side-effects rare, but rashes, blood disorders; acute pancreatitis reported after prolonged use; **important:** liver damage (and less frequently renal damage) following **overdosage**, see Emergency Treatment of Poisoning, p. 20

Dose: *by mouth*, 0.5–1 g every 4–6 hours to a max. of 4 g daily; CHILD 2 months 60 mg for post-immunisation pyrexia; otherwise under 3 months (on doctor's advice only), 10 mg/kg (5 mg/kg if jaundiced); 3 months–1 year 60–120 mg, 1–5 years 120–250 mg, 6–12 years 250–500 mg; these doses may be repeated every 4–6 hours when necessary (max. of 4 doses in 24 hours)

For full Joint Committee on Vaccination and Immunisation recommendation on post-immunisation pyrexia, see section 14.1

Rectal route, see below

Paracetamol (Non-proprietary)

Tablets PoM[1], paracetamol 500 mg. Net price 20 = 11p. Label: 29, 30

Available from APS, Cox, Norton, Sterling Health (*Panadol*® NHS)

Soluble Tablets (= Dispersible tablets) PoM[2], paracetamol 500 mg. Net price 60-tab pack = £2.32. Label: 13, 29, 30

Available from Sterling Health (*Panadol Soluble*® NHS)

Paediatric Soluble Tablets (= Paediatric dispersible tablets), paracetamol 120 mg. Net price 24-tab pack = 82p. Label: 13, 30

Available from R&C (*Disprol*® *Soluble Paracetamol* NHS)

Paediatric Oral Solution (= Paediatric Elixir), paracetamol 120 mg/5 mL. Net price 100 mL = 30p. Label: 30

Note. Sugar-free versions are available and can be ordered by specifying 'sugar-free' on the prescription.

Available from Berk, Norton, Rosemont (*Paldesic*® NHS), Wallace Mfg (*Salzone*® NHS)

Oral Suspension 120 mg/5 mL (= Paediatric Mixture), paracetamol 120 mg/5 mL. Net price 100 mL = 43p. Label: 30

Note. BP directs that when Paediatric Paracetamol Oral Suspension or Paediatric Paracetamol Mixture is prescribed Paracetamol Oral Suspension 120 mg/5 mL should be dispensed; sugar-free versions can be ordered by specifying 'sugar-free' on the prescription

Available from Cupal (*Medinol*® *Paediatric*, sugar-free), Norton, R&C (*Disprol*® *Paediatric*, sugar-free), Rosemont (*Paldesic*®), Sterling Health (*Panadol*®, sugar-free), Warner Lambert (*Calpol*® *Paediatric*, *Calpol*® *Paediatric* sugar-free)

Oral Suspension 250 mg/5 mL (= Mixture), paracetamol 250 mg/5 mL. Net price 100 mL = 75p. Label: 30

Available from Cupal (*Medinol*® *Over 6* NHS), Hillcross, Rosemont (*Paldesic*®), Warner Wellcome (*Calpol*® *6 Plus* NHS)

Suppositories, paracetamol 60 mg, net price 10 = £9.96; 125 mg, 10 = £11.50; 250 mg, 10 = £23.00; 500 mg, 10 = £9.90. Label: 30

Dose: by rectum, ADULT and CHILD over 12 years 0.5–1 g up to 4 times daily, CHILD 1–5 years 125–250 mg, 6–12 years 250–500 mg

Available from Astra (*Alvedon*®), 60 mg, 125 mg, 250 mg), Aurum (120 mg, 240 mg, 500 mg)

■ Co-codamol 8/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed.

Co-codamol 8/500 PoM[2] (Non-proprietary)

Tablets, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg) Net price 20 = 27p. Label: 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD 6–12 years ½–1 tablet

Available from APS, Cox, CP, Galen, (*Parake*® NHS), Generics, Norton, Sterling Health (*Panadeine*® NHS)

Effervescent or *dispersible tablets*, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 20 = 70p. Label: 13, 29, 30

Dose: 1–2 tablets in water every 4–6 hours, max. 8 tablets daily: CHILD 6–12 years ½–1 tablet, max 4 daily

Available from Roche Consumer Health (*Paracodol*® NHS), Sterwin

Note. The Drug Tariff allows tablets of co-codamol labelled 'dispersible' to be dispensed against an order for 'effervescent' and *vice versa*

Capsules, co-codamol 8/500 (codeine phosphate 8 mg, paracetamol 500 mg). Net price 30 = £2.14. Label: 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily

Available from Roche Consumer Health (*Paracodol*® NHS)

■ Co-codamol 30/500

When co-codamol tablets, dispersible (or effervescent) tablets, or capsules are prescribed and **no strength is stated** tablets, dispersible (or effervescent) tablets, or capsules, respectively, containing codeine phosphate **8 mg** and paracetamol **500 mg** should be dispensed (see preparations above).

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-codamol 30/500 (Non-proprietary) PoM

Tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Available from CP

Kapake® (Galen) PoM

Tablets, scored, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 30-tab pack = £2.26 (hosp. only), 100-tab pack = £7.53. Label: 2, 29, 30

Dose: 1–2 tablets every 4 hours; max. 8 tablets daily; CHILD not recommended

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-cap pack = £7.53. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

1. May be sold to the public provided packs contain no more than 32 capsules or tablets; pharmacists can sell multiple packs up to a total quantity of 100 capsules or tablets in justifiable circumstances; for details see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

2. May be sold to the public under certain circumstances; for exemptions see *Medicines, Ethics and Practice*, No. 22, London, Pharmaceutical Press, 1999 (and subsequent editions as available)

Sachets (*Kapake Insts*®), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg), net price 100-sachet pack = £8.53. Label: 2, 13, 29, 30

Dose: 1–2 sachets every 4 hours; max. 8 sachets daily; CHILD not recommended

Solpadol® (Sanofi Winthrop) PoM

Caplets (= tablets), co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-tab pack = £7.90. Label: 2, 29, 30

Dose: 2 tablets every 4 hours; max. 8 daily; CHILD not recommended

Capsules, grey/purple, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £7.90. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 18.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 100-tab pack = £9.48. Label: 2, 13, 29, 30

Dose: 2 tablets in water every 4 hours; max. 8 daily; CHILD not recommended

Tylex® (Schwarz) PoM

Capsules, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Net price 100-cap pack = £8.60. Label: 2, 29, 30

Dose: 1–2 capsules every 4 hours; max. 8 capsules daily; CHILD not recommended

Effervescent tablets, co-codamol 30/500 (codeine phosphate 30 mg, paracetamol 500 mg). Contains 13.6 mmol Na^+/tablet; avoid in *renal impairment*. Net price 90-tab pack = £8.53. Label: 2, 13, 29, 30

Note. Contains aspartame 25 mg/tablet (see section 9.4.1)

Dose: 1–2 tablets in water every 4 hours; max. 8 tablets daily; CHILD not recommended

■ Co-codamol 60/1000

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Kapake® (Galen) PoM

Sachets (*Kapake Insts*®), co-codamol 60/1000 (codeine phosphate 60 mg, paracetamol 1 g), net price 50-sachet pack = £8.53. Label: 2, 13, 30

Dose: 1 sachet every 4 hours; max. 4 sachets daily; CHILD not recommended

■ With methionine (co-methiamol)

A mixture of methionine and paracetamol; methionine has no analgesic activity but may prevent paracetamol-induced liver toxicity if overdose taken

Paradote® (Penn)

Tablets, f/c, co-methiamol 100/500 (DL-methionine 100 mg, paracetamol 500 mg). Net price 24-tab pack = £1.05, 96-tab pack = £2.77. Label: 29, 30

Dose: 2 tablets every 4 hours; max. 8 tablets daily; CHILD 12 years and under, not recommended

▬ denotes preparations that are considered to be less suitable for prescribing (see p. vi)

■ With dihydrocodeine tartrate 10 mg

See notes on p. 198

Co-dydramol (Non-proprietary) PoM

Tablets, scored, co-dydramol 10/500 (dihydrocodeine tartrate 10 mg, paracetamol 500 mg). Net price 20 = 31p. Label: 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Available from APS, Cox, CP, Galen (*Galake*® NHS), Generics, Norton, Sterwin

When co-dydramol tablets are prescribed and no strength is stated tablets containing dihydrocodeine tartrate 10 mg and paracetamol 500 mg should be dispensed.

Note. Tablets containing paracetamol 500 mg and dihydrocodeine 7.46 mg (*Paramol*® NHS) are on sale to the public. The name *Paramol*® was formerly applied to a brand of co-dydramol tablets

■ With dihydrocodeine tartrate 20 or 30 mg

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Remedeine® (Napp) PoM

Tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Net price 112-tab pack = £12.21. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 20 mg. Contains 15.2 mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £7.39. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Net price 56-tab pack = £7.54. Label: 2, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

Forte effervescent tablets, paracetamol 500 mg, dihydrocodeine tartrate 30 mg. Contains 15.2mmol Na^+/tablet; avoid in *renal impairment*. Net price 56-tab pack = £9.15. Label: 2, 13, 21, 29, 30

Dose: 1–2 tablets every 4–6 hours; max. 8 tablets daily; CHILD not recommended

■ Other compound preparations

See warnings and notes on p. 198 (**important**: special care in elderly—reduce dose)

Co-proxamol (Non-proprietary) PoM

Tablets, co-proxamol 32.5/325 (dextropropoxyphene hydrochloride 32.5 mg, paracetamol 325 mg). Net price 20 = 23p. Label: 2, 10 patient information leaflet (if available), 29, 30

Dose: 2 tablets 3–4 times daily; max. 8 tablets daily; CHILD not recommended

Available from APS, Berk, Cox (*Cosalgesic*® NHS), Dista (*Distalgesic*® NHS), Norton, Sterwin

When co-proxamol tablets are prescribed and no strength is stated tablets containing dextropropoxyphene hydrochloride 32.5 mg and paracetamol 325 mg should be dispensed.

Fortagesic® (Sanofi Winthrop) NHS CD

Tablets, pentazocine 15 mg (as hydrochloride), paracetamol 500 mg. Net price 100-tab pack = £7.00. Label: 2, 21, 29, 30

Dose: 2 tablets up to 4 times daily; CHILD 7–12 years 1 tablet every 4 hours, max. 4 tablets daily

TK

WITNESS STATEMENT

STATEMENT OF **ROBERT PENNELLS**

AGE: OVER 18

This Statement consisting of 6 pages 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.

DATED this 26 day of July 2009

Signed Code A .....

ROBERT PENNELLS

I am Robert Pennells of Code A I am a Registered Medical Practitioner and was until September 2007 a General Practitioner in Gosport, Hampshire having started work there in 1978. I trained at St Mary's Hospital, London, passed my finals in 1971, and registered in 1972. Between 1972 and 1978 I undertook hospital work in various specialties in England, Bermuda and New Zealand. I then worked as a GP in Gosport, becoming Senior Partner in my practice in 1990.

I first met Dr Jane Barton when she did locum work at my own practice in 1979 or 1980 before she joined her present practice. Indeed, my partners and I at the time did not realise that Dr Barton was looking for a permanent post and would have considered offering her a post in our practice if we had. The reason for this is that we appreciated how she good she was at general practice even in that short time. Since then, I have known her as a cheerful, hardworking and caring physician. She became Clinical Assistant in Elderly Medicine in the 1980s or 1990s, and

Signed.. Code A ..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

was also involved in the formation of Gosport Primary Care Group and acted as Chairman for some time. I was part of that group and her performance in that role was excellent.

Gosport is very fortunate in having the Gosport War Memorial Hospital, which is a local hospital with in-patient beds. There have been changes over the years, but the Hospital has a mix of elderly medicine beds, GP beds, and out-patient services. The elderly medicine beds are further sub-divided in to long stay beds, rehabilitation beds and terminal care beds. These categories are not necessarily definable and there are areas in between that would best be described as grey areas – because elderly people may change in their condition without warning, depending on their illnesses or circumstance. Elderly patients would therefore be looked after long term perhaps while awaiting a place in an 'Old Peoples' Home' or being rehabilitated to a stage where they could live in the community or an Old Peoples' Home, or they were in a position of having been investigated and treated but not being expected to recover – ie palliative care.

Dr Barton worked in the elderly medicine department as a Clinical Assistant, as far as I know with the supervision of the Consultant in charge of the beds and, as far as I could see, very efficiently. Dr Barton was effectively working as a Junior Doctor – equivalent to a Senior House Officer or Registrar. My surgery was in the Gosport Health Centre at the time of the allegations now made against Dr Barton, and our building was attached to the Gosport War Memorial Hospital on the same site. As I drove to work in the morning I often saw Dr Barton's car parked outside the hospital as she was visiting the Wards before going on to her own surgery to do her GP work. I took this to be an indication of her dedication to the post which she was serving.

In relation to Jane's work as a Clinical Assistant, I understand that she worked for 3½ or 4 sessions a week. I have been told that Dr Barton was looking after patients in up to 44 beds at any one time. This is a high workload and became increasingly more difficult in the time allocated. I think initially her position was a nice job – she was doing it at her speed and the patients were likely to improve.

Signed.. Code A ..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

During her time as Clinical Assistant, Dr Barton asked me to sign cremation forms for some of the patients who had died in the Elderly Medicine Department. Sometimes these patients had been registered with my practice and I would have had some background knowledge of their previous condition. I believe that in seeking an opinion in relation to the Cremation Forms Dr Barton would often ask a doctor from the patient's own practice to help with these forms.

The signing of the second part of the cremation form is a legal act not to be taken lightly. I have signed many of these forms over the years and always made sure I was in possession of all relevant facts before doing so. The procedure is as follows: the clinician that was looking after the patient at the time of death contacts another physician who was not in the same practice or department and tells him or her the cause of death and the circumstances leading up to the death. The second clinician then speaks to someone who had been looking after the deceased or who had some knowledge of the events leading up to the death. If the second clinician is sure that there is no reason the cremation needs to be delayed, then and only then, does he or she sign the form.

In considering the Cremation Forms relating to patients Dr Barton had been looking after, I never came across a case in which I thought there was a problem in signing the Cremation Certificate. Before considering whether or not it was appropriate to sign the Certificate I always looked at the patient's notes and spoke to the Nursing Staff who had had care of the patient. In the case of the patients from the Elderly Medicine Department there was always a Senior Nursing Staff Nurse, Sister or Nurse Manager to interview and also the hospital notes to inspect. To my mind there never appeared to be any question about Dr Barton's clinical abilities. In no case in which I was asked to sign the Cremation Form did I feel there was a problem with the way the patient had been treated. My general impression of her was that she was a good Clinical Assistant from all the information I was able to gather, including my liaison with the Nursing Staff.

In reviewing the notes of patients when being asked sign Cremation Forms, it appeared to me that over the mid to late 90s, patients who had been transferred into beds at Gosport War Memorial Hospital appeared to be more ill than in previous years.

Signed.... Code A ..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

In later years I found that I was signing more cremation forms, and it seemed that this resulted from a change in the nature of the patients who were being transferred to Daedalus Ward and Dryad Wards at the War Memorial Hospital – they were more acutely ill and dependent than previously.

As a General Practitioner it was apparent to me that over the years local hospital trusts had increasing difficulty in relation to beds. General hospital beds were routinely filled, and often consultants at the Queen Alexandra Hospital, for example, would ask us to take patients onto Sultan Ward at the War Memorial Hospital. On occasion we would be told that the patients would be able to go home shortly after their admission to the Ward, only to find out on transfer from the District General Hospital that they were in a worse condition than we had been led to believe. Ultimately in 2000 it became necessary to set clear criteria for admission to the Ward.

Closure of beds was our main problem, the lack of availability of beds at District General Hospitals meant that more patients were transferred to us. I think there might have been a slight criticism from the Hospital Trust that Sultan Ward, for example, was only 80% occupied, whilst other units were at 95% capacity.

In relation to the quality of notes I reviewed when considering the Cremation Certificates, I do not believe there was a problem in picking out the important information. It was of course open for me to speak with the Nursing Staff which I did, and any apparent gaps in the notes were filled by that.

Not all the patients who died on those Wards were receiving Diamorphine and Midazolam by way of syringe drivers. I think it is fair to say that a high proportion were receiving such medication as time went on, but that resulted from the different type of patient being admitted, with an increasing number being in pain than had been the case earlier. Towards the end of Dr Barton's time as a Clinical Assistant at the Hospital, I would estimate that about half of the patients that died were receiving this medication and by such a method of administration.

Signed.. Code A ..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

That had not been the case in earlier years. I am aware that from time to time syringe drivers were donated to the Hospital by grateful relatives of patients who had been treated and indeed who had died there.

Originally at the War Memorial Hospital, there had been male, female and children's wards, all with GP beds. However, when the Hospital was developed, an extra 3 wards were added, including Sultan Ward, being the new GP Ward. Patients were admitted to Sultan Ward under GP Care if we felt the patient needed more support than was generally available at home. If I admitted a patient to Sultan Ward, I would then go to see that patient on most days, to ensure that the patient was progressing as I had hoped – or indeed arrange for the patient then to be transferred to a Local District General Hospital if necessary. Alternatively, it was possible to get the view of a clinician in Elderly Medicine, who could arrange admission to one of the other Wards at the Gosport War Memorial Hospital if that was felt to be appropriate and a bed was available.

It is only fair to point out that the War Memorial Hospital is not a District General Hospital, and patients were dealt with in a different way. We had good nursing staff at the Hospital, but there was limited medical cover.

I am aware of the detail of the allegations made against Dr Barton contained in the various Heads of Charge. I appreciate there is some concern that the doses of opiates drugs prescribed were not in the patients' best interests. I understand that variable doses were prescribed. I never felt the doses were excessive in the cases I was asked to comment upon when dealing with Cremation Forms. At the time in the Elderly Medicine Department the prescription of these drugs was put in this manner in order for the staff to be able to increase the dose of the drug without the difficulty of having to find a prescribing Clinician to change the dose. This was particularly for out of hours and weekend times when undue suffering may have been caused if a patient had to wait for someone to be called in to the Hospital. This manner of prescribing is not only confined to elderly medicine. I have come across it in treatment of pain especially with regard to cancer sufferers.

Signed... Code A .....Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

Over the years patients came to register with our practice who had fallen out with other GPs locally, and they were therefore transferring. At no time, however, did I ever have a patient transferring to me from the list of Jane Barton.

In my view, Dr Barton is a competent and caring clinician who has spent the last 10 years at least in a very unnatural condition waiting for her case to be completed. In describing her, I cannot think of any bad words to say about her.

Of Dr Barton and I her husband, I would say they are a remarkable couple. Both are extremely resilient. Several medical colleagues have commented to me that they would simply not have been able to put up with the pressure under which Dr Barton has suffered over recent years.

Dr Barton puts on a brave face about her predicament, but it has taken a toll upon her.

Signed.... Code A ..... Witnessed Code A

Signed.. Code A ..... Witnessed Code A Code A

WITNESS STATEMENT

STATEMENT OF **GILLIAN ELIZABETH HAMBLIN**

AGE: OVER 18

This Statement consisting of 2 pages 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.

DATED this 16 day of February 2008

Signed Code A ....

GILLIAN ELIZABETH HAMBLIN

I am Gillian Elizabeth Hamblin Code A

I make this statement further to my statement of 23 October 2007, in relation to events at the Gosport War Memorial Hospital in Hampshire.

In that statement, I described difficulties which were encountered in relation to record keeping, both on the part of the Nursing Staff, and the part of Dr Jane Barton, the Clinical Assistant on Dryad Ward.

I also described the arrangement which came to exist concerning the prescription of certain medications in a dose range, which prescription could be made anticipating the future need of the patient.

From my knowledge, I do not believe there was a situation in which a patient was ever put at risk by the more limited note keeping that the Nurses and Code A were effectively forced to. We

Signed ... Code A ..... Witnessed.... Code A ...

routinely communicated at handovers, ward rounds, and generally, concerning the condition and treatment of our patients.

Similarly, from my knowledge, I do not believe a patient was ever actually put at risk through the system of prescribing which was operated. The Pharmacist for the Hospital, Code A attended on the Ward each Monday, reviewing all the drug charts and the drug stock. She would give advice and guidance, but I do not believe she ever raised criticism, or that concern was ever expressed by her about the arrangements for prescribing in the way that we had adopted.

Signed..... Code A ..... Witnessed... Code A .....

A I think most of the relatives just wanted their loved ones kept comfortable, pain-free, so I cannot honestly recall them asking about that really, about whether or not they would be more conscious or pain-free. As I say, the majority of relatives wanted their loved ones kept comfortable.

Q So in general terms, in terms of responsiveness to the concerns of the relatives how open was the doctor to taking on board the wishes and desires of the relatives?

B A Dr Barton was very sensitive to that and obviously took on board what the relatives were saying; and hopefully that that was the case – that they wanted them either kept pain free, which was what most of the relatives wanted for them.

THE CHAIRMAN: That was all I had. The very final bit is that I have to ask the barristers whether they have any questions arising out of those. Mr Kark.

C MR KARK: No, sir.

THE CHAIRMAN: Mr Jenkins.

MR JENKINS: No, sir.

D THE CHAIRMAN: Then that completes your testimony. Thank you very much indeed for coming. It follows that you will not need to come back on Friday. We are most grateful to you for your assistance. We do rely on the help of parties such as yourself to help us in our inquiries and you leave with our thanks.

THE WITNESS: Thank you very much.

(The witness withdrew)

E

THE CHAIRMAN: We will be starting at 11.30 tomorrow. If there is nothing else we will adjourn now and meet again at 11.30 tomorrow. Thank you very much, ladies and gentlemen.

(The Panel adjourned until Tuesday 28 July 2009 at 11.30 a.m.)

F

G

H

General Medical Council

Dr Jane Barton

Statement of Sheelagh Joines

I, **Sheelagh Joines**, will say as follows:

1. I qualified as a nurse in August 1958 and qualified as a midwife in 1960. I started working at Gosport War Memorial Hospital in 1973 and worked on Daedalus ward from 1993.

2. I was the Ward Sister in charge of Daedalus Ward.

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

4. I have previously made two statements to the Hampshire Police and exhibit these to this statement.

5. Exhibited to this statement and marked "**SJ1**" is a copy of my witness statement dated 12 February 2003.

6. Exhibited to this statement and marked "**SJ2**" is a copy of the witness statement dated 13 October 2004 I made in relation to the care of Elsie Lavender and the use of syringe drivers on the ward.

7. I can confirm that I have been given the opportunity to re-read these statements and would like to make the following comments to clarify matters.

8. In relation to page 2 of my statement dated 12 February 2003, on reflection I do not feel that the fourth paragraph reflects the clinical position. I would therefore like to add the following words. "My work also involved the care of terminally ill patients. These were so ill that their quality of life was minimal and further treatment would not help. They could be in pain or distressed and unable to take oral medication. My aim was to give these patients a peaceful, pain-free and dignified death. I also thought this was beneficial for the relatives and caused them less distress."

9. Because the patients could not take oral analgesia, a syringe driver would be used to give the patient 24-hour pain relief. Also we could add sedation and other drugs, ie. to "dry up" secretions if necessary."

10. In relation to page 3 of my statement of 17 February 2004 I would like to add that Dr Barton would visit the hospital between about 8-8.30 am.

11. I cannot remember the exact date but I was present when Dr Lord carried out a ward round with Dr Barton. It was decided during this ward round that Dr Barton would prescribe medication prior to it being required to prevent patients being left in pain. Sometimes patients deteriorated rapidly and if Dr Barton was not present then her GP partners may be unwilling to prescribe painkillers as they did not know the patients' history. It was during this ward round that we decided that Dr Barton could prescribe medication prior to it being required. This was not a written policy and I think it was only in place on Daedalus Ward. We did not use the policy regularly but it did happen for the patients' good.

12. In relation to paragraph 3 I clarify that I would speak to Dr Barton prior to commencing the syringe driver and would start the patient on a minimal dosage. I spoke to the relatives and explained this to them but if Dr Barton was around then she would speak to them. I always recorded my actions in the medical notes. I feel that the patients' relatives were well aware of what had happened.

13. I had no concerns myself regarding this practise or Dr Barton. I set up quite a few syringe drivers and never had any doubts about whether or not they were required. I think that the relatives benefited from the patient's treatment.

14. I would never start a patient on a syringe driver without a relative's consent. I would make sure that the patient's relatives were fully aware about the effects of the syringe driver. The syringe driver does not cause death but helps the process.

15. I would make an entry in the notes that I had spoken to Dr Barton and that the relatives were informed and their permission was granted to go ahead.

16. In January 1997 I retired from Daedalus Ward at the age of 69.

17. No staff ever raised concerns with me about the use of syringe drivers and I did not have any myself.

18. I relation to the statement I made on 13 October 2004 I would like to add that I cannot remember Elsie Lavender. Nothing about her care sticks in my mind.

19. Whilst I was the Ward Sister of Daedalus Ward there was appropriate staffing levels and I had an excellent team working for me. We split the staff into two teams, blue and red, the staff all knew what they were doing and knew which patients were under the care of their team.

20. I worked very closely with Dr Barton and would say that she was all for the patients. Dr Barton was very open with the relatives.

21. 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.....

Sheelagh Joines

Dated: ....27th February 2008....

General Medical Council

Dr. Jane Barton

Exhibit SJ1

This is the Exhibit marked "SJ1" referred to in the statement of Sheelagh Joines:-

- Statement dated 12 February 2003 (regarding Elsie Devine)

No. 1

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)

Generic

Statement of: JOINES, SHEELAGH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED RGN

This statement (consisting of 5 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: S A JOINES Date: 12/02/2003

I am the above named person and I live at the address overleaf. I began my training as a nurse in 1955 at the Royal and Queen Alexander Hospital in Portsmouth. I qualified in August 1958 as a State Registered Nurse and went on to qualify as a midwife in 1960 at Beckenham in Kent.

In 1961 I married my husband who was in the RAF. In 1963 we were stationed in RAF Changai where I worked as a civilian sister for about 2½ years. I returned to England in 1966 and I began working at the GWMH as a staff nurse on the female ward. I worked there until 1968 when I adopted a son. I gave up work and had a daughter in July 1969.

In March 1970 we moved to South Africa where I again started work as a nurse at the Vordrekkerhoogte Military Hospital. I was a sister on a general ward leaving in 1971. I then worked in Nedpark Hospital Arcadia as a sister for about a year. In early 1973 we returned to Gosport in the UK.

Having returned to England I began working again at the GWMH, I was a staff nurse on the male ward for about two - three months and then began work at Northcote Annex as a sister for about 18 months. This was a geriatric ward, the first one I had worked on.

I then had a period of 18 months on a children's ward before going back to Northcote Annex where I worked for about a year before returning to the children's ward. I think this would have been about 1977.

In 1979 until 1997 (rough dates) I worked on the male ward at GWMH as a sister, dealing with

medical, surgical, geriatric and terminal care patients. During that period the male ward moved to Daedalus Ward in 1993. The male ward at the GWMH came under GP's but Daedalus Ward was under the control of a consultant, Dr LORD . I enjoyed a good working relationship with Dr LORD, who in my opinion was an excellent doctor.

The other doctor who worked on Daedalus Ward was Dr Jane BARTON , who was the clinical assistant. Dr BARTON would make the early morning visits and review the patients. I found Dr BARTON to be one of the best doctors I worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone I trust and respect highly. Although we had a first class working relationship we never went out socially.

Although Daedalus Ward was there to cater for rehab patients in my opinion this was not always possible. We would take stroke rehab where it was not always possible to rehabilitate them. We did rehabilitate some patients and got them home or into nursing homes. The rest of the beds in the ward were long stay patients. Many of these patients were at the hospital for respite care. However if it was felt that their relatives were unable to cope with them at home they would then be transferred into a long stay bed. This decision would be made by Dr LORD.

Whilst working I was involved in terminal care of very ill patients. There were people who were so ill they were expected to die. It was always my aim to give these people care, comfort and dignity. I was given instruction in the use of syringe drivers. These provided patients with 24 hour pain relief, normally for patients who were unable to swallow oral analgesics. We could also administer sedation and drugs to dry up secretions.

Only a doctor could authorise the use of a syringe driver, they would be put up by two trained nursing staff and with the consent of the patients family. With regard to the very ill patients for whom there was no further treatment who were in pain or distressed, I would inform the family that the use of the syringe driver would lead to a peaceful, dignified death. The use of the syringe driver did not accelerate the process of dying. In the four years I was at Daedalus only one family declined and asked for treatment by antibiotics. This was done as per their request.

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Whilst at Daedalus Ward some patients would suffer from pain for a period of time prior to being seen by Dr BARTON. This was because quite rightly the patients were being seen by partners of Dr BARTON who did not know the case history and were therefore unwilling to prescribe analgesic drugs required by the patients.

To that end it was agreed by Dr LORD, Dr BARTON and myself that Dr BARTON would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up as a patients admission in case they were needed, not as a matter of routine. I do not know if this practice was used on other wards.

Once the drug had been prescribed if and only if the patient deteriorated I would inform Dr BARTON and tell her I thought the time had come for the drugs to be given. I would see the relatives and discuss the situation with them in detail, involving the outcome and only if they agreed I would speak to Dr BARTON again informing her the family had given their permission and on her authority commence a syringe driver on minimal dosage given the scale as laid down by Dr BARTON. Any increase in dosage could only be authorised by Dr BARTON.

Dr BARTON would only give her permission to start a syringe driver, a few hours after having seen the patient and was fully aware of their medical condition and the need for a syringe driver. At no time did Dr BARTON and I ever disagree about the use of syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr BARTON. Had I been worried I would have questioned Dr BARTON had she failed to answer me in a satisfactory manner I would have spoken with my manager or Dr LORD.

I am not aware of any trained or auxiliary staff voicing concern about the use syringe drivers. I am not aware of any of the families I dealt with making complaints about syringe drivers or Dr BARTON.

In my opinion as a result of the current investigation many people will not get the pain free,

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dignified deaths they would otherwise have had.

In January 1997 I retired from the GWMH. Since then I have worked as a night nurse co-ordinator which is a clerical post based at Waterlooville.

General Medical Council

Dr. Jane Barton

Exhibit SJ2

This is the Exhibit marked "SJ2" referred to in the statement of Sheelagh Joines:-

- Statement dated 13 October 2004 (regarding Elsie Lavender and the use of syringe drivers on the ward)

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)

Pt B

Lavender

Statement of: JOINES, SHEELAGH ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: NIGHT NURSE COORDINATOR

This statement (consisting of 6 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: S A JOINES Date: 13/10/2004

I am Sheelagh Ann JOINES and I live at an address known to the Police.

Further to my previous statement made to the Police on 12th March 2003 (12/03/2003), I would like to add the following; my current role is that of a Night Nurse Coordinator at St Christopher's Hospital in Fareham. I have held this position for some 7 years since my retirement from Nursing.

In 1996 my role at the Gosport War Memorial Hospital was that of Sister in charge of Daedalus Ward. On a day to day basis I was responsible for the running of the ward in general. My responsibilities also included the clerical work, and accompanying the Doctor on the Ward round, usually between 0800 and 0830 hrs.

I am unsure who my line manager was at this time, it could have been Isobel EVANS , Barbara ROBINSON or Sue HUTCHINGS who would have held the position of what we used to call Matron, the person who is charge of the staff is the best way I can describe it.

My weekly hours of work at that time were 371/2. My duties, as far as I can recollect were from 0730 to 1330, 0730 to 1630/1700 and 1215 to 2030.

I was not certified to use IV drugs, and in any event these were not used on the ward at that time.

I have no knowledge of the term Wessex Protocols, but if it means the analgesic ladder, I am of course familiar with that.

RESTRICTED

I am fully trained in the use of syringe drivers but I am unsure what type of driver was being used at the time in question.

With regards to training for nurses regarding syringe drivers I had been trained in their use, But I can't remember now by whom. It could have been someone from the company that supplied it, a trained nurse, or a Marie Curie or Countess of Mountbatten nurse who would use them far more often that we would. The training would have been for a day at the most but probably less than that. It quite a simple procedure and I have trained it myself. The training consists of how to set up the syringe driver and how to put the required dose into the driver. Trained nurses only would be allowed to use such equipment. Health care and support workers would not.

At this time the there were two teams of nurses, the red and blue teams. The named nurse was the person in overall charge of each of those teams.

The time and date of all entries in the patient notes were usually completed first thing in the morning after handover or done on the day.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after referring to her medical notes, exhibit reference BJC/30 pages 131,151, 153, 200 to 228 and a letter page 13.

I can confirm that on the 23rd February 1996 (23/02/1996), page 131 I wrote the following on what I believe to be a Diabetes prescription nursing record:

Date	Time	Drug Name and Dose	Reason	Signature
23/2/96 (23/02/1996)	1730	Mixtard Insulin	Blood Sugar 8	S JOINES

With reference to this I can now see that I did not record the actual dose of insulin, which is not like me and I have no explanation as to why. This particular type of insulin is subcutaneously injected just under the skin, usually in the abdomen, upper arm or thigh

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The blood sugar figure is a sign of whether the diabetes is controlled. The reading 8 is satisfactory.

I must say that I really do not recognise this form, after all this time.

I can confirm that also on the 23rd February 1996 (23/02/1996), page 151 I wrote the following at 1720 hrs on what I believe to be the Kardex admission notes - Pathology phoned- Platelets 36? Too small sample. To be repeated Monday. Dr BARTON informed - will review. This entry is signed by me.

With reference to this entry I believe this to mean that not enough blood was taken, therefore it was not possible to do a full blood count. To repeat and take more blood on Monday, the right amount. Platelets are concerned in the make up of blood. I am not familiar with chemical pathology records so I am unable to comment on any attempt to cross reference the two records.

I can confirm that in a letter from Dr JC TANDY (Consultant Physician in Geriatrics) which reads;

Elsie LAVENDER, **Code A**

I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron deficient anaemia. Upper GI investigation might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here (I would be reluctant to consider Warfarin as I think she's going to be at great risk of falling). Alas, I don't think her brain stem stroke would show up particularly well on a CT and were now 11 days post-ictus.

I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and x rays could go with her.

Thank you for asking me to see her.

Yours sincerely

Signed: S A JOINES

Signature Witnessed by: D WILLIAMSON

RESTRICTED

Dr JC TANDY
Consultant Physician in Geriatrics
CC Dr EJ PETERS , the Surgery, 149 Forton Road, Gosport, P0123HH
Sister S JOYNES, Daedalus Ward, GWMH.

I am shown as being a recipient of this letter, I believe purely because I was the Sister in Charge of the Ward and for no other reason. As I have said I have no recollection of this patient. I don't know Dr TANDY personally, but I know of her.

On Daedalus Ward at that time there were 8 stroke beds and 14 geriatric long stay beds.

I can confirm that on page 153 of Exhibit BLC/30 dated 25th and 26th February 1996 (26/02/2004), I wrote the following 1900 hrs on 25/2/96 (25/02/1996).

Appears to be in more pain, screaming "My back" when moved but uncomplaining when not. Son would like to see Dr BARTON; this entry was signed by me.

On 26/2/96 (26/02/1996), I wrote the following;

Seen by Dr BARTON MST> 20mgms BD. She will see Mr LAVENDER @ 1400 hrs this afternoon. I did phone him. Blood sugars 20> this entry was signed by me

Insulin dose increased
1430 hrs - Son's wife seen by Dr BARTON- prognosis discussed. Son is happy for us to just make Mrs LAVENDER comfortable and pain free. Syringe driver explained.

1440hrs- All mattress needed changing- 10 MST mgms given prior to moving on to Pegasus mattress.

The meaning of this is almost self explanatory in that the use of the syringe driver was explained to Mr LAVENDER junior's wife in order for the patient to be comfortable and to be

RESTRICTED

free from pain.

MST means Morphine Slow release Tablets were used as Mrs LAVENDER was not responding, it was not controlling the pain.

The Pegasus air mattress was required for release of pressure from bed sores.
I can confirm that on page 151 of Exhibit BJC/30, dated 24/2/96, I wrote the following

Pain not controlled properly by DF 118. Seen by Dr BARTON- boarded for MST 10Mgs BD, this entry was signed by me.

I knew that the pain was not being controlled by observing that the patient was in pain when moved. Another reason would be that the patient informed us of pain.

Because of this I informed Dr BARTON who visited and boarded for MST 10 Mgs twice a day. This was usually at 0600 and 1800

Boarded means, written up or prescribed in treatment sheet
BD means twice a day
DF 118 is a strong Analgesic tablet
Dr BARTON increased the MST to 20Mgs on 26/2/96 (26/02/1996)
This is shown on page 145 of BJC/30, the prescription charts.

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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)

LAUENDER

Statement of: JOINES, SHEELAGH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED RGN

This statement (consisting of 5 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: S A JOINES Date: 12/02/2003

I am the above named person and I live at the address overleaf. I began my training as a nurse in 1955 at the Royal and Queen Alexander Hospital in Portsmouth. I qualified in August 1958 as a State Registered Nurse and went on to qualify as a midwife in 1960 at Beckenham in Kent.

In 1961 I married my husband who was in the RAF. In 1963 we were stationed in RAF Changai where I worked as a civilian sister for about 2½ years. I returned to England in 1966 and I began working at the GWMH as a staff nurse on the female ward. I worked there until 1968 when I adopted a son. I gave up work and had a daughter in July 1969.

In March 1970 we moved to South Africa where I again started work as a nurse at the Vordrekkerhoogte Military Hospital. I was a sister on a general ward leaving in 1971. I then worked in Nedpark Hospital Arcadia as a sister for about a year. In early 1973 we returned to Gosport in the UK.

Having returned to England I began working again at the GWMH, I was a staff nurse on the male ward for about two - three months and then began work at Northcote Annex as a sister for about 18 months. This was a geriatric ward, the first one I had worked on.

I then had a period of 18 months on a children's ward before going back to Northcote Annex where I worked for about a year before returning to the children's ward. I think this would have been about 1977.

In 1979 until 1997 (rough dates) I worked on the male ward at GWMH as a sister, dealing with

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medical, surgical, geriatric and terminal care patients. During that period the male ward moved to Daedalus Ward in 1993. The male ward at the GWMH came under GP's but Daedalus Ward was under the control of a consultant, Dr LORD . I enjoyed a good working relationship with Dr LORD, who in my opinion was an excellent doctor.

The other doctor who worked on Daedalus Ward was Dr Jane BARTON , who was the clinical assistant. Dr BARTON would make the early morning visits and review the patients. I found Dr BARTON to be one of the best doctors I worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone I trust and respect highly. Although we had a first class working relationship we never went out socially.

Although Daedalus Ward was there to cater for rehab patients in my opinion this was not always possible. We would take stroke rehab where it was not always possible to rehabilitate them. We did rehabilitate some patients and got them home or into nursing homes. The rest of the beds in the ward were long stay patients. Many of these patients were at the hospital for respite care. However if it was felt that their relatives were unable to cope with them at home they would then be transferred into a long stay bed. This decision would be made by Dr LORD.

Whilst working I was involved in terminal care of very ill patients. There were people who were so ill they were expected to die. It was always my aim to give these people care, comfort and dignity. I was given instruction in the use of syringe drivers. These provided patients with 24 hour pain relief, normally for patients who were unable to swallow oral analgesics. We could also administer sedation and drugs to dry up secretions.

Only a doctor could authorise the use of a syringe driver, they would be put up by two trained nursing staff and with the consent of the patients family. With regard to the very ill patients for whom there was no further treatment who were in pain or distressed, I would inform the family that the use of the syringe driver would lead to a peaceful, dignified death. The use of the syringe driver did not accelerate the process of dying. In the four years I was at Daedalus only one family declined and asked for treatment by antibiotics. This was done as per their request.

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Whilst at Daedalus Ward some patients would suffer from pain for a period of time prior to being seen by Dr BARTON. This was because quite rightly the patients were being seen by partners of Dr BARTON who did not know the case history and were therefore unwilling to prescribe analgesic drugs required by the patients.

To that end it was agreed by Dr LORD, Dr BARTON and myself that Dr BARTON would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up as a patients admission in case they were needed, not as a matter of routine. I do not know if this practice was used on other wards.

Once the drug had been prescribed if and only if the patient deteriorated I would inform Dr BARTON and tell her I thought the time had come for the drugs to be given. I would see the relatives and discuss the situation with them in detail, involving the outcome and only if they agreed I would speak to Dr BARTON again informing her the family had given their permission and on her authority commence a syringe driver on minimal dosage given the scale as laid down by Dr BARTON. Any increase in dosage could only be authorised by Dr BARTON.

Dr BARTON would only give her permission to start a syringe driver, a few hours after having seen the patient and was fully aware of their medical condition and the need for a syringe driver. At no time did Dr BARTON and I ever disagree about the use of syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr BARTON. Had I been worried I would have questioned Dr BARTON had she failed to answer me in a satisfactory manner I would have spoken with my manager or Dr LORD.

I am not aware of any trained or auxiliary staff voicing concern about the use syringe drivers. I am not aware of any of the families I dealt with making complaints about syringe drivers or Dr BARTON.

In my opinion as a result of the current investigation many people will not get the pain free,

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dignified deaths they would otherwise have had.

In January 1997 I retired from the GWMH. Since then I have worked as a night nurse co-ordinator which is a clerical post based at Waterlooville.

RESTRICTED

WITNESS STATEMENT

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

Statement of: JOINES, SHEELAGH ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: NIGHT NURSE COORDINATOR

This statement (consisting of 6 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: S A JOINES Date: 13/10/2004

I am Sheelagh Ann JOINES and I live at an address known to the Police.

Further to my previous statement made to the Police on 12th March 2003 (12/03/2003), I would like to add the following; my current role is that of a Night Nurse Coordinator at St Christopher's Hospital in Fareham. I have held this position for some 7 years since my retirement from Nursing.

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I am unsure who my line manager was at this time, it could have been Isobel EVANS , Barbara ROBINSON or Sue HUTCHINGS who would have held the position of what we used to call Matron, the person who is charge of the staff is the best way I can describe it.

My weekly hours of work at that time were 37 1/2. My duties, as far as I can recollect were from 0730 to 1330, 0730 to 1630/1700 and 1215 to 2030.

I was not certified to use IV drugs, and in any event these were not used on the ward at that time.

I have no knowledge of the term Wessex Protocols, but if it means the analgesic ladder, I am of course familiar with that.

RESTRICTED

I am fully trained in the use of syringe drivers but I am unsure what type of driver was being used at the time in question.

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I can confirm that in a letter from Dr JC TANDY (Consultant Physician in Geriatrics) which reads;

Elsie LAVENDER, Code A

I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron deficient anaemia. Upper GI investigation might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here (I would be reluctant to consider Warfarin as I think she's going to be at great risk of falling). Alas, I don't think her brain stem stroke would show up particularly well on a CT and were now 11 days post-ictus.

I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and x rays could go with her.

Thank you for asking me to see her.

Yours sincerely

RESTRICTED

Dr JC TANDY
Consultant Physician in Geriatrics
CC Dr EJ PETERS , the Surgery, 149 Forton Road, Gosport, P0123HH
Sister S JOYNES, Daedalus Ward, GWMH.

I am shown as being a recipient of this letter, I believe purely because I was the Sister in Charge of the Ward and for no other reason. As I have said I have no recollection of this patient. I don't know Dr TANDY personally, but I know of her.

On Daedalus Ward at that time there were 8 stroke beds and 14 geriatric long stay beds.

I can confirm that on page 153 of Exhibit BLC/30 dated 25th and 26th February 1996 (26/02/2004), I wrote the following 1900 hrs on 25/2/96 (25/02/1996).

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RESTRICTED

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DF 118 is a strong Analgesic tablet
Dr BARTON increased the MST to 20Mgs on 26/2/96 (26/02/1996)
This is shown on page 145 of BJC/30, the prescription charts.

WITNESS STATEMENT

STATEMENT OF **ROBERT PENNELLS**

AGE: OVER 18

This Statement consisting of 6 pages 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.

DATED this 26 day of July 2009

Signed ..Code A....

ROBERT PENNELLS

I am Robert Pennells of Code A I am a Registered Medical Practitioner and was until September 2007 a General Practitioner in Gosport, Hampshire having started work there in 1978. I trained at St Mary's Hospital, London, passed my finals in 1971, and registered in 1972. Between 1972 and 1978 I undertook hospital work in various specialties in England, Bermuda and New Zealand. I then worked as a GP in Gosport, becoming Senior Partner in my practice in 1990.

I first met Dr Jane Barton when she did locum work at my own practice in 1979 or 1980 before she joined her present practice. Indeed, my partners and I at the time did not realise that Dr Barton was looking for a permanent post and would have considered offering her a post in our practice if we had. The reason for this is that we appreciated how she good she was at general practice even in that short time. Since then, I have known her as a cheerful, hardworking and caring physician. She became Clinical Assistant in Elderly Medicine in the 1980s or 1990s, and

Signed....Code A..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

was also involved in the formation of Gosport Primary Care Group and acted as Chairman for some time. I was part of that group and her performance in that role was excellent.

Gosport is very fortunate in having the Gosport War Memorial Hospital, which is a local hospital with in-patient beds. There have been changes over the years, but the Hospital has a mix of elderly medicine beds, GP beds, and out-patient services. The elderly medicine beds are further sub-divided in to long stay beds, rehabilitation beds and terminal care beds. These categories are not necessarily definable and there are areas in between that would best be described as grey areas – because elderly people may change in their condition without warning, depending on their illnesses or circumstance. Elderly patients would therefore be looked after long term perhaps while awaiting a place in an 'Old Peoples' Home' or being rehabilitated to a stage where they could live in the community or an Old Peoples' Home, or they were in a position of having been investigated and treated but not being expected to recover – ie palliative care.

Dr Barton worked in the elderly medicine department as a Clinical Assistant, as far as I know with the supervision of the Consultant in charge of the beds and, as far as I could see, very efficiently. Dr Barton was effectively working as a Junior Doctor – equivalent to a Senior House Officer or Registrar. My surgery was in the Gosport Health Centre at the time of the allegations now made against Dr Barton, and our building was attached to the Gosport War Memorial Hospital on the same site. As I drove to work in the morning I often saw Dr Barton's car parked outside the hospital as she was visiting the Wards before going on to her own surgery to do her GP work. I took this to be an indication of her dedication to the post which she was serving.

In relation to Jane's work as a Clinical Assistant, I understand that she worked for 3½ or 4 sessions a week. I have been told that Dr Barton was looking after patients in up to 44 beds at any one time. This is a high workload and became increasingly more difficult in the time allocated. I think initially her position was a nice job – she was doing it at her speed and the patients were likely to improve.

Signed.. Code A ..... Witnessed Code A ....

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

During her time as Clinical Assistant, Dr Barton asked me to sign cremation forms for some of the patients who had died in the Elderly Medicine Department. Sometimes these patients had been registered with my practice and I would have had some background knowledge of their previous condition. I believe that in seeking an opinion in relation to the Cremation Forms Dr Barton would often ask a doctor from the patient's own practice to help with these forms.

The signing of the second part of the cremation form is a legal act not to be taken lightly. I have signed many of these forms over the years and always made sure I was in possession of all relevant facts before doing so. The procedure is as follows: the clinician that was looking after the patient at the time of death contacts another physician who was not in the same practice or department and tells him or her the cause of death and the circumstances leading up to the death. The second clinician then speaks to someone who had been looking after the deceased or who had some knowledge of the events leading up to the death. If the second clinician is sure that there is no reason the cremation needs to be delayed, then and only then, does he or she sign the form.

In considering the Cremation Forms relating to patients Dr Barton had been looking after, I never came across a case in which I thought there was a problem in signing the Cremation Certificate. Before considering whether or not it was appropriate to sign the Certificate I always looked at the patient's notes and spoke to the Nursing Staff who had had care of the patient. In the case of the patients from the Elderly Medicine Department there was always a Senior Nursing Staff Nurse, Sister or Nurse Manager to interview and also the hospital notes to inspect. To my mind there never appeared to be any question about Dr Barton's clinical abilities. In no case in which I was asked to sign the Cremation Form did I feel there was a problem with the way the patient had been treated. My general impression of her was that she was a good Clinical Assistant from all the information I was able to gather, including my liaison with the Nursing Staff.

In reviewing the notes of patients when being asked sign Cremation Forms, it appeared to me that over the mid to late 90s, patients who had been transferred into beds at Gosport War Memorial Hospital appeared to be more ill than in previous years.

Signed.....Code A..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

In later years I found that I was signing more cremation forms, and it seemed that this resulted from a change in the nature of the patients who were being transferred to Daedalus Ward and Dryad Wards at the War Memorial Hospital – they were more acutely ill and dependent than previously.

As a General Practitioner it was apparent to me that over the years local hospital trusts had increasing difficulty in relation to beds. General hospital beds were routinely filled, and often consultants at the Queen Alexandra Hospital, for example, would ask us to take patients onto Sultan Ward at the War Memorial Hospital. On occasion we would be told that the patients would be able to go home shortly after their admission to the Ward, only to find out on transfer from the District General Hospital that they were in a worse condition than we had been led to believe. Ultimately in 2000 it became necessary to set clear criteria for admission to the Ward.

Closure of beds was our main problem, the lack of availability of beds at District General Hospitals meant that more patients were transferred to us. I think there might have been a slight criticism from the Hospital Trust that Sultan Ward, for example, was only 80% occupied, whilst other units were at 95% capacity.

In relation to the quality of notes I reviewed when considering the Cremation Certificates, I do not believe there was a problem in picking out the important information. It was of course open for me to speak with the Nursing Staff which I did, and any apparent gaps in the notes were filled by that.

Not all the patients who died on those Wards were receiving Diamorphine and Midazolam by way of syringe drivers. I think it is fair to say that a high proportion were receiving such medication as time went on, but that resulted from the different type of patient being admitted, with an increasing number being in pain than had been the case earlier. Towards the end of Dr Barton's time as a Clinical Assistant at the Hospital, I would estimate that about half of the patients that died were receiving this medication and by such a method of administration.

Signed. Code A ..... Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

That had not been the case in earlier years. I am aware that from time to time syringe drivers were donated to the Hospital by grateful relatives of patients who had been treated and indeed who had died there.

Originally at the War Memorial Hospital, there had been male, female and children's wards, all with GP beds. However, when the Hospital was developed, an extra 3 wards were added, including Sultan Ward, being the new GP Ward. Patients were admitted to Sultan Ward under GP Care if we felt the patient needed more support than was generally available at home. If I admitted a patient to Sultan Ward, I would then go to see that patient on most days, to ensure that the patient was progressing as I had hoped – or indeed arrange for the patient then to be transferred to a Local District General Hospital if necessary. Alternatively, it was possible to get the view of a clinician in Elderly Medicine, who could arrange admission to one of the other Wards at the Gosport War Memorial Hospital if that was felt to be appropriate and a bed was available.

It is only fair to point out that the War Memorial Hospital is not a District General Hospital, and patients were dealt with in a different way. We had good nursing staff at the Hospital, but there was limited medical cover.

I am aware of the detail of the allegations made against Dr Barton contained in the various Heads of Charge. I appreciate there is some concern that the doses of opiates drugs prescribed were not in the patients' best interests. I understand that variable doses were prescribed. I never felt the doses were excessive in the cases I was asked to comment upon when dealing with Cremation Forms. At the time in the Elderly Medicine Department the prescription of these drugs was put in this manner in order for the staff to be able to increase the dose of the drug without the difficulty of having to find a prescribing Clinician to change the dose. This was particularly for out of hours and weekend times when undue suffering may have been caused if a patient had to wait for someone to be called in to the Hospital. This manner of prescribing is not only confined to elderly medicine. I have come across it in treatment of pain especially with regard to cancer sufferers.

Signed.. Code A .....Witnessed Code A

STATEMENT OF ROBERT PENNELLS

AGE: OVER 18

Over the years patients came to register with our practice who had fallen out with other GPs locally, and they were therefore transferring. At no time, however, did I ever have a patient transferring to me from the list of Jane Barton.

In my view, Dr Barton is a competent and caring clinician who has spent the last 10 years at least in a very unnatural condition waiting for her case to be completed. In describing her, I cannot think of any bad words to say about her.

Of Dr Barton and I her husband, I would say they are a remarkable couple. Both are extremely resilient. Several medical colleagues have commented to me that they would simply not have been able to put up with the pressure under which Dr Barton has suffered over recent years.

Dr Barton puts on a brave face about her predicament but it has taken a toll upon her.

Signed Code A ..... Witnessed Code A

Signed Code A ..... Witnessed Code A

General Medical Council

Dr Jane Barton

Statement of Sheelagh Joines

I, Sheelagh Joines, will say as follows:

1. I qualified as a nurse in August 1958 and qualified as a midwife in 1960. I started working at Gosport War Memorial Hospital in 1973 and worked on Daedalus ward from 1993.

2. I was the Ward Sister in charge of Daedalus Ward.

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

4. I have previously made two statements to the Hampshire Police and exhibit these to this statement.

5. Exhibited to this statement and marked "**SJ1**" is a copy of my witness statement dated 12 February 2003.

6. Exhibited to this statement and marked "**SJ2**" is a copy of the witness statement dated 13 October 2004 I made in relation to the care of Elsie Lavender and the use of syringe drivers on the ward.

7. I can confirm that I have been given the opportunity to re-read these statements and would like to make the following comments to clarify matters.

8. In relation to page 2 of my statement dated 12 February 2003, on reflection I do not feel that the fourth paragraph reflects the clinical position. I would therefore like to add the following words. "My work also involved the care of terminally ill patients. These were so ill that their quality of life was minimal and further treatment would not help. They could be in pain or distressed and unable to take oral medication. My aim was to give these patients a peaceful, pain-free and dignified death. I also thought this was beneficial for the relatives and caused them less distress."

9. Because the patients could not take oral analgesia, a syringe driver would be used to give the patient 24-hour pain relief. Also we could add sedation and other drugs, ie. to "dry up" secretions if necessary."

10. In relation to page 3 of my statement of 17 February 2004 I would like to add that Dr Barton would visit the hospital between about 8-8.30 am.

11. I cannot remember the exact date but I was present when Dr Lord carried out a ward round with Dr Barton. It was decided during this ward round that Dr Barton would prescribe medication prior to it being required to prevent patients being left in pain. Sometimes patients deteriorated rapidly and if Dr Barton was not present then her GP partners may be unwilling to prescribe painkillers as they did not know the patients' history. It was during this ward round that we decided that Dr Barton could prescribe medication prior to it being required. This was not a written policy and I think it was only in place on Daedalus Ward. We did not use the policy regularly but it did happen for the patients' good.

12. In relation to paragraph 3 I clarify that I would speak to Dr Barton prior to commencing the syringe driver and would start the patient on a minimal dosage. I spoke to the relatives and explained this to them but if Dr Barton was around then she would speak to them. I always recorded my actions in the medical notes. I feel that the patients' relatives were well aware of what had happened.

13. I had no concerns myself regarding this practise or Dr Barton. I set up quite a few syringe drivers and never had any doubts about whether or not they were required. I think that the relatives benefited from the patient's treatment.

14. I would never start a patient on a syringe driver without a relative's consent. I would make sure that the patient's relatives were fully aware about the effects of the syringe driver. The syringe driver does not cause death but helps the process.

15. I would make an entry in the notes that I had spoken to Dr Barton and that the relatives were informed and their permission was granted to go ahead.

16. In January 1997 I retired from Daedalus Ward at the age of 69.

17. No staff ever raised concerns with me about the use of syringe drivers and I did not have any myself.

18. I relation to the statement I made on 13 October 2004 I would like to add that I cannot remember Elsie Lavender. Nothing about her care sticks in my mind.

19. Whilst I was the Ward Sister of Daedalus Ward there was appropriate staffing levels and I had an excellent team working for me. We split the staff into two teams, blue and red, the staff all knew what they were doing and knew which patients were under the care of their team.

20. I worked very closely with Dr Barton and would say that she was all for the patients. Dr Barton was very open with the relatives.

21. 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.....

Sheelagh Joines

Dated: 27th February 2008

General Medical Council

Dr. Jane Barton

Exhibit SJ1

This is the Exhibit marked "SJ1" referred to in the statement of Sheelagh Joines:-

- Statement dated 12 February 2003 (regarding Elsie Devine)

No - Generic

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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: JOINES, SHEELAGH

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED RGN

This statement (consisting of 5 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: S A JOINES Date: 12/02/2003

I am the above named person and I live at the address overleaf. I began my training as a nurse in 1955 at the Royal and Queen Alexander Hospital in Portsmouth. I qualified in August 1958 as a State Registered Nurse and went on to qualify as a midwife in 1960 at Beckenham in Kent.

In 1961 I married my husband who was in the RAF. In 1963 we were stationed in RAF Changai where I worked as a civilian sister for about 2½ years. I returned to England in 1966 and I began working at the GWMH as a staff nurse on the female ward. I worked there until 1968 when I adopted a son. I gave up work and had a daughter in July 1969.

In March 1970 we moved to South Africa where I again started work as a nurse at the Vordrekkerhoogte Military Hospital. I was a sister on a general ward leaving in 1971. I then worked in Nedpark Hospital Arcadia as a sister for about a year. In early 1973 we returned to Gosport in the UK.

Having returned to England I began working again at the GWMH, I was a staff nurse on the male ward for about two - three months and then began work at Northcote Annex as a sister for about 18 months. This was a geriatric ward, the first one I had worked on.

I then had a period of 18 months on a children's ward before going back to Northcote Annex where I worked for about a year before returning to the children's ward. I think this would have been about 1977.

In 1979 until 1997 (rough dates) I worked on the male ward at GWMH as a sister, dealing with

medical, surgical, geriatric and terminal care patients. During that period the male ward moved to Daedalus Ward in 1993. The male ward at the GWMH came under GP's but Daedalus Ward was under the control of a consultant, Dr LORD . I enjoyed a good working relationship with Dr LORD, who in my opinion was an excellent doctor.

The other doctor who worked on Daedalus Ward was Dr Jane BARTON , who was the clinical assistant. Dr BARTON would make the early morning visits and review the patients. I found Dr BARTON to be one of the best doctors I worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone I trust and respect highly. Although we had a first class working relationship we never went out socially.

Although Daedalus Ward was there to cater for rehab patients in my opinion this was not always possible. We would take stroke rehab where it was not always possible to rehabilitate them. We did rehabilitate some patients and got them home or into nursing homes. The rest of the beds in the ward were long stay patients. Many of these patients were at the hospital for respite care. However if it was felt that their relatives were unable to cope with them at home they would then be transferred into a long stay bed. This decision would be made by Dr LORD.

Whilst working I was involved in terminal care of very ill patients. There were people who were so ill they were expected to die. It was always my aim to give these people care, comfort and dignity. I was given instruction in the use of syringe drivers. These provided patients with 24 hour pain relief, normally for patients who were unable to swallow oral analgesics. We could also administer sedation and drugs to dry up secretions.

Only a doctor could authorise the use of a syringe driver, they would be put up by two trained nursing staff and with the consent of the patients family. With regard to the very ill patients for whom there was no further treatment who were in pain or distressed, I would inform the family that the use of the syringe driver would lead to a peaceful, dignified death. The use of the syringe driver did not accelerate the process of dying. In the four years I was at Daedalus only one family declined and asked for treatment by antibiotics. This was done as per their request.

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Whilst at Daedalus Ward some patients would suffer from pain for a period of time prior to being seen by Dr BARTON. This was because quite rightly the patients were being seen by partners of Dr BARTON who did not know the case history and were therefore unwilling to prescribe analgesic drugs required by the patients.

To that end it was agreed by Dr LORD, Dr BARTON and myself that Dr BARTON would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up as a patients admission in case they were needed, not as a matter of routine. I do not know if this practice was used on other wards.

Once the drug had been prescribed if and only if the patient deteriorated I would inform Dr BARTON and tell her I thought the time had come for the drugs to be given. I would see the relatives and discuss the situation with them in detail, involving the outcome and only if they agreed I would speak to Dr BARTON again informing her the family had given their permission and on her authority commence a syringe driver on minimal dosage given the scale as laid down by Dr BARTON. Any increase in dosage could only be authorised by Dr BARTON.

Dr BARTON would only give her permission to start a syringe driver, a few hours after having seen the patient and was fully aware of their medical condition and the need for a syringe driver. At no time did Dr BARTON and I ever disagree about the use of syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr BARTON. Had I been worried I would have questioned Dr BARTON had she failed to answer me in a satisfactory manner I would have spoken with my manager or Dr LORD.

I am not aware of any trained or auxiliary staff voicing concern about the use syringe drivers. I am not aware of any of the families I dealt with making complaints about syringe drivers or Dr BARTON.

In my opinion as a result of the current investigation many people will not get the pain free.

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dignified deaths they would otherwise have had.

In January 1997 I retired from the GWMH. Since then I have worked as a night nurse co-ordinator which is a clerical post based at Waterlooville.

General Medical Council

Dr. Jane Barton

Exhibit SJ2

This is the Exhibit marked "SJ2" referred to in the statement of Sheelagh Joines:-

- Statement dated 13 October 2004 (regarding Elsie Lavender and the use of syringe drivers on the ward)

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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: JOINES, SHEELAGH ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: NIGHT NURSE COORDINATOR

This statement (consisting of 6 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: S A JOINES Date: 13/10/2004

I am Sheelagh Ann JOINES and I live at an address known to the Police.

Further to my previous statement made to the Police on 12th March 2003 (12/03/2003), I would like to add the following; my current role is that of a Night Nurse Coordinator at St Christopher's Hospital in Fareham. I have held this position for some 7 years since my retirement from Nursing.

In 1996 my role at the Gosport War Memorial Hospital was that of Sister in charge of Daedalus Ward. On a day to day basis I was responsible for the running of the ward in general. My responsibilities also included the clerical work, and accompanying the Doctor on the Ward round, usually between 0800 and 0830 hrs.

I am unsure who my line manager was at this time, it could have been Isobel EVANS , Barbara ROBINSON or Sue HUTCHINGS who would have held the position of what we used to call Matron, the person who is charge of the staff is the best way I can describe it.

My weekly hours of work at that time were 37 1/2. My duties, as far as I can recollect were from 0730 to 1330, 0730 to 1630/1700 and 1215 to 2030.

I was not certified to use IV drugs, and in any event these were not used on the ward at that time.

I have no knowledge of the term Wessex Protocols, but if it means the analgesic ladder, I am of course familiar with that.

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I am fully trained in the use of syringe drivers but I am unsure what type of driver was being used at the time in question.

With regards to training for nurses regarding syringe drivers I had been trained in their use, But I can't remember now by whom. It could have been someone from the company that supplied it, a trained nurse, or a Marie Curie or Countess of Mountbatten nurse who would use them far more often that we would. The training would have been for a day at the most but probably less than that. It quite a simple procedure and I have trained it myself. The training consists of how to set up the syringe driver and how to put the required dose into the driver. Trained nurses only would be allowed to use such equipment. Health care and support workers would not.

At this time the there were two teams of nurses, the red and blue teams. The named nurse was the person in overall charge of each of those teams.

The time and date of all entries in the patient notes were usually completed first thing in the morning after handover or done on the day.

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after referring to her medical notes, exhibit reference BJC/30 pages 131,151, 153, 200 to 228 and a letter page 13.

I can confirm that on the 23rd February 1996 (23/02/1996), page 131 I wrote the following on what I believe to be a Diabetes prescription nursing record:

Date	Time	Drug Name and Dose	Reason	Signature
23/2/96 (23/02/1996)	1730	Mixtard Insulin	Blood Sugar 8	S JOINES

With reference to this I can now see that I did not record the actual dose of insulin, which is not like me and I have no explanation as to why. This particular type of insulin is subcutaneously injected just under the skin, usually in the abdomen, upper arm or thigh

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The blood sugar figure is a sign of whether the diabetes is controlled. The reading 8 is satisfactory.

I must say that I really do not recognise this form, after all this time.

I can confirm that also on the 23rd February 1996 (23/02/1996), page 151 I wrote the following at 1720 hrs on what I believe to be the Kardex admission notes - Pathology phoned- Platelets 36? Too small sample. To be repeated Monday. Dr BARTON informed - will review. This entry is signed by me.

With reference to this entry I believe this to mean that not enough blood was taken, therefore it was not possible to do a full blood count. To repeat and take more blood on Monday, the right amount. Platelets are concerned in the make up of blood. I am not familiar with chemical pathology records so I am unable to comment on any attempt to cross reference the two records.

I can confirm that in a letter from Dr JC TANDY (Consultant Physician in Geriatrics) which reads;

Elsie LAVENDER, Code A

I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron deficient anaemia. Upper GI investigation might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here (I would be reluctant to consider Warfarin as I think she's going to be at great risk of falling). Alas, I don't think her brain stem stroke would show up particularly well on a CT and were now 11 days post-ictus.

I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and x rays could go with her.

Thank you for asking me to see her.

Yours sincerely

Signed: S A JOINES Signature Witnessed by: D WILLIAMSON

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Dr JC TANDY
Consultant Physician in Geriatrics
CC Dr EJ PETERS , the Surgery, 149 Forton Road, Gosport, P0123HH
Sister S JOYNES, Daedalus Ward, GWMH.

I am shown as being a recipient of this letter, I believe purely because I was the Sister in Charge of the Ward and for no other reason. As I have said I have no recollection of this patient. I don't know Dr TANDY personally, but I know of her.

On Daedalus Ward at that time there were 8 stroke beds and 14 geriatric long stay beds.

I can confirm that on page 153 of Exhibit BLC/30 dated 25th and 26th February 1996 (26/02/2004), I wrote the following 1900 hrs on 25/2/96 (25/02/1996).

Appears to be in more pain, screaming "My back" when moved but uncomplaining when not. Son would like to see Dr BARTON; this entry was signed by me.

On 26/2/96 (26/02/1996), I wrote the following;

Seen by Dr BARTON MST> 20mgms BD. She will see Mr LAVENDER @ 1400 hrs this afternoon. I did phone him. Blood sugars 20> this entry was signed by me

Insulin dose increased
1430 hrs - Son's wife seen by Dr BARTON- prognosis discussed. Son is happy for us to just make Mrs LAVENDER comfortable and pain free. Syringe driver explained.

1440hrs- All mattress needed changing- 10 MST mgms given prior to moving on to Pegasus mattress.

The meaning of this is almost self explanatory in that the use of the syringe driver was explained to Mr LAVENDER junior's wife in order for the patient to be comfortable and to be

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free from pain.

MST means Morphine Slow release Tablets were used as Mrs LAVENDER was not responding, it was not controlling the pain.

The Pegasus air mattress was required for release of pressure from bed sores.
I can confirm that on page 151 of Exhibit BJC/30, dated 24/2/96, I wrote the following

Pain not controlled properly by DF 118. Seen by Dr BARTON- boarded for MST 10Mgs BD, this entry was signed by me.

I knew that the pain was not being controlled by observing that the patient was in pain when moved. Another reason would be that the patient informed us of pain.

Because of this I informed Dr BARTON who visited and boarded for MST 10 Mgs twice a day. This was usually at 0600 and 1800

Boarded means, written up or prescribed in treatment sheet
BD means twice a day
DF 118 is a strong Analgesic tablet
Dr BARTON increased the MST to 20Mgs on 26/2/96 (26/02/1996)
This is shown on page 145 of BJC/30, the prescription charts.

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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: EVANS, ISOBEL

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED PATIENT CARE MANAGER

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: I EVANS Date: 12/11/2002

I am the person named above and live at the address shown on the attached form.

In 1961 after completing my training I became a State Registered Nurse.

Then in 1966 I commenced employment at the Gosport War Memorial Hospital as a Staff Nurse in the Accident and Emergency Department.

In 1978 I became Ward Sister in the female ward at the hospital.

Eventually, in 1988 I progressed to become a Matron and a few years later I then became Patient Care Manager. I fulfilled this role until my retirement in 1996.

My responsibilities in 1991 as Patient Care Manager was for all nursing care within the hospital units. Which consisted of 3 wards, operating theatre, outpatients and the Accident and Emergency Department.

There was also two annexes known as Redcliffe House and Northcote House , which I was also responsible for.

In regard to the Redcliffe House annexe this was a 22 bed unit for the long term care of elderly patients who were all under the care of a consultant.

The staff requirements for the unit was 5/6 in the morning, 3/4 in the afternoon and evening and a minimum of 2 at night.

When I took control of the Redcliffe House annexe it was obvious that there were problems with the unit and the staff. These were mainly due to outdated nursing practices, poor morale and inappropriate treatment of patients.

A nursing auxiliary indicated that some patients were being force fed and that the general manner in which patients were treated by some staff was quite poor.

One example given was of a patient who was incapable of moving who was sat in chair one day. When two nurses told her that there was a rat behind her and that if she did not cease to be

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troublesome they would leave it there. I conducted an enquiry into these allegations but was unable to prove or disprove. However as a result of this enquiry one member of staff was moved and another retired.

I also started implementing other measures to improve nursing practices and help morale at the unit.

Unfortunately some of these ideas were resisted by some of the nurses at the unit, who were not happy with this 'culture change'.

In 1991 we started using syringe drivers at the unit. This was a result of some staff attending study days where it was recommended that pain relief given a regular/constant basis would alleviate pain better than giving painkilling drugs irregularly, which was the normal practice.

One of the painkilling drugs we used on a regular basis was Diamorphine and sometimes a syringe driver was used.

Shortly after we began this practice some of the staff from Redcliffe House approached me, this included Anita TUBBRITT and Sylvia GIFFIN . They expressed concerns over the amount of Diamorphine used at the unit.

I was already aware at this time that Sylvia GIFFIN, who was a staff nurse at the unit, did not give patients Diamorphine at night unless they were awake, when she was on duty. She complained that she had been criticised for this. After listening to their concerns I spoke to Dr BARTON , who was the clinical assistant for the unit and the unit sister, Gill HAMBLIN . They satisfied me that all usage of the drivers at the unit was safe and appropriate.

I felt that the problem was that the drivers were new and the staff did understand the thinking behind their usage.

Therefore I arranged training for them and Steve KING , a pain control expert, to attend on study days to give lecture on drivers.

Another expert Linda FOSTER , also came along and showed them how to set the drivers up and who to use them on.

In regard to the amount of Diamorphine used some of the staff were under the perception that patients were getting more. This was because they were used to giving the patient for example 10 milligrams of Diamorphine orally every four hours.

However, now with the use of the syringe drivers they were getting 60 milligrams at once but this was fed to them over a 24 hour period by the driver at a constant level. This obviously

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equated to 6 doses of 10 milligrams over 24 hours but some of the staff could not originally comprehend this.

The other complaint by the staff was that patients who were not in pain were placed on the syringe driver. However they could not give any examples. I think the problem here was that at the time we had patients who could not express themselves due to the fact they were suffering from strokes or were confused. Therefore they could not indicate if they were in pain.

At the time I had no concerns about syringe drivers and indeed I instigated their purchase. I believed that they offered the highest level of pain control on the smallest dosage possible.

Furthermore in 1991 there was only five syringe drivers in the entire hospital complex, with Redcliffe House only having one driver with access to another spare one. So their usage then was rather conservative. Although I was totally surprised by the staff fears, I did not think it was likely to become a problem.

I did make Doctor LOGAN , the senior consultant at the unit, aware of their concerns. I must add here that the doctors were responsible for the prescription of painkillers to patients and who should be placed on a syringe driver.

In respect of Doctor LOGAN and Doctor BARTON, I found them both approachable and capable professionals.

However despite the training I received a letter from the staff representative stating that they still had concerns over the syringe drivers.

I spoke to Doctor LOGAN who said that he would not respond to this letter without examples of their misuse. Therefore I sent a memo to all the staff at the unit requesting examples. Unfortunately I did not receive one reply. I was still anxious to address this problem so a meeting was arranged. Which was attended by Doctors BARTON and LOGAN and all the trained staff and myself from the unit.

I brought up all the concerns raised by the staff and gave them the opportunity to amplify these. Doctor LOGAN answered all their concerns over the syringe drivers and the prescribing of Diamorphine. I felt that everyone was satisfied by the answers given. Indeed the issue was never again raised between then and my retirement in 1996.

I would like to state that Dr BARTON was also the clinical assistant to two other units within the hospital complex, the Northcote House annexe and the geriatric beds within the female/male ward in the main building.

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There was never any complaints forthcoming from those units about Dr BARTON prescribing medication.

My personal opinion is that these problems in 1991 were due to the culture changes at the unit which I helped impose there.

These were mainly the use of painkillers and bringing the nursing practices up to date.

I was supported in the effort to impose the changes by Gill HAMBLIN, the sister in charge of the unit.

I recently became aware of problems at the hospital through the local papers.

On 23rd October 2002 (23/10/2002) I was shown various papers with identification reference number JEP/GWMH/1/7 . This is a collection of meeting minutes, letters and memos. Some of which I recognise. In respect of the report by Gerri WHITNEY I cannot recall seeing it but I may have seen it at the time.

However in respect of the minutes of the meeting held on 18th September 2002 (18/09/2002). This document is misleading and does not show the full circumstances.

I can honestly say that I did not do anything incorrectly and I am satisfied that all patients who were placed on syringe drivers were appropriate.

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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: ROBINSON, BARBARA FRANCES

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: INVESTIGATING OFFICER

This statement (consisting of 5 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: B F ROBINSON Date: 02/03/2006

I am the above named person and I live at the address shown overleaf. I trained as an SRN Nurse between 1964 and 1967 at the Royal Free Hospital in London. My registration number with the Nursing and Midwifery Council is Code A .

Having qualified as a staff nurse I worked at the Royal Free and as a sister from 1969 - 1971. I then worked as a district nurse in London from 1971 -1972. I then worked as a ward sister at the Royal Victoria Hospital in Folkestone between 1972 and 1973. I then had a gap whilst I started a family.

In 1981 I worked as a district nurse in Portsmouth and in 1982 I moved to Gosport, as a district nurse. I did this until 1987. I then worked as an assistant community nurse manager in Fareham from 1987 - 1990. After this I worked as a neighbourhood nurse manager for West Fareham until 1994. From 1994 I managed St Christopher's Hospital in Fareham which is an elderly care hospital. I also arranged the out of hours district nursing service for Portsmouth and S E Hampshire. In 1996 I became the service manager for Fareham and Gosport Elderly Services. I was based at the Gosport War Memorial Hospital . This included the management of St Christopher's Hospital and all the elderly mental health services for Fareham and Gosport.

I worked at the GWMH until 2000. As service manager my role was to manage both the GWMH and St Christopher's Hospital. I was responsible for nursing, administration and cler ical staff as well the catering staff, cleaning staff, chaplains and other non medical staff.

I worked closely with the medical staff. I had two deputies, Sue HUTCHINGS and Bridget HOWES. As a manager within the NHS I studied with the Open University and I obtained certificates as an effective manager, managing change and accounting on the personal computer. I also hold a degree in community studies which included management modules and care of the elderly modules. Whilst at the GWMH I also undertook the National Facilitators Certificate for the NHS.

I would describe general nursing care at the GWMH as excellent. The hospital had very much a community feel with both the staff and the patients. Patients were not left in beds, there were large day rooms with access for both beds and wheel chairs. This meant people were not isolated. Both Dryad and Daedalus had an activities co-ordinator.

There was access to both occupational therapy which prepares people to go home and good physiotherapy.

I was aware of the use of both syringe drivers and diamorphine at the GWMH. As service manager I liked to get out onto the wards. I spoke with staff, patients and their families. I never heard anyone raise any concerns about the use of syringe drivers or diamorphine.

I was aware of two complaints with regard Gladys RICHARDS and the mother of a Mr WILSON. I was not involved in the investigation of these matters. I can say that as a result of these investigations other staff did not come forwards to voice concerns.

I have been asked about the following medical procedures. I can state that we did not use venflons and giving sets for intravenous infusions, nor did we use bags of saline 5% dextrose for intravenous infusions. We did not use these because we did not have a resident medical officer. The use of oxygen was prescribed by the consultant or clinical assistant but in an emergency a nurse might use it for resuscitation purposes.

An ECG machine was available and this was used all over the hospital by a trained technician or doctor. Blood transfusions would not be given at the GWMH. I am unable to say if intravenous

antibiotics were ever given. If they were it would have been done by a doctor.

In the event of a medical emergency the staff would administer first aid and then ring 999 for an ambulance.

At no stage whilst I was at the GWMH did I ever have any complaints with regard the conduct of Gill HAMBLIN or Dr BARTON in relation to medical procedures or any other matter.

I am not aware of any concerns prior to 1996 regarding syringe drivers or training needs. I did ask every ward to prepare a training needs plan which either I or the ward sisters implemented. This includes syringe driver training. This was part of the basic core skills for qualified nurses at the GWMH.

I have been asked directly about any issues between Shirley HALLMANN and Gill HAMBLIN. I was aware they did not get on. Shirley tended to think Gill would not try out new ideas. Shirley was a member of staff I had to manage quite a bit. She found fault in other staff and felt her ideas were the best. She never complained about syringe drivers or diamorphine with regard Gill HAMBLIN. Shirley was quite a highly strung lady who was very critical.

Gill HAMBLIN was the ward sister of Dryad Ward and also the continence advisor for the hospital. I think she also advised on wound care.

Dr BARTON was the Clinical Assistant for both Dryad and Daedalus Ward. She would be in at 0730 Monday - Friday and visit both wards. If the staff rang she would come back in. The role of Clinical Assistant was paid by the session but it was not a full time role. Dr BARTON was very attentive to patient needs and always came in when called. I would describe her as an excellent doctor. She was also a part time GP in a local surgery. She was held in high regard by staff, patients, other GP's and indeed the local community. It was of note that the service was never as good when she was on leave.

Signed: B F ROBINSON Signature Witnessed by:
2004(1)

I have been shown exhibit BJC/89 the admission book for Dryad Ward 97/03. I understand that this was a book filled out by a ward clerk. I don't think this was a role that would have been done by a doctor.

In March 2000 I was asked to transfer to the Department of Medicine for Elderly People based at the QA Hospital and St Mary's in Portsmouth. This was as a promotion and I became Chief Nurse for older people services. This included supervising the senior staff in the elderly mental health services across the district.

I retired in March 2004, I currently take on investigations on behalf of the Fareham, Gosport and East Hampshire Primary Care Trusts.

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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: ASTRIDGE, YVONNE ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: CLINICAL MANAGER

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: Y ASTRIDGE Date: 25/10/2004

I am Yvonne Ann ASTRIDGE and I live at an address known to the Police. I am a Clinical Manager (RGN) at Gosport War Memorial Hospital and I have 25 years experience in the Nursing profession.

I began my training in 1979 at the Nightingale School of Nursing at St Thomas's Hospital London and qualified as an RGN in 1981, my pin number is 78C0813E.
From 1981 I was employed as a Staff Nurse at St Thomas's Hospital, London where I worked on a night pool for three months and for the next three months on an elderly care ward.

From 1985 to 1986 I worked at the Royal Free Hospital in London as a Staff Nurse on a medical ward

From 1982 to 1984 I worked at Abingdon Hospital as a Staff nurse on a GP ward with a maternity annex

From 1986 to 1987 I worked as an RGN Nursing Officer at a Nursing Home, where when on duty I was in charge of the Nursing Home, its staff and the care given to elderly clients. I was also responsible for recruitment of staff

1987 - 1997 ?.

From 1987 to 1998 I was employed as a Staff and Senior Staff Nurse at the Gosport War Memorial Hospital where I assisted the Clinical Manager (Ward Sister) in the administration of the Department and took an active roll in the development of nursing practice, where I was involved in the rehabilitation of stroke patients and I ran an NVQ group to help other Nurses

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study for NVQ qualifications.

From 1998 until 2004 I worked at St Christopher's Hospital in Fareham, on Rosewood Ward and latterly Shannon Ward this is a hospital for the elderly.

I recently returned to Gosport War Memorial Hospital where I am currently employed as the Clinical Manager (Ward Sister) on Dryad Ward.

I am an extremely experienced Nurse having kept up to date with all of my courses including stroke handling and positioning, critical companionship, stroke rehabilitation safe movement and handling of loads, care of the elderly and social services guidelines for the placement of patients.

I am also the holder of a City and Guilds Certificate in further and adult education and a further City and Guilds qualification for assessing a candidate's performance, and assessing candidate using diverse evidence. I also hold an English National Board qualification in the care of the elderly.

Palliative Care ?

In 1996 I was the Senior Staff Nurse on Daedalus Ward at Gosport War Memorial Hospital where I would run the ward in the absence of the ward manager. But my primary role was that of patient care. At that time my line manager was Sheelagh JOINES .

I have had training in the use of IV drugs, but last used them in London in the 1980's. I have not given IV drugs in Hampshire.

The term Wessex Protocols, refers to the Palliative Care Book, used for guidance in what drugs are to be used in that care. I believe that these guidelines were used at the Gosport War Memorial Hospital.

Know more ?

Before 1996 I think it was, I had training in the use in the setting up of syringe drivers . This training would have been purely sessions on the ward. I believe that the brand of syringe drivers

→ in operation, not used / medication

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used at that time was "Gravesby" and in fact I'm sure these are still used today.

There was formal training in the use of syringe drivers but I am unsure if this was before 1996. There have also been Syringe Driver refresher courses at the Queen Alexandra Hospital .

The Named Nurse is the nurse responsible for overseeing the care of patients, in broad terms. The named nurse does not actually need to do it.

My working hours in 1996 were 37½ hours per week and my tour of duty would have been;

0730 - 1615 for 2 days
0730 - 1330 for 1 day
1215 - 2030 for 2days

I have been asked to detail my involvement in the care and treatment of Elsie Hester LAVENDER . I can say that I have no recollection of this patient, but after reference to her medical notes (exhibit BJC/30) pages 95, 97, 99, 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 137, 151, 153, 167, 169, 171and 173, I can confirm that on the 27th February 1996 (27/02/1996) page 95, I was shown as the named nurse in the nursing care plan of Elsie LAVENDER which states that ,The problem, "the patient has painful shoulders and upper arms." The desired outcome is "To relieve pain and make Elsie more comfortable" The desired action is "Position patient for comfort. Elsie can lift her arms if given time and dependent on pain. Administer analgesia as prescribed and monitor effectiveness". I have no recollection of this document. On looking at this care plan however I would say that the nursing action in relation to drugs is satisfactory.

I can confirm that on page 97 of the nursing care plan dated 2nd March 1996 (02/03/1996) it is written "slight pain in shoulders when moved" This is signed Y ASTRIDGE and J MOSS . This is neither my writing nor my signature. It was policy at that time that a Healthcare support worker should have any entry countersigned, or a trained member of staff could sign an entry. I rather feel that Jean MOSS the health care support worker signed this entry. The account given

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should and would be in order.

I can confirm that on page 99 of the notes, dated 22nd February 1996 (22/02/1996) the following is written in the nursing care plan, the problem, "Restricted mobility" The desired outcome "To increase mobility and encourage independence" the Nursing Action, "To assist Elsie to transfer from bed to chair x 2 nurses. Refer to physiotherapists" I didn't start this care plan. My name is at the top means that I am the named nurse, not that I wrote the entry. This is not my writing nor do I recognise whose it is. I would add that if it is painful for the patient to get up then they remain in bed. The patient has the final say if they get up or not.

I can confirm that page 103 and 105 of the notes is a nursing care plan dated the 22nd February 1996 (22/02/1996). and reads, the problem," Unable to care for hygiene needs unaided" The desired outcome," To promote an adequate level of hygiene" the nursing action " Assist to wash and dress daily, offer a bath regularly. Ensure hair teeth and nails are cared for. Encourage independence where possible" This entry of page 103 is written by me but page 105 which is a continuation for page 103 is not. I would add that patients are asked if they can wash and clean their teeth. If not, this should be done with assistance from a nurse. A care plan means a plan of how to address a problem which the patient has. If there is no problem then there is no care plan. In general there is a specific care plan for every problem.

Page 107 dated the same day is another nursing care plan with the named nurse, SSN.Y ASTRIDGE; this is not in my writing and states, Problem, "leg ulcer on R leg and dry skin." Desired outcome" To aid healing." Nursing action," Dress alternate days with kattostat soaked in n/saline, cover with NA dressing and 9x9- bandage. Apply emulsifying ointment to both legs. Even though I am the named nurse I would not necessarily issue such instructions. N/saline means normal saline.

Page 109 dated the same date is a continuation of page 107 regarding leg ulcers. This is not my writing.

Staff would interact with the patient by asking such questions that were necessary and recording

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such in the notes. In 1996 it was common practice to ditto entries if those were unchanged, it not however practice now.

I can confirm that on page 111 and 113 of a nursing care plan dated the 22nd February 1996 (22/02/1996) I am shown as the named nurse, but this is not in my writing. The following is written, Problem, Indwelling urinary catheter. This means pertaining to a tube left within an organ for draining. Potential problems of, a) trauma b) infection c) Retention of urine. Desired outcome, to minimise the risk of trauma, infection and retention of urine. Nursing action; catheter care to be carried out daily. Monitor urine output and report. Test urine if infection suspected. Secure tube at catheter to leg to minimise trauma.

This is what I would call a bog standard care plan to assist the patient with the toilet.
The catheter would be inserted if the patient had retention of urine, in the main.
Permission of the patient is required to pass (insert) a catheter, or if that patient is incapable then a medical decision would be necessary. For the catheter to work correctly it should be clean and in working order. If the patient is in retention, with a large amount of urine in the bladder, then in turn it can cause back pressure on the kidneys. Of course once the patient is better then the catheter would be removed.

I can confirm that on pages 115 and 117 dated 21st February 1996 (21/02/1996) of a nursing care plan of Elsie LAVENDER, where I am shown as the named nurse, again this is not in my writing, and the following is written. Problem, red and broken Sacrum.

Desired outcome, to heal. Evaluate daily. Spray minute broken area with Betadene. Nursing action, 24/2/96 (24/02/1996) broken area sprayed with Betadene and signed by a nurse. The other entries are signed by other medical staff, not by me.

Betadene is an iodine spray which kills bacteria. It was a standard pressure sore treatment, but is not used in the same way now. I have reviewed the rest of the entries and it would appear that apart from the spray, iodine dressings were also used.

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From viewing the notes I can see that on admission her sacrum was red, she was overweight, immobile and not able to get out of bed. On the 27th February 1996 (27/02/1996) the area was blackened, this is bad news for the sacrum.

The Sacrum is the triangular bone just below the lumbar vertebrae.

I can confirm that on page 119 of the notes dated 1st March 1996 (01/03/1996) to the 6th March 1996 (06/03/1996); I am again shown as the named nurse. These entries are not in my writing. The following is written, Problem, "Constipation due to medical problems". Desired outcome; "monitor bowel action daily. Give a high fibre diet and plenty of fluids. Give suppositories or enemas as required". Nursing Action; "Suppositories and enemas given with little result and patient continues to leak faecal fluid". These notes are written by other medical staff and not by me.

From viewing the notes I can see that the patient was not eating and drinking, therefore she was likely to be constipated. She was in pain and this would not encourage the bowels to open. The use of suppositories and enemas was a reasonable course of action.

I can confirm that on page 121 of the notes, dated the 22nd February 1996 (22/02/1996), that a nursing care plan was started. These entries are not in my writing and I do not recognise whose it is. I can say that the following page 123 is linked to page 121. The following is written; problem," Requires assistance to settle for night". Desired outcome, to ensure patient has adequate sleep. Nursing action, "transfers to seat with assistance of 2 nurses" On page 123 the entries range from 22nd February to 3rd March 1996 (03/03/1996) and appear to be a nightly record of her sleep pattern. It also shows analgesic given and records that medication was refused on 1st March 1996 (01/03/1996). I also observe that there are blank spaces on 25/2/.96 (25/02/1996), 27/2/96 (27/02/1996), 28/2/96 (28/02/1996) and 29/2/96 (29/02/1996). It was the practice back then that if there was nothing to report then it would be left blank.

I can confirm that on page 137 of the notes dated 5th and 6th March 1996 (06/03/1996) that this is a doctor's drugs prescription written by Dr BARTON. On 6th March at 0945 hrs I gave the

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patient 100 mgs of diamorphine for pain relief and 40 mgs of midazolam as a sedative.

I can confirm that on page 151 of the notes BJC/30 at 1700 on 22nd February 1996 (22/02/1996), this is an admission summary and written by me. I am unsure though if I actually admitted the patient. The entry states," 83 yr old lady, insulin dependant, registered blind, atrial fibrillation; (an irregular often rapid heartbeat) had a probable brain stem CVA 5th Feb 96 (05/02/1996). CVA means a Cerebrovsacular accident (Stroke). She now has problems with her grip in both hands and also experiences pain in arms and shoulders. She can transfer with 2 nurses. Seen by Dr BARTON, medication prescribed. Catheterised size silastic (a trademark for a substance similar to rubber) which drained 750 in the first hour? Retention. General bath given and leg ulcer on right leg redressed. Area on left leg appears healed". This entry is signed by me.

On 23rd February 1996 (23/02/1996) I have written, "Referred to physio, FBC ESR U's & E's taken". This entry is signed by me. FBC means Full blood count. ESR means check for sedimentation speed of erythrocytes when spun.

"S/B Dr BARTON. Antibiotics prescribed for probable UTI ". This entry is signed by me. UTI means urinary tract infection.

Transfer with 2 nurses' means that the patient can be got out of bed and into a chair, with a 90 degree turn with 2 nurses'

S/B means seen by Dr and medication written up. U's and E's mean urea/creatine and electrolyte in bloods taken

I can confirm that on page 153 of the notes of Elsie Lavender dated 27th February 1996 (27/02/1996) that I have written "Bloods taken" This means that blood samples were obtained from the patient. I have no idea why these were taken. It could have been because of a spoiled previous sample, or some other results were required or that the patient's condition had deteriorated. This would probably have been authorised by a doctor, and a blood nurse would

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have taken the sample.

I can confirm that on page 167 of the notes which is an abbreviated mental study dated 22/2, that I wrote the name Elsie Lavender on the top of the page. This is a mental test score of which the patient scored 10/10, which means that this lady had all her marbles.

On page 169 of the notes which is a Waterlow Pressure Sore Prevention/Treatment Policy dated 22/2/96 (22/02/1996), I can confirm that I wrote the patients name at the top of the page. This is what we call a Waterlow score and details the patient's susceptibility to bed sores. This patient has a score of 21 which is very high and places that patient as a very high risk. A score of below 10 is ok, a score of above 10 is a risk, a score of above 15 is a high risk and over 20 is, as I have said is a very high risk. If the patients appetite is poor this just adds to the problem.

On page 171 of the notes also dated 22/2/96 (22/02/1996) which is Lifting/Handling Risk Calculator. This patient scored 15, which means she was difficult to move. Any score of above 10 means that a specific care plan is needed.

On page 173 of the notes which is a Daybar Basic Nutritional Assessment Plan, the patient has scored a 3 which is ok. A score of above 5 means that the patient would usually need additional nutritional supplements. A score of below 5 means that the patient would require reassessing regularly. This plan is no longer used.

I have been asked to comment if I have any issues regarding patient care at the Gosport War Memorial Hospital. I would like to say that if I did have any concerns then I would not work at the Hospital. It is a good hospital and the standard of care is excellent. The use of diamorphine was in my estimation an ideal way of making patients more comfortable and I had no problem with its use in syringe drivers in 1996.

Taken by D WILLIAMSON

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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: ASTRIDGE, YVONNE ANN

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: CLINICAL MANAGER

This statement (consisting of 1 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: Yvonne ASTRIDGE Date: 23/02/2005

I am Yvonne Ann ASTRIDGE and I live at an address known to the Police.

Further to my previous statement made to the Police in relation to Operation Rochester, an investigation into alleged suspicious deaths at the Gosport War Memorial Hospital , I would like to add that on page 155 of the medical notes, (exhibit BJC/30) relating to Elsie Hester LAVENDER dated 6th March 1996 (06/03/1996), I have written in a Patient's summary" Seen by Dr BARTON , medication other than through syringe driver discontinued as patient unrousable" I have signed this entry.

Unrousable means that she was deeply asleep, or comatose. Y ASTRIDGE

Because this patient was unable to swallow, the only route to administer medication considered was through a syringe driver. Y ASTRIDGE

Taken by:D WILLIAMSON

Signed: Yvonne ASTRIDGE Signature Witnessed by: D WILLIAMSON

WITNESS STATEMENT

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

This Statement consisting of 6 pages 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.

DATED this 1st day of June 2009

Signed .... Code A

DR JOHN ALBERT HENRY GRUNSTEIN

I am Dr John Albert Henry Grunstein of Code A

I was (voluntary erasure) a Registered Medical Practitioner, and was formerly a Consultant Physician specialising in elderly medicine, employed by the Portsmouth District Health Authority and successor Trust organisations. I retired from full time practice in 2000.

As indicated in my statement to the Police of 4th November 2005 I qualified at the London Hospital, Whitechapel in 1963. I hold the qualifications of MBBS, MRCS, and LRCP, together with the further qualifications of MRCP and FRCP (London). Following qualification, I was a Senior Registrar in Geriatric Medicine at Guy's Hospital before being appointed in 1971 as Consultant Physician in Geriatric Medicine in Portsmouth. Although I retired from full time practice in 2000 I continued to work for a time as a part time locum in various capacities until 2006.

Signed.... Code A .... Witnessed..... Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

Again, as I indicated in my Police statement, shortly after I was appointed, I initiated an out-patient service at the Gosport War Memorial Hospital. In addition, I shared responsibility for the continuing care wards in Gosport which were initially sited in the Northcote and Redcliffe Annexes of the Hospital. I believe I shared Consultant responsibilities for these Annexes with Consultant, Dr Bob Logan.

Initially my responsibilities at Gosport included carrying out out-patient clinics, and visiting the GP Wards, when asked to see patients admitted by local General Practitioners. As I have indicated, I shared responsibility for the medical care of the patients on Northcote and Redcliffe Annexes.

GP clinical assistants provided day today clinical care and dealt with emergencies. Elderly medicine consultants and registrars were available for telephone advice and occasional emergency visits. It was more usual to transfer patients with difficult problems back to the DGH.

From my appointment in 1971 I saw a number of Clinical Assistants come and go at the Hospital. In due course, when the post became vacant, Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Hospital – in March 1988. Indeed, I believe that she was the only applicant for the post at the time. I think we were very glad to get someone who had an interest in elderly medicine, who had a liking for frail, elderly patients, and who was competent. Unfortunately, in my experience there were others involved in elderly medicine who were less competent, reliable and dedicated than Dr Barton. For example, when asked to see a patient one might have the impression that they were somewhat reluctant to do so. Dr Barton was certainly in the category of a good Clinical Assistant.

As a consultant in Geriatric Medicine I did not send patients to Gosport whose medical needs were unsorted or where rehabilitation had realistic prospects for discharge from hospital. This was because fundamentally it was a long stay or so called slow stream unit not equipped to deal with patients requiring this type of active management. Thus patients sent to Gosport were in the main those we did not think could be discharged to their own homes or residential homes.

Signed.... Code A ..... Witnessed.. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

Exceptions might be those with large sores requiring lengthy healing and those awaiting transfer to alternative accommodation.

Over the period 1988 to 1992, when I ceased to have responsibilities in relation to Gosport, I think the needs of patients did not alter that much. I, and the other Consultants, chose to send patients to the Hospital who needed care, as opposed to investigation and very active treatment. The patients we admitted there were not those in need of rehabilitation, diagnosis and active medical management. We would have admitted patients there because we had concluded that there was no other place for them to go, and they were unlikely to improve. Geriatricians and other specialists need to keep empty beds in District General Hospitals (DGH) so that it is always possible to admit emergencies. None the less I resisted attempts to fill vacancies in our Gosport beds with unsuitable patients, when there was pressure on DGH beds, for the reasons outlined above.

I recall that when I arrived in 1971, some of the patients had been there for many years, inevitably due to the initial unsuitable selection for the unit.

I believe that in 1988 Dr Barton as Clinical Assistant was not likely to have been required to care for patients with technically demanding medical needs on a day-by-day basis. I felt that Dr Barton was able to do the amount of work required of her at that time within the allocated sessions. (I have been reminded that this was 4 sessions to include out of hours work). I believe the wards were visited daily, new patients were briefly clerked and there were weekly ward rounds with the consultant. I think we alternated both consultants and annexes.

In working with Dr Barton, I felt I was in the presence of someone who knew her stuff. I am conscious that Dr Barton did not write much by way of medical records. However, I felt she was doing a very reasonable job. It is fair to say that in my last years as a Consultant we had much better notes in long stay units because we had doctors there who were expected to create much more detailed notes. However, I believe that by the time I retired we would have effectively had 1.5 doctors to cover what Dr Barton was responsible for at Gosport.

Signed. Code A ..... Witnessed.. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

As a comparison Kingsclere Ward at St Mary's Hospital was a double ward with acute rehabilitation patients on one side, and long stay beds on the other. I think there were about 40 beds on the Kingsclere Ward. By comparison with Gosport, I remember being surprised that we were able to fund a full time medical appointment to look after the medical needs of those patients.

Over the period of Dr Barton's appointment until 1992, I thought that in the context of the type of patient coming to the Hospital, the patients were being properly and adequately assessed on admission by Dr Barton. At the same time, I knew that it was impossible to insist on the dotting of Is and the crossing of Ts which might seem to have been required by the job description.

I felt it was extremely important for the referring unit (preferably the consultant) to write usually no more than about a paragraph with essential information for the admitting doctor at Gosport, as I knew how difficult it was for the receiving doctor to go through what would be a very thick set of notes and distil the most pertinent information. I am afraid this did not always happen.

In my view, the writing of a standard (House Physician type) clerking in the notes on the admission of the patient was inessential and more than one should expect of a Clinical Assistant. Although I was not at the War Memorial Hospital after 1992, my understanding was that the Wards there started to be used for patients transferred for rehabilitation. Certainly in the 90s there was a great deal of pressure on District General Hospitals to get patients out of hospital who were perceived to be bed blockers. It would have been patently obvious that the work at the War Memorial Hospital would have become much more onerous, with more patients being taken on for rehabilitation.

When I retired, I was involved in the transformation of the long stay ward in Petersfield to a Rehabilitation Ward. In consequence of this, the GPs who were involved in providing care were given more sessions. None the less there were protests from the GP's, nurses and ancillary staff at the number of admissions. Another difficulty was the tendency for patients to arrive from the DGH late in the day. This causes particular difficulties for GPs.

Signed.... Code A ..... Witnessed. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

After my close Gosport involvement ceased in 1992, I was not directly aware of acutely ill patients being sent down to Gosport, although it is possible that I might have been made aware of disquiet from Dr Barton that patients were being transferred to the Hospital who were too ill. Certainly I would never countenance the transfer of an ill patient – ie someone in need of active management. The transfer of an ill patient would only be appropriate where everything possible had already been done for them at the District General Hospital. Geriatricians recognise that the act of transferring a frail ill patient often has a deleterious effect on their health. Mortality rates amongst this group are increased.

I have a recollection of being aware of some sort of problem on one of the Annexes with one or two of the nursing sisters there at some point before I ceased working at Gosport in 1992. I do not, recall any Nursing Staff expressing concern about the use of opiate medication and syringe drivers.

I understand that Dr Barton came to employ a method of prescribing for patients on an anticipatory basis – where it was perceived that the patient might require medication at some point in the near future. I can see that from a background in general practice, someone might be concerned to consider provision of medication for example via syringe driver in this way, in anticipation of the development of pain for example, over a weekend when a doctor might not be immediately available.

I have attempted to recall relevant matters once the (often difficult) decision had been made that a patient was dying and suffering and that active treatment with a curative aim should be abandoned in favour of palliative care, or that a patient was suffering. In these circumstances the question of opiate prescription arose. Oft times a dose was arbitrarily prescribed with instructions to repeat it at set intervals or on an as necessary basis. There was a period when rules governing dose titration were much more haphazard than they later became. I cannot recall when dose titration became protocol governed (if ever) in our department. I do recall being concerned that sometimes patients were left without effective analgesic cover.

Signed..... Code A ..... Witnessed. Code A

STATEMENT OF DR JOHN ALBERT HENRY GRUNSTEIN

AGE: OVER 18

In these circumstances the early use of a syringe driver might well be appropriate.

The dose range (Diamorphine 20-200mg by driver has been quoted) appears wide and the starting dose a little high, if the patient had not previously been on a codeine like preparation, but with that proviso if the titration was expertly and carefully supervised I cannot condemn it. Indeed it may have been meritorious.

In any event, knowing Dr Barton, I believe that she would have adopted such a practice only in the best interests of her patients.

I recall that we had policies whereby it was not necessary to call out a doctor from the Surgery or at night in order to confirm death if a patient had died. The nursing staff could then confirm the death. I believe that this was permitted at the War Memorial Hospital. I do not recall a specific phrase being utilised to the effect that the doctor was happy for the Nursing Staff to confirm death, but there would be nothing odd about this. Indeed I do recall that some such instruction was sometimes written in the notes, if the Clinician perceived that the patient might die.

Of Dr Barton, I would say that she was someone in whom one was able to place confidence. She was intelligent and knew her stuff. She could be quite blunt on occasion, but she looked after her elderly patients in a way which I felt was caring and expert. We greeted the allegations which appeared in the media – to the effect that patients were put on drugs effectively as a form of euthanasia, with disbelief. I refused to believe any such allegation of Dr Barton, and any such suggestion does not fit with the person I know.

She was assiduous in attending the educational training sessions provided for her upon her appointment and subsequent sessions described in my statement to the police.

We thought ourselves lucky to have her as a colleague in Gosport.

Signed..... Code A

Witnessed... 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: GRUNSTEIN, JOHN ALBERT HENRY

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

This statement (consisting of 2 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: J.A.M Grunstein Date: 02/06/2005

I am a retired Consultant Geriatrician.

From 1990 until January 2000 I was the Consultant Geriatrician for Dickens Ward at the Queen Alexandra Hospital in Portsmouth .

I have been asked to detail my involvement with the patient Robert WILSON Code A Code A who was admitted to Dickens Ward on September 23rd 1998 (23/09/1988).

I had no involvement with this patient between the 19th September 1998 (19/09/1988) and 11th October 1998 (11/10/1988). I was away on holiday between these dates.

I have checked the medical records and I cannot find any entries that I have made relating to this patient.

Whilst I was on leave my ward rounds would have been performed by a Registrar.

There would also have been nominal Consultant cover via the duty Consultant.

Prior to going on leave I would have arranged for a Registrar to cover the wards.

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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: GRUNSTEIN, JOHN ALBERT HENRY

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: RETIRED MEDICAL CONSULTANT

This statement (consisting of 6 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: J GRUNSTEIN Date: 04/11/2005

I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000.

My qualifications and CV are as follows:

1. Date of Birth: Code A
2. Place of Birth: London
3. Medical School: London Hospital, Whitechapel 1968-1963
4. Registrable Medical Qualifications:
    a. 1963 MRCS, LRCP
    b. 1963 MB, BS Lond.
5. Higher Registrable Medical Qualifications:
    a. 1968 MRCP Lond.
    b. FRCP Lond.
6. Relevant Appointments:
    a. 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital
    b. 1971 Appointed Consultant Physician in Geriatric Medicine to the Portsmouth Health District and successor organizations.
    c. 2000 Retired.
7. Since retirement I have continued to work as a part time locum in various capacities.
8. *Responsibilities in Gosport:*
    a. Shortly after I was appointed I initiated an outpatient service in Gosport.

b. I shared responsibility for the continuing care wards in Gosport. Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.

c. In 1992, I believe, I gave up all responsibilities in Gosport.

Dr. Jane BARTON applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants . This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment, I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr. BARTON was an experienced doctor with her own general practice in Gosport. I remember her as being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed in similar capacities). She had a liking for these very frail elderly patients. Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attended ward rounds, outpatients and day hospital sessions in order to get "hands on" training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as "in depth".

Dr. BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I recall her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Program - Elderly. (CATPE). This was a series of lectures given in the training of most aspects of elderly medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would also have heard about the

"analgesic ladder" which describes the incremental use of drugs to control pain and distress. The analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

Routine Business Ward Rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients. I would expect my advice to be followed as ultimate responsibility for patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr. BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON. Dr. PETERS and others from her practice worked on the wards while she was unavailable. My department didn't vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.

Admissions to all elderly medicine continuing care wards (long stay wards) were authorized by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

During their time in hospital the patients own General Practitioner had no responsibility or supervisory rights.

During the time that I had specific responsibilities in Gosport (1971-1992). Patients

transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in Gosport.

Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

The bulk of patients transferred to Gosport were considered too incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

The survival time of new admissions was short (on average less than a month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.

I believe that allegations have been made concerning the quality of care given by Dr BARTON. I have never seen any of these in writing, but I have had informal occasional chats with colleagues (no more than gossip) and come across references in the media. To say that I was incredulous is to understate my position.

I considered Dr BARTON to be an outstanding, caring and compassionate Physician.

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: GRUNSTEIN, JOHN ALBERT HENRY

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: RETIRED CONSULTANT

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: J GRUNSTEIN Date: 19/01/2006

I am Dr John Albert Henry GRUNSTEIN, a retired Medical Consultant and previously worked the Queen Alexandra and Gosport War Memorial Hospitals, Hants.

I worked for a time with Dr Jane BARTON.

I produce as exhibit JAHG/1 Dr BARTON's application for the post of Clinical Assistant in Geriatric Medicine dated 17/3/88, a letter from Miss K SOUTHWELL , Portsmouth and South East Hampshire Health Authority of 18th March 1988 to me and my correspondence of 19th April 1991 confirming that Dr BARTON received ten half day sessions from 27th - 31st November 1989.

I cannot recall why she was trained a year and a half after her appointment. The letter is addressed To whom it may concern' so I think there may have been something in the GP contract which required additional formal training.

I do not believe I ever interviewed Dr BARTON formally.

Dr Jane Ann Barton

Rule 27(2) Advice

1. You have now reached the stage where, under Rule 27(2), you have to consider which, if any, of the remaining unadmitted facts have been proved to your satisfaction, and whether the proved and admitted facts would be insufficient to support a finding of serious professional misconduct. Although at this stage you will produce one determination, Rule 27(2) clearly requires you to go through 2 separate processes.
2. The first part of Rule 27(3) requires you to record your findings in relation to Rule 27(2): the remainder of Rule 27(3) sets out the procedure you should follow if you conclude, either that none of the facts have been proved [here Dr Barton has, of course, made admissions], or that such facts as have been proved would be insufficient to support a finding of serious professional misconduct.

Rule 27(2)(i): The Facts

3. It is not my role to advise you as to the facts, or express any view in relation to them, and I certainly do not do so. You are the judges of both fact and law.
4. Although it is a matter for you, you will doubtless wish to take into account any concessions made by Mr Kark in relation to the strength of evidence on some of the charges.
5. In relation to any given allegation, it is open to you to find part of that allegation proved, and part not proved. This does not require any amendment. For example, it would be theoretically open to you to find 2bi proved, but only in relation to Diamorphine. Other combinations are possible. This means that, when you are considering whether, for example, Dr Barton's actions or omissions in relation to a certain matter were inappropriate, or not in the best interests of the patient, you must be careful to take into account only those matters in relation to which you have made positive findings, or which are admitted. If you do make partial findings, you should make the fact of the partial finding clear in your determination.
6. Rule 24(4) gives the Panel a qualified discretion, at any stage, to amend a charge. If, during its deliberations, the Panel wishes to consider exercising that power, it should return to open session to allow the parties to make representations, and to receive advice from me.
7. You should not regard a given witness as falling into the GMC camp or the Defence camp, simply on the basis of which side called or read that witness. It is for you to decide whether the evidence of any witness assists you one way or another in deciding the relevant issues. You should consider the evidence of Dr Barton herself in the same fair way as you would consider any other evidence in the case.
8. You may, if you see fit, draw a reasonable inference from evidence. But you must not speculate.
9. You are not bound by the opinion of an expert witness. If you find it of assistance, you are entitled to rely upon it in coming to your conclusions. If you do not find it of assistance, then you are entitled to reject it and not place reliance on it. In the end, what you make of expert evidence is a matter entirely for you.

10. You have heard evidence given by way of TV and indeed telephone link. You must assess the witness concerned in the same way, and with the same care, as you would assess any witness giving evidence in the room before you.
11. You have heard me advise the Chairman to warn witnesses of their right not to give replies which might be used by the Crown to establish guilt or decide whether to prosecute. My advice to give such a warning is no indication whatsoever of my personal view of a witness, and the giving of a warning does not undermine a witness's evidence. As always, the credibility of a witness is a matter for you.
12. You are entitled to take into account the formal, written statements which Dr Barton made to the police. You have heard it said that she made those statements, and that she declined to answer specific police questions. But it has not been suggested to you by Mr Kark that that failure to answer questions should in any way be held against Dr Barton – no doubt she received and followed legal advice on the point - and I advise you that you must not do so.
13. You have had a number of statements read to you. They fall into two categories. The statements in the first category were read to you on the basis that their contents were agreed by the other party. In respect of that category of read statements, you are entitled, but not obliged, to accept the contents of those statements as true, and you should give the evidence in those statements the same weight as you would have given it had it been given orally by the witness in Court. The statements in the second category were read to you on the basis, not that the other party agreed their contents, but on the basis that it was agreed that the statements could be read to you. In respect of that second category of statements, the evidence in the statements is not admitted, and you should not assume that the content of the statements is true. You should look at those statements critically, assessing the maker of the statement as best you can, and comparing the evidence in those statements with other evidence in the case. Unless you are told to the contrary, you should assume that the other side has not had the opportunity to cross-examine that witness – certainly the Panel has not been able to ask that witness questions – and you should bear in mind that your impression both of that witness and of their evidence might be different had cross-examination taken place. Subject to those caveats, it is up to you to make what you will of the content of such a statement. So far as I am aware, the only statements which you have heard read which fall into the second category are those of Ernest Stevens, June Bailey, Jeanette Florio, Sylvia Giffin, Ingrid Lloyd and Gill Hamblin.
14. Mr Langdale QC has referred to a complaint by Nurse Hallmann not being upheld. It is for you to decide whether that affects your view of her credibility. But you have also in the course of this case heard reference made to other more formal inquiries, such as an inquest. Although of course you may take into account what evidence witnesses in our hearing gave in those other formal proceedings, if they have been asked about it, I advise you that the actual decisions of other formal bodies are not relevant to your considerations here, even were you to be aware of them. You do not know precisely what evidence they received, or what their terms of reference were. It is your independent judgement which you have to apply in this case.
15. In considering whether acts or omissions are, for example, inappropriate, potentially hazardous or not in the best interests of the patient concerned, it is proper for you to take into account documents such as Good Medical Practice,

the British National Formulary, the 'Wessex Protocol'/Palliative Care Handbook, and the other items in your Bundle 1, as well as the evidence you have heard from witnesses about those publications, in deciding what the proper standard of reasonable and competent medical practice was at the relevant time, and whether Dr Barton has departed from it.

16. These allegations are all of some age. It has not been suggested by anyone that this means Dr Barton cannot have a fair hearing. But you will no doubt wish to bear in mind the age of these allegations, and the undoubted difficulty that Dr Barton and indeed anyone would experience in recalling the detail of any incident taking place a significant period of time ago. In particular, you should bear in mind, when assessing the weight of their evidence, that a number of people in this case are very largely reliant upon notes made at the time, or at least upon statements made nearer the time, and are able to give relatively little evidence from actual memory now of any individual patient.
17. You should be careful, especially given the age of these allegations, to ensure that you are applying only those standards applicable at the time of the dates specified in the allegations. You should guard against making judgments with the benefit of hindsight. To apply to any acts or omissions the standards of 2009 would be unfair to Dr Barton, because you might be allowing the passage of time to penalise her.
18. In applying the proper standards applicable at the dates specified in the allegations, you are applying an objective test. For example, note-making may, it seems, have been briefer in the 1990's than is the case today. But, if inadequate note-making was prevalent in the 1990's, that does not mean that making very short notes, or none at all, was even then an acceptable practice according to the proper standards of the time. Certainly, by her admissions made in relation to note-making, Dr Barton has accepted that her conduct was, in that respect, inappropriate and not in the best interests of her patients.
19. You have also heard reference made to what is said to be Dr Barton's heavy workload, the issue of resources, the management structure at the GWMH and the premature moving of patients to the GWMH. Professor Sikora, in particular, repeatedly gave evidence as to the differences in various respects between the situation in the 1990's, and the situation now. Clearly, the issue, for example, of the premature moving of patients has relevance to the case as a whole, because it may have a bearing on the reasons for a patient's deterioration. Similarly, any apparent non-intervention by a consultant or pharmacist who knew of Dr Barton's prescribing practices, including her practice of anticipatorily prescribing, may, you think, be potentially relevant to the issue of whether her acts and omissions were a departure from the proper standards of the time. However, in relation to the issue of whether there was any pressure upon Dr Barton affecting her care of patients, I advise you that any such surrounding difficulties, if I may call them that, are not in themselves directly relevant to your fact-finding exercise; they are clearly the background to Dr Barton's work, but you may think that such surrounding difficulties cannot make an inappropriate action or omission appropriate. The same goes for any failings on the part of persons other than Dr Barton. When you are coming to judgments about the quality of Dr Barton's acts or omissions, you are applying an objective test, taking into account as I have said those standards properly applicable at the time of the dates specified in the allegations. If, even taking into account any surrounding difficulties, Dr

Barton's actions or omissions fell below those standards, they fell below them, and it matters not for the purposes of fact-finding that those surrounding difficulties may have contributed to the actions or omissions of Dr Barton.

20. However, issues such as management, staffing and premature patient transfers may be relevant when you come on to consider serious professional misconduct.
21. This case as charged concerns only the 12 specified patients. You have heard some evidence as to how Dr Barton treated other patients at the GWMH; for example, in relation to advance prescribing and the institution of syringe drivers. I advise that you can take into account any such evidence you have heard concerning the treatment of patients at the GWMH other than the 12, but only in so far as it assists you to decide whether the allegations in relation to the 12 patients are proved. In respect of evidence concerning Dr Barton's assessment of GWMH patients other than the 12 before you, I advise you that that evidence is capable of lending support to Dr Barton's contention that, whether she made a note of it or not, she did assess each of the 12 patients before you. Of course, the weight to be given to such evidence is entirely a matter for you. But what you should not do is draw any inferences from the fact itself that you only have these 12 patients to consider. You certainly should not assume, for example, that the GMC chose these allegations relating to these 12 patients as 'specimen' charges; that is to say, as a manageable number of samples of a wider picture of wrongdoing. There are a number of possible reasons as to why you only have these 12 before you, and you must not speculate as to why that is the case. The position is that you have to make findings only in relation to these 12.
22. Dr Barton's good character is not in doubt. She is a doctor of many years' standing, and there are no previous adverse findings against her. The allegations raise in themselves no issue as to character; they don't allege motives; they allege facts. But that is not the end of the matter. I advise that the doctor's good character is relevant to your considerations. The reason for this is that, you may think, there are, at least potentially, particular disputes between the GMC and the doctor which may bring into issue, either whether or not this doctor has behaved in a specifically discreditable way (as opposed to making, for example, an error of judgement), or whether she has been telling you the truth. You may think that an example of such an area of dispute directly relevant to a charge is whether or not Dr Barton performed an assessment on a given patient. Where you are of the view that such a specific issue arises, you should take her good character into account in two ways. Firstly: she is entitled to have taken into account on her behalf the fact of her good character, and to argue that her good character makes it less likely that she would act in a discreditable way. Secondly: if there are issues upon which her credibility and truthfulness have in your view been called into question, you should, again, take her good character into account: she is entitled to argue that her good character makes it more likely that she has been telling you the truth on any specific issue in relation to which her credibility has been called into question.
23. I have advised as to how you may take into account specific evidence as to how Dr Barton treated patients at the GWMH other than the 12 before you. I have also just advised that you should take into account Dr Barton's good character. But you have also heard, for reasons I have outlined in an earlier

advice, what is effectively general testimonial evidence as to what is said to be Dr Barton's pleasant and approachable personality, and general medical skills in relation to non-GWMH patients. I advise you that you are entitled to take into account any evidence you have heard as to Dr Barton being a caring or committed doctor, because this you may think is capable of being relevant to the factual issues of whether Dr Barton assessed the 12 patients in this case. But I advise you also that general testimonial evidence as to a doctor's personality or as to her general medical skills is not relevant at this particular stage of the proceedings.

Rule 27(2)(i): Proof of the Unadmitted Facts

24. Because of the age of this matter it is, as you are well aware, the old rules that apply. As is still the case under the new rules, the burden of proof in respect of any disputed fact rests throughout upon the Council; there is no burden here upon Dr Barton to prove anything. However, as regards the standard of proof, you must apply the criminal standard, not the civil standard which applies under the new rules: in other words, in this case, the Council must satisfy you so that you are sure before you find any fact proved against Dr Barton. Anything less, and Dr Barton is entitled to a finding of not proved. It may help if I give an example; one also posited by Mr Langdale QC; the issue of whether Dr Barton assessed a given patient. The fact that she did not, as she accepts, make adequate notes does not mean for one moment that it is up to her to prove to you by other means that she did assess the patient. It is for the GMC to make you sure that she did not.
25. When you have come to your decision as to the facts not admitted, you should then go on to consider Rule 27(2)(ii), on the basis of both the facts admitted, and those not admitted, but found proved.

Rule 27(2)(ii): Whether the Proven or Admitted Facts would be Insufficient to Support a Finding of Serious Professional Misconduct

26. Although you are not now making a formal finding as to serious professional misconduct, you do at this stage have to go on to consider and determine whether the proven or admitted facts would be insufficient to support a finding of serious professional misconduct. This means that I do have to advise you on this in some detail now. Should this case proceed to the next stage, there may be much of this part of my advice that I will not need to repeat.
27. The application of Rule 27(2)(ii) is a matter for your judgement, rather than for the application of any burden or standard of proof [CRHCP v. GMC & Biswas [2006]].
28. At this stage, you should consider the cumulative effect of the facts admitted or found proved. In other words, you will ask yourselves: would all the facts admitted or found proved, taken together, be insufficient to support a finding of serious professional misconduct?
29. What does 'serious professional misconduct' mean? As was pointed out in the case of Roylance v. General Medical Council, referred to in more detail below, the phrase is not defined in the legislation, and it is not an area in which an absolute precision can be looked for.
30. Even a single incident can amount to serious professional misconduct (McCoan v. General Medical Council [1964] 3 All ER 143).
31. In the 1987 case of Doughty v. General Dental Council [Privy Council], in relation to the phrase 'serious professional misconduct', it was stated that the Council had to establish that there was conduct connected with the profession

in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that such falling short as is established should be serious.

32. In the 1999 case of Roylance v. General Medical Council [Privy Council], assistance was given as follows [at page 21]:
    - 'Serious professional misconduct is presented as a distinct matter from a conviction in the British Islands of a criminal offence, which is dealt with as a separate basis for a direction by the committee in section 36(1) of the Medical Act 1983. Analysis of what is essentially a single concept requires to be undertaken with caution, but it may be useful at least to recognise the elements which the respective words contribute to it. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. Firstly, it is qualified by the word 'professional' which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious.'
33. "It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence" (per Lord Cooke of Thorndon in Preiss v. General Dental Council [2001] 1 WLR 1926, 1936C [28]).
34. In deciding whether the facts proved or admitted would be insufficient to support a finding of serious professional misconduct, what evidence can you take into account? As I have already pointed out, it is not the case that you can take into account any evidence that you have heard up to now.
35. Assistance was given in the 2005 case of Campbell v. GMC [Court of Appeal], which I quote or summarise as follows:
    - [Paragraphs 19-20.] The character and previous history of the practitioner may be relevant to the issue of whether the practitioner is guilty of serious professional misconduct. There may be an overlap, in that evidence may be relevant, both to that issue and to the later issue, if relevant, of mitigation. Thus, the professional history of the practitioner may support a finding of serious professional misconduct on the basis that he has previously been found to have committed an identical professional error. This may not have been regarded as serious professional misconduct on the first or previous occasion, but the 'history' may lead the Committee to conclude that that on this occasion it does, just because the conduct in question was repeated. Without the previous history an acquittal would be appropriate. In a different context, the error under consideration may need to be examined in the context of a dedicated practitioner working in isolation and under huge pressure, say, of an epidemic. Such circumstances may be relevant to the question whether he should be found guilty of serious professional misconduct. It may indeed provide mitigation of

circumstances, unrelated to penalty. If notwithstanding this evidence the case is proved, then precisely the same circumstances may also be relevant to mitigation of penalty. In short, the same facts may on occasion impact both on the question whether the practitioner's conduct amounted to serious professional misconduct, and on the appropriate consequential sanction. Nevertheless, although the same evidence may be relevant on both questions, it does not follow that they cease to be distinct issues requiring separate determination.

- [Paragraph 46.] Although the committee can, if it thinks it right to do so, consider the circumstances in which the practitioner found himself when committing the relevant misconduct, it should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty rather than to the question of whether the professional misconduct was serious; in particular committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct. At this stage, the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty.

36. I advise as follows.
    (i) As I have advised you in relation to fact-finding, any general testimonial evidence you have heard in relation to Dr Barton's personality or general medical skills is not relevant to the issue of serious professional misconduct, either.
    (ii) But the context and circumstances in which Dr Barton was working at the relevant time, including any pressure upon her, are capable of being relevant to the issue of serious professional misconduct. It is for you to decide, for example, whether there was such pressure in this case and, if so, whether it goes to the issue of serious professional misconduct in the particular circumstances of this case. The issue of whether any proven or admitted lapse is an isolated one may also be relevant to the issue of serious professional misconduct.
    (iii) It is important that you look carefully at the evidence you have heard, and that you decide at what stage or stages of your deliberations it is relevant.
37. However, I emphasise that, at this stage, you are not making any substantive finding as to serious professional misconduct. All that you are doing is deciding whether the proven and/or admitted facts would at this stage be insufficient to support a finding of serious professional misconduct and that, therefore, the case should proceed no further.

6th August 2009

Francis Chamberlain

Legal Assessor

WITNESS STATEMENT

STATEMENT OF **FIONA SMART**

AGE: OVER 18

This Statement consisting of 3 pages 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.

DATED this 15th day of June 2009

Signed Code A

FIONA SMART

I am Fiona Smart of Omega House, 112 Southampton Road, Eastleigh, Hampshire. I am Associate Director for Clinical Standards at NHS Hampshire at the above address.

Having worked as Services Manager for Community Hospitals in East Hampshire, I was appointed as Interim Divisional General Manager for Fareham and Gosport Division of Portsmouth Healthcare NHS Trust in January 2000. As such, I was responsible for two community hospitals in the area, Gosport War Memorial Hospital and St Christopher's Hospital, District Nursing and health visiting and physiotherapy, dentistry and occupational therapy Trust wide. My appointment was initially on an acting basis, and I was then appointed to the substantive post.

In my capacity as Divisional General Manager, I met Dr Jane Barton on a number of occasions. I believe that she was involved with the Primary Care Group at this time.

Signe Code A ..... Witnessed..... Code A

STATEMENT OF FIONA SMART

AGE: OVER 18

I recall that Dr Barton came to see me on one occasion, when we had a conversation about the pressures associated with her work at the Gosport War Memorial Hospital (the Hospital) where she was a Clinical Assistant in Geriatrics. I recall that I was told Dr Barton would come to the Hospital at 7:30 in the morning in order to do a Ward Round, and would also have to undertake weekly Ward Rounds. I was told that her partners were not sufficiently supportive of her to enable her to get back to the Hospital to carry out further work as she would wish. Our discussion was about the need for her to be available in the hospital later than had been her practice. Whilst I recall that the level of dependency of patients had increased over time and they were generally less well on admission, I cannot now recall if this was specifically discussed by us.

The demands on Dr Barton were such that she felt obliged to resign at the end of April 2000. A copy of her resignation letter was passed to me, and in consequence of that I felt it appropriate to write to her, which I did by way of a letter dated 19th May 2000. A copy of that letter is attached to this statement and marked "FS1", the letter being written in my previous married name of Fiona Cameron. In that letter I made the point that over the period Dr Barton had been at the Hospital (which I stated in error as 7 years) there was little doubt that both the Client Group and the workload had changed. I was aware of and acknowledged Dr Barton's contribution, commitment and support to Gosport War Memorial Hospital. I fully acknowledged her "contribution to the service whilst working under considerable pressure". I would not have complimented Dr Barton in my letter unless I had felt that this was clearly appropriate and deserved.

Although I did not know Dr Barton well, I felt she was a person of integrity. She had a reputation for being very straight talking, and her level of forthrightness may have meant that some would feel that she was brusque. I considered her very easy to deal with.

STATEMENT OF Code A

AGE: OVER 18

In my letter to Code A I stated 'acceptance of the above pressures, coupled with your resignation, has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising'. The review proposed enhanced medical input. In due course a number of changes were made to the service at the War Memorial Hospital. A full time staff grade doctor was appointed in September 2000, providing greater medical input. There was also an additional consultant session to provide greater consultant support.

Signed Code A Witnessed..... Code A

19-MAR-2002 09:57 FROM Code A & PARTNERS TO Code A P.15

11·5

FS1

PORTSMOUTH HealthCare TRUST

Private & Confidential

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
Code A

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Peter King has formally responded.

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

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Fiona Cameron
Divisional General Manager

End 6.

GUIDELINES FOR ADMISSION TO DAEDALUS WARD
(COMMUNITY REHABILITATION)

Code A

Code A

Code A

Code A

Exhibits list (as at 6 July 2009)

FTP Panel: Case of Dr Jane Ann BARTON
Commencing 8 June 2009
London

GMC documents

8 June 2009	---	Schedule of witnesses
8 June 2009	---	Key to patients
8 June 2009	C1	Panel bundle 1
8 June 2009	C2	Bundle for Patient A
9 June 2009	---	Skeleton argument – GMC application to admit expert's reports
10 June 2009	C3	Bundle for Patient B
22 June 2009	C4	Bundle for Patient C
10 June 2009	C5	Bundle for Patient D
10 June 2009	C6	Bundle for Patient E
11 June 2009	C7	Bundle for Patient F
12 June 2009	C8	Bundle for Patient G
15 June 2009	C8a	Originals of pages 643, 644,645 and 647 of notes for Patient G (**with Panel Secretary**)
15 June 2009	C9	Bundle for Patient H
17 June 2009	C10	Bundle for Patient I
17 June 2009	C11	Bundle for Patient J
11 June 2009	C12	Bundle for Patient K
17 June 2009	C13	Bundle for Patient L
6 July 2009	C14	Original prescription / drug charts (**with Panel Secretary**)
6 July 2009	C15	Dr Barton's statements
6 July 2009	C16	Syringe driver (as described by Professor Ford during evidence-in-chief on 6 July 2009. Instruction leaflet copied and circulated to the Panel.)

Defence documents

9 June 2009	---	Skeleton argument – Response to GMC argument to admit expert's reports
25 June 2009	D1	Mrs Hallman's letter dated 24 March 2000 addressed to Mrs Cameron
25 June 2009	D2	Note of meeting between Mrs Hallman, Betty Woodland and Rosemary Salmond on 30 March 2000
25 June 2009	D3	Note of meeting between Dr Barton and Rosemary Salmond on 7 April 2000

30 June 2009	D4	Memorandum from Barbara Robinson to Max Millet, then Chief Executive of the Trust, dated 27 October 1999
30 June 2009	D5	Protocol for prescribing Diamorphine by sub-cutaneous infusion (Dr Reid's document)

Code A

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 29 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-FOUR)

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

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

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

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THE CHAIRMAN: Good morning everybody. Mr Jenkins?

MR JENKINS: I know that a problem has arisen with the Panel secretary. We had anticipated there might be a slight delay but, obviously, things go seamlessly as always; I should have known better. I am going to ask for 10 or 15 minutes. I am hoping to call a witness first thing this morning. I have raised certain matters with Mr Kark and, indeed, with your Legal Assessor. We were having a discussion about certain legal matters which we had not quite concluded when the Panel came in. I am going to ask for 10 or 15 minutes so we can finish that discussion. It may be things can move on smoothly after we have had that time.

THE CHAIRMAN: I am wondering how firm that time is likely to be. In other words, whether the Panel should remain in or should we wait to be called in.

MR JENKINS: I would take your ease as they say. You will have made your own judgment yesterday about my time estimates and the reliability of them.

THE CHAIRMAN: They are no worse than mine!

MR JENKINS: Mr Kark is laughing. When I said to you I would be 15 minutes with a witness, Mr Kark says I was half an hour, so when I say it will be 10 or 15 minutes it may be better for the Panel ---

THE CHAIRMAN: Very well, we will rise now and we will return when we are told that you are ready for us.

(The Panel adjourned for a short time)

MR JENKINS: We have had some discussions. I am not going to pursue matters with that witness now. It may be there will be legal argument about that witness at a later stage. We have asked the lady to go home.

MR LANGDALE: The next witness to be called is Dr Sikora. He is sitting at the back of the room and I will call him forward now.

PROFESSOR KAROL SIKORA, Sworn

(Following introductions by the Chairman)

Examined by MR LANGDALE

MR LANGDALE: I announced you as Dr Sikora, but I think it is Professor Sikora. Is that correct?

A Correct.

Q Your first name is Karol – K A R O L?

A Correct.

A Q I would like you to tell the Panel your qualifications, medical and otherwise.
A I qualified in 1972. I pursued a career in oncology, cancer medicine. My longest job was Professor of cancer medicine at Hammersmith Hospital where I have been for 23 years. I am now Medical Director of a joint venture between the NHS and the private sector, Cancer Partners UK.

B Q Forgive me for interrupting, would you, first, just give your qualifications and then I will go through the history in a moment.
A My qualifications are BA from Cambridge; MBBCh Cambridge, having done that at Middlesex Hospital; MRCP which became FRCP; FRCR which is Fellow of the Royal College of Radiologists to learn radiotherapy; I am also a Fellow of the Faculty of Pharmaceutical Medicine at the College of Physicians.

C Q Medical Director currently of Cancer Partners UK?
A Correct.

Q What are Cancer Partners UK?
A It is an interesting joint venture between the private and public sector to improve capacity in cancer services around the UK, both radiotherapy and chemotherapy.

D Q Is it right that you were Professor and Chairman of the Department of Cancer Medicine at Imperial College School of Medicine?
A That is correct.

Q I think you are still a consultant oncologist at Hammersmith?
A I am. I spend one day a week running clinics at Hammersmith.

E Q Is it also right that you run a Chair of Scientific Advisory Board of Source BioScience Plc, which is one of this country's leading diagnostic companies?
A That is correct.

Q I think you have said something about this already in your evidence – are you Dean and Professor of Medicine at what is this country's first independent medical school at the University of Buckingham?
A That is correct.

F Q Also a Fellow of Corpus Christi, Cambridge?
A Yes.

Q I think you have indicated that you studied medical science and biochemistry at Cambridge, then after clinical training where was your first post at a hospital?
A My first consultant post was at Cambridge Addenbrooke's Hospital, where I was a consultant oncologist for five years.

G Q After your training had you been, initially, a house physician at the Middlesex?
A Yes.

Q And then a registrar in oncology at St Bartholomew's?
A Yes.

H

Q You were then a research student at the MRC Laboratory of Molecular Biology in Cambridge?
A Yes.

Q You then obtained your PhD and became a clinical Fellow at Stanford University in California before returning to this country to direct the Ludwig Institute in Cambridge, so back in Cambridge again.
A Exactly.

Q As you indicated, you were a Clinical Director for cancer services at Hammersmith for 12 years. Is that right?
A Correct.

Q Involved in the setting up of a cancer research laboratory. Is that right?
A Correct.

Q Also chairing Help Hammer Cancer, an appeal, which raised a certain of amount of money, in terms of millions, towards the construction of a new cancer centre at Hammersmith?
A That is correct.

Q Just dealing with remaining matters, Deputy Director of Clinical Research of the ICRF?
A Correct.

Q From 1997 to 1999, Chief of World Health Organisation, WHO, cancer programme?
A Correct.

Q From 1999 to 2002 Vice President of Global Clinical Research Oncology at the Pharmacia Corporation?
A Correct.

Q I am not going to ask you all the detail, but I think you have published a number of papers and written or edited a number of books?
A Correct.

Q Are you also a member of the UK Health Department's Expert Advisory Group on cancer?
A Yes.

Q The Committee on Safety of Medicines?
A Yes.

Q Do you remain an adviser to the World Health Organisation?
A Correct.

Q I think, Professor Sikora, you prepared a report in connection with issues in this case?
A I have.

Q I am going to ask you, first, about the material that you have had the opportunity of seeing, in the sense of it being provided to you one way or another. I think you have reviewed the notice of inquiry, that is Fitness to Practise Panel hearing notice of inquiry setting out the allegations against Dr Barton?
A I have.

Q You also had the opportunity, although I am not going to ask you about it, but you saw the Commission for Health Improvement or CHI report material?
A I did.

Q Which was back in 2002. You had the opportunity of reading the reports of Professor Ford?
A I did.

Q Have you also had the opportunity of reading transcripts of the evidence he has given to this Panel?
A I have.

Q You have also had provided to you the general police statement, as we have called it, of Dr Barton herself and you have also seen the statements she made with regard to twelve patients?
A I have.

Q It follows that you have seen statements that she made with regard to all twelve, nine of which I think were police statements prepared for the assistance of the police. May I also ask you, in terms of material that you have seen, you have seen transcripts of her evidence?
A I have.

Q Sir, I am going to ask a number of questions in leading form, simply to establish what it was this witness understood the position to be. It is all factual, it is not asking his opinion. I am trying to take you through certain matters of which you became aware with regard to the history of this case. On the information you have been able to gather from what you have seen and so on in terms of Dr Barton, you understood, you cannot give direct evidence for this, that she had been contracted as a clinical assistant for four to five sessions a week at the Gosport War Memorial Hospital?
A Correct.

Q We are familiar with the dates, 1988 to 2000. The hours, as you understood it, were flexible to allow her and her general practice to provide 24 hour cover to the patients at the hospital?
A Yes.

Q A total of 40 plus beds, I think it may have a total of 48 all together, designed for the long term care of elderly patients?
A Yes.

Q As you understand it on the information you have been given, the nature of the clinical case mix changed during the 1990s to include patients transferred from the acute sector for rehabilitation?
A That is my understanding.

Q As you understand it, no increase in medical or nursing time and no enhancement of social services, physiotherapy, occupational therapy or support staff to help to meet that new function?
A That is correct.

Q Is it your understanding that Dr Barton worked as a part-time GP locally with a personal list of something like 1500 patients?
A That is correct.

Q Furthermore, I am going to ask you more about what your understanding of the matter was because it will assist the Panel in terms of understanding the basis of your opinion about certain matters. Was it your understanding that Dr Barton had no specific training or postgraduate qualifications in internal medicine, care of the elderly or rehabilitation?
A That is correct.

Q In your experience is that normally the case with clinical assistant posts?
A That is the purpose of a clinical assistant.

Q Work, as you understand it, was supervised by two consultants initially, Doctors Lord and Tandy, with Dr Reid replacing Dr Tandy at some point in 1999?
A That is correct.

Q On your understanding those consultants all have major clinical responsibilities elsewhere and their contribution to the care of the Gosport patients was apparently limited to a weekly ward round which did not always take place?
A Correct.

Q Again, the Panel will have heard evidence about this but that is your understanding about the position. You were also informed about Dr Tandy being away on maternity leave from some point in the late 1990s, I think in April 1998, and the Trust made the decision not to provide any full-time locum cover for her until she returned in February 1999?
A That is correct.

Q We have heard evidence from Dr Tandy about it. You were also given information about Dr Barton's habitual work pattern – I am not going through it – the morning visit, returning not necessarily every day but around about lunch time to deal with the new admissions, clerking in and so on and then an evening visit depending on the needs of relatives and so on?
A Correct.

Q You were given the history about that?
A Yes.

Q You were aware of the evidence that Dr Barton raised the problem, or the difficulties, with increasing work load with more than one person, but no changes were implemented?
A That is correct.

Q Was it also your understanding, and the Panel have heard the evidence, that at no time during her twelve years at Gosport were any changes suggested to Dr Barton in relation to her mode of work, prescription habits or her abbreviated style of note keeping?
A Correct.

Q You have read the evidence that there has been in relation to her rapport with the nursing staff, which appears, so far as you can judge it, to have been excellent?
A It does.

Q What is your view in terms of the material you have seen as to whether it was effective or not in terms of the way her unit dealt with a pretty large patient volume with the staff that were available. What was your impression?
A My view, based on my experience as a clinical manager at Hammersmith including palliative care, is that the work load changed, the pattern of patients changed over a decade and although the staffing may have been suitable at the beginning of the decade, by the end of the decade the patient flows had changed, the dependency on nursing care had changed, but the staff had not changed in numbers.

Q In terms of criticisms of Dr Barton's work, is it right that you have summarised the common themes in the allegations against her as being – in relation to the fitness to practice allegations themselves, they can be summarised as being – that the lowest doses in the sliding scale of her prescriptions for diamorphine and midazolam were too high?
A Correct.

Q That the dose range was too wide?
A Correct.

Q Are you aware of the fact that Dr Barton has accepted, not in every case but in a number of cases, the dose range in the 20 to 200 mg range was too wide?
A Correct.

Q That the prescription created a situation whereby drugs could be administered but were excessive to the patient's needs, adequate assessment of patients was not made and properly recorded and, again, are you aware of the fact that Dr Barton has accepted that her recording, her note keeping and other recording, was not as it should have been?
A I do.

Q Also an allegation that advice from a senior colleague was not obtained when patients deteriorated?
A Yes.

Q In terms of Professor Ford's report, which you have considered and you have read transcripts of his evidence, you are aware of the fact that he looked at the generic issues around the use of pain control medication?
A Yes.

Q What is your view as to the only way to judge accurately a patient's needs for analgesics?
A The only way is to be with the patient and see what happens after a given dose of an analgesic that is given. The teaching in the World Health Organisation when I started ten

A years ago is very much doing things by the drugs; in other words where in the ladder of analgesics, strength of analgesics, you start; by the route, whether it is by mouth to start with or subcutaneous injection by infusion; by the clock, to avoid periods when the patient is in pain because the level of analgesic has dropped, and by the patient. The teaching is very much "by the patient" is the most important thing. So without seeing the patient, without looking at detailed notes, which are often not recorded in people that are terminally ill, it is impossible to make a judgment unless you were there.

B

Q Just going back over that, that sequence you have just dealt with in terms of the World Health Organisation approach, number one the drug?
A Correct.

Q What are we thinking of there?
A There are several drugs, increasing in strength, to get rid of pain. The WHO twenty
C years ago constructed what is called the WHO pain control ladder that is widely used round the world, especially in countries where there really is not much active treatment because of costs. The ladder is to begin with a mild analgesic – paracetamol, aspirin; to go to a middle analgesic, dihydrocodeine, for example, and then to go to an opiate such as morphine and diamorphine. That ladder is a way of getting the right drug in a sequence that is logical, to teach doctors and nurses to give a logical sequence for pain control.

D Q Would you look please at a file marked "1", in the collection of files to your left, in those boxes. Would you look, please, in file 1 at tab 4. In tab 4 we can see it contains a photocopy of something called the *Palliative Care Handbook*, which was something that was available at Gosport and other places as well known, I think also, as the Wessex Procedure. Look, please, at page 5 in tab 4. We can see there mention of the WHO analgesic ladder?
A Yes.

E Q Without troubling about the detail, is that the same thing, in effect, as what we were just talking about?
A The same one.

Q Thank you. That was the drug. We dealt with that. Then the route was the next thing itemised.
A The route – the most convenient route – for most patients is oral but some patients
F cannot swallow and sometimes the oral route is not adequate because they start vomiting because of the side effects of the drug. The next way to do it would be parenteral injection, which means injecting something under the skin. That could be subcutaneous, it could be intramuscular. Over the last twenty years the availability of subcutaneous pumps, relative cheaply, has meant that one can give 24-hour infusions, which give a much better pharmacological distribution of pain-killer drug, and therefore better pain control, over a longer period of time.

G

Q Does that bring us onto the clock, which was the next in the sequence you were citing?
A By the clock is the idea that you do not wait for the patient to complain. In every healthcare environment all over the world there will be a delay, even if the patient has one-to-one nursing, which is a great luxury. In most environments, patients do not have that, and therefore giving drugs by the clock means that you do not allow the analgesic level in the
H blood to drop to a level where the pain comes back and the patient is suffering, maybe for an

A hour or two hours, but intermittently. It is not just one or two hours. It is every few hours the level drops, and they start suffering. So "by the clock" is a way of teaching healthcare workers to avoid that trough in level, and therefore the pain.

Q Then you said "the patient".
A That is the most important. A patient's pain is judged by what they say it is. No one else can judge pain. Obviously if someone is completely well and they say they are in severe
B pain you want to work out why, but if a diagnosis has been made of the cause of that pain or distress – and it can be caused by multiple factors, especially in the elderly – then you want to make sure that the patient has enough drug by the right route to get rid of that pain.

Q We may have to come back to it later, but may I just ask you in the context of what you just said about material in relation to which the Panel have heard quite a lot of evidence. As you are aware, no doubt, from read the transcripts, reference has been made to the BNF?
C A Yes.

Q Principally the *Palliative Care Handbook*, and so on, all of which set out particular matters with regard to, and we are focusing here obviously on analgesics.
A Yes.

Q They set out dose ranges, what the drugs can and cannot do?
D A Yes.

Q What are possible adverse side effects and so on. You will obviously be familiar with all this?
A I am.

Q But in relation to patients who are reaching, or who are on, what has been described in
E the context of this hearing as a terminal care pathway is anything set out in any documentary material of which you are aware as to how much? In other words what sort of dosage and at what rate the patient should receive when they are on a terminal care pathway?
A There is no literature or guidelines on the actual doses because it is so patient sensitive. It is the individual patient who has to be judged there and then. There is no other way of doing it, so certainly in the WHO teaching literature, there is nothing about the absolute level at which to do things.
F

Q As you know, in relation to Professor Ford's report and his evidence, he was examining issues with regard to wide dose ranges, use of PRN prescriptions, drug combinations and the use of subcutaneous infusions and the use of anticipatory prescribing?
A That is correct.

Q We will come back to those, in some respects, later. Obviously everybody is
G proceeding on this basis and I think you are proceeding on this basis. The responsibility of Dr Barton as the physician responsible for Gosport War Memorial Hospital on a day to day basis, her responsibility lay in relation o all of those issues?
A Yes.

Q They are matters for her to deal with?
A Yes.
H

Q But as you are aware, and Dr Barton was only one member of a team?
A That is correct.

Q We will come back to that in due course.
A Did you find in relation to Professor Ford's report and evidence on these wider issues, that he had really addressed the question as to whether there was any practical solution for the circumstances that Dr Barton found herself in in that period?
A I could not find the practical solution. I think Dr Barton was using various recipes because it was the only practical solution to the situation she found herself in.

Q Again, we can come back to that in some more detail. What was your view as to what degree Professor Ford addressed the wide, individual variation between patients with regard to opiate needs?
A You must not base that on the actual patient data because there was no patient data presented to consider. Therefore "by the patient" was not being considered in that. I think also the dose ranges presented were from 20 to 200 mg per 24 hours in the pump, but of the 12 patients only one got above 100 mg.

Q I think it was broken down for you, and you set it out in your report, that the ranges were 120 in terms of the twelve the Panel are considering – that is in one instance, Patient A, and then the variation was 100, 90, 80, 60, 40, 30 and 20, in terms of the maximum amount of diamorphine that was being received by the patient at the time of their death?
A That is correct.

Q In relation to those – we have heard these figures before – in two the maximum was 20; in one the maximum was 30; two, maximum 40; two, maximum 60; two, maximum 80; one at 90 and one at 100, in addition to the 120 we referred to?
A Correct.

Q Would you help, please, with regard to this question in individual variation between patients to opiate need in your experience?
A It is very complex. There are multiple factors. First of all, psychosocial factors – people that are disturbed in unfamiliar environments feel more pain than if they are in a more relaxed environment – the availability of skilled nursing care and close relatives able to help reduces the need for analgesics. Then there are pharmacological factors: the fact that the patient may be metabolising the drug in different ways, partly because they have other disease problems, such as liver and renal problems, and also because there are different kinetics in how each of us as individuals disposes of morphine-like drugs. So there are many, many factors that play, and that is why the teaching is "Look at the patient and see what happens," rather than use any pre-conceived dosage or formula.

Q In terms of care for patients, we have heard evidence about this to some degree already. Does one have to look at the question of how is a patient best cared for by considering different aspects of care. We have heard about – and you have indeed just referred to, as it were – psychological support?
A Correct.

Q The importance of good nursing care?
A Yes.

A Q And obviously drug therapy to relieve anxiety, distress, pain, whatever it might be?
A Correct.

Q Where does the balance lie? Is it impossible to say where the balance lies between those aspects of patient care in relation to the type of patient we are considering in this hearing?
A It is very difficult, and certainly in elderly patients it is much more difficult because B they may not be able to communicate exactly what the problem is in the way a younger patient may be able to.

MR LANGDALE: I am going to ask, with some hesitation, that the Panel receive a document. My learned friend Mr Kark has seen it. It is not a document prepared by Professor Sikora himself. He has seen it. It has been prepared by those instructing me and it is an attempt to show by way of a chart that the level of morphine which a patient will receive C if it is administered subcutaneously. It is not absolutely mathematically precise, and the Panel will see that it has been divided into two charts. One shows the picture if the half life of the morphine is two hours; the other shows the picture if the half life of the morphine is four hours. The Panel have heard a certain amount of evidence, in particular from Professor Ford, about the sort of level you would expect the morphine seemed to have peaked at, and so on, in the course of the evidence you have already heard. I am putting this in with the agreement – and I am grateful for it – of counsel for the GMC, simply to assist the Panel D to get an idea. It is not set in stone, and I am going to ask Professor Sikora to deal with it in very general terms. I wonder, sir, if those documents could be put in.

THE CHAIRMAN: They will be D7.

MR LANGDALE: Thank you very much. That is D7. D7a will be the two hour one, and D7b for the four hour one, perhaps.

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THE CHAIRMAN: By all means.

MR LANGDALE: Perhaps Professor Sikora could also have a copy. (Document marked and circulated) Sir, I stress, this is not his document. (To the witness) Professor Sikora, I am going to invite you to look at this with us and ask you some very general questions about it.
F A Of course.

Q We are looking at subcutaneous infusion of diamorphine. Both of these charts are headed "Diamorphine Blood Levels" on the assumption that it is a dose of 20 mg subcutaneously over 24 hours. First of all 7a, with a two hour half life; secondly, 7b, a four hour half life. Looking first at 7a, the way in which this document has been set out shows on the left hand column the hours. In other words, after hour one – at the top on the left – 0.83 G mg has (in my words) gone into the patient?
A Correct.

Q So at the end of an hour, it is 0.83, assuming a two hour half life. The rest of the plan sets out the figure you reach after each one of the hours up to and including hour eleven after administration?
A Correct.

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Q If it is a two hour half life we can see how the amount of morphine in the patient, allowing for the fact that at each stage you have to take into account the remaining morphine from the previous infusion and how it declines. On the right hand side you have the amount, so after two hours, 1.46 and so on. Then, after eleven hours it reaches the peak that at any one time would be in the patient's body, 2.86?
A Correct.

Q I am told Mr Barker has rounded up these figures to avoid any kind of misleading impression. Looking at the position with regard to the four hour half life, 7b, the same method has been used, and we can see that in relation to the first hour the same amount has been received by the patient, but as you go on, if you assume a four hour half life, the amount in the patient's body is in general terms higher?
A Yes.

Q Because the morphine is there (again in my words) for longer?
A Correct.

Q On this particular exercise, again staying with the 20 mg over 24 hours, after 21 hours the peak has been reached of 5.32?
A Correct.

Q This is just an exercise to try and demonstrate a general picture. It is not meant to be, as I say, a certain standard, but in general terms without your having checked the figures – they are not yours – is that the sort of view or understanding we should have with regard to the way the morphine gets into the patient, stays there and eventually declines?
A Yes. It is a good teaching exercise on the value of a subcutaneous pump rather than intermittent injection, where you would have peaks and troughs. Peaks may have an overdose of morphine or diamorphine, and a trough where you get breakthrough pain. With a subcutaneous pump you reach a plateau and you can see with the two hours you reach the plateau actually at about the fifth or sixth hour. There is very little rise from 2.41 up to 2.86. With the four hour half life patient, you see you reached the plateau when you get to about 13 hours. It really goes up very little from then.

Q So in the case of the four hour half life plateau it is reached more or less after thirteen?
A Correct, yes.

Q And the lower figure for the two hour half life. Thank you for dealing with that. I am going to ask you a little bit more about your area of expertise, and about your experience with regard to palliative care generally. As you set out in your report, your area of expertise is cancer medicine?
A Correct.

Q And you have been a consultant in that discipline for getting on for 30 years.
A I have.

Q Does that experience of yours include the palliative care of elderly patients suffering from cancer?
A It does. The majority of patients with cancer are elderly and palliative care is, unfortunately, necessary for many patients.

A

Q As you have already indicated you have worked as a consultant at two teaching hospitals, Addenbrookes and also the Hammersmith Hospital.
A I have.

Q You have obviously had appropriate support from more junior colleagues.
A I have.

B

Q It is also right to point out that you yourself have never had to practise in an isolated clinical environment.
A That is the case.

Q So you have never been in the same sort of situation as Dr Barton for instance.
A No.

C

Q When you were clinical director for cancer services between 1986 and 1998 at the Hammersmith Hospitals NHS Trust did that include the management of the palliative care services?
A It does. We created a palliative care position among the consultants and, with the local hospice, we developed palliative care as a separate sub-specialty within our department.

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Q It may be that one will have to draw some distinction between the palliative care of cancer patients and patients who are not suffering from cancer. We can come on to that later and it may be an issue which will be explored with you, but I just want to ask you about this: in terms of the whole concept of palliative care – and your experience in this particular field obviously embraces the period of time that the Panel are concerned with in this hearing, the 1990s – can you give us a thumbnail sketch as to how you saw it in terms of palliative care either originating in hospices or whatever it might be; a little picture of how things have

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developed?
A When I began in cancer medicine as a registrar there was really no palliative care. It developed in London at St Christopher's Hospice and migrated around the UK, both in hospitals and in community settings, together with charitable support from the Macmillan Fund, which was one of the major drivers of the palliative care movement. Today it has changed beyond all recognition. Initially it was just for cancer patients, now the protocols and the way in which the teaching is given applies to all situations including a common

F

pathway of terminal decline which happens in all diseases, so the lessons from cancer have been applied right across the board. Currently there are major forces trying to get palliative care more into the community; the current Government has an initiative to allow people to choose where they wish to die, and that is a very challenging effort, whether they wish to die at home or in a hospice or indeed in a hospital. It is difficult to implement because obviously it costs money – it is not about drugs necessarily, it is about staffing to make sure that people can die in the home, for example, which is much more consuming of staff time.

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Q May I ask you this, again in general terms: is there any significant difference between the approach to be adopted in palliating symptoms of pain, distress, agitation and so on – again, my words because we have heard different labels such as terminal restlessness and so on – in patients who are suffering from some form of cancer and patients who are suffering as a result of some other problem such as illness, comorbidity, whatever words we use?
A I personally do not think there is and I think it has been very tragic that it has taken

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our profession so long to recognise that. The lessons from cancer, where palliative care has

A really been developed, are now being applied across the board to all terminal phases of illness and, indeed, hospices are opening their doors now to non-cancer patients for the first time. I suspect the origin of this is that cancer is thought of as an incurable illness; many other diseases are not thought to be incurable and that was the reason for that distinction. A terminal pathway is a terminal pathway by definition.

Q We have heard evidence that certainly for a period in the early 1990s a nurse or two
B or three nurses at Gosport War Memorial Hospital were concerned about subcutaneous analgesia, in particular diamorphine, being administered to patients who were not cancer patients. There was a concern of that kind or at least a thinking process of a similar kind elsewhere was there?
A There was.

Q We heard evidence from Professor Ford who said in relation to Patient C – Eva Page,
C the lady who was suffering from the carcinoma of the bronchus – that in his view it was acceptable and appropriate to prescribe and administer opiates to relieve anxiety and distress, whereas he certainly seemed to be indicating at other parts of his evidence, as you may have read, that in his view opiates such as diamorphine should be administered simply for the relief of pain. What do you say about that?
A The only way to decide is to judge it by the patient. Diamorphine is a valid drug for people in severe distress and various other indications, not just for pain, but it has to be a
D clinical decision, done on the spot.

Q It is right to say that he accepted that there was a body of opinion which might hold the same view as you just expressed in the country at large. In looking at your consideration of the position Dr Barton was in, did you go on the basis that when she took on the job in the first place it was on the basis that she understood it would be a commitment which could initially be managed within the time constraints of her comparatively limited sessions?
E A That is what I assumed.

Q And as you have already indicated you proceeded on the basis – I do not think there is any dispute about this – that the nature of the clinical workload at Gosport changed very significantly as the 1990s moved on.
A It did.

F Q In terms of what you have seen of the evidential picture in this case, what do you say about the adequacy of clinical consultant support provided to her?
A Dr Barton was, however competent, untrained in any specialty other than general primary care, general practice, and the patients were managed by a named consultant. There would have been on the notes, maybe even above the bed, the name of that consultant. That is normal practice throughout the world. The consultant was responsible for patient care. My understanding is that the consultant ward round was once a week, sometimes once every two
G weeks, and for a period when there was maternity leave not at all – for nine months presumably. Clearly there was a system problem in terms of consultant monitoring of patient care. It may be acceptable if it really is a nursing home type of atmosphere with just long term admissions with no changes, but certainly towards the end of the nineties that was not the case. These people were being discharged from neighbouring acute hospitals with serious medical problems and it would imply there should be consultant cover almost on a two or three day a week basis.
H

Q Similarly with regard to the evidential picture presented to you, did the staffing model at Gosport continue on the basis of low dependency care of elderly patients or did it in any way change as a result of the change in the patient mix?
A I only changed after the various investigations; until then there was no change and there was no change in the back-up professionals such as occupational therapy, physiotherapy, radiology and so on.

Q If that is the right evidential picture I would just like to ask you about the situation that is created as a result for those concerned with trying to care for patients of this rather different kind. It is a truism perhaps for us to state, but perhaps one would make it clear with you, that obviously drugs form an important part of good palliative care. There is no dispute about that.
A Yes.

Q In the context within which we are operating in this hearing there are drugs to control pain, anxiety and distress – I will use those three labels as being convenient shorthand ways of describing it. What about the importance of good nursing care, what would you say about that?
A Good nursing care is vital in this situation and obviously it allows not only psychological care for the patient but also the monitoring on a regular basis of what is happening and therefore there is an inter-relationship between drug therapy and its monitoring and the availability of staff.

Q What is the consequence, therefore, in terms of the practicalities as to what is to be done with any particular patient or patients within a particular category. What are the practical consequences if nurses are trying to provide good care, the clinical assistant is trying to provide good care, but the ratios and the resources are as you understand them to be? What is the practical consequence?
A If we take the relationship between nursing care and drug therapy there is no doubt in my mind that if the availability of nursing care is low and there are few nurses for many patients, then in doing the prescribing you are going to have to start at a higher dose and have a sliding scale to allow decisions to be made quickly. There also was not medical cover as far as I can see, the medical cover was inadequate, and therefore the idea that you could call a doctor and get action within a three or four-hour time period was unrealistic in the set-up as described in the various documents, so the nursing, medical and drugs all are intertwined.

Q You say the impact in terms of what the doctor is going to prescribe and have administered in terms of drugs is going to be affecting the doses. How do you square that with what is in the patient's best interest?
A The idea is to write out a prescription that can be delivered with freedom to the clinical observer at the time; in other words it does not require someone to be called from the other side of Portsmouth to come and make the decision, the people on the spot – who inevitably were the nursing staff – could make a decision about what to do. That is the attraction of having a sliding scale and a subcutaneous pump, it allows the person on the spot to take the clinical decision, looking at the clinical parameters and make their own decision. Of course, different people, different staff, will come to different conclusions, but at least they can do what they think is the best for the patient.

Q Are you aware of the evidence from the nursing staff – although their evidence varied to some degree – about the practice of seeking approval or consent or authorisation (whatever

the right word is) from Dr Barton, in default of her from an on-call doctor, in relation to decisions of that kind?

A I am, and that seemed an eminently sensible way to approach it. If Dr Barton was there she knew all the patients so she could guide the decision. If she could not be contacted someone in the practice who was on call could be contacted, but they would not know the patient so inevitably – and certainly in my experience – you would go with whatever the nurse was asking for, unless there was some special reason not to. The third way is that the nurses make the decision on their own if they could not get hold of anybody.

Q Just looking at it as a matter of practicality, if you had got full resources – say in a teaching hospital – in terms of the administration of analgesia of the kind we are talking about, what is the best picture? Assuming you have got the resources what do you try to do with regard to administering opiates?

A If you have got a patient who is in distress what you really need is to assign much more nursing time – maybe not one to one but getting towards that level. In a teaching hospital there may not be a resident doctor but there will be someone on call 24 hours a day who could come and change the prescription if necessary, so the combination of being able to change the prescription 24 hours a day, to have a doctor there 24 hours a day if necessary and to have good nursing care available, very frequently making observations, is a luxury that was not available, from what I have read, at Gosport.

Q If the luxury is available does that have an impact on whether it is appropriate to titrate doses up? Just give us the picture with regard to what you would do if you had all those resources available.

A If you have all the resources available and you are able to titrate things in real time you do not need to leave a blanket prescription, you can just change it as you go. If the resources are not there you have to leave a wider range to allow whoever is there to adapt to the circumstances the patient finds themselves in.

Q If you have not got the resources to titrate up in steps, say after every four hours checking and so on and so forth, what is appropriate in terms of the initial dose if your objective is to prevent pain or to control pain?

A In terms of diamorphine I would say at least 20 mg to start with.

Q I will come on to that in a moment; so that may be affected by the practical situation you are in.

A Absolutely.

Q Apart from relieving the distress of patients, if you are operating in the sort of circumstances that Dr Barton was operating in, what about the distress of their relatives or close family?

A That can be very distressing. It is part of therapy – one treats the patient but one is treating the whole carer group as well and to see an older person who may be severely demented, suffering because of some physical illness as well, and disturbing the family is profoundly unpleasant. Doing something about that is part of good practice.

Q You have seen the general picture – I am not asking you about individual patients – with regard to opiates being prescribed with quite wide dose ranges and with, as I think you described it, an effective minimal dose.

A Correct.

Q We have covered the picture with regard to what discretion the nursing staff had in relation to the administration of these drugs but in terms of your experience of doctors involved in palliative care teams, do they all share one philosophy in relation to the actual level of the starting dose of diamorphine?
A Absolutely not. In cancer medication the drugs for cancer are rigidly adhered to around the country. If you have 100 oncologists they will be using the same drug dose. If you go to palliative care it is much more subjective how you do palliative care and there is much greater variation between different palliative care physicians about the starting dose and the scales that they use.

Q Can I come back to something you mentioned a moment or two ago in relation to a starting dose with diamorphine. I appreciate different patients and different situations but in general a starting dose of diamorphine of, say, 10 to 20 – or 20 as we have commonly come across in this case – what do you say about that generally speaking, bearing in mind it is subcutaneous delivery by means of a syringe driver over 24 hours?
A To me 20 mg seems a reasonable starting dose.

Q I would like to ask you about plasma levels of active drug achieved over a 24 hour period. What do you say about that in terms of the level?
A The plasma level – one is trying to achieve a level where one can get rid of pain over a smooth curve of 24 hours and the levels with 20 mg depend on how quickly the drug is metabolised, how quickly it is destroyed by the body. That is a variable and we have seen the two charts, the two hours and the four hours, which show that in both cases you inevitably reach a plateau.

Q In relation to the sort of plateaus, appreciating it varies from patient to patient and so on, but just looking at the broad brush picture, with those sorts of levels of morphine in the body would they be such as to be likely to lead to dangerous side effects? Just taking our 20 mg administration.
A Over a 23 hour period, even in an opiate naïve patient – someone that has not received opiates before – it would not lead to serious consequences in most patients.

Q Again, there is no dispute in the evidence in this case that whether a patient has been on some form of opiate before subcutaneous administration may affect, first of all, when you start subcutaneous analgesia and the amount that it is appropriate to administer.
A That is correct.

Q That, I think is a given in this case. It is also the case, as you will see from the pattern of the prescriptions, that the analgesia administered in the form of diamorphine, also on many instances had the addition of a sedative or tranquilising drug, midazolam?
A It did.

Q First, in general terms, anything unusual with patients falling into this sort of category in the administration of diamorphine and midazolam together?
A No, and indeed the BNF is quite clear. There are a series of drugs tabled there that can be given in the same syringe driver at the same time.

Q In terms of any other drugs that had been administered in the syringe driver in this case, haloperidol is one we have seen from time to time and also hyoscine?

A A That is correct.

Q Looking at those.
A They can be mixed and the are used for different indications; haloperidol for people who are severely distressed and agitated depression, and hyoscine especially if the terminal event involves a lot of fluid gathering in the lung which is very distressing both for the patients and for relatives. Hyoscine essentially dries up the membranes of the lung.

B

Q In terms of the dose, the dose needed of an analgesic and an anxiolitic in relation to the dose, the amount, when considering the need to allay symptoms in the individual patient in general, is that affected by the increase that patients experience as a result of fear, isolation, unfamiliar environment and so on. Does that affect the dose that you think it is appropriate to administer?
A I believe it does and, basically, pain has multiple components and anxiety, distress and lack of familiarity increase fear. That fear means to get the same analgesic effect you have to give more drug. That is why cocktails of drugs, midazolam with diamorphine, are effective because one takes away some of the fear allowing the analgesic, where there is pain, to have a better effect.

C

Q So one has to be looking at the combined effect and the combined situation?
A Exactly, and the art of good palliative care is to make the decision as to what the key problem is to vary the doses appropriately.

D

Q In terms of patients who are on the terminal path, an expression that has been used in this case more than once – I am looking at your report on page 6, the third paragraph down – you deal with what you describe as dying patients. I would like you to deal with the question of the size of the dose that may be appropriate because, obviously, a given in this case, you do not have to worry about drug dependency with regard to a patient in that situation?
A One of the fears in giving opiates to any patient is that they will become dependent on the drug and you will have to wean the patient off the drug just like an addict. That does not apply to people who are dying, whatever the cause of that death. The only way to sort out the correct dose is to make individual patient assessments. Physicians who are not in palliative care, or indeed in oncology, tend to be very sparing on opiates and one of the problems in many general wards for surgery and medicine is that there are patients in serious pain even still, and palliative care education is one of the ways to try and deal with that.

E

F

Q You have already covered the point, and we have already heard it from other witnesses in this case, that pain and distress are enormously variable from patient to patient. We have heard about what the severity of the pain may depend on and you have covered that in your evidence. In terms of the causes of deterioration – you will have seen from the transcripts you have read that patients are described as deteriorating and so on – I am not asking about individual patients in this case but, in general terms with elderly patients with multiple sometimes comorbidities, what is the practicality in terms of the clinician endeavouring to establish the cause of the deterioration?
A In most of the situations where patients are deteriorating, especially if they are doing so rapidly, there is absolutely no point doing more investigations. At Gosport it would not have been possible to get urgent investigations, x-rays or blood tests and unnecessary to do so. Only good clinical decision making can really contribute and a clinical assessment on the spot by a doctor or nurse and a decision how to vary the drugs appropriately.

G

H

Q If I could ask you to deal with this issue in general terms. In terms of the doctor concerned, in this case obviously the clinical assistant Dr Barton, trying to determine what is the product or what is the contribution of the medication you are providing to control symptoms as to where the balance lies, how can you check whether you are right?
A The only way is to go back an hour, two hours, later and see what has happened. It is a continuous circle of monitoring and then varying the dose appropriately, changing the composition of the drugs in the syringe driver appropriately.

Q What do you say about the stopping of subcutaneous analgesia, first stopping it to check whether the patient is suffering more from their condition or more from the sedating effect of the drug or the respiratory depressive side of the other drug that has been administered?
A I think it would be very difficult to do that. It is very rarely done in any clinical situation when one knows the patient is on the terminal pathway. It would almost, to me, be unethical to make the patient suffer unnecessary pain in the last few hours or last few days of life by doing that experiment.

Q What about reducing to see if the pain breaks through again. What is the appropriate approach there?
A That is certainly possible, but on the whole a good clinical assessment would mean that it is unlikely that you get to a point in a dying patient where you start reducing the dose.

Q The reasons for that being unlikely with a patient who is on a terminal pathway?
A Because, inevitably, if you reduce the dose enough, you will get symptoms coming back and why would you want to see that?

Q In your report you dealt with the issue of, what I always mispronounce, parenteral fluids. I do not think it is an issue that the Panel is any more concerned with in terms of allegations in this case because it is clear that at Gosport they did not have the facilities to hydrate patients in that way and we have heard about the different views as to the propriety of trying to hydrate in these sort of circumstances. If anyone wants to raise the issue with you, no doubt you can deal with those questions but I am not going to ask you about it.

THE CHAIRMAN: Mr Langdale, the witness has been up for a little over an hour. Would that be a convenient moment?

MR LANGDALE: Yes, I do not have a great deal more, but it is more than five minutes.

THE CHAIRMAN: We will have a break now. You will be taken somewhere you can get some refreshment and some rest before you come back for further questions. I am going to say 15 minutes, 11.20am.

(The Panel adjourned for a short time)

THE CHAIRMAN: Professor, you of course remain on oath. Mr Langdale?

MR LANGDALE: Professor Sikora, I am dealing with matters which are contained on page 7 of your report. I have covered issues with you with regard to the combination of anxiolitics, such as midazolam and haloperidol with diamorphine and so on and I am not going to go over that material with you again. I would like to ask you about the practical

position. In a hospital with full resources, if a doctor is able, with the aid of nursing staff and so on, to give a much more closely monitored assessment of the condition of a patient than if the resources are rather more limited because of the practical consequences of lesser resources, if it is the case that a doctor with less resources, with the sort of resources that we are talking about at Gosport War Memorial Hospital, is aiming to control pain and distress symptoms to prevent the patient suffering from pain and distress and with any one possible dose range – just take a dose – at which to start the administration of subcutaneous analgesia or indeed the level to which it is to be increased, if there is no absolute set rule as to precisely how much should be prescribed, there is a variation, in terms of a doctor tending to go higher rather than lower within the possible or permissible range, what do you say about where the choices really lie?

A I would believe the choices lie between increased suffering if the dose is not enough, or increased suffering is the delay in which you can get someone to rectify the low dose to convert it to a high dose, or starting at a higher dose. If there is one to one observation, if there is a doctor on call who can change the prescription, it is a very different situation to what was happening in Gosport.

Q You have covered the position with regard to anticipatory prescribing which you touch upon in relation to the third paragraph of this particular page of your report, and I am not going over the procedure, you have already indicated what your understanding of it was. What effect does the reduction of staff levels proportionate to the increased and different patient mix, what effect does that reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?

A It means that there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore, using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances.

Q Did you take on board the fact that so far as you could judge it – it is for the Panel to decide, not you, but as far as you could judge it – what Dr Barton was doing had the approval, certainly did not have the dissent, of the consultants, nursing staff and pharmacist?

A Absolutely, and there was no formal appraisal in those days and clinical assistants were exempt from appraisal until relatively recently so there was no mechanism of feed back, but there was tacit acceptance. The charts were written up and if a consultant does not look at the chart that is his responsibility in my mind.

Q Looking at the situation in general terms with regard to the general practice and the general procedure adopted by Dr Barton, taking into account the position that she was in – we have looked at the different aspects – what is your view as to what the alternatives were in terms of being available to her?

A She could live in the place 24 hours a day, that would be one alternative, or otherwise what she did seems to me perfectly reasonable. As I say in the report, it is a very vulnerable end of health care all over the world. It is a forgotten area, it is an area which not much is invested in; nothing to do with the NHS, it is throughout all health care systems.

Q Would you enlarge on that. You say "a vulnerable area" and isolated as it were, what do you mean by that?

A Isolated because geographically it was isolated from mainstream medicine. Junior doctors were not available to Dr Barton or the whole of Gosport War Memorial Hospital.

A The patients had multiple comorbidities. Once they went into the terminal phase they were outside mainstream medicine. That is quite fair, they needed to be given symptom control in an environment which is not luxurious in terms of staffing.

Q You say this is a world wide problem. In relation to palliative care generally, do you mean?
A Britain has exported some of the finest palliative care regimens outside to the rest of
B the world, I think we have driven that. There is no doubt that palliative care all over the place is under resourced and terminal care particularly so.

Q Considering the position again, broad bush, what were the practicalities, apart from walking away from the job, for any doctor in terms of doing anything different to what Dr Barton did?
A Developing systems internally to try and cope with the problem, which I think she
C did; trying to lobby for more staff which, from reading the various bits of evidence, she did. One of the problems is that it was an outpost of the main Hospital Trust and, therefore, the management control did not seem to be clear how the place was being managed from the centre. How would you actually go about getting better resources and whose responsibility was it? I would say it was not the responsibility of a five session clinical assistant to have to do that.

D MR LANGDALE: Professor Sikora, that is all I am going to ask you because were you not asked to look at the individual twelve patients and check all their records, and so on and so forth. Obviously you have seen material relating to them in your reading of the transcripts, but I am not asking you to go into individual cases. That is all from me at this stage. Would you wait there because you will be asked some more questions.

THE CHAIRMAN: Thank you, Mr Langdale. Yes, Mr Kark.
E

<u>Cross-examined by MR KARK</u>

Q Professor Sikora, I was going to start where Mr Langdale left off. That was to just examine with you what you have not reported on, as it were. So far as the material that you were given, I do not think you were given any of our patient notes, were you?
A That is correct.
F

Q So you have not actually examined the individual cases of those patients?
A That is correct.

Q In terms of what the Panel have looked at but you perhaps did not – and this is not criticism of you whatever – although you had Dr Barton's statements, the notice of inquiry, Professor Ford's reports, and you have read his evidence and her evidence – I do not think
G you were given the patients' relatives' statements?
A No, I was not.

Q The nurses' or the consultants'?
A I have seen the transcripts.

Q You have seen the transcripts – of whom?
H A The consultants.

Q And the nurses?
A Some of them.

Q And the actual prescriptions that were written by Dr Barton. I know, obviously, you have seen the reports about them. You have seen what people said about them. Have you examined the prescriptions yourself?
A I have not examined the original prescriptions.

Q For that reason, quite properly, you have not sought in your report or your verbal evidence now to comment on the treatment of any of the patients?
A That is correct.

Q So far as your own practice is concerned, you are a cancer specialist?
A I am.

Q You are, if I may say so, a very well known cancer specialist. You would not class yourself as a geriatrician?
A No.

Q And obviously you deal frequently with people who are in the terminal stages of illness, do you?
A I do.

Q And have to be treated with palliative care or by palliative care?
A I do.

Q As you are probably aware, I think only one of our patients in fact had a carcinoma of the bronchus?
A That is correct.

Q Just thinking about the position at the Gosport War Memorial Hospital obviously you have not practised anywhere similar to that community hospital, or the like?
A I have been responsible for palliative care in a community hospital.

Q In a consultant role?
A No. In a management role.

Q As I think you commented in your report, there are various things one can say about the Gosport War Memorial Hospital. First of all, there seems to have been a lack of supervision over what Dr Barton was doing?
A That is correct.

Q It may well be that the consultants whom you have spoken about were not as available or indeed as active as perhaps they should have been?
A It is difficult to judge.

Q And you have also spoken about the changes in the nature of the patients in the latter half of the nineties. Just looking at that for a moment, that was a nationwide problem, I think. That is not restricted to the Gosport Peninsular, is it?
A No. It is ubiquitous.

Q That was happening, fortunately or quite possibly unfortunately, in community hospitals up and down the country?
A Correct.

Q And so people in Dr Barton's role – and her role, again, was not unique, was it?
A No.

Q The role of clinical assistant where a doctor would be visiting a community hospital and not there on a full time basis is – was – a very well known position?
A Correct.

Q And so people in Dr Barton's role would be having to deal with that sort of change nationwide in community hospitals, up and down the country?
A There would be local variation on the severity of the issue.

Q Absolutely. I absolutely take you point, and we all understand, that when a doctor is prescribing for a patient, and you have very much highlighted this, it is important obviously to observe the signs and symptoms of a patient?
A Correct.

Q And I think in your report you commented on the difficulty of going back through sparse, sometimes sparse, notes and then forming an opinion about the management of the patient?
A Correct.

Q I expect that you accept that there are circumstances where a prescription can be so obviously wrong, or a plan of treatment or lack of treatment can be so obviously wrong, that an expert is entitled to comment?
A Yes.

Q Because that, of course, is the nature of expert evidence?
A Absolutely.

Q So far as the issue of note-making is concerned, you have not commented on it particularly but, again, the vast majority of doctors working in a hospital environment, particularly one suspects in the NHS, would describe themselves accurately as very busy?
A Yes.

Q And quite possibly overworked?
A Possibly.

Q And perhaps particularly geriatricians?
A The numbers of patients involved are large.

A Q And although we know that doctors are taught to make notes about everything that they do, it is not always possible?
A No.

Q Some notes, I expect you would agree, are rather more important than others?
A They are.

B Q I am going to run through it, if I may. A note of an assessment when a patient first arrives at a hospital can be fairly critical to give the doctors and nurses a starting baseline?
A It can.

Q Such a note can be critical for the future care of the patient, because without it you do not know where you started from?
A It can.

C Q You would expect, would you not, in general terms for major changes in the condition of the patient, or deterioration of a patient, to be made?
A Yes.

Q You would expect in general terms for major changes in the management of a patient to be noted?
D A Yes.

Q And when there is a major change in the drug regime, and by way of example, starting opiates where a patient has not been on opiates before, you would expect a careful note to be made about that decision?
A Yes.

E Q And the decision to enter into non-curative palliative care is a particularly important decision in a patient's life, is it not?
A It is.

Q And is that something which in your own practice you would either note down yourself, or I expect now you may be too lofty to do so, but you would certainly ensure that doctors under your management would note it?
F A Yes.

Q You have spoken about starting doses. I think in your report you say this:

"A range of starting doses between 10 mg to 20 mg"

– and you are referring, I think, to diamorphine?
G A I am.

Q

"A range of starting doses between 10 mg to 20 mg subcutaneously delivered by a syringe driver over 24 hours would in my opinion be reasonable."

A Correct.
H

A Q In what circumstances?
A When someone has chronic pain. When someone is chronically agitated and is going into a terminal phase of their illness.

Q Plainly you would not write out such a range unless you felt there was good reason either for believing that the patient was at that time in chronic pain, although perhaps that is a misnomer. Chronic pain means long term pain, does it not?
B A Correct.

Q Or very soon to be visited by serious pain?
A Yes.

Q In general terms, and you have been dealing with this sort of patient for a long time, a range of the starting dose between 10 and 20 mg – is that something that you yourself have
C written in the past?
A Yes, yes.

Q And it is the sort of prescription that you would expect to see among those practising under you?
A Yes.

D Q What matters, of course, is the patient, as you said, in front of you?
A Correct.

Q And an attitude of "one size fits all" would be wholly inappropriate, would it not?
A It would.

Q You also said in the course of your evidence, and this was not quite consistent with
E your report, I think you said, "A starting dose of 20 mg seems a reasonable dose". I did not quite understand in what circumstances you intended that to be read?
A I think in a unit where the doctor cannot return within an hour, and where the staff ratios are relatively low. There it would be reasonable to start at 20 mg rather than 10 mg, for example.

Q But for what sort of patient? What are you referring to?
F A For a patient who is either in pain or severe distress, or likely to be in pain.

Q Over what time period? Presumably before the doctor can get back?
A Yes. Twenty-four hours, I would assume in this case.

Q I do not know if you are aware of this, but in relation to this particular hospital, we have heard a number of things about the cover that was available there.
G A Right.

Q We have in fact heard that there was effectively – that horrible expression – 24/7, but there was in fact round the clock on-call cover. Were you aware of that?
A I was, but it was clear from some of the statements that that cover was very variable in terms of its actual delivery.

H

Q So far as the starting dose is concerned, you have spoken about the WHO, the analgesic ladder. I just want to ask you a little bit about that. Do you still have that binder near you? You have been an adviser to the WHO, although in a different capacity of course, and I do not think you took any role in the devising of these particular guidelines. Indeed, the analgesic ladder, I expect, has been around as long as you have, Professor Sikora?
A Yes. It was there twenty years before I arrived.

Q It is a very well known basic medical principle, really. Does it go hand in hand with the titration of doses?
A It does. It does, and the ladder itself is about the type of drug, so by the drug, by the route, by the clock and by the patient. These are the four bits in the WHO, but the ladder is specifically about moving from mild pain control to severe pain. One of the problems right across the world is the unwillingness of systems to actually move patients through to the severe pain when it is indicated.

Q And these guidelines and, indeed, the guidelines in the BNF that you have not looked at, but these guidelines are devised to deal with people potentially in chronic pain?
A That is the case.

Q People dying of cancer and other serious illnesses?
A The guidelines were made for cancer but, as I think I said earlier, the palliative care movement across the world is adapting very similar guidelines to other areas of terminal care outside the oncology world.

Q And the guidelines, can we assume, were devised by people on the basis of knowledge built up from dealing with patients in chronic pain?
A And it applies also to acute pain that is not caused by something ---

Q You are quite right. You are quite right to correct me. I keep using "chronic pain". I mean both chronic and acute pain.
A Yes.

Q So it is to guide those who are dealing with patients at the patient's bedside, perhaps, who are in serious pain?
A Correct.

Q This is not a purely academic exercise, is it?
A This is not an academic exercise.

Q You do not have the BNF or the *Palliative Care Handbook* in your pocket, as it were, and then you throw them out of the window as soon as you are confronted with a patient?
A Exactly.

Q These are there to help you prescribe for the patient in front of you in chronic or acute pain?
A They are also there to help health workers, whatever their rank, to give benefit to patients.

Q We have heard quite a lot about the effects of these drugs on the elderly. Again, I do not want to spend very much time with you on this issue, but I do not think you have been

A asked to deal with it specifically. Again, we have looked at the BNF. We have looked at the palliative care guidelines. It is a well known principle, is it not, and fact that the elderly are more susceptible, more sensitive, to the use of opiates?
A That is the case.

Q And just by way of example, the sort of half lives that we are looking at in these two documents, that the defence have produced, D7a and b, if one is dealing with an elderly
B patient, possibly with renal impairment, you would not be looking at a two hour half life, would you?
A No. It would be nearer four.

Q Four or above?
A Could be above.

C Q Let us put 7a away, and let us look at 7b. What I think you said was that it demonstrates that there is a plateau at 13 hours and the effectiveness of the drugs goes up a small margin, as it were, beyond 13 hours, but it reaches its effective point – is that fair – at the 13 hour point?
A It probably reaches it in some patients a bit before that, but then it plateaus off slowly.

Q Just looking at the column on the right hand side, and I am focusing on 7b because it
D is much more relevant to elderly patients, is it not than others?
A It is.

Q We can see that after five hours you in fact only reach 2.71 mg?
A I think it is 3.13.

Q I am sorry. Thank you. It is the one below – 3.13. And so 3.13 mg; if you had a
E patient who had what I think is described as breakthrough pain ---
A Yes.

Q --- and you wanted to give them an immediate relief from pain, you might give them – what – a 2.5 mg dose or a 5 mg dose by injection?
A That would be possible, so you get an immediate spurt of plasma level.

F Q And you would hope, would you, that that sort of dose would deal with breakthrough pain?
A It could deal with the breakthrough pain, but then you would have to do it again in four hours.

Q I understand that.
A It may not be possible.
G

Q I entirely understand that. That is the peaks and troughs problem?
A Correct.

Q What this does demonstrate is that a syringe driver is not actually very well equipped to deal with a patient who is suddenly in pain?

H

A A Not a patient that is suddenly in pain, but that is usually not the case. The patients develop pain slowly and the attraction of the syringe driver, once it is there it goes on smoothly for 24 hours a day.

Q In terms of setting your starting dose with a syringe driver, and we have talked about the analgesic ladder and titration, it is important if at all possible to have titrated to the dose which you want to start the syringe driver at. That is very bad English, but does it make
B sense?
A That would be the ideal situation to go for, to have either oral morphine or long-acting morphine or, in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine.

Q Because unless you do that there is a serious danger that you are either going to start too low or too high.
C A That is the case.

Q With your syringe driver.
A Exactly.

Q I have dealt with the *Palliative Care Handbook* and the WHO guidelines but the principle of titration does not go out of the window because you are dealing with a patient in
D pain; it is very relevant, is it not, for a patient in pain?
A It is. One of the reasons the subcutaneous drivers are not mentioned in any WHO book is because they are from low resource environments where you do not have the luxury of them, but they are recognised as a superior form of long term pain control.

Q The principle of titration does not mean, does it, that you need to have a nurse sitting watching the patient for a 24-hour period at the bedside, it means fairly regular review and
E occasional notice, is that fair?
A It does, but it also means variable prescription and, if necessary, injections every four hours.

Q Certainly, but if you were trying to titrate the dose to get to a point where you knew you could control the patient's pain, presumably you would have your nurses observe the patient every hour or two – sorry, you are nodding.
F A Yes, that would be the case.

Q And then make a note of it every four hours perhaps.
A Yes.

Q I think that actually is the guidance given by the Liverpool Care Pathway, is it not?
A It is.
G

Q You spoke about the use of opiates and I think you were talking about for a dying patient.
A Yes.

Q Who is very fearful and agitated.
A Yes.
H

Q Do you yourself use opiates in those circumstances?
A Yes, I have done.

Q You have done.
A I have done.

Q Can you just tell us something about the circumstances in which that occurred?
A Death is very difficult to deal with for all of us, however experienced you are at seeing it, and the specialty of palliative medicine has made it much easier for the broader community of physicians and other health professionals. Sudden declines are very common within a 24-hour period – a patient goes from being relatively stable into a decline – and with older people it is very difficult to work out what the cause of that decline is. If patients are in pain or distressed then some form of medication is necessary, and that can be done in a variety of routes. Ideally one begins with the oral route but often patients cannot take it – they have sickness, they vomit up the drug that is given, and therefore converting to a parenteral route is the next step. The advent of subcutaneous pumps about 20 years ago through palliative medicine really changed the way in which the terminal pathway can be implemented in patients that are estimated to be within three or four days of death. One of the problems is that it is very difficult to make that estimate, it is very difficult to know the true situation, and I have certainly seen that in my patients – that patients have died much more rapidly than I would ever predict and, conversely, people have hung on for weeks.

Q It follows from that that if you take the decision that your patient is on a terminal care pathway too early you may get it wrong.
A You might.

Q What I was asking about in fact was the use of opiates in the agitated and distressed dying patient who is not in pain, and I was asking about the circumstances in which you yourself have used opiates in those circumstances.
A Can you just repeat that – the patient in pain or not in pain?

Q Not in pain.
A Okay.

Q Do you use opiates in those circumstances or do you use sedatives?
A No, I use opiates and sedatives.

Q Can you just tell us about the circumstances?
A The most vivid memory is a patient who was in severe distress, a relatively young man, not an old patient, and we just could not get rid of the pain – sorry, we could not get rid of his distress. He was not in any pain.

Q What was his distress arising from?
A A fear of death. He was extremely agitated and it could not be allayed by his family; the nursing care was superb, we were well-staffed. We decided to put a subcutaneous pump in and give diamorphine.

Q That was to give the patient a sense of euphoria and calmness.
A A sense of euphoria and a smooth passage.

Q Right. Was that a relatively unusual event?
A Unusual in a young person, not so unusual I do not think in older people.

Q You have spoken quite a bit about diamorphine, but of course in this case I think it was invariably used in conjunction with midazolam.
A Correct.

Q You can confirm, can you not, that midazolam itself has a powerful sedating effect?
A It does.

Q One therefore has to be doubly cautious when using the two together.
A Yes.

Q I am sorry to keep coming back to it, but it is relevant to what you just said, if a patient is on a terminal care pathway we can take it that that does not avoid the necessity of using the analgesic ladder or the guidelines so as to ensure you are not over-sedating.
A Correct.

Q Because the danger is otherwise that you can end up with an unconscious patient who does not need to be.
A That is correct.

Q Or a dead patient who does not need to be.
A Correct.

Q You spoke about the possibility of stopping a syringe driver completely perhaps in the circumstances we have heard in this case, if a relative wanted that to happen. There would be no difficulty, would there, if there were strong reasons for doing so, good reasons for doing so, in reducing the amount of opiate to see if you could find yourself in the position of having a conscious patient but a patient without pain.
A There is a fine balance and it can only be done on an individual patient basis. People do not die from at one moment being completely well and pain-free and not distressed and then at another moment they keel over and that is it. That is not the sort of patients that were at Gosport in any case.

Q I entirely understand that but if you have a patient who one day has been talking and eating, let us say, and the next day is unrousable and a relative wants to be able to speak to that patient to find out if that is the state in which they wish to be, you would consider, would you not, reducing the dose if you felt it appropriate so that the patient could be roused to speak to?
A It would depend totally on why they had been started on that but just to do it for the relative's wish to speak to them is not reasonable I would have thought.

Q It depends on the level that was needed in the first place.
A It depends on the whole clinical circumstance.

Q You spoke about the possibility of having to start at a higher dose than you would otherwise want to if you have inadequate staffing levels, and I just want to ask you a little bit about that. Was it your understanding and the basis for that comment that the nursing levels at this hospital were inadequate?

A A They seemed to be inadequate from many of the documents I have read towards the end of the period, in the late nineties, not so much the beginning of the nineties.

Q Can I just read a comment. We have heard from a lot of nurses and I am just taking the words of a nurse that we heard from just yesterday, a sister, who was asked this:

> "Did the nursing notes suffer in any way as a result of the increasing workload?
> A No. I must point out I had an excellent team of nurses. I am afraid I am a bit old school and I like to think my standards were quite high and my nursing staff knew of this, and if there had been any backlash from this, they would have either come to me or gone to management and it would have been discussed, but I never found that the extra workload affected my nurses' care in any way at all."

That was Sister Joines. If the position was in general terms that the nursing care on these two wards that we have been dealing with has been described as either very good or excellent, yes? You are nodding and it will not appear on the transcript.
A Yes.

Q Although Dr Barton's time was plainly limited, as we have heard, we have heard from a number of nurses that although the patient type changed and they had to account for that, the patients did not suffer as a result.
A Right.

Q You are not saying, are you, that in the circumstances in which Dr Barton found herself at this hospital she was entitled to ignore either the *Palliative Care Handbook* or the *BNF* when writing out her prescriptions?
A Well, did she ignore it?

Q Apparently, yes, she said so.
A Okay.

MR LANGDALE: I am sorry, that is not what her evidence was. She was not saying "I ignored ..." She was well aware of what was in the *Palliative Care Handbook* and the *BNF* and she took her decisions for reasons which she explained to the Panel. She was not ignoring it in the sense that my learned friend is suggesting.

MR KARK: We will have to check the transcript. My recollection is – perhaps it does not matter what my recollection is but certainly Dr Barton accepted that she was not following the principles in either the *BNF* or the *Palliative Care Handbook.* I do not know if that is challenged as well.

MR LANGDALE: You say "the principles" – she gave the reasons why she prescribed as she did and the reasons for them not being according to specific guidelines set out in the *BNF* and the *Palliative Care Handbook.*

THE CHAIRMAN: Can we work on an agreed basis that she made a conscious decision not to adhere to the guidelines. Would that be a reasonable way of proceeding?

MR LANGDALE: Speaking for myself I think that covers it.

MR KARK: We have a measure of agreement. Can I just ask you this: are there circumstances in which you yourself have taken the decision not to adhere to the guidelines?
A Yes.

Q What have those circumstances been?
A Relevant to this to give much higher doses of analgesics in certain circumstances.

Q Can I ask you what those circumstances were, please?
A They are all related to cancer and they are all in patients with really severe pain and in one case distress and agitation that was really very distressing for the family.

Q Were you there on the spot?
A I was there on the spot. I was called by the senior registrar who was not able to deal with the situation. It is very unusual but it does happen, even in a very well-staffed environment.

MR KARK: That is all that I ask, thank you very much.

Re-examined by MR LANGDALE

Q Professor Sikora, two matters arising out of the questions you have just been asked by Mr Kark. May I take up the last matter you were asked about when you said what you yourself had done. In terms of the *BNF* is there any guidance in the *BNF* as to the dose that is appropriate in patients who are on a terminal pathway?
A That is avoided in all literature because there is no written dose that is standard, it has to be decided on the spot.

Q Something that you said earlier on when Mr Kark was asking you about the analgesic ladder and so on and asked you to look at the particular passage in the *Palliative Care Handbook*, you said if I have noted it correctly that there was a reluctance – I think you said worldwide – to move to the higher strength or stronger opiates. I may not have got your words down precisely but in broad brush terms is that what that was saying?
A That is correct.

Q Could you just enlarge on that?
A In many countries it is not the availability of the opiates, it is the willingness to use them. Often on cancer wards the patients gain because people are used to it but on non-cancer wards there is much more hesitation. That is changing but it is there. There are also professional differences, so nurses may be much more reticent to use opiates compared to physicians and I guess it is to do with the recognition that the patient really is terminal. Nurses that are there caring for the patient all the time may not wish to acknowledge that inside and therefore are much more hesitant before committing a patient to that, and that may be one of the reasons for the difference.

Q There has been some evidence – I do not know whether you will have picked it up in the transcripts that you yourself have had the opportunity of reading or not – that in the hospitals, the common hospitals that we have been encountering in these cases – the Haslar and also the Queen Alexandra Hospital, the two main local hospitals – there was some evidence to the effect that in the hospitals for patients who had received some kind or surgical

intervention or some kind of acute treatment as it were there was a tendency to tolerate higher levels of pain in patients than you would find, perhaps, elsewhere.
A Absolutely, that is a common phenomenon in all hospitals. When I had my appendectomy I made sure I got my own private bottle of analgesics.

MR LANGDALE: We will not go into that. That is all I need to ask you about that. Sir, that is the last of the questions I need to ask in re-examination. Thank you.

THE CHAIRMAN: Thank you Mr Langdale. Professor, we have reached the point when it is for the Panel to consider whether they have other questions for you. I am afraid we operate in a somewhat lower gear to learned counsel and we are unlikely to be in a position to launch straight into questions. What I suggest, Mr Langdale, Mr Kark, is that we go into camera now for the Panel to consider such questions as they may have and say at this stage not before two. After the luncheon break hopefully we will be in a position to proceed.

Professor, we will rise now. You remain on oath so please do not discuss the case with anybody during this period. You are very free to leave the building and you can have, as a consequence, a somewhat longer lunch than might otherwise have been the case, but please be back here for two, at which time I hope, but cannot guarantee, that the Panel will be in a position to go forward. Thank you very much indeed, ladies and gentlemen.

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

(Luncheon adjournment).

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back everyone. I am sorry we lost an additional half-hour but it just goes to show I was correct when I consoled Mr Jenkins with the observation that my time estimates are no better than his.

Professor, I remind you that you remain on oath. What will happen now is that individual members of the Panel will put their questions to you. When we have done that, there is a final hurdle, which is that counsel themselves have an opportunity to ask you any questions that might arise out of any of the questions that we have asked. Is that clear?

THE WITNESS: Thank you, yes.

Questioned by THE PANEL

THE CHAIRMAN: Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Professor Sikora, much of the evidence you have been giving us is related to terminal care and patients who are on a terminal care pathway. I understand you to say that when moving on to a terminal care pathway, there is an expectation, there is a clearly defined diagnosis, that we have patients for whom there is no further cure for their medical conditions.
A Right.

Q Part of those medical conditions is really around extreme pain so the management of that pain takes the priority. When we are considering the patients we are considering through this hearing, we have patients who have been admitted to the hospital for continuing care and for rehabilitation. They have then speedily moved, seemingly speedily moved, on to a terminal care pathway. What standards would you expect there to be in place as we move into a different pathway?

A In an ideal world, you would want to compare this unit with another unit. You would want to be able to audit. Audit really came in acute NHS facilities around the time of this incident, during the 1990s, but, even to this day, has not come to the chronic long term care environment in the way one would like. What one would really like to see is, using information technology, was there something different going on during different time points and you cannot do that because there is no comparator. You are quite right, it is difficult to know retrospectively. One assumes that patients are going there for chronic rehabilitation and that was something that changed with time, and a certain percentage of those patients will suddenly deteriorate over a week or so and go into a terminal phase. I do not know from the evidence I have seen what the denominator – we know there are 12 patients being considered here – I do not know what that was out of. Was it out of 20 patients in which case it would be a little alarming, or was out of several thousands of patients which would make it not alarming?

Q I accept what you are saying, but I would like to direct your attention not to any particular patient, but if we are thinking around any standard relating to any particular patient as you are moving from one to another, so protecting the patients' interests and all those sorts of processes, what are the sort of standards that you would expect around processes for individual people to protect their interests?

A One would like to see a multidisciplinary team discuss the patient before doing it. However, that, certainly with the staffing structure as alluded in the evidence, would not be possible. I do not believe there was a conventional multidisciplinary team meeting to do just that, certainly not one that can be convened quickly to deal with a patient who is deteriorating over a 24 hour period, for example. To my knowledge there are no written standards of that sort of thing around, certainly in the 80s and 90s. Now people are much more careful about starting a terminal care pathway and document it much more thoroughly, but 10 to 15 years ago this was not the case.

Q Although there was not a disciplinary team, there were consultants around that Dr Barton could consult with, who perhaps were the people who were responsible for those patients when admitted. What would have been your expectations round that?

A My expectation would be that Dr Barton and the nursing team would make the decisions and the consultants would ratify it when they came round. I would not have thought they would come especially to see a patient out of hours. That would be unusual and really not possible. It is clear that the consultant's attendance was not on a regular basis for some of the time, it was not even weekly some of the time, therefore you could not get that ratification, so I think Dr Barton and the team of nurses are acting on their own in many ways with the sort of decision. They would not be able to get advice as to whether to go or not go on a terminal care pathway, they would have to make the decision themselves.

Q You are saying that in a multidisciplinary team meeting everyone would have had to have seen the patient to have made that decision?

A Not usually, but some of the staff would have seen the patient but they would sit around, discuss the patient, those who had seen would contribute and then an agreed decision would be made, but that takes time.

Q It does, but it is a far cry from it then becoming Dr Barton's decision and the nurses' decision?
A I understand.

B

Q What would have been an intermediate step – phoning the consultant, discussing?
A It would be difficult for the consultant to contribute down the phone. I think he or she would have to come and visit if they were going to make a meaningful contribution. They could be contributing to policy but not to an individual case.

Q Let us look at another standard about the choice for patients. What about patients' C involvement? If a patient is suffering from dementia and is not articulate and cannot contribute, that is one set of circumstances, but when patients are actually articulate, what about their actual involvement in the choice about whether it is going to be terminal care or perhaps more invasive surgery?
A I think it is very rare surgery versus terminal care, it would be very unusual for that to happen. Involving patients is something that, again, there has been a huge change of patient empowerment over the last 15 years. My clinics with new cancer patients take a lot longer D and my colleagues in cardiology say the same thing. All the options are gone through and the patient is then involved in choosing the decision-making. That certainly was not the mode of operation in the 1990s – the challenge in these particular circumstances, the very age of the patients in many cases and the fact that they had multiple comorbidities. Many of the cases, I am sure, reading the evidence would not have been able to take part in the decision-making in a meaningful way. Their families would but they would not.

E Q I will bear in mind within that that you do not actually know the individual patients because you have not looked at their circumstances.
A Exactly.

Q I move on to a slightly different point, because all the time we have to look at how we protect the interests of patients. You said that in terminal care it is open to the discretion of the clinician, the doctor, as to the dosage of opiates that actually may be used. What F safeguards should there be in place to prevent that patient being over dosed?
A Audit and monitoring: in other words, the pharmacy; there should be monitoring in what is going on in real time with good information technology, which was available – local computer programmes were available but not in place; consultants checking protocols and checking that policy is adhered to; nurses who were also involved in this should be the same; and management, who are ultimately responsible for day to day operation and strategic development, should also be involved in the process. There should be checks. The difficulty G is the change in era. Today there are checks everywhere and people are very conscious of this aspect. In the 1990s there was not anywhere.

Q Clinical governance was in place, was it not, in the early 1990s?
A I suspect Gosport was the sort of place where governance reached last because of the nature of it.

H

Q From the perspective of the personal accountability of the doctor, how would you see the standards being managed? You talked about the audit and you have talked about management and overseeing the doctor, from the personal accountability of the doctor when making such critical decisions when to move someone into terminal care, how would you see that doctor making sure that their standards were very transparent and overt?
A I imagine the best way in those days was discussion with the consultant ultimately responsible for that patient – named consultant, named patient – and Dr Barton; obviously, if it cannot be done immediately at the next available opportunity. The problem, again, from the evidence is that the consultants were busy, mainly elsewhere. It is not that they were not working, it was just that were tied up in clinics and ward rounds elsewhere within the Portsmouth system. To them it is relatively low priority.

Q Is that sufficient justification for the doctor not to make that a priority?
A Dr Barton or the consultant?

Q We have heard that the consultants could be available. If Dr Barton wanted the consultants to be available, they could be available. You are saying that a good standard would be for the doctor to discuss the patient's condition with the consultant and then to jointly form a decision, or at least discuss it the next time that the consultants are on the ward. I am looking at the standard for that and you are saying they were busy people, but that cannot overcome what is actually in the interests of the patient, can it?
A Absolutely not, but I would imagine that the patients were discussed with the consultant at the next available visit but, unfortunately, that visit may not be for two weeks after a decision had been made and that is one of the issues. The ideal situation is to have a daily meeting of some form where every patient is discussed, but that would not have been possible for Dr Barton with her plan, or her self constructed job plan, because there was no formal job plan for her.

Q What accountability does the doctor have to make sure that there are certain standards put in place?
A To me it would be the responsibility of the consultants to make sure that they have a system in place that allows their patients to be protected. It was not up to Dr Barton to construct that, she was the part-time clinical assistant who was implementing policy that was the responsibility of the consultants.

Q A final question from me. I understood you to say when you looked at it that you saw that the Gosport had no easy access to x-ray equipment or to acute services, but what you are not saying is that moving to a terminal pathway can be justified because you do not have access to those services?
A No.

Q Have I understood you correctly, or were you saying you might move to a terminal pathway because you do not have those sorts of services?
A No. The only option if you are going to have x-rays and other investigations done, was to transfer the patient over 20 miles. If a patient is near death, that would seem almost cruel to me because the chances are that whatever is causing the symptoms is going to get worse if you start transferring patients. Also acute services, certainly on the south coast during the 1990s, were very over stretched, so you would be moving patients around on a regular basis which would be difficult.

MRS MANSELL: Thank you.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

MS JULIEN: Good afternoon. Some of my questions slightly overlap so, unfortunately, I may need you to go over some ground you have already gone over, but from a different perspective. My first question is in relation to the range of the doses of what you described as a cocktail of opiates, the wide range of the cocktail. I think you had said that the wide range allowed the nurses freedom and flexibility, I do not know your exact words. My question is that, in a situation where there are fewer resources, the nurses using that wide range would be going in straight at the higher rate than they would possibly in another situation. What I am concerned about is, if there is not titration from the beginning, how do you think, under that sort of regime, the risks to the patients could be managed?

A The only way to manage the risk is closer observation. The reassuring factor, looking at the data, is that there was only one patient given at the higher end, at 120 mgs, of the diamorphine. The majority of patients were actually under 80 mgs, so it looks as though, from that evidence, there has been a titration process in place and the nurses were following it. I have not seen the patients, but one assumes the 120 mg patient was had severe problems and that is why the dose was given at that level.

Q The range allowed them to be in a position that they could have gone higher?

A They could have gone to 200 mg, yes.

Q It may be that they did not, but they could have.

A Exactly.

Q That is really my point. In that sort of situation, how would the risk be managed, particularly in terms of adverse effects?

A The way to manage it would be to have the pharmacy monitoring it, producing weekly, monthly reports so you can see any trends in the patters of diamorphine, midazolam and other drug usage.

Q It is the pharmacist who has to manage the risk?

A There was a ward pharmacist, the clinical pharmacist and it would be they who were responsible for patterns of drug use that were changing with time.

Q Would that be sufficient to prevent over sedation of the patient?

A Together with observation by the nursing and medical staff, that should be.

Q If it is a weekend or late at night and it is just the nurses and they are working within that regime, the pharmacist is not necessarily going to be around at that sort of time. Is that sufficient to manage the risk?

A I think all one can do is observation by the staff. What one does retrospectively is to have the pharmacy audit to see if there is a pattern change which happened. That would ring the alarm bells if there was.

Q Would that sort of system be in place at that time in your experience?

A I have seen no evidence that it was in place.

A Q You have seen no evidence that that was in place, so the nurses were working under a system where they had quite a lot of discretion?
A They had discretion. The fact that they did not go to the top end immediately and there was a distribution of doses, suggests that they were using that discretion appropriately, although, as you know, I have not seen the individual cases so I cannot comment on that.

Q You accept that there could have been a situation where they may not have done that,
B it was left open?
A Indeed.

Q Going back to the terminal pathway situation, I think you said that once a patient gets to the point where they are on the terminal pathway, that would not be the time to conduct or to initiate any sort of investigations. I think you said it was a time for good decision making?
A Exactly.
C

Q What about before you get to that point, would a doctor need to be sure that they had carried out all the investigations before they got to that point?
A I think these patients in many cases had been actively treated not at Gosport but another hospital, and transferred there, so the whole purpose of Gosport was to try and free up space in the acute hospitals, and also to provide a more gentle environment for the management of a patient. If a patient started deteriorating for whatever reason, if there was
D thought to be a medical problem that could be elucidated, they could be sent for further investigation. On the other hand, if they were beyond that, if they were deteriorating rapidly, there would be no point and a decision would be made just not to further investigate the patient. That would be the normal practice.

Q The doctor would have to be sure in herself that she had carried out all the investigations, because you are saying there would be no point once they were on the
E terminal pathway?
A It would be based on the history. It would be based on the medical details of that individual patient. Over the last few months, why have they come to that point? If there are factors that are essentially irredeemable – renal failure, cardiac problems, chest problems and so on – you make the decision there is no active treatment that can be done. In cancer it is slightly easier because you have good ways of monitoring the cancer. In general medicine, it is a bit more difficult. In post-surgical procedures such as hip surgery, and so on, it is a bit
F more difficult, and in patients that cannot give you a history, it is doubly difficult but I think you can come to a point where you say, "No more active treatment. Tender loving care only," and you put the patient into that pathway. You deal with the symptoms as they arise.

Q And that pathway can take quite a lot time to get to the end of?
A It is extremely variable. It can be 24 hours or it can be 24 days.

G Q Let us suppose in the event that it is 24 days, under no circumstances would you consider it would be appropriate to conduct any sort of investigation or another opinion?
A Unless the investigation was going to lead to a change in treatment, and that seemed very unlikely in this group of patients, even a simple chest X-ray – what would it do? Would you really start patients like this on antibiotics, for example? So why do the chest X-ray? We always teach students that diagnosis is only a guide to treatment.

H

A Q Possibly you could consider it. You may not actually carry it out but it does not mean you close the door and you do not consider it?
A You could consider it. I am sure there were patients transferred back to the acute sector over the years from Gosport.

Q Just moving on to the syringe drivers in general, there was a point where you were talking about the possibility of reducing, or taking someone completely off a syringe driver, I B think you said that it could be seen as unethical to do so. My question is this: in a situation where a patient could be taken off and a level of consciousness could come up to a level but they have not actually started to experience pain – maybe just before that pain threshold if you understand what I am talking about?
A Yes, I do.

Q Surely that would not be unethical at that stage, would it?
C A It would require close monitoring because otherwise the patient could be in pain for several hours before anything is done about it. It is possible to do that.

Q The hospital could do it. And if they were experiencing some pain but not intense pain, but some pain that they could communicate?
A If they could communicate, you could then increase the dose again. They go back to a higher dose.
D

Q And it would not be unethical to do that, but I think to stop everything would be unethical, which is really the only way to find out what is going on – to stop all medication and see what happens to the patient.

Q So stopping would, but a reduction would not?
A The problem with a reduction is, you would have to do it stepwise and monitor the E whole thing. It may take several days before you knew what was going on. There are circumstances in medicine where we do stop everything where we are not sure if it is the drugs that are actually contributing to the medical problem. We stop everything and see, but in a very controlled and monitored environment.

Q And that could be seen to be in the best interests of the patient, would you say?
A It the environment is properly monitored it can be, but it depends on the type of F patient. I would have thought with this group of patients, to me, it does not seem likely that you are really going to get any benefit. The idea is to make these people comfortable.

Q Does the reason for not stopping its impact and reducing, whether you think it would be ethical or not, the reason for doing it? I am thinking of, let us suppose, the next of kin want to speak to the patient, or want to make necessary arrangements, what would be your take on that?
G A I think that would be difficult. I think if the patient had had severe symptoms, I would try and persuade the relative that it would be unkind to do that sort of thing if they wanted to. Patients do surprising things in the terminal phase. Sometimes people suddenly wake up and suddenly have a lucid moment. They talk for ten or fifteen minutes, and they express their wishes – and this does happen – but on the whole the terminal event tends to be a progressive downward spiral as the organs shut down. So it is really unkind to suddenly stop everything and try to get the patient to... We have ways of counteracting diamorphine H with drugs. If someone takes an overdose we have an antidote that we can give, and is given

A across the road but it would be unethical, I would have thought unethical, to do this in this group of patients where the illness trajectory is definitely downhill.

Q So in those particular circumstances unethical, but you are not saying it is a blanket situation?
A No. There are circumstances where we do do it, and it would not be unethical.

B Q My other question is about the options available to Dr Barton. You had said at one point that you considered the various options or alternatives would have been available to her once she found herself in that particular situation. I think you had started to talk about her resigning being an option, but you were not able to pursue that. I just wanted you to elaborate on that?
A One option for her is walk away from the whole issue – just say, "This is no good. I cannot stand it." The other option would be to discuss the issues with the consultants, which
C ---

Q Yes. I think you did talk about that. I was specifically interested in her resigning.
A Right.

Q Just what your view is about that.
A I think morally it would be difficult to do. She would be leaving. The next person
D would come along to the same circumstances, so changing the system would seem better than just walking away from the system, to get the whole thing better. I think the difficulty is, there was no clear leadership amongst management, both general management and medical management, that she could go to so far as I can see from reading the evidence.

Q We do know that after Dr Barton resigned there was an improvement in terms of resources.
E A Right.

Q Do you have any different take on the matter, knowing that?
A I think the public outcry at the time was great and the health authority had to do
– something. They funded a full time position permanently based at the hospital, not offsite at all, afterwards.

F Q And my last question relates to note-taking. You would accept that keeping clear and accurate records. It is part of good clinical practice?
A Yes.

Q It is part and parcel of clinical practice in general?
A Yes.

G Q Would you say it is an integral part?
A It is an integral part.

Q Would you say it has equal weighting to actually providing treatment and care?
A I think if you had to chose or the other, you would choose the care first and the notes afterwards. There is no doubt that is the way. The other thing is doctors in different specialties and different levels of experience tend to write less and less as they get older.
H Certainly comparing my notes in outpatient clinic to the registrar's notes – the registrar fills a

page and I put two lines down. I like to think that there is enough information in those two lines. And the medical student fills three pages, and that has always been the case in my experience.

Q In principle they have the same weighting though? The treatment and the ---
A To me the treatment and care are more important than the note-taking, but the note-taking is important because it decides future treatment.

Q But according to *Good Medical Practice*, when you look at it, there is not a hierarchy. It has equal status?
A I did not write *Good Medical Practice* but I would have thought, if you had the choice, if you were lying on the street and you had a man with a notebook or a man with a stethoscope, you would choose the man with a stethoscope.

Q But you do accept that it is an integral part of clinical practice?
A I accept fully it is an integral part.

Q And do you accept that if a doctor does not give sufficient weight to note-taking, that he or she does that at her peril?
A I think, again, it is difficult for an individual. My notes last week, because I was in a hurry for a variety of reasons, were brief. No one has told me that my notes were too brief. I had no feedback. I had the feeling from the papers I read that Dr Barton had no feedback about this.

MS JULIEN: Thank you very much.

THE CHAIRMAN: Thank you. Mr William Payne is a lay member of the Panel.

MR PAYNE: I am going to take you back right to the first part of your evidence that you gave because I want to be refreshed. I do not expect you for one minute to be critical of any colleagues, but I want to discuss the input that you said that you first made when you were first asked questions by Mr Langdale with regard to the consultants that were looking after the ward. I think you said – and you have also just said it to my colleague – there was insufficient leadership, no clear guidance and you did not say "insufficient input" but you went on to be very kind, and say they were obviously very busy people, but there was not a lot of input from the consultants above. Can you tell me how you came to that conclusion, to start with?
A A combination of reading the papers before and then the transcripts of this, and listening to them talking. There is no doubt that management in hospitals and health care facilities is best if there is one person that is clearly responsible, a single person that is clearly the place where things get solved. That one person has to be available and approachable and willing to be approached, not just by his medical colleagues but also nursing colleagues, even the cleaning ladies if there is some problem. There has to be that in good management. That was clearly not the case here, and that was the impression I got from the transcripts and the notes.

Q I think you said that the name above the patient's bed was the person who was in charge, and that was the consultant?
A Yes. That is the tradition in British hospital. It is the consultant's name, not the patient's name.

Q Thank you. I believe that you also said that Dr Barton had had inadequate training for the role that she was expected to do as the nature of the work changed. Am I correct in that?
A She was a GP, and she was trained as a GP. She had done no specialist training in internal medicine or palliative medicine or, indeed, care of the elderly as far as I know.

Q Right, thank you.
A She was competent, I would have thought, from her training to be a clinical assistant but by its title "clinical assistant" implies there is someone that is not the assistant who is looking after her.

Q Right. If you have someone in that situation that you identified as not necessarily having the adequate training, and you have a consultant who obviously had the adequate training, who should be responsible for making the decision to put someone on a terminal pathway or an end of life pathway?
A Ultimately it is the consultant's responsibility, definitely, but having said that they can delegate that to people on the spot, and they did delegate it to people on the spot.

Q How did you come to that conclusion, that they had delegated it?
A They were not there. Without seeing the patient, it would be difficult. Even if they knew the patient, and the patient had changed, and they did not come to see the patient, and they were not running the place on that basis – they were not available to come on a Tuesday afternoon, for example, suddenly to see one patient, it would disrupt their normal clinical patterns of work, then they would have to delegate, and that is what they did.

Q You went on to speak about the best way to assess the needs and requirements of a patient is to be by the bedside and see them?
A Correct.

Q And if you were going to have to make a decision with regards to, say, pain relief, then the best decision would be after you had seen the patient?
A Yes.

QBut would you agree with me that it is also – I have to use the word – "guesswork", but there has to be some form of working it out, and a stab in the dark to start with perhaps. Would you agree with that?
A I would, and that is the purpose of the sliding scale; that you start off at one end and you can go higher if necessary, so getting started is a stab in the dark.

Q Would that be more difficult if you have not had adequate training for the specific area that you are working in?
A It is a difficult question because a lot of my generation of doctors were trained by observation in the work place, and no formal training programmes. I do not mean in cancer medicine, but in things like palliative care. I had to do palliative care as a registrar without any training whatsoever. We did it. The consultants were not interested in talking about it and that sometimes happens.

Q Can I just take that slightly further with you? We have listened to your C.V., and you are very eminent in your field, you are a leader of your field probably, but if you were being

A taken out of that scenario and placed into a different field, you would not feel too comfortable about making the decisions for someone else, would you?
A No. I thought long and hard what I would do if I had been in Dr Barton's shoes in Gosport. I cannot see any other way out as to what happened. She was delegated. The consultants were there. They knew they were responsible. They could not get more hours at Gosport. Whatever they did there was no way they could spend more time there. The ward seemed to run well and the system worked as far as I could see.

B

Q But if you were in that situation, Professor, and you were having to make a decision, and you are not adequately trained and you are having to use opiates, for instance, would you not rely to some degree on the use of knowledge that is available to you, like the BNF or the Wessex Protocol, for guidance with regard to the size and the width of the drugs you are going to prescribe?
A Unfortunately the BNF does not have that. It recommends 10 to 20 mg as a start
C dose, but it does not have an upper limit of the range in it. It does not have a range, in fact, so I think that will be very difficult. A competent GP is trained to give opiates, is trained to give palliative care in patients' homes. This is an extension of that primary care role.

Q Correct me if I am wrong, but the BNF does give a guide to the conversion from, say for instance, Oramorph onto diamorphine?
A It does.

D

Q By subcutaneous ---
A Exactly.

Q Would it be for someone who, as you have described it, has not had the adequate training to use that as a guide to move forward, initially at least?
A The conversions at two-thirds of the dose of oral morphine – that is presumably what
E you are alluding to – a patient on 60 mg of morphine ---

Q A third to a half.
A A third to a half, morphine to diamorphine, continuous over 24 hours, that is at two-thirds of the dose to diamorphine. The evidence I have looked at – I agree I have not looked at all the notes – suggest that that was adhered to essentially when the patients had been on opiates before.

F

Q So you would not be aware that perhaps those doses were maybe twice and three times higher than the recommendations from the BNF?
A The reason for starting the subcutaneous pump was that some event had happened to require a change in the management from oral dose. It may be that the patient was being sick, but in most cases it was because, as far as I can see from Dr Barton's statements, there had been a deterioration in the patient requiring more analgesic and therefore the conversion
G may not be quite correct. It may not be exactly the same. It would be at a higher level basically.

Q Can I just press you a little more on that? If someone comes to you, let us say, who has been on step one – paracetamol perhaps – would it be appropriate then to write out, even as an anticipatory prescription, a prescription for diamorphine that is three times higher than, say, the minimum start?

H

A A It depends on the clinical circumstances. If that patient is in severe pain we may go to a very high level and then maybe come back. Lots of things depend completely on the clinical situation.

Q What would be the situation where you would come back?
A If the pain disappeared or if the symptom, whatever the symptom of the distress or anxiety, also disappeared.

B

Q If a patient is heavily sedated with, say, midazolam, if you have introduced that as well which leads to heavy sedation, how will you know that you have over-prescribed the diamorphine?
A It is an educated guess, as I think you said earlier, and clinical skill that you realise that the symptoms have now gone and the patient is comfortable. That is the level at which you continue.

C

Q You think that the system was working acceptably here.
A I think for that decade it was working in an acceptable way. I could find no evidence of huge, inappropriate doses being given of any of the drugs in the syringes.

MR PAYNE: Thank you very much indeed for answering my questions.

D THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: Good afternoon, Professor. Let us go back to the terminal pathway. The terminal care pathway is predicated on knowledge that the patient is in the terminal stage. In your world of cancer that is pretty well defined, is it not, it is a chronic process that is pretty much predictable.
A Yes.

E

Q Apart from one patient in our bundle, 12, there is not a patient with cancer, so I want to ask you this really. First of all, if you are dealing with pain does the object have to be to render the patient pain-free or is it a reasonable alternative to get the patient to a position where they are in a degree of pain that is acceptable to them?
A I would prefer to be pain-free and usually it is achievable, to get pain-free without troubles from the side effects of the medication including over-sedation side effects by
F judicious use of the drugs in most patients. I would certainly rather be pain-free.

Q I think you suggested that in the terminal phase it is reasonable to have a patient drowsy or even unconscious if you know what the course of their illness has been.
A Yes.

Q That is fine for chronic pain.
G A Yes.

Q And you have said that it would be unethical perhaps to withdraw some or all of the treatment to see what they are like, except in exceptional circumstances.
A Yes.

Q What if the pain, as part of a chronic decline in an old person, with many
H comorbidities, was an acute pain and because of the acute pain a syringe driver was started

A with the full knowledge and intention that it would not be stopped, that the terminal pathway had now been entered?
A I think the implication in that question is that the syringe driver was the termination event, and I do not think that was the case. I do not think anyone would consider that in this country. The syringe driver was there ---

Q Explain to me what you mean by that, nobody would consider that.
B A You are suggesting that the syringe driver was used to bring about a terminal event.

Q I did not suggest that.
A I am sorry, I misunderstood. Basically if a patient is in acute pain and one agrees that the patient has no way of coming back to a normal existence the symptoms are treated in the most appropriate way. In some patients a syringe driver is the most appropriate way.

C Q If he was in acute pain how do you know if the pain has gone? It is a silly question.
A Death is a mysterious business, as you know, and the events that put a patient into the decline and the timing of the physiological events are really completely unknown and under-researched – for obvious reasons it is a very difficult area to research. To me a doctor's duty is to get rid of symptoms. Sure, if a patient has no other disease and they are in some short term problem – say acute post-operative recovery – things may be different. But that was not this class of patients here; these patients had chronic disease, long term illnesses, that were
D gradually going down, and some of them exhibited a sudden deterioration which involved symptoms, so getting rid of those symptoms when the patients are deteriorating in the most appropriate way seems reasonable.

Q But would you still apply the adjective "unethical" in that situation if you were to pull back on the dose to see?
A Unethical only in the sense that patients are suffering and have suffered. You have
E got them out of suffering with the medication and now you are going to make them suffer again to satisfy the curiosity of seeing the effects of the drug versus the effects of the disease.

Q What if that change of tack and that treatment were applied in a situation where there was not pain?
A That is more tricky but distress and anxiety are well-known pre-terminal events and seeing a patient is distressed, often shouting, often very disturbed and very disturbing to
F families, sometimes with death rattles and so on, is a very disturbing experience for everybody including the patient, so stopping the drugs under those circumstances would not make much sense.

Q With your expertise would you be prepared to answer a question about a patient with very advanced dementia who did not have cancer?
A If they have got symptoms – whatever they are, not symptoms of dementia but
G symptoms of anxiety, distress or pain – they should be treated like anybody else. The difficulty of course is getting the response.

Q Are you happy to answer a question if I put it to you about such a patient?
A Yes.

Q Do you have experience of looking after elderly demented patients who do not have
H cancer?

A A Only as a registrar in medicine.

Q I will ask it because it is pertinent to our inquiry. Would you agree, from that experience as a registrar, that elderly demented patients in hospital, because of inter-current illnesses or events, can become extremely agitated?
A Yes.

B Q As an acute event.
A Yes.

Q And that such episodes can be well-defined episodes – that is to say they occur and they resolve.
A Yes.

C Q So then if such an event occurred and to that patient was applied a terminal pathway because of that event, what would you expect to be the justification for such a decision?
A Starting a patient on terminal pathway would require more than just having dementia, there would have to be some other underlying problem that was going on that was basically pointing out the fact that this patient was coming to the end phase of their life, so that would trigger the terminal pathway, not the dementia as such.

D Q Such a treatment renders the patient unconscious. This is not pain: would it be unethical to pull back on the treatment or stop the treatment to see if the agitation had gone away?
A It is possible to do that but, as you know, it would require adequate monitoring to do that sort of procedure.

Q Just in relation to old people you drew attention to the distress of a fear of dying, and I
E think you talked about a young man with cancer. You may not be able to answer this but you may through your experience. Is the fear of dying a prominent problem in the elderly or the very old or does it tend to wane with age?
A I certainly do not know of any information on that or any data that it does that. One would like to think it wanes and older people have a much more realistic approach about death generally when you talk to them, even people that have not got serious, life-threatening illnesses, but it depends completely on the circumstances around the terminal event whether
F people get frightened or not.

Q Thank you. You said that titration is the ideal but what if I put it to you that it is the norm?
A I would say that it may be the norm under certain circumstances but not everywhere.

Q I am not into semantics so I will not go further than that. This is a side issue because
G you said in a certain context that the consultant cannot make the decision – it was a decision about terminal care over the telephone. I wonder how different that is to you being phoned by a registrar in the night when you are on call and given the full details of a patient's situation and then being able to make a decision that helps that registrar.
A There is a similarity but then we have 24/7 cover by registrars, 24/7 cover by SHOs or foundation year doctors, which was not present in Gosport. Occasionally even now I do get phoned up by the registrar to say do you want to resuscitate the patient, for example; if I
H know the patient it is usually quite easy, if I do not know the patient – and these consultants

A in Portsmouth had a lot of patients under their overall care and they could not possibly remember the details of all the patients I would have thought – it would be very difficult to know what to do.

Q Even with a very experienced clinical assistant who had been there for ten years or 20 years.
A Exactly.

B

Q Right. Can we turn to guidelines? You have said that you stepped out of guidelines.
A Yes.

Q I am sure we all have. When you step out of guidelines what do you do?
A You write it down.

C Q Why?
A So you do not come to the GMC I guess. No, so that people can understand, so that other staff members understand the rationale for you diverting from guidelines.

Q To justify it.
A Justify it, yes.

D Q Would you expect to do that on an individual patient basis every time you do it?
A I do not do it every time, it depends how unusual the event I am doing and how far I am going from the guidelines.

Q Some doctors – indeed quite a lot of doctors – when you mention the word "guidelines" groan.
A They do.

E

Q We have even heard one doctor here say that they are tramlines, but guidelines are there for a purpose are they not? They are there to guide us as to what to do. Dr Barton has made, in her evidence, a number of references to not taking account of or ignoring guidelines in the form of either the little green book, the *Palliative Care Handbook* or the *BNF* when writing prescriptions for syringe drivers. She cites as her justification her long experience, and indeed Mr Kark on one of those occasions asked her about writing such a prescription F that was called anticipatory, some days before it was started. He asked her what the justification was for making that decision about that level in anticipation that something would happen and she said that it was based on "knowledge of the patient, having seen him the previous week, and long experience of starting doses of subcutaneous analgesia when needed, faced with a particular patient." I wonder if you would find that an acceptable thing if that was applied to one or two patients.
A Yes.

G

Q If it was applied to a large number of patients is that acceptable?
A The number of patients flowing through Gosport during Dr Barton's period working there must have been several thousand so one would imagine that a handful of patients where she had experience, she knew the patient, she could predict what was likely to happen seems reasonable in an experienced GP.

H

Q Does it become reasonable that the norm is rejecting guidelines on the basis of your own experience?
A I think we all do it, all doctors do it.

Q You said in certain circumstances.
A Yes, in certain circumstances where one's experience is that this patient is going to suffer if we do not do something then we go away from guidelines.

Q What if you have had no training?
A One of the difficulties now is we are comparing practice 15 years ago with practice today. Why tramlines comes out is that guidelines are a relatively recent invention and certainly in the 1990s there were very few guidelines.

Q The *BNF* has been around for 300 years or more.
A Okay, but the guidelines in the *BNF* are about analgesics mainly – and other drugs obviously – they are not about patient management. Now there are guidelines everywhere for every aspect of patient management as you know and we do frequently divert from them.

Q You alluded to the fact that, like me, you were not trained, you got experience, but if your experience is gained in a place where there are no checks and balances how valid is that experience?
A The checks and balances are relatively recent additions to modern medicine. Certainly when I trained as a medical student and then as a registrar there were really no checks on what I was doing, it is just that things have changed.

Q Do you think you got there by luck?
A No, I think I did not have any disasters by luck but I did not get there by luck.

Q Just one other question. You said that it was perfectly reasonable to start at 20 mg of diamorphine in a syringe driver and you have gone through a number of discussions about that. But if I tell you that the *BNF* cautions that the elderly should receive one-third of the dose of an adult then would you agree that that 20 mg becomes 60 mg equivalent?
A I am not sure it does say that but it tells you to be careful of the doses in elderly patients; I do not think it had any specific – I could look it up for you.

Q We will, just to be sure that I am on the right track. It is in bundle 1 again, I have in mind half to a third. If you look at page 7, this is from September 1997. This is "Prescribing for the Elderly" and it says "Guidelines" on the left. It starts "First always question"?

A No, I am looking at the wrong --

Q It is behind tab 3, page 7.
A Fifty per cent of the adult, not a third of the adult.

Q Let us take that. That becomes the equivalent of 40 mgs in an adult, otherwise called an adult.
A Right.

Q Is 40 mgs, as a norm, in anticipation that pain may occur, a reasonable starting dose?

A A It might be depending on the clinical circumstance.

Q I did not ask about that, I asked about the norm in anticipation in case something happened.
A I reply again that it totally depends on the clinical circumstances, not just the patient but what the clinical background is that is leading to the clinical situation and how reversible it is, or non reversible it is, and the speed of deterioration. A lot of this is like watching a
B ballet where what you are seeing is a series of still shots, you are not seeing the movements and, therefore, you cannot predict what is going to happen. You have to do it looking at the stills.

Q Is that not the point?
A If you need that sort of evidence, if you need to see the ballet, you will not relieve the symptoms, you will be watching what is happening all the time and not actually taking
C effective action.

Q You are describing something of an unpredictability in these patients.
A Death and life is unpredictable and these patients are unpredictable.

DR SMITH: Thank you.

D THE CHAIRMAN: You are down to me. I am a lay member, as I am sure will become very apparent. I would like to pick up very quickly on one of the points raised by Ms Julien when she was talking about note-taking. Note-taking is an integral part of clinical care, is it not?
A It is.

Q Any suggestion that, on the one hand you will take care of the patient and then you will do the notes, is by definition inappropriate?
E A Yes.

Q You talked earlier about the delegation of some fairly important functions. One of them is the whole issue of when that decision that the change over is occurring and that the patient is now moving from general care or general palliative care into that terminal pathway. Who do you perceive the delegation extended to in the making of the decision as to when you move from one to the other?
F A To me, the consultant is responsible and the delegation was to Dr Barton to make the decision. In an ideal world that decision would be reviewed at some point in the future but not at the time. It was not necessary at the time.

Q You would be quite happy that Dr Barton was more than competent to make such a decision?
A Yes.
G

Q What about the nursing staff?
A They were not making the decision to start a terminal pathway, they were involved in the decision about the dose escalation.

Q With respect, not just that. You have talked about anticipatory prescribing and I think you have dealt, very specifically, with instances where there would be an absence of
H consultation with Dr Barton because she was not available and an absence of consultation

with any other doctor because they were not available. One of the consequences of anticipatory prescribing of a syringe driver where there is no start date on it, inevitably is that there is at least the risk that nursing staff, of their own volition, will make that judgment, no doubt with the best of intentions, but that is a risk, is it not?
A It is.

Q Is that in your view an acceptable risk?
A I think for the period of time and the location in terms of the structure, it was an acceptable risk. I cannot see any other way of getting appropriate symptom control. These are not well patients, the ones who are being written up for the syringe driver. They are not people who are ever likely to go out of hospital, so the decision is made to give them the best palliative care as quickly as possible if they do develop symptoms and the person on the spot, in this case the nurses, make the final decision and then it is reviewed the next day by the doctor.

Q They do that in the presence of an open ended prescription which takes the patient directly on to what you describe as the cocktail of opiates and the syringe driver. You also discussed with Mr Kark, and indeed with Dr Smith, what you had indicated was the ideal approach, which was, I think you said, to spend up to a couple of days defining, through titration, the appropriate dose for the patient to start on the syringe driver?
A Yes.

Q The reason why in the ideal world you would want to do that rather than go directly on to the syringe driver, or the reasons, is what?
A So that you give an accurate dose, no more than is needed and no less than is needed, and the patient's comfort is assured for the next few days.

Q No more than is needed; what are some of the effects of that, of not over sedating?
A All drugs have side effects and, therefore, one wants to avoid those side effects, including sedation.

Q I will come to the side effects, but just the sedation itself to be less obscure about it. Is it that, if you do not over sedate, you are going to have an alert patient?
A An alert patient that has no symptoms is great, but, sadly, that cannot often be achieved. You have to get a certain level of sedation to get rid of certain symptoms.

Q Absolutely right and I think you said to us a few moments ago that usually it is possible to get pain free without side effects and over sedation by judicious use of the opiates?
A Yes.

Q What I am suggesting is that when you said, "In the ideal world what we would do is titration over a period of up to two days", that would indeed be a judicious use of opiates?
A It would.

Q Its consequence, if it was done properly, would be that a patient would be able to remain pain free whilst at the same time sufficiently alert to spend his or her last hours or last days, at least part of the time, in the company of their family in a meaningful way.
A I think death is, what one reads about it, from the practicality there is a great difference. It is very difficult. When you actually have patients dying, the vagaries of the

process are tremendous. The only way to ensure comfort in any environment, even when you have doctors on call all the time and so on, is to make sure that the patient's symptoms are treated, and that was the reason for the WHO Guidelines on Pain Control, but it also applies to other symptoms than pain.

Q I am sure we have all taken on board very clearly that in the terminal situation a patient can, for perfectly natural reasons, become drowsy, become unrousable and so on. What I am concerned about is your phrase, "judicious use of opiates to best effect". It seemed to me that what you were saying was that, if one were to have this judicious use of opiates through a period of titration, it would reduce the risk of a patient being treated for what appeared to be symptoms, such as agitation and restlessness, as a result of the terminal process, but which were actually created as a consequence, as a side effect, of the over use of the opiate. By titrating you make that much less likely to happen. Was that your point?
A Yes, but the titration is far more labour intensive than just putting up the syringe driver.

Q You said that to us and you said one of the reasons for not going down that particular route was that a doctor would have to keep coming back every four hours or so. I did not quite understand that because the system that Dr Barton had developed of anticipatory prescribing with a range of doses, surely would allow for that. If, before one reached a prescription for the syringe driver one had a prescription, in effect for this up to 48 hour period of titration whereby the nurses themselves are able to monitor the patient, and indeed they are there to do just that, then they will go and administer because they have a prescription for it an increased individual dose if there is a need for it, but if there is not, then they would not do it. As a consequence, the patient could not become over sedated and, as a consequence, there would be less likelihood of the patient exhibiting symptoms as a result of the overdose of opiates that might be mistaken for end of life restlessness or agitation?
A I think if the patient was titrated orally with oral morphine, either slow release morphine or soluble morphine which acts quickly, one could get the 24-hour need. The difficulty is that if you start giving it intramuscularly or subcutaneously by bolus injection and you want to change that dose, that requires much closer monitoring to get the 24-hour level. It also allows variable prescriptions. I have never seen a practice where people, other than oral morphine, write variable prescriptions of intramuscular morphine in advance, whereas with the subcutaneous pump it is common practice to have a range of doses.

Q Aside from breaking a new path, because I do not think that is something that this doctor has been accused of not doing, you say that there would be a need for a greater degree of – I forget your words exactly – supervision and monitoring.
A Exactly.

Q How would that be more so than every four hours going to see how the patient is, making a determination as to whether you were (a) going to give any further sedation of opiate or diamorphine intramuscularly at all; or whether you were going to give the same as the previous dose; or whether you were going to give more?
A Intramuscular prescriptions are one at a time. It would be difficult to see how you would give a variable dose and know what was going on because you could have a different person every four hours – it has to be given every four hours – coming along and drawing up a different size of injection and then the kinetics would be all over the place. With subcutaneous pump the kinetics are smooth, with the oral medication the kinetics are smoothing out because of the time taken to absorb the dose.

Q Your clear evidence is that it would be in impractical to adapt that course?
A It would be.

Q The risk of not taking that difficult course, of course, is that you are going to therefore go straight to the syringe driver. Is that right?
A Yes.

Q That, without titration, carries with it the risk that you get the dose wrong and over sedate the patient.
A You begin at a low dose and work up with the syringe driver.

Q There has been a considerable discussion about whether a dose is low or not, but the risk would be in the abstract that, whatever dose you chose, you would run the risk of over sedating the patient?
A That is always the case with any form of analgesic.

Q The particular danger when that analgesic is an opiate is what?
A Respiratory depression, sedation.

Q Both of which lead ultimately to?
A To death.

Q What we are looking at here, it appears, is a regime where the single, most important element is to keep a patient pain free at all times?
A Yes.

Q You have discussed the potential for discussing with the patient, prior to putting them on to a syringe driver, whether that is a course that they would want to take and you rightly point out that in many cases that would not be something that elderly patients, with the sort of comorbidities we have been looking at, might be able to participate in?
A That is right.

Q In the cases where – and there may only be a few – they would be able to do that, would you regard that as an essential prerequisite before putting them on to that particular path?
A I would certainly try and explain what was going on and get their views on it, but that may not be possible in this group of patients.

Q I am specifically referring to those for whom it might be possible.
A In my experience it is pretty rare because people who are either in severe pain or very distressed just want the distress and the pain to end, they do not want to enter into an intellectual discussion about it or, indeed, have the existentialist thought about death with you.

Q Even in those very rare circumstances, do you think it should be for you to decide whether or not the patient wants to enter into that discussion, or would you feel it appropriate to at least give them the opportunity to do so?
A It may be that this group of patients could not get involved in the discussion.

Q If they could not, what would have been lost?
A Their consent to it, but I would go ahead.

Q If they could not consent, then you would not have lost the consent. You have only lost the consent, have you not, when they could have given it and you did not ask them?
A Yes, that is the case.

Q The whole business of keeping the patient pain free, is not automatically achieved by placing them on to a syringe driver with this combination of opiates, is it?
A Absolutely not.

Q Because breakthrough pain, at some stage there is the potential they are going to require more opiates?
A Yes.

Q The only way to be absolutely sure that your patient never again experiences pain is to keep increasing the dosage on a daily basis?
A That is the case, or not, to reduce it, to keep it steady and make sure they are still pain free or symptom free.

Q If you are doing either, but particularly if you are increasing it every day, the end result is obvious, is it not?
A Not having studied the patient, I am not sure it was increased every day.

Q I am talking in the abstract?
A In the abstract yes.

THE CHAIRMAN: Thank you, that completes my questions and, therefore, all the questions from the Panel. I am conscious that you have been grilled by us since 2.30. We normally reckon an hour is about enough. You have had coming up to an hour and a half. We will take a break now, because I am sure counsel will have more than one or two questions for you. Am I right in that, I think so, yes.

MR LANGDALE: I think I saw Mr Kark nodding, so I will be guided by him.

THE CHAIRMAN: We will return at ten past four.

(The Panel adjourned for a short time).

THE CHAIRMAN: Welcome back everyone. I hope you have had a chance to refresh yourself a little, Professor Sikora. I am going to pass you now to Mr Kark.

Further cross-examined by MR KARK

Q Professor Sikora, I am going to work backwards, as it were, from the Chairman's questions round. I just want to deal with the topic that you were dealing with shortly before the break. That is the issue of titration. I want to make sure that I understand it. First of all, is it right that it is easier to titrate before you start a syringe driver?
A Both are possible, and it depends on the clinical circumstances. If things are very slowly changing, then normally what happens, you begin at a low dose of an oral analgesic,

A often a mild one, and go up the ladder, get to the opiate, titrate the opiate and then convert to a syringe driver. That is if there is a slow progress of the symptoms. If the progress is more rapid, which does occur, you may decide to just go straight into the subcutaneous pump.

Q If you are trying to deal with pain immediately, I think we have already established that a syringe driver is not actually the way to do it. To deal with acute immediate pain, you do not start the syringe driver, do you?

B A Very few patients get the sudden onset – one minute they are pain-free, the next minute they get sudden onset severe pain. It is usually a build-up that comes.

Q But the best way of titrating, as you said, I think, is you start with oral doses. You find out what the level is that will deal with the patient's pain and then, if necessary, you can convert to a syringe driver?

A Correct.

C

Q I just want to understand how titration works with a syringe driver. Have you still got this schedule that was produce, D7b?

A Yes.

Q From what you told us, the patient is not going to get to the plateau that you have described until about 13 hours into the medication?

D A Pretty close to the plateau, much sooner than that, but I agree they do not get into the final end of the plateau till then.

Q So it might take ten hours, not thirteen hours, but it takes a good while?

A It does.

Q You may then find that you need to increase the dose because the patient is still in

E pain, and you are going to increase it incrementally. Just using this table for a moment, let us imagine that we do not follow the guidelines and we double up, and you add another 20 mg to the syringe driver. If we go to hour 13, just to see if I can follow this, what will be in the patient's system before the new dose is put in is around, is it, 4.88?

A Yes.

Q And then, when the second dose of 20 mg is put in, so the patient is now receiving 40,

F they are going to still be receiving 4.88 but additionally to that, in the first hour, another 0.83?

A Correct.

Q That increased dose itself, of course, takes a long time to work up to the system?

A It does.

G Q If you are trying to deal with immediate pain, I suppose there is a danger that you increase the syringe driver by too much in order to deal with that immediate pain, but in hour 12-13 you are going to hit a problem, are you not?

A There is. The aim of the syringe driver is to reach a steady state over a 24 hour period, and just keep repeating that. Now, what one does if one doubles from 20 to 40, one has the plateau for 20, and if at any time you add another 20, you gradually go up to a new plateau.

H

A Q Yes.
A Within 12 hours.

Q And there is a danger, is there not, if you do that too quickly that you are not just dealing with a patient's pain, but you are going to over-sedate them in ten hours' time?
A Certainly these drugs have side effects and, as you mentioned, that is one of the side effects. When you add an incremental dose to a syringe driver, you have to be thinking
B forward, as it were, to what that is going to peak to in ten or eleven hours' time?
A Yes.

Q That is very helpful. And so does it follow from that, that your responsibility for monitoring the patient is obviously that much greater?
A It is.

C Q You told the Chairman when he was asking you questions about delegation, that nurses were not taking the decision to move to palliative care, and that may or may not be wrong. I just want to know on what basis you said that. Is that because you have taken that from Dr Barton's statements? Where have you got that from?
A Because only a doctor can write these drugs up, and therefore the doctor has to be involved in the decision. The nurses cannot write them up.

D Q No, I am sorry. Okay. I might have misunderstood you. When we have an anticipatory prescription, we have a prescription sitting on the sheet - yes?
A Yes.

Q For a syringe driver to be started?
A Yes.

E Q That can be started by nurses, can it not?
A Indeed, that can, but the doctor has made that decision that if the pain gets to a certain level, as judged by the nursing staff, they are empowered to start it.

Q Of course, it is difficult for the doctor to make that decision if the patient does not have any pain at that time – at the time she or he writes a prescription?
A But if they know the patient, and they can assess the progress of the disease, rather
F like ballet, they get the moving picture, then it may reasonable to do that.

Q I understand that. If they had known the patient for a good period of time, and they see how things progress ---
A Yes.

Q --- is that what you are talking about?
G A Exactly so.

Q You spoke on a number of occasions about "this group of patients", and you said, for instance, "These patients have chronic diseases and long-term illnesses". You said earlier, "I cannot see the benefit of reducing the drugs to this group of patients". How are you grouping this?
A I was reading ---
H

Q They are twelve individuals.
A After the denominator that is unknown to me or presumably to us here, simply by reading the statements from Dr Barton on these patients, which I have read.

Q I am not criticising you for this, but which you accepted?
A Yes.

Q Because, of course, it is dangerous, is it not, to look at this as a group of patients because these are twelve individuals?
A Yes.

Q Some had hip fractures, one had a broken arm, some had sacral sores, some had dementia. It is dangerous if you start grouping ---
A It is. All had distress in common, and most had pain in common.

Q On the basis of Dr Barton's statements?
A Yes.

Q I see. Dealing with Dr Barton, you were being asked questions by Mr Payne about the issue of training, and I think your view. We have heard a bit of evidence about some training that Dr Barton had, but your view was that Dr Barton did not have specific training in palliative care, and obviously she was not a geriatrician, as it were, although she dealt with old patients?
A Yes.

Q For a doctor in that position, the guidelines, the Wessex protocol, which I expect you have heard of ---
A I have.

Q --- and the BNF take on an even greater significance, do they not?
A Yes.

Q The guidelines are there to guide the average doctor?
A Yes.

Q Is that fair?
A That is the case.

Q And of course there are circumstances, as you have told us, where a doctor can step outside the guidelines, but they have to exercise considerable caution when doing so?
A Yes.

Q And note it?
A Yes.

Q You said in your answers to Ms Julien that the fact that the nurses did not go to the top end demonstrates that the nurses were using their discretion appropriately. That is my précis; that is not by any means an exact note of your comments, but does that properly reflect an observation that you made?
A The twelve doses and the twelve patients was a wide range, the top dose given.

Q Yes.
A Which would imply that there is some form of titration going on.

Q I just want to examine how you feel able to say that, not having seen the notes?
A Simply that if all patients had been put onto 100 mg, for example, every one of the twelve patients, that would imply that that is what they are using as standard, and they are not really using a sliding scale. The fact they vary from 20 to 120, with the average between 60 and 80, that suggests the sliding scale is being used appropriately.

Q It certainly suggests that a scale is being used, does it not?
A Yes.

Q Whether or not it is being used appropriately depends entirely on what the nurses were actually reacting to when they either started the syringe driver, or when they increased it, does it not?
A That is correct.

Q If it was inappropriate at the start, or that the increases were inappropriate, then the fact they did not get up to 100 mg does not matter ---?
A No.

Q --- at all, does it?
A Absolutely.

Q You were asked by Mrs Mansell about checks and balances, and Dr Barton was in a particular position at this hospital. She had the check, as it were, of the consultants?
A Yes.

Q But they were coming in less frequently than perhaps one might hope. They came in apparently on a weekly or fortnightly basis?
A Yes.

Q And she was not working in a hospital environment – an acute hospital environment – when she was surrounded by other doctors doing a similar sort of thing. But she did have, as we understand it, those consultants on the end of a telephone, did she not?
A Right.

Q Of course, for a doctor in Dr Barton's position, it takes a certain insight, I suppose, to say to yourself as the doctor, "I think I had better pick up the phone and speak to a consultant about whether I am going to start a terminal path with this patient." That requires the doctor to think about what she or he is doing?
A Yes, but I assume she did that on ward rounds. Patients were discussed on ward rounds.

Q With whom?
A With the consultant, when the consultant came round.

Q I think you said it was the responsibility of the consultants to adopt the role, to take the role of checking?

A A Yes.

Q But again, there is a personal responsibility, is there not, on the doctor who writes the prescription, to ensure that their practice is appropriate?
A Yes.

Q Just finally this on the issue of notes – again, you were asked about this by Mrs
B Mansell, and I think you said, now, before a patient is started on a terminal pathway or even a palliative pathway, you would expect there to be a multi-disciplinary team decision. Yes?
A Yes.

Q And you said that that should be noted, and the reasons should be noted now, but were you saying that was not the case ten or fifteen years ago? Are you saying that even ten or fifteen years ago a doctor should not have made a note that a patient was being put on a
C terminal pathway?
A In a sense, the prescription could serve as the indication that that has started – the very prescription is a note. But in an ideal world certainly you would expect to see at least a one line note saying this has happened, and maybe an annotation of the reasons.

Q It is not just an ideal world, is it, the cake with frosting on the top? It is pretty basic, is it not, ten or fifteen years ago to make a note that you are entering a patient on a terminal
D pathway?
A I have not seen the notes, so I do not know what notes were made.

Q But that would be a pretty basic note to make?
A Some sort of annotation would be optimal.

MR KARK: Thank you.
E

THE CHAIRMAN: Mr Langdale.

<u>Further re-examined by MR LANGDALE</u>

Q Professor Sikora, I am only going to take about half a dozen matters arising out of questions you were asked by the Panel. I am going to take them more or less in the order in
F which the Panel members dealt with them. The question of – my words – Dr Barton consulting the consultant before concluding that a patient's condition was such that they were in a state of terminal decline – again, my words. Did you realise that the evidence from the consultants was that they did not expect Dr Barton to consult them about that? Did you realise that that was the evidence?
A I did not realise.

G Q So in relation to a clinical assistant in the position of Dr Barton, with the consultants not expecting her to consult with them, and not expecting her to consult with them about whether a syringe driver should be started or not, what do you say about the clinical assistant's position?
A She or he has to do the best they can within their capacity, within the system and the constraints of it, and I have done the same. When I was first a consultant, I consulted on many patients by telephone with a senior colleague at another hospital before making a
H

A clinical decision. In the end he told me politely not to bother him. "You are now on your own. Just do it. You make the decision," and I suspect that may have happened here.

Q In relation to the question of nurses, as it was put to you, the risk of nurses going in at a higher rate, I am not going to trouble you with the detail that we have heard in this case about whether nurses started at the bottom of the range prescribed, or did not, but just so we can consider this in relation to the case of the patient who, when he died, was receiving 120 mg of diamorphine in 24 hours, I think you indicated it would depend on how it was built up.
A Yes.

Q This particular patient had been on Oramorph for something like four or five days before diamorphine at 80 mg was started. He was on that for two days, and then the dose had 50 per cent added to it, so it became 120, and he was being treated with medication in terms of the diamorphine at 120 mg per day for six days. Is that something which would appear to you to be a consistent kind of build-up, or not?
A Yes, yes.

Q In terms of Dr Barton as clinical assistant, matters were raised with you about her training. It is not suggested in this case, and has never been suggested by the GMC, that she was not properly, adequately trained to be a clinical assistant.
A Absolutely not.

Q And I think it follows from what you have told us that that was the view you had formed?
A Yes.

Q In relation to a clinical assistant being somebody who was a competent and experienced GP, would there be anything to cause anyone concern in relation to such a person being entitled to make a decision as to what was an appropriate amount of opiate to prescribe to a patient in this elderly type of patient group?
A I would imagine that is perfectly within the capability of an experienced GP.

Q Similarly, in relation to whether it was appropriate to commence the administration of opiates by means of a syringe driver?
A Yes, again, within the capability of a GP.

Q We have heard evidence about GPs being responsible, not only in general, but also in Dr Barton's case, for people who are on a syringe driver, say, at home?
A Yes.

Q It was suggested to you that the significance of the experience of a clinical assistant like Dr Barton would be affected by whether their experience had been or had not been subject to any checks and balances in the sense of other people having some input into what they did. Were you aware that before Dr Lord and before Dr Reid were consultants, there were also consultants – I think Dr Wilkie was one name, Dr Grunstein may have been another, although I may not be remembering them correctly – who were in place right from the time that Dr Barton started as a clinical assistant?
A I was unaware of that.

Q Were you aware that we have an example in this case in 1991 of Dr Logan, another consultant who was in post at the time, giving clear indications as to what he thought was appropriate with regard to the administration in particular of diamorphine?
A No, I did not have that information.

Q In terms of the *BNF* I think it was put to you that it had been in existence for 300 years – unless I misheard the evidence. What was the position with regard to the length of time the *BNF* has been in existence so far as you are aware?
A Certainly not more than 40 years.

Q We can check on that. You were also asked about the question of acceptable risk with regard to anticipatory prescriptions. Obviously this is clear, there is no dispute about it, that with an anticipatory prescription which has a range there is a dose range, quite a wide dose range, there is a risk that a member of the nursing staff might administer to a patient an unacceptably high dose of analgesic, within the range but unacceptable because it did not meet the patient's condition. You indicated that of course there is a risk; does the nature of the risk, the degree of the risk, depend on the trust the prescribing doctor has in her nursing staff?
A Yes, a nurse under these circumstances is perfectly entitled to give a patient a pump with 200 mg for 24 hours because they have made the assessment that that patient needs it. So there is a degree of trust and there is no evidence from the 12 cases that that was happening.

Q Would the degree of trust placed by a doctor in her nursing staff depend on her experience of their actions over a period of time?
A It would.

MR LANGDALE: A question was asked by a member of the Panel about the issue of dementia. Sir, the reason I am not going to pursue this with Professor Sikora is because I think I know which patient may have been in the Panel member's mind but I do not think it is appropriate to ask Professor Sikora about it because I shall immediately go into what were the other features of the patient's case, so I am going to specifically avoid going into a specific patient. That concludes what I have to ask; thank you very much.

THE CHAIRMAN: Thank you, Professor. That then completes your testimony. We are most grateful to you for coming to assist us today. As you will have gathered there are a lot of issues that at the end of the day the Panel are going to have to wrestle with and reach a conclusion on; your expert assistance in that area is of course greatly appreciated and we thank you very much indeed for coming. You are free to go.

(The witness withdrew).

MR JENKINS: Sir, you will recall that at the start of the day I was intending to call a witness but after some discussion with Mr Kark and your learned Legal Assessor we delayed that witness and sent them home. I would like nonetheless to call that witness and a couple of others tomorrow. I know that there is objection from Mr Kark.

THE CHAIRMAN: Just that witness or the other couple as well?

MR JENKINS: They are in a similar category to the witness and so the argument that we are about to embark on relates to all three of them. Sir, you now get some legal argument – you may want to take a break first or you may be happy to embark on it. I do not think it will be terribly long.

THE CHAIRMAN: We may want to take a break after we have heard it and consider it.

MR JENKINS: You will certainly have to take time to consider it. The issue is this: if I am allowed to call the witnesses then obviously they can come tomorrow. If I am not allowed to call the witnesses I do not want them to come tomorrow and then be told to go away again. If it were possible I would be very grateful if a decision were reached today. You will be aware, I am sure, of the practice that is sometimes followed at the GMC where Panels deliberate, reach a decision and give the parties their decision and hand down reasons for the decision at a later time. If that were something that was convenient to the Panel I would be very grateful if that could be followed today because I recognise, of course, that on occasion it is the drawing up of the reasons for the decision that may take a longer period of time – the decision itself may be taken relatively shortly.

THE CHAIRMAN: We are certainly happy to attempt to embark on that course but I do observe that we are already past twenty-five to five. If the arguments are of themselves both quickly put and relatively straightforward we might be able to accommodate you, but if there is anything of substance we may not be able to. We are certainly willing to try at this stage.

MR JENKINS: Why do I not crack on? The rules that govern these proceedings – at the moment we are rule 27(g) which is the rule that says:

> "The Practitioner may then address the Committee concerning any charge which remains outstanding and may adduce evidence, oral or documentary (including his own) in his defence."

Clearly, we are at the defence part of the case where the defence are calling such witnesses and such evidence as they wish. There is a fetter on that and we have looked at rule 50 before that deals with evidence. Can I remind you what it says? It is in these terms:

> "The Professional Conduct Committee [this is a Fitness to Practise Panel but it is under the Old Rules] may receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them, provided that ..."

It then goes on to say if it would not be admissible under criminal proceedings the Panel can receive it if they have received advice from the Legal Assessor and they think that their duty of making due inquiry into the case before them makes its reception desirable.

What I would like to call is evidence from three individuals, two of whom are patients of Dr Barton and all three of whom have had a parent treated by Dr Barton at the Gosport War Memorial Hospital at the time when Dr Barton was there, that is before she resigned in early 2000. The patients themselves are able to speak about their treatment by Dr Barton; each of them can speak of the way in which Dr Barton treated the parent. Two of them are nurses and one of them is the practice nurse at the general practice where Dr Barton works and has done for many, many years.

The evidence of those individuals obviously includes an opinion as to how Dr Barton treated the patients – whether that be the witness or their parent – it includes evidence as to how Dr Barton treated her patients at the War Memorial Hospital during the relevant time. It obviously includes a view as to how conscientious Dr Barton was and the extent to which she was acting in the best interests of the patients.

I know there is an objection to calling evidence about other patients and the objection is this, that you as a Panel are only dealing with the 12 individuals listed in the Notice of Hearing and in respect of, let us say, Patient A, part of the allegation relates to a specific prescription and the suggestion is that that prescription was or was not appropriate or not in the patient's best interest.

I agree entirely that the evidence of other individuals relating to other patients does not assist you as to whether a specific prescription for Mr Pittock was appropriate for his then needs or not, but there are of course other allegations against Dr Barton included in the Notice of Hearing. It is alleged in respect of every single patient that Dr Barton failed to assess them before prescribing for them, it is alleged in respect of certainly two of the patients that Dr Barton did not carry out an assessment or an examination of that patient.

On those allegations any evidence that goes to Dr Barton's conscientiousness, of her wish to do what was best for the patient, is evidence in respect of the suggestion that she did not assess the 12 patients in front of you. It is evidence as to disposition, it is evidence as to her general commitment to patient care, it is relevant evidence on factual allegations that you have to determine.

To take a different example, if someone were accused of dishonesty on a specific occasion the defence would obviously be entitled to call evidence to say this man is honest; he is honest on other occasions. It is evidence as to disposition and it is plainly relevant on factual matters that have to be determined. I say exactly that analysis applies here to the allegations in the Notice of Hearing that Dr Barton failed to assess any of the 12 patients.

There are issues in this case. You have heard general allegations about Dr Barton's practice. You have heard allegations about how she dealt with relatives, how she dealt with patients. You have heard from about four individuals the suggestion that she was brusque or cruel – I think that was one word used of her conversation with one of the relatives. We are entitled to meet that evidence otherwise the evidence that you hear is entirely one-sided, and we are entitled to meet that by calling evidence, evidence from witnesses who were there when a patient was spoken to or who are patients themselves.

The case has ranged fairly widely so far as the Gosport War Memorial Hospital is concerned. One of the panellists – sir, I think it was you – asked one witness whether the wards were "safe". We are entitled to call evidence to deal with that allegation if it is a concern that the panellists have, any one of them or all of them. We must be entitled to call evidence to deal with that suggestion.

What I say – keeping it short because of the time – is that we are entitled to call evidence from other patients, from the relatives of patients who have seen how Dr Barton deals with patients and patients at the War Memorial Hospital, and that that evidence is relevant to the

hearing that you are embarked upon. That is the application and the basis upon which I make it.

THE LEGAL ASSESSOR: Sir, I do not wish to add unnecessarily to the length of time but I simply would like to establish this if I can, Mr Jenkins. If one looks at rule 27(2) when the Panel retires at the first stage it has to consider two matters, firstly whether the remaining facts alleged in the charge are proved and, secondly, whether such facts would be insufficient to support a finding of serious professional misconduct.

I obviously would like to keep my advice as short as possible and I wonder whether Mr Jenkins is able to concede that the evidence he proposes to lead is not relevant to the issue of serious professional misconduct. If that concession is not made it may well be that I do have to give some advice to the Panel about that because that would affect the issue of that evidence's admissibility.

MR JENKINS: I am sorry, could you say that again? The difficulty with 27(2) is that it has got a double negative in it and sometimes it is difficult to quite understand what is meant. The Panel are enjoined to consider, once they have considered factual questions and made determinations on the facts –

> "The Panel shall consider whether such facts as have been so proved or admitted would be insufficient to support a finding of serious professional misconduct and shall record their finding."

I am prepared to make the concession and I do not invite the gloss that I know the Legal Assessor was considering when he and I discussed the matter at an earlier stage. What I say simply is that the evidence I seek to call from other patients and others who are the relatives of patients treated by Dr Barton and at the War Memorial Hospital during the relevant period is directly relevant to some of the factual findings that the Panel have to make and it is certainly relevant to other evidence that has been given, other issues that have been raised, including raised by the Panel in the evidence that you have heard so far.

R KARK: I do not perhaps need to say very much because Mr Jenkins has not only presented his own argument but he has anticipated, on this occasion correctly, mine, so I can be quite short.

This really is simply character evidence. Of course there are circumstances where you should receive character evidence, we all know about the case of *Campbell* and the line that was followed thereafter, but what those cases provide is that you have to consider what evidence is actually relevant and is going to help you in relation to the specific charges that you are considering. For instance, if a doctor is charged with offences of dishonesty it is obviously appropriate that you should hear evidence that that doctor has not been convicted previously of offences of dishonesty and has a good character, so the only issue is whether it is going to help you to hear from either the relatives or the patients themselves who have been treated properly.

The GMC have not suggested to you that other than in relation to these 12 cases that have been put before you Dr Barton otherwise generally was not assessing her patients properly or prescribing properly. These charges are what you have to do. There may be all sorts of other cases where she has assessed patients properly.

Mr Jenkins wants to call some evidence as I understand it from people who have nothing to do with these patients that you are dealing with at all to say that they were properly treated. It is not going to be any part of my speech that anybody else was not properly treated; I am concentrating for my part on behalf of the GMC on these patients and these issues. It is entirely a matter for you to decide whether you think this sort of evidence is going to help you to make those decisions or not.

*MR JENKINS: Can I reply? You do have evidence about other patients. If you go to tab 6 of bundle 1 you have got the information from Giffin, Tubritt and others relating to patients whose details we have never seen; we do not know who those individuals are. You have been asked to look at that evidence relating to other patients. Shirley Hallman has talked about at least one other patient – we know nothing about that patient. We do not know who they are, we have been in no position whatsoever to contradict what has been advanced. Mr Kark has called that evidence in front of you and for him to say we are only concerned with these 12 is not right. He has placed evidence in front of you in relation to others. We have not objected because it was part of the history and we have allowed that to go before you, but to say you are only concerned with these 12 is simply not right. It is true that you only have to make factual findings in respect of 12 but the case is wider than that and many, many questions have been asked that go far wider than the 12 patients. It has been suggested by Mr Kark or raised as a question did she do this in every case? We have not seen the records of every case that Dr Barton did. We have been in absolutely no position to respond to that sort of suggestion. There were hundreds or thousands of patients that went through the system – we have seen the notes I think of 42 and you have got 12.

All we can do to respond to that sort of suggestion is to call evidence in respect of other patients. That is what we are seeking to do. It would be wholly wrong for us to be shut out from doing that.

Patient B, the allegation in the Notice of Hearing at 3(d) is:

> "In relation to your management of Patient B you
>
> (i) did not perform an appropriate examination and assessment of Patient B on admission;
> (ii) did not conduct an adequate assessment as Patient B's condition deteriorated."

Where is the evidence as to that? The evidence is that there is a lack of a note. Have you heard from a single witness who says there was no assessment undertaken? No, there is not. What you have got to do is to deal with the evidence that you have heard, but if there is more evidence in addition to some of the nurses that you have heard from and Dr Barton herself, who would say, "Yes, she was a very conscientious doctor, she always wanted to do what was best for her patients" that must be relevant to the issue is Dr Barton likely to be right when she says she did perform an examination and assessment, she did conduct an assessment as Patient B's condition deteriorated. Of course it is relevant and of course we should be allowed to call it.

Forgive the vehemence but it is a way of keeping the submissions short.

THE CHAIRMAN: Thank you very much Mr Jenkins. I will hear now from the Legal Assessor.

THE LEGAL ASSESSOR: Sir, I hope to be short without being vehement. Mr Jenkins seeks to call certain evidence from three individuals relating to the character, skills and patient examination practices of Dr Barton – I hope that that summarises the situation fairly.

Mr Kark seeks to put down a marker at this stage concerning the timing of that evidence and the use to which that evidence may be put. He is concerned as to whether Mr Jenkins is straying into the area of pure character evidence. I only offer advice, what you decide is entirely a matter for you.

We have heard character evidence already from some of the witnesses called on behalf of Dr Barton and from other witnesses. That frequently happens in cases before the GMC, sometimes because of timetabling difficulties, but more often because the witness concerned is able to give mixed evidence as to fact and character. It would be a waste of time and resources to have to call that witness twice over at different stages of the proceedings.

It does not mean that all the evidence you have so far heard is relevant to the first stage of your deliberations. In due course I will give a detailed advice as to precisely what evidence you can take into account at each of the stages of your deliberations, but I give the following advice now. When you go into camera during the first stage of your deliberations, you are considering not just whether you find the outstanding facts proved but thereafter also whether any facts proved or admitted would be insufficient to support a finding of serious professional misconduct. That latter part of the process I will not address again, given the concession made by Mr Jenkins.

There are, you may think, two possible uses to which the proposed evidence could be put at this stage. First, to the issue whether Dr Barton is guilty of the allegations. It is said that, because Dr Barton treated other witnesses well and considerately, that tends to show that the allegations are not made out; and, secondly, it is evidence as to Dr Barton's skill and character generally.

In order to be relied upon by you, any evidence must be relevant to the specific allegations faced by Dr Barton. You may find it helpful to consider separately the issues of good character and general medical skills on the one hand and Dr Barton's examination practices on the other. Although it is a matter entirely for you, you will no doubt wish to consider the position very carefully before you conclude that any character evidence as to the medical skills is relevant to the fact finding part of the first stage. This is because the allegations are patient specific, they are not general allegations as to, for example, the overall competence of Dr Barton generally. You will decide the allegations on the evidence you have heard. Some of the unadmitted allegations relate not to the issue of whether Dr Barton did or did not do something, but to the issue whether what she did was, for example, inappropriate. You may think that there, the proposed evidence, whether as to skills, character or examination practices, would certainly be of little assistance to you in your fact finding process. Furthermore, you will hear in due course that Dr Barton is agreed to be a person of good character. If that is the case, I will advise you formally in due course that her good character may be taken into account when you consider her credibility and any allegation that she has acted discreditably. Do these aspects, namely the general medical skills and character, amount purely to personal mitigation? It is a matter for you.

Moving on, some of the allegations do allege that Dr Barton did not do something, for example assess a patient. Mr Jenkins wishes to call evidence as to the fact that Dr Barton properly did assess other patients. It is not in dispute that Dr Barton clearly did assess patients with the exception of the patients charged. Moreover, the fact that she assessed one patient does not mean that she necessarily assessed the patients you are considering. You may also wish to take into account that the evidence Mr Jenkins wishes to call in this respect is not professional medical evidence. It is clearly the case that purely personal mitigation is not to be taken into account by you at the fact finding stage. The issue for you to consider is to what extent, if at all, the proposed evidence goes beyond mere personal mitigation and assists you as to a live issue at the fact finding stage.

I conclude by saying that it is open to you to admit a part only of the disputed evidence.

THE CHAIRMAN: Thank you Legal Assessor. Mr Kark, do you have any observations on the advice just tendered?

MR KARK: No.

THE CHAIRMAN: Mr Jenkins, do you have any observations?

MR JENKINS: No, thank you.

THE CHAIRMAN: We will go into camera now. We will call you back reasonably shortly to tell you how we are getting on and how we propose to handle things.

STRANGERS THEN WITHDREW, BY DIRECTION OF THE CHAIR AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. I will put you out of your misery quickly, Mr Jenkins. We cannot give you an answer today. If we could have done, we would have done, but not just your vehemence, but the strength of your arguments has convinced us that this is something that should be given proper weight and proper consideration. At this end of the day, even if it were just to reach a decision, it would still be taking us a substantial period of time.

We have done our best to crystal-ball gaze as to how much time the process will take us, starting from 9.30 tomorrow. Our most realistic estimate is that we should say to you not before two o'clock. By that time we should have both an answer and a full written determination for you.

There is always the possibility in these cases, as you know, that we run into difficulty and discussion and require further legal advice, in which case, before we can take that advice we need to call the parties so that they can hear it and comment on it. For that reason, what I am going to do is to ask the lawyers in the case, please, to ensure that the Panel Secretary has a contact detail for each that will allow her to call you and get you to this room within about 30 minutes of the call. I think you can safely say in any event, it would not be before, say,

10.30. We are unlikely to plough straight into difficulties, but if we do have those, we will not want to wait and delay you until 2 o'clock before we can put them before you.

MR JENKINS: Thank you for that. I quite understand.

THE CHAIRMAN: Please make sure before you depart that the Panel Secretary has those details. We will resume in camera tomorrow morning at 9.30, and we are hoping at this stage that we will be able to go back into open session not before 2 o'clock which, hopefully, will not be too long after two.

Thanks you very much, ladies and gentlemen.

(The Panel adjourned in camera until not before 2.00 p.m. on Thursday 30 July 2009)

(Parties were released until 2.00 p.m. on Thursday 30 July 2009
but to be contactable after 10.30 a.m.)

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT I – ENID SPURGIN

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
19/3/99	Admitted to Royal Haslar Hospital, following a fall, causing right sub-trochanteric femur fracture. *PC: R femur sub-trochanteric fracture. Pulled over by dog and landed on R hip. Lives alone, self-caring, independent. O/E: Well alert + orientated, abraded R forearm/elbow. Plan: Admit F6, IV fluids pre-op, analgesia.*	Clinical notes	356	
	Takes no drugs and has no other health problems. Non-smoker. Has a brandy and ginger every morning at 11am. No difficulties breathing. Small appetite. Loves to walk her dog and do the garden. Sleeps a lot, always falling asleep on her chair. Patient is alert and understands everything although a little deaf.	Nursing assessment	70, 73, 76	

		Nursing notes Ambulance notes A&E notes	317 360 361	
	Drug charts indicate: • Diclofenac: 50mg administered, • Paracetamol: 1g administered.	Drug charts	328	
20/3/99	Anaesthetic pre-operative assessment at 12.00. *92 year old lady for DHS hip. Previously well – nil major medical problems. Analgesia: Volterol 50mg given + paracetamol 1g, nil else. Plan: Cyclizine 50mg + morphine 2mg iv, stop voltarol.*	Clinical notes	358-359	
	Reviewed by SHO following hallucinations. *Morphine 2mg → pt hallucination therefore nil further opiates. For spinal A @14.30.*	Clinical notes	359	

	Surgery carried out under spinal anaesthetic, with insertion of right dynamic hip screw. Blood transfusion given.	Operation record	363-370	
	Post-op review SHO: R leg held in external [unclear]. +++ ooze from wound, drainage approx 40mls – thigh subjectively 2 x size of left. ? haematoma. P = 88 reg. BP = 140/90. Pt c/o discomfort in leg and pain on palpation. Otherwise nil else.	Clinical notes	359	
	Nausea and pain controlled as per drug chart.	Nursing notes	315, 317	
	Drug charts indicate: • Paracetamol: 1g administered • Morphine: 2mg administered IV, then 5mg administered twice.	Drug charts	326, 328	

21/3/99	*AM: Seen by doctors today. X-ray checked and ok. Mrs Spurgin able now to get into chair. Please give morphine before moving Mrs Spurgin – a lot of pain on movement. Push fluids as much as possible.* *Nocte: Urine output poor. Bladder wash-out performed. IV fluids speeded up. Urine output improved. Recatheterised.*	Nursing notes	317	
	Reviewed by Dr Woods. *23.30: Urine output abysmal but pt not c/o thirst. Oral intake this AM ½ litre + IVI, but UO plummeted, then ↑ to 120mls in a single episode. Nurses asked to flush catheter – no obstruction. Clinically this lady is slightly dry but not excessively so, but when UO taken into account she is in acute pre-renal failure. Urgent U+Es requested. Ct blood, ct fluids are prescribed.* *Note: R hip painful +++ no ooze but thigh enlarged. Possible bleed into thigh but no evidence of hypovolaemia. Monitor.*	Clinical notes	371-372	
	Drug charts indicate: • Paracetamol: 1g administered. • Morphine: 5mg administered.	Drug charts	328	

22/3/99	Reviewed on ward round. *Poor oral fluid intake. Apyrexial. Needs check Hb today. Hb 11.1.*	Clinical notes	372	
	Sat out by physios. Drinking and eating much better today. Oral fluids pushed. *19.50: Oral intake of fluids encouraged. Urine output monitored. 1 hourly measurements satisfactory. Dressing changed due to large amount of ooze.*	Nursing notes	317-318	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	

23/3/99	*05.00: Patient removed catheter @ 05.00. In no obvious discomfort. Not reinserted.* *AM: No re-catheterisation. Moved patient to chair with 2 assistances. Patient has difficulty and pain ++ with mobility. Is able to wash face and upper torso on her own, needs assistance with lower torso. Redressed ulcer on R leg. Applied mepore dressing to small laceration to R ankle. Patient seems comfortable in chair.* *19.53: Transferral and mobilising not well. No ooze on wound on hip.*	Nursing notes	315	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
24/3/99	Reviewed on ward round. *Skin v thin + fragile lower legs. Need to elevate. Would benefit from Dr Lord for rehab.*	Clinical notes	373	

	Referred to Dr Lord. *92 year old lady sustained sub-trochanteric fracture of R femur, having been pulled over by her dog. Previously well, with no significant past medical history, living alone and independently with no social service input. Transfused with 3 units of blood, but otherwise made unremarkable post-op recovery. Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. Quality of skin, especially lower legs, is poor and at great risk of breaking down. Would appreciate advice regarding her rehabilitation and consideration of a place at GWMH.*	Clinical notes	373-374	
	Reviewed by Dr Reid. *Fully orientated and able to give good account of herself. Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful. Would like to be reassured that all well from orthopaedic viewpoint. If all is well, happy for transfer to GWMH for further assessment and hopefull remobilisation.*	Correspondence	301	

	Dr Reid: Still in a lot of pain, which is main barrier to mobilisation at present – could her analgesia be reviewed?	Clinical notes	374	
	Legs remain elevated. No episodes of incontinence. Dressings changed. *PM: Sat in chair this afternoon. Seen by Dr Reid.*	Nursing notes	315	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
25/3/99	*WR: R leg ↑ swelling. Skin tissue-paper thin + very fragile. Haematoma developed + broken down. Dress with gelonet. Elevate. Ready for GWMH when bed available. Needs great care of skin + warn GWMH of skin state.*	Clinical notes	375	

	Mobilised to commode with 2 staff. Assisted with hygiene. No incontinence. Skin tear to back of R calf dressed with steri-strips jellonet-zyofoam with wool and crepe bandage. Mepore applied to R ankle. Very reluctant to mobilise. Needs encouragement.	Nursing notes	315, 318	
	Drug charts indicate: • Paracetamol: 1g administered.	Drug charts	328	
26/3/99	Transferred to Dryad Ward, GWMH. *She is now mobile from bed to chair with 2 nurses and can walk short distances with a zimmer frame. No urinary catheter. Sometimes incontinent at night. Skin on lower legs paper thin. Right lower leg very swollen and has a small break on the posterior aspect. Needs encouragement eating and drinking but can manage independently. Her only medication is analgesia (paracetamol) PRN.*	Transfer letter	23	

	Reviewed by Dr Barton. *Transfer to Dryad Ward. HPC: Fractured NO femur R 19-3-99. PMH: Nil of significance. No weight bearing. Tissue paper skin. Not continent. Plan sort out analgesia.*	Clinical notes	27	
	Admission for rehabilitation and gentle mobilisation. In Haslar she was mobile with zimmer frame and 2 nurses – short distances and apparently transferring satisfactorily. However, transfer has been difficult here since admission. Complained of a lot of pain for which she is receiving oramorph regularly now, with effect. Has very dry, tissue paper skin to lower legs, with small break on back of right calf. Legs are swollen. Eats and drinks with encouragement. Can feed herself. *Turnbull: Night: Requires much assistance with mobility at moment due to pain/discomfort. Oramorph 10mg given 23.15 + 5mg at 06.50.*	Significant events	132	

	Oramorph given for pain in hip (p89, 91). *Experiencing a lot of pain on movement (p96).* *Has wound on right elbow and right calf. Skin very fragile, right leg swollen and oedematous. Both wounds dressed (p104).* *Waterlow score 32 (p110).*	Nursing care plan	89, 91, 96, 104 110	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN subcutaneously. Dr Barton also prescribes as regular prescription 2.5ml (5mg) four times daily and 5ml (10mg) nocte. Three doses of 2.5ml (5mg) administered. One dose of 5ml (10mg) administered.	Drug charts	160, 164	

27/3/99	Drug charts indicate: • Oramorph: One dose of 2.5ml (5mg) administered then discontinued. Dr Barton then prescribes 5ml (10mg) four times daily and 10ml (20mg) nocte. Two 5ml (10mg) doses administered. One 10ml (20mg) dose administered. • Codydramol: Dr Barton prescribes two tablets four times daily.	Drug charts	164	
	Is having regular oramorph, but still in pain (p96). *Used commode, passed urine. In some pain, needs 2 nurses to transfer at present (p144).*	Nursing care plan	96, 144	
28/3/99	Drug charts indicate: • Oramorph: Two 5ml (10mg) doses administered, then discontinued. • Codydramol: Two tablets four times daily administered.	Drug charts	164	

	Has been vomiting with oramorph. Advised by Dr Barton to stop oramorph. Is now having metaclopramide TDS and codydramol. Vomited this afternoon after using commode. Refused supper.	Nursing care plan	96, 98	
Unclear	Drug charts indicate: • Metoclopramide: Dr Barton prescribes 10mg tds (pp Dr Barton, then counter-signed). Administered from 28/3/99 until 11/4/99.	Drug charts	178	
29/3/99	Drug charts indicate: • Codydramol: Two tablets four times daily administered.	Drug charts	164	
	Please review pain relief this morning (p98). *Both wounds redressed with paramed. Steri-strips removed from calf wound as were hanging off (p106).* *Barthel 6 (p113).*	Nursing care plan	98, 106, 113	

30/3/99	Drug charts indicate: • Codydramol: Two tablets four times daily administered.	Drug charts	164	
	Both wounds redressed with paranet. Steri-strips from surgery removed. One small area near top oozing slightly – mepore dressing in situ. Check in a couple of days (p106). *Henning: Sat out in chair for assisted wash/dressed. Zinc and castor oil applied to bottom, liquid paraffin 50/50 applied to legs (p150).*	Nursing care plan	106, 150	
31/3/99	Drug charts indicate: • Oramorph: 2.5ml (5mg) administered at 13.20. • Codydramol: Two tablets four times daily administered. • MST: Dr Barton prescribes 10mg bd. Two doses administered.	Drug charts	160, 164, 178	

	Now commenced on 10mg MST bd. Walked with physiotherapist this am but in a lot of pain. Physio demonstrated how to get Enid from chair onto zimmer frame (p98). *Both wounds redressed (p106).*	Nursing care plan	98, 106	
1/4/99	Reviewed by physiotherapist. *Please nurse Mrs Spurgin on bed over weekend rather than in chair, but she will need to walk x 2 daily using frame.*	Physio notes	116	
	Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound (p91). *Still having pain on movement (p98).*	Nursing care plan	91, 98, 106	
	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	

2/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
3/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
	MST 10mg bd continued. Still continues to complain of pain on movement (p98).	Nursing care plan	98, 150	
4/4/99	*Wound on R hip oozing serous fluid and blood. Steri-strip in situ at present (p100).* *Dressings renewed. No new leakage seen, dry dressing reapplied (p102).*	Nursing care plan	100, 102, 106	
	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	

5/4/99	Drug charts indicate: • MST: Two doses of 10mg administered.	Drug charts	178	
6/4/99	Reviewed by Dr Barton. *Shaw: Seen by Dr Barton. MST increased to 20mg. Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter and she is going to think about it.*	Significant events	132, 134	
	Henning: Swabs taken from suture line rt hip and rt calf.	Nursing care plan	102	
		Microbiology report	57	

	Drug charts indicate: * MST: 10mg administered. Dr Barton then prescribes 20mg bd. One dose administered.	Drug charts	178	
7/4/99	*Fracture site red & inflamed. Seen by Dr Barton. To commence Metronidazole 400mg + Ciprox 500mg BD.*	Significant events	134	
	Commenced antibiotics as hip wound may be infected.	Nursing care plan	106	
	Reviewed by Dr Reid. *Still in a lot of pain and very apprehensive. MST ↑ to 20mg bd yesterday. Try adding flupenthixol. For x-ray R hip as movement still quite painful – also, about 2'' shortening R leg.*	Clinical notes	27	

	Drug charts indicate: • MST: Two 20mg doses administered.	Drug charts	178	
8/4/99	Drug charts indicate: • MST: Two 20mg doses administered	Drug charts	178	
	MST increased to 20mg bd (p98). *Wound oozing slightly overnight. Redness at edges of wound subsiding (p102).*	Nursing care plan	98, 102	
9/4/99	Drug charts indicate: • MST: Two 20mg doses administered.	Drug charts	178	
	To remain on bed rest until Dr Reid sees x-ray of hip (p98). *Agreed to urinary catheter – very distressed when put onto commode earlier – urine very concentrated (p146).*	Nursing care plan	91, 98, 146	

		Significant events	134	
10/4/99	Drug charts indicate: * MST: Two 20mg doses administered.	Drug charts	178	
	Very poor night. Appears to be leaning to left. Does not appear to be as well and experiencing difficulty in swallowing. Stitchline inflamed and hard area. c/o pain on movement and around stitch line. Oramorph 5mg given at 07.15hrs (p91). *Waterlow score 31 (p110).* *Barthel 5 (p113).* *Enid not drinking despite encouragement + help (p146).*	Nursing care plan	91, 110, 113, 146	

11/4/99	*Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods (p94).* *Nelson: In pain on movement. Oramorph 5mg given at 07.15hrs (p98).* *Commenced antibiotics a few days ago. Wound not leaking today but hip feels hot and Enid c/o tenderness all round site. Enid very drowsy and irritable (p102).*	Nursing care plan	94, 98, 102, 146	
	Reviewed by Dr Barton. *Nephew telephoned at 19.10, as Enid's condition has deteriorated during this afternoon. She is very drowsy – unrousable at times. Refusing food and drink and asking to be left alone. Site round wound on rt hip red and inflamed. 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 Enid be kept as comfortable as possible. S/B Dr Barton. To commence syringe driver.*	Significant events	134	
	Drug charts indicate: • Oramorph: 2.5ml (5mg) administered at 07.15. • MST: Two 20mg doses administered.	Drug charts	160, 178	

12/4/99	Reviewed by Dr Reid. *Now v drowsy (diamorphine infusion established). Reduce to 40mg/24hrs. If pain recurs, ↑ to 60mg. Able to move hip without pain, but pt not rousable!*	Clinical notes	27	
	S/B Dr Reid. Diamorphine to be reduced to 40mg over 24hrs. If pain recurs the dose can be gradually increased as and when necessary. Enid's nephew has been spoken to and is aware of the situation.	Significant events	136	
	Collins: Condition remains ill. Urine very concentrated. Oral hygiene attended to. Syringe driver satisfactory. Appears to be in some discomfort when attended to. Breathing very shallow.	Nursing care plan	94	

	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. 80mg/24hrs administered at 08.00. Dose discarded and 40mg/24hrs administered at 16.40. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous infusion (in regular prescriptions, marked PRN). Not administered. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion. 20mg/24hrs administered at 08.00. Dose discarded and 40mg/24hrs administered at 16.40. • Cyclizine: Dr Barton prescribes 50-100mg/24hrs by subcutaneous infusion (in regular prescriptions, marked PRN). Not administered.	Drug charts	174	
13/4/99	Death recorded at 01.15.	Clinical notes Significant events	27 136	
	Cause of death: Cerebrovascular accident.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT J – GEOFFREY PACKMAN

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
30/6/99	Reviewed by Dr Keohane, consultant dermatologist, in relation to bilateral severe leg oedema. *Bilateral severe leg oedema with some leg ulceration secondary to venous hypertension. Would like to apply four layer bandaging.*	Correspondence	31	
		Correspondence Clinical notes	33 39	
6/8/99	Admitted to A&E, Queen Alexandra Hospital, following a fall at home. *Fall at home. Unable to mobilise. Obese. Diagnosis: Bilat LL oedema/ulcers on L, obsesity, not [unclear]. Admit to Anne Ward. No acute care needed in A&E.*	A&E notes	29, 43	

	Admitted to Anne Ward. ECG, chest x-ray and blood test performed. Swabs from groin and leg ulcers obtained. Intravenous antibiotics commenced. *Admission via A&E. PC: ↓ mobility. HPC: Obesity, bilaterial lower leg oedema, ↑ swelling legs over past 6/12, ulcers on legs for 1/12 L calf R calf, 1/12 ↑ weakness, now unable to mobilise. Unable to sit forward. Cellulitis groin and L lower leg. Plan: Urinalysis, blood tests, chest x-ray, ECG, swabs from groin and ulcers, IV antibiotics, ↑ diuretics.*	Admission notes	45-46	
	Reviewed by Dr Curtis, registrar. *Cellulitis L leg, chronic leg oedema, poor mobility, morbid obesity, ↑ BP, ?AF. Plan: As above, clexane as DVT prophylaxis, repeat ECG to confirm AF, if AF → anticoag. Needs CXR +/- echo ? LV dysfunction. If AF and LV good consider sotalol. Watch diuretics don't → dehydration.* *Dowse: In view of premorbid state + multiple medical problems, not for CPR in event of arrest.*	Clinical notes	47	

	Catheterised due to incontinence and broken skin around groin. All broken areas covered with bioclusive. Commenced on IV antibiotics. Temp up to 38.7°C at 20.10. 1g paracetamol given. Diet and fluids taken (p134).	Nursing notes	125, 134, 144, 150, 152	
		Patient profile Drug charts Analysis reports	106 176-182 207, 226-236	
7/8/99	Reviewed by Dr Grunstein and registrar. *Morbid obesity – says he was walking till about a week back, however has pressure sores on low back. Doesn't look that ill. Get good L/x from NOK. Continue IV antibiotic over w/e, mainly a nursing problem. Watch renal function once infection clears.*	Clinical notes	48	

	Buttocks continually oozing, bioclusive not staying in situ. Nocte: Geoff reports a good night, sleeping for big periods. Groin/[unclear] still leaking. Hoisted up bed this morning. Taking oral fluids well.	Nursing notes	135	
8/8/99	Reviewed on ward. *IV antibiotics. Spoke with wife. She is very stressed, awaiting biopsy results for ca breast. Discussed that Mick will probably need rehab/long term care (p125).* *Full assisted wash given, catheter draining, remains on bed rest (p135).* *Low grade pyrexia today, IV antibiotics continued (p144).* *Allevin renewed to sacrum. Groin and [unclear] crease much improved (p152-153).*	Nursing notes	125, 135, 144, 150, 152-153, 157	
9/8/99	Reviewed on ward. *Dr Reid: Cellulitis L leg settling. Oedema L → R foot – continue frusemide. Apyrexial.*	Clinical notes	49	

	Spoke with wife. Informed of what Dr Reid had said. Looking to go to GWMH (p124). *Remains on bed rest, dressing in sacral cleft renewed. Chatted with Geoff about losing weight. He would like to chat with dietician (p135-136).*	Nursing notes	124, 135-136	
10/8/99	Reviewed on ward. *Patient well, cellulitis improving on antibiotics, still awaiting physiotherapy.*	Clinical notes	49	
	S/B OT for initial interview. Will liaise with physio and ward staff re future plans (p124). *Nocte: Excellent night sleeping soundly for most of it on side (p136).* *Benzylpenicillin given. Apyrexial this afternoon (p144).* *Ability to mobilise remains unchanged (p151).* *Wounds appear improved (p153).*	Nursing notes	124, 136, 144, 151, 153	

11/8/99	Reviewed by registrar. *Patient well. Cellulitis improved on Ab. Continue physio. Apyrexial.*	Clinical notes	50	
	Request made for occupational therapy assessment.	Correspondence	107	
	Full wash given. Dressing changed. Stood with physio using neurological table and 5 members of staff (p136). Large necrotic blister observed on left heel (p137).	Nursing notes	124, 136-137, 145, 151, 153	
12/8/99	Reviewed by dietician. *Due to leg ulcers and pressure areas on lower back, inappropriate to give weight reducing [missing] (p124). Groin very offensive, appears very sore from sweating. Bioclusive applied to abdominal flap as very sore and red. Remains bright in mood (p137).*	Nursing notes	123, 124, 137, 153	

13/8/99	Reviewed by registrar. *Carry on antibiotics for total of 10 days. Continue oral fluids. Continue dressings as now. Transfer to Dryad Ward on 16/8/99. Not for 555.*	Clinical notes	51, 53	
	Full bed bath given. Groin area much better than yesterday. Dressings to sacrum intact. Bioclusive applied to left heel as blistered and soft (p137).	Nursing notes	122, 137-138	
15/8/99	Notes record Dryad Ward bed unavailable. *Assisted wash given. Serous fluid leakage continues. Appears comfortable at time of report. Uncomplaining afternoon. Nocte: Slept for long periods, turned from side to side with patient participation, slight leakage of serous fluid from sacral sores (p138-139).* *Remains in bed. Requires 4 nurses to roll for dressing changes (p151).* *All dressings changed. Slough +++ and necrotic areas observed. Malodorous + exuding from all areas of skin breakdown. Intrasite, allevyn + bioclusive to large broken areas and intrasite + bioclusive to smaller wounds (p156).*	Nursing notes	120, 138-139, 145, 151, 153, 156	

16/8/99	Reviewed. Dryad Ward bed unavailable. Seen by Dr Tandy. *Obese, cellulitis, p.sores – buttocks/sacrum, thighs. Legs – top much better. → Dryad when bed available.*	Clinical notes	52	
	Blister on L heel still evident. Dressing renewed with granuflex (p112). *Washed and changed with maximum assistance. Dressing renewed to heel (p139).*	Nursing notes	112, 120, 139, 145, 153	
18/8/99	Reviewed by registrar. *Wounds look better. Stop antibiotics from tomorrow. Continue as planned.*	Clinical notes	52	
	Reviewed by Dr Tandy, consultant geriatrician. *P sores – extensive. Feeds himself. Not mobilising. Black stool overnight – nil today. ° pain. Abdo [unclear]. Check Hb – R/O bleed.*	Clinical notes	53-54	

	Dressing renewed to heel. Dressings to bottom and groin intact. No complaints (p140). *Remains apyrexial (p145).* *Continuing to improve with physiotherapy. Continue to hoist until physios instruct nursing staff on appropriate transfers (p151).*	Nursing notes	112, 120, 140, 145, 151, 153	
20/8/99	Reviewed by registrar. *Nausea°, epigastric pain°. Epigastric tenderness° → stop felodipine. Check FBC (?↓Hb). For Gosport 23/8/99. Not for 555.*	Clinical notes	54	
	Heel reviewed and reassessed. Changed dressing to 15x20cm granuflex (p112). *Continue with current dressings. Review condition daily. Will write full step by step plan for Dryad Ward (p118).* *Following full reassessment of pressure sores, the wounds though malodorous don't appear to be as deep as first thought. Until necrotic tissue is removed, the wound appears to be a grade 3 (p128).* *All dressings changed. No complaints (p141).*	Nursing notes	112-119, 128, 141, 151	

23/8/99	Admitted to Dryad Ward, GWMH. Reviewed by Dr Ravindrane. *Problems: Obesity, arthritis bilat knees, immobility, pressure sores. On high protein diet. MTS = very good. No pain. Better in himself. Legs: [Unclear], chronic skin change. Ulcers dressed yesterday. Need review later this week.*	Clinical notes	55	
	PMH: Bilateral lower leg oedema, cellulitis, obesity, ↑ BP.	Nursing notes	61-62	
	Hallman: Admitted from Anne Ward following episode of immobility and sacral sores. Catheterised. Able to feed himself.	Significant events	63	
		Nursing care plan	79-88, 97-101	

	Drug charts indicate: • Doxazosin, frusemide, clexane and paracetamol (1g four times daily) prescribed by doctor other than Dr Barton. Paracetamol 1g administered between 23/8/99 and 26/8/99.	Drug charts	173	
24/8/99	Blood sample sent for analysis. *Reported on 25/8/99. Hb: 12.0*	Analysis report	212	
	Drug charts indicate: • Temazepam: Dr Barton prescribes 10-20mg PRN. 10mg administered at 22.10.	Drug charts	171	

25/8/99	Verbal message from Dr Beasley to withhold clexane dose and review with Dr Barton mane. *Passing fresh blood PR. ? clexane. Verbal message from Dr Beasley to withhold 18.00. Dose and review with Dr Barton mane. Also vomiting. Metoclopramide 10mg given I.M. at 17.55 with good effect.*	Significant events	63	
	Transferred to heavy duty bed. Patient slide and 6 members of staff used.	Contact record	69	
	Drug charts indicate: • Temazepam: 20mg administered at 22.05. • Gaviscon: 10ml administered at 12.00. Prescribed PRN by doctor other than Dr Barton, date unclear. • Metoclopramide: 10mg im 8 hourly prescribed verbally by Dr Beasley. 10mg administered at 17.55.	Drug charts	171, 174	

26/8/99	*08.45: Visited to ensure no problems with moving and handling. Discussed situation with sister. Agreed to encourage Mr Packman to do as much as he can himself. Physio to see pt today with view to starting pressure physio.*	Contact record	69	
	Dr Ravi consulted re clexane. Reviewed by Dr Barton. *Hamblin: Fairly good morning. No further vomiting. Dr Ravi contacted re clexane. Advised to discontinue. Repeat Hb today and tomorrow. Not for resuscitation. Unwell at lunchtime. 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 10mg stat – given at 18.00. Metoclopramide 10mg given IM. Mrs Packman will visit this evening.* *Hallman: 1900: Dr Barton here. For oramorph 4 hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used.*	Significant events	63	

	Blood sample sent for analysis. *Reported on 26/8/99: Hb: 7.7. Many attempts made to phone these results, no answer from GWMH switchboard.*	Analysis report	210	
	Review by Dr Barton. *Called to see male, clammy, unwell. Suggest ? MI treat stat diamorph and oramorph overnight. Alternative possibility GI bleed but no haematemisis. Not well enough to transfer to acute unit. Keep comfortable. Happy for nursing staff to confirm death.*	Clinical notes	56	

	Drug charts indicate: • Metoclopramide: 10mg administered at 17.40. • Diamorphine: 10mg im administered at 18.00. Prescribed verbally. Subsequent prescription by Dr Barton, dated 28/8/99. • Oramorph: Dr Barton prescribes 5ml (10mg) four hourly. Not administered. • Oramorph: Dr Barton prescribes 5-10ml (10-20mg) qds and 10ml (20mg) nocte. 10ml (20mg) nocte administered. • Diamorphine: Dr Barton prescribes 40-200mg/24hrs by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion.	Drug charts	171, 174-175	
27/8/99	Reviewed by Dr Barton. *Hamblin: Some marked improvement since yesterday. Seen by Dr Barton this am – to continue with oramorph 4 hourly – same given, tolerated well. Some discomfort this afternoon, especially when dressings being done. Wife has visited this afternoon and is aware that condition could deteriorate again. Still remains poorly.*	Significant events	64	

	Drug charts indicate: • Oramorph: Four 5ml (10mg) doses administered during day. 10ml (20mg) nocte administered.	Drug charts	175	
28/8/99	Reviewed by Dr Barton. *Remains poorly but comfortable. Please continue opiates over weekend.*	Clinical notes	56	
	Hallman: Remains very poorly – no appetite, has refused all food. Wife visited – very distressed as she is having surgery this coming week – QA thurs. *Nocte (28^{th}-29^{th}): Oramorph given as prescribed. Condition remains poorly and variable. Dressings remain intact.*	Significant events	64	
	Drug charts indicate: • Oramorph: Four 5ml (10mg) doses administered during day. 10ml (20mg) nocte administered.	Drug charts	175	

29/8/99	Drug charts indicate: • Oramorph: Four 10mg doses administered during day. 10ml (20mg) nocte administered.	Drug charts	175	
	Nocte (29th-30th): Slept for long periods. Oramorph given as prescribed.	Significant events	64	
30/8/99	*Hamblin: This mane 30/9/99 c/o left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. Very small amount diet taken, mainly puddings. Recatheterised. When possible encourage fluids. Dressings renewed.*	Significant events	64	
	Drug charts indicate: • Oramorph: Two 5ml (10mg) doses administered during day. • Diamorphine: 40mg/24hrs administered at 14.45. • Midazolam: 20mg/24hrs administered at 14.45.	Drug charts	174-175	

31/8/99	*Appeared to have comfortable and peaceful night (30th-31st). This morning has passed a large amount of black faeces.* *Nocte: Comfortable night – continues to pass tarry black faeces.*	Significant events	64	
	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 15.45. • Midazolam: 20mg/24hrs administered at 15.40.	Drug charts	174	
1/9/99	Reviewed by Dr Reid. *Rather drowsy, but comfortable. Passing melaena. stools. Abd huge, but quite soft. Pressure sores over buttock and across posterior aspect of R/L thigh. Remains confused. For TLC – stop frusemide + doxazosin. Wife aware of poor prognosis.*	Clinical notes	56	

	Hamblin: Syringe driver renewed at 19.15 with diamorphine 60mg + midazolam 60mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman has visited and is aware of poor condition. *Nocte: Incontinent of black tarry faeces. Peaceful night. All care given.*	Significant events	65	
	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 15.45. Increased to 60mg/24hrs at 19.15. • Midazolam: 40mg/24hrs administered at 15.45. Increased to 60mg/24hrs at 19.15.	Drug charts	174	
2/9/99	Drug charts indicate: • Diamorphine: 90mg/24hrs administered at 18.40. • Midazolam: 80mg/24hrs administered at 18.40. • Hyoscine: Dr Barton prescribes 800-2000µg/24hrs by subcutaneous infusion. Not administered.	Drug charts	174-175	

	Florio: Diamorphine increased to 90mg/24hrs. Midazolam 80mg.	Significant events	65	
3/9/99	Death recorded at 13.50.	Clinical notes Significant events	56 65	

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT K – ELSIE DEVINE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
1/4/99	Reviewed in clinic of Dr Logan, consultant geriatrician. *Dr Ravindrane: Diagnosis: Nephrotic syndrome ?myeloma. Complaining of swelling of feet. Blood test shows high ESR, renal impairment, low protein. Not complaining of anything apart from swelling of legs. Urine showed +++protein. Blood pressure 150/90. Comfortable. Chest clear.*	Correspondence	81	
		Clinical notes	145-147	

15/4/99	Reviewed in clinic of Dr Logan. *Referred to Dr Cranfield. Patient moderately frail. Very bright mentally. Peripheral oedema and hypoalbuminaemia. Creatinine is 151. Has nephrotic syndrome and paraproteinaemia. Not sure whether has myeloma.*	Correspondence	89	
29/4/99	Radiology report on chest and skeletal survey. *No evidence of myeloma or any other focal bone abnormality.*	Report	383	
13/5/99	Examined by Dr Cranfield, consultant haematologist, including examination of skeleton system. *Diagnosis: Nephrotic syndrome, IgA lambda paraprotein. Her only complaint is bilateral leg oedema. No other evidence to suggest multiple myeloma. Bone marrow test performed.*	Correspondence	75	
		Clinical notes	144	

2/6/99	Reviewed by Dr Cranfield. *Insufficient evidence of myeloma or lymphoma. Both kidneys small on ultrasound. Reluctant to offer chemotherapy. Referred to renal unit.*	Correspondence	65-73	
8/6/99	Reviewed by Dr Stevens, consultant renal physician, at request of Dr Cranfield. *Albumin of 20, creatinine of 160. 3+ protein on urine analysis. Creatinine level of 160 only a little higher than I would normally expect at her age. Likely to be long-standing glomerulonephritis rather than a new problem. Steroids unlikely to help. Preference is to treat her conservatively.*	Correspondence	61, 63	
		Clinical notes	152	
20/7/99	Reviewed by SHO to Dr Stevens. *Remains well on current treatment with no new problems. Creatinine slowly worsening – 192 on test sample. Albumin low. Symptomatic treatment only.*	Correspondence Clinical notes	53 153	

28/7/99	Reviewed by Dr Cranfield. *Looking much better. Leg oedema better controlled. No significant deterioration in renal function. Some tenderness and discomfort over sacrum. Not keen to start aggressive treatment. Keep steroids in reserve.*	Correspondence	51	
7/9/99	Reviewed by Dr Cranfield. *Oedema marked up to knees.*	Correspondence	41	
		Clinical notes	154	
9/10/99	Admitted to Queen Alexandra Hospital with episode of acute confusion. *Confused, aggressive and wandering. Diagnosis: Multi-infarct dementia, CRF.*	Discharge summary	25	

		Care plan Correspondence Nursing notes	32 39 159	
14/10/99	Reviewed by Dr Taylor, clinical assistant in old age psychiatry. *Remains confused and disorientated but no longer aggressive or difficult in behaviour. Sleeping better. On examination, calm and cooperative. Speech normal. Denied feeling unhappy. 9/30 on MMSE. Very deaf. Diagnosis: Dementia. Recommend referral to social services for residential care.*	Correspondence	29-30	
		Nursing notes Patient assessment Correspondence	164-165 395-404 411	
15/10/99	Discussion with Dr Smith, GP. Plan to transfer patient to St Christopher's.	Nursing notes Care plan	165-167 173	

19/10/99	Reviewed by Dr Jayawardena, consultant geriatrician. Transfer arranged to GWMH. *Moderate chronic renal failure. Admitted with history of UTI. Quite alert. Can stand. Rather unsteady on walking. Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation programme. Will arrange transfer to GWMH.*	Correspondence	21	
		Nursing notes	169-172	
21/10/99	Transferred to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. HPC: Acute confusion. Admitted to Mulberry→QA→Dryad. PMH: Dementia, myeloma, hypothyroidism. 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.*	Clinical notes	155	

	Needs minimal assistance with ADLs. Very pleasant lady. Appetite not good. Can be a little unsteady on feet. Both feet swollen. Seen by Dr Barton.	Significant events	223	
		Transfer letter Care plan	23 190	
	Drug charts indicate: • Thyroxine: Dr Barton prescribes 100µg od. Administered from 22/10/99 to 17/11/99. Not administered on 2/11/99 or from 18/11/99. • Frusemide: Dr Barton prescribes 40mg od. Administered from 22/10/99 to 17/11/99. Not administered from 18/11/99. • Temazepam: Dr Barton prescribes 10mg nocte PRN. • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. Not administered.	Drug charts	279	

25/10/99	Reviewed by Dr Reid, consultant geriatrician. *Mobile unaided. Dresses self. Continent. BP 110/70. Chronic renal failure.*	Clinical notes	155	
		Care plan Significant events	186 223	
1/11/99	Reviewed by Dr Reid. *Physically independent but needs supervision of washing and dressing, help with bathing. Continent. Quite confused and disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home.*	Clinical notes	156	
		Significant events	223	

	Drug charts indicate: • Amiloride: Dr Barton prescribes 5mg od. Administered from 2/11/99 to 18/11/99. Not administered from 19/11/99.	Drug charts	279	
10/11/99	*Confused during the night, wandering around ward. Refused night sedation.*	Nursing care plan	190	
11/11/99	Drug charts indicate: • Temazepam: 10mg nocte administered. • Trimethoprim: Dr Barton prescribes 200mg bd. Administered from 11/11/99 to 15/11/99. Not administered from 16/11/99. • Thioridazine: Dr Barton prescribes 10mg tds PRN. Administered at 08.30.	Drug charts	279	
		Care plan	190	

12/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 13.20.	Drug charts	279	
		Contact record	229	
13/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 08.25 and 18.00.	Drug charts	279	
14/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 08.25 and 19.45.	Drug charts	279	
		Care plan	190	

15/11/99	Seen by Dr Reid. Request for review by Dr Lusznat. *Very aggressive at times. Very restless. Ask Dr Lusznat to see.*	Clinical notes	156	
		Care plan Significant events	190 223	
	Drug charts indicate: • Thioridazine: 10mg administered at 08.30 and 21.30.	Drug charts	279	
16/11/99	Referral to Dr Lusznat by Dr Barton. *Using thioridazine. Renal function ↓ MSU showed no growth.*	Clinical notes	156	

	Slept well, out once in night. Refused medication in morning.	Care plan	195	
	Drug charts indicate: • Thioridazine: 10mg administered at 08.45.	Drug charts	279	
17/11/99	Drug charts indicate: • Thioridazine: 10mg administered at 17.40.	Drug charts	279	
	Slept well. Out to toilet twice. Thioridazine not required.	Care plan	195	

18/11/99	Reviewed by Dr Taylor. *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 (p157).* *Mrs Devine now at Dryad GWMH. Transferred 21.10.99. Aggressive, wandering, moving other people's clothes, refusing medication, poor appt. Reviewed on ward. Happy, no complaints. Waiting for her daughter. Says tablets make her mouth sore. Plan – Transfer to Mulberry C when bed available (p407).*	Clinical notes	157, 407	
	Drug charts indicate: * Fentanyl: Dr Barton prescribes 25mcg skin patch (every three days). Administered at 09.15.	Drug charts	279	

19/11/99	Reviewed by Dr Barton. *Marked deterioration overnight. Confused, aggressive. Creatinine 360. Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs SC analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death.*	Clinical notes	157	
	Marked deterioration over last 24 hours. Extremely aggressive this am. Refusing all help from staff. Chlorpromazine 50mg given IM at 08.30 – taken 2 staff to special. Syringe driver commenced at 09.25. Fentanyl patch removed. Son seen by Dr Barton at 13.00, situation explained. He will contact his sister Mrs Reeves & inform her of Elsie's poor condition. *20.00: Daughter has visited – seen by Dr Barton. All care given to Elsie.* *Nocte: Peaceful night. Syringe driver satisfactory.*	Significant events	223-224	
	Elsie had a peaceful night. Syringe driver satisfactory.	Care plan	195	

	Social services informed to close the case. Mulberry ward also informed.	Contact record	230	
	Drug charts indicate: • Chlorpromazine: Dr Barton prescribes 50mg by injection at 08.30. Administered. • Diamorphine: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hrs administered at 09.25. • Midazolam: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hrs administered at 09.25.	Drug charts	279B, 281	
20/11/99	Drug charts indicate: • Diamorphine: 40mg/24hrs administered. • Midazolam: 40mg/24hrs administered.	Drug charts	281	

	Hamblin: Condition remains poor – family have visited & are aware of poorly condition. *Nocte: Peaceful night. Skin marking. Position changed regularly. Extremities remain oedematous.*	Significant events	224	
	Peaceful night. Position changed regularly. Skin marking. Extremities remain oedematous. Oral care given.	Care plan	195	
21/11/99	Drug charts indicate: • Diamorphine: 40mg/24hrs administered. • Midazolam: 40mg/24hrs administered.	Drug charts	281	
	8pm: Condition continues to deteriorate slowly. Family have visited, all cares continued, driver satisfactory.	Significant events	224	

	Death recorded at 20.30.	Clinical notes Significant events	157 224	
	Cause of death: Chronic renal failure.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT L – JEAN STEVENS

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
2/2/99	Reviewed by locum consultant re left iliac fossa pain.	Correspondence Clinical notes	154 205	
9/3/99	Referred to consultant anaesthetist re abdominal pain.	Correspondence	144-145	

26/4/99	Admitted to Royal Hospital Haslar after experiencing chest pain and collapsing at home. CT brain scan conducted. *A&E referral. c/o L weakness. Had a fall whilst getting out of bed to go to toilet. Weakness L side. Has had chest pain all day. PMH: IHD – MI x 2 – AF, COPD/asthma, sigmoid resection. Chest clear. Abdomen soft. Imp: R sided CVA → L side weakness.* *WR: Complains for headache. L sided weakness. Speech slurred, gag reflex present. Plan: Chase blood results, urgent CT scan, LP if inconclusive, speech/language therapist r/v.* *CT result: No SAH or intracranial haemorrhage. Probable rt non-haemorrhagic infarction rt parietal lobe.* *SLT: Reduced but adequate [unclear] movement. [Unclear] swallow and at risk of aspiration on solids + liquids. Will review 2-3 days.*	Clinical notes	208-211	

	Mobilising: Normally independent. Unable to stand O/A due to weakness (p96). *Mane: c/o headache & backache, pt states has arthritis in back.* *SCT: Swallow assessment. Drowsy but rousable. Back pain makes upright posture difficult. Unable to produce [unclear] swallow. At risk of aspiration. Cont NG feed until review.* *AM: PR paracetamol given with poor effect. Analgesia needs reviewing.* *PM: NG feed in progress. c/o painful back, analgesia given with fair effect. Special mattress ordered (p98,100).* *Waterlow score 25 (p125).*	Nursing notes	92, 94, 96, 98, 100, 125, 131	
		A&E notes CT scan results Drug charts	146-149 255 73-78, 703-725	
27/4/99	Nasogastric tube feeding continues. *Apyrexial. L sided neglect. L facial weakness. L tongue deviation. ↑ tone L leg. Plantar ↑ L. Plan: Continue. Tolerating NG feeding.*	Clinical notes	212	

		Intake notes Nursing notes	51-68 100	
28/4/99	Transferred to Coronary Care Unit. Chest x-ray conducted. Antibiotics commenced. *Feels lousy today. L facial. L neglect. L weakness arm and leg. Speech improving.* *16.45: Pt has ? chest and L arm pain. Has had similar pain since Sunday morning. 2 x MI in past – different sort of pain. Tender over sternum on palpation. No response to GTN spray. ECG much as on admission ? [unclear] MI. ? MI over W/E. Now ? angina as tachycardic (?) due to ↓ digoxin dose. ? postural related, due to turning difficulties.*	Clinical notes	213-215	

	Feed continues by NG tube. *PM: Co-codamol given twice for a headache.* *Nocte: Turned 2 hourly as complaining of being very uncomfortable. Analgesia given for headache (p100).* *Transferred to CCU.* *ECG performed, ST elevation resolving slowly but still present. In AF, rate 90-100bpm.* *Complaining of back pain – oral analgesia given via NG tube.* *No chest pain (p108).*	Nursing notes	100, 108	
29/4/99	Reviewed by SHO. *Pain free for the first time this am. Mouth dry. Swallowing needs reassessing. Plan: Transfer to Ab. ? for nitrate.*	Clinical notes	216	
30/4/99	*Awake. Dense L hemiplegia present. ECGs confirm [unclear] MI on 28/4/99. No further chest pain. Chest clear.*	Clinical notes	216	

	Reviewed by HO on call. *Pt "bubbly" this pm. Suction no effect. Pt ° gag reflex and NG tube down. ? aspiration. OE: Distressed ++. Sats 80% on 10cl O_2. Widespread course crept. all lobes. Ankle oedema. Imp: ?aspiration pneumonitis +/- fluid overload. ABG: Type 1 resp failure.* *CXR: No NG tube seen but NG tube in! On RO NG tube this was found to be in nasal cavity, therefore feed has been placed directly down nasopharynx therefore can't exclude aspiration.*	Clinical notes	217-218	
1/5/99	Reviewed on ward round. *O_2 98%. Consolidation at L base course crept. Continue Ab.*	Clinical notes	219	
2/5/99	Reviewed by physiotherapist. *Being treated with [unclear] hands on + nasal suctioning with NR continuing. Improving.*	Clinical notes	219	

3/5/99	Reviewed on ward round. *ATSP re feeding. Can swallow water. To try thickened fluids.*	Clinical notes	219	
4/5/99	Reviewed on ward round and by dietician. *Still not speaking. Speech therapy to assess gag reflex.* *SLT: Swallow assessment. Adequate range of movement. Rec puree diet + thickened fluids.*	Clinical notes	219, 223	
5/5/99	Patient begins taking food orally. Referred to Dr Lord, consultant geriatrician. *To start foods as directed by speech therapist. Some residual weakness + sensory inattention but improving.* *Referral to Dr Lord: Could you give your opinion as to best path for rehabilitation of this 73 y o female. She is improving slowly. Nothing more we can do for her on acute medical side.*	Clinical notes	224	

	Treated with oxygen and diamorphine for respiratory failure. *Now aspiration pheumonia + in respiratory failure. Poorly ++. In distress. Plan: Still for resus, not for ventilation, O_2, Physio, small doses of diamorphine to keep comfortable, CXR.*	Clinical notes	225	
	AM: Remains very chesty. For thickened fluids and puree diet. Nasopharangeal suctioning administered, small effect. For chest physio this pm. *PM: Physio seem – NBM again. Still having problems with IVI going slow. 2.5mg IV diamorphine, pt agitated and complaining of discomfort/non-specific – unable to position her comfortably. S/B physio – aspirating fluids/softened diet therefore NBM until further review.* *Nocte: Family spoken to. Aware of poor prognosis. Remains for 444. Condition remains very poor.*	Nursing notes	110	
		Intake notes	44-50	

6/5/99	*Discussed with consultant. Not for resuscitation. Fluid overloaded. Bibasal creps. Plan: 80mg frusemide, IVI. SLT – remains NBM.* *Dietician: In view of NBM, recommend NG feeding recommenced.*	Clinical notes	226-227	
	Reviewed by Dr Lord. *Admitted with left hemiparesis and anterior myocardial infarct as well as atrial fibrillation. CT scan confirmed right parietal infarct. Also asthmatic and has had sigmoidcolectomy. Extremely unwell. Very dense left hemiplegia, left ventricular failure and aspiration pneumonia. Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH. Overall prognosis poor. If Mrs Stevens survives and is stable next week, happy to take her to slow stream stroke care bed at GWMH towards end of next week.*	Correspondence	734	
	Dr Lord notes: Suggest: (1) ↓ Total fluids to 1½l /day (2) Salbutamol nebs if wheezy (3) Diamorphine if distressed (4) Not for NG/PEG feeding (5) If stable early next week for transfer to slow stream stroke care GWMH later in the week.	Clinical note	228	

	Remains poorly. Needs regular suction. IV diamorph given as px. *PM Condition remains poor. Not for resuscitation.*	Nursing notes	110, 112	
7/5/99	Reviewed by Registrar. *Pt ° further deterioration. Obs stable. Plan: For 1½l fluid restriction daily, not for PEG, stop Ax, not for active blood tests, continue.*	Clinical notes	229	
10/5/99	Reviewed on ward round. Nasogastric feeding recommenced. *Pt improved. Obs stable. Plan: CXR, Dr Lord [unclear] feeding.*	Clinical notes	229-230	

	Reviewed by Dr Tandy, consultant geriatrician. *Appeared to improve over weekend. Barthel is zero. Has dense flaccid hemiparesis with very dysarthric speech. Can only obey simple commands. Tolerating NG feeds so far (this morning). When I arrived on ward she developed further central chest pain. Don't think stable enough to transfer to GWMH at present.*	Correspondence	69	
	Dr Tandy notes: Please normalise sodium, rule out MI, make sure tolerating NG. If above OK, please transfer to GWMH next week.	Clinical notes	230-232	
	Reviewed on ward. *15.50: ATSP re chest pain. Central chest pain. Looks unwell. Relieved after 4 sprays of GTN. ECG much as 4/5/99.* *16.10: Pain settled. Further escalation in treatment appropriate.*	Clinical notes	232-233	

	Nocte: NG tube feeding continues. Bottom and perineum very sore and peeling.	Nursing notes	114	
		Intake notes	32-43	
11/5/99	Reviewed by SHO and SLT. *c/o chest pain. Obs stable. Plan: Continue NG feeding, small amounts of thickened fluids orally, put nitrates through NG tube for chest pain, not for 444.* *SLT: Tolerated small amounts of thickened fluid.*	Clinical notes	233-234	
12/5/99	Reviewed on ward round. *Feeding well through NG tube. c/o chest pain, relieved by GTN. Obs stable.* *Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why pt would be allowed to die naturally, rather than be resuscitated or put on ITU, if she had a further MI or respiratory failure/arrest.*	Clinical notes	234	

13/5/99	Reviewed on ward round, and by dietician. *Pt worse this am. Plan: Bloods, continue with good skin care, continue rehabilitation.*	Clinical notes	235	
14/5/99	Reviewed by orthopaedic specialist. Subluxation of shoulder diagnosed. *Pt worse this am. Obs stable.* *Orthopaedics: This is an inferior subluxation. No [unclear] intervention needed.*	Clinical notes	236	
	Nocte: Very uncomfortable this evening. Diamorphine 5mg S.C. given to assist settling with good effect.	Nursing notes	118	
		Drug charts	73	

15/5/99	*Full bed bath given. Appears more weary this pm. Diamorphine 5mg S.C. given with good effect.*	Nursing notes	120	
		Drug charts	73-78	
16/5/99	*AM: Care continues as plan. No incontinence this am. Settled and slept very well without diamorphine. Feed continues as per regime.*	Nursing notes	120	
		Drug charts	73-78	
17/5/99	Reviewed by SHO, and by dietician. *Pt no real change. ° further pyrexia since 14/5. Creps L base. P: Continue, check bloods.* *Tolerating feeds without any problems. Bowels now open. Continue.*	Clinical notes	237	

	Paracetamol given with effect. Feed continues. Very demanding overnight. Continues to disturb other patients with calling out.	Nursing notes	120	
		Drug charts	73-78	
18/5/99	Reviewed on ward round. Liaison between Royal Haslar Hospital and GWMH. *Pt sitting in chair. Obs stable.* *Blood test results.* *Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating NG feeding well. Seems to have recovered from aspiration pneumonitis. Slow improvement in orientation, speech and strength. Still faecally incontinent and requires catheter in situ.*	Clinical notes	237-238	

	Hoisted into bath this morning. Still c/o general aches + pains despite regular co-dydramol.	Nursing notes	120	
		Drug charts	73-78	
19/5/99	Reviewed by physiotherapist. *Referred for collection of sputum sample, but no added sounds and has poor cough. Nasopharangeal suctioning not indicated, so sample not obtained. To monitor.*	Clinical notes	238-239	
	Settled and slept all night.	Nursing notes	122	
		Drug charts	73-78	

20/5/99	Transferred to Daedalus Ward, GWMH. Upon transfer, patient receiving aspirin, enalapril, digoxin, isosorbide, mononitrate and PRN subcutaneous diamorphine 5mg. *Diagnosis and treatment in hospital: Stroke. For rehab at Gosport WMH.*	Transfer record	70-71	
	Admitted following R CVA 26/4/99. Dense left hemiplegia unresolved. Recovery affected by MI 28/4/99. Now remains with dense L hemiplegia with no swallow. Catheter in situ. Faecally incontinent. History of angina and IBS. Has had aspiration pneumonia, now resolved. All care required with all ADLs. NG feeding. Pressure areas intact though very sore in groin area – improving with sudacrem. Diarrhoea at present.	Nursing referral	86	

	Neville: Transferred from Haslar today, following R CVA on 26/4/99. Had been at home complaining of chest pain all day, then collapsed. Whilst in Haslar had possible MI on 28/4/99 – confirmed by ECG. Due to this episode a PEG was not inserted due to the risks. NG feed required due to poor gag reflex. Speech slurred slightly but Jean appears quite alert of surroundings. Has a dense L weakness. Catheter in situ. Faecally incontinent.	Significant events	1299	
	Reviewed by Dr Barton. *Transfer to Daedalus Ward 555K. HPC: R cva 26-4-99. Dense L hemi. Aspiration pneumonia and MI 28-4-99. PMH: IHD MI x 2, AF, COPD asthma, sigmoid resection. Barthel: Needs help with ADL, catheterised, ng tube in situ, transfer with hoist, Barthel 0.*	Clinical notes	1292	

	Unable to answer on O/A. But husband says whilst in Haslar she knew she had been unwell. Poor hearing in R. Poor vision – wears glasses most of the time. Speech slow and slurred at times. Orientated. Diet: NG feeds. Pain: Not controlled [ticked] c/o abdo pain due to history of bowel problems. Oramorph given O/A (p1302). *Waterlow score 25 (p1304).* *Barthel 1 (p1306).* *Abbreviated mental study score 4 (p1307).* *Neville: Slurred speech. Compliant. Pain: Abdo pain. Skin dry, intact (p1318).* *Nutritional assessment tool score 20, at high risk (p1322).*	Nursing assessment	1302-1307, 1318-1322	
	Requires assistance to settle and sleep at night. Oramorph 2.5mls (5mg) given. c/o pain in stomach and arm. Condition poor (p1337).	Nursing care plan	1324-1337	
		Nursing notes (Haslar) Admission notes	122 1296-1297	

	Drug charts indicate: • Digoxin: Dr Barton prescribes 1.2ml od. • Enalapril: Dr Barton prescribes 5mg od. • Aspirin: Dr Barton prescribes 75mg od. • Isosorbide: Dr Barton prescribes 60mg. Not administered. • Suby C: Dr Barton prescribes. Not administered. • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 2.5ml (5mg) administered at 14.30, 18.30 and 22.45. • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion.	Drug charts	1342-1346	

21/5/99	Drog charts indicate: • Digoxin: 1.2ml administered. • Enalapril: 5mg administered. • Aspirin: 75mg administered. • GTN spray: Dr Barton prescribes 2 puffs PRN. Not administered. • Oramorph: 2.5ml (5mg) administered at 07.35. Dr Barton then prescribes 5ml (10mg) four times daily and 10ml (20mg) nocte. 5ml (10mg) administered at 10.00 and 14.00. • Diamorphine: 20mg/24hrs administered at 19.20. • Midazolam: 20mg/24hrs administered at 19.20.	Drug charts	1342-1346	
	11.30: To have GTN spray PRN. Now on regular (4 hourly) oramorph 10mg/5ml. *Beed: 18.00: Uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen & care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life.* *Beed: 19.45: Commence syringe driver.*	Contact record	1309	

	Turnbull: Remains poorly but comfortable.	Nursing care plan	1337	
22/5/99	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 08.00. 20mg/24hrs administered at 10.30. • Hyoscine: 800µg/24hrs administered at 08.00. Dr Beasley then verbally prescribes 1600µg/24hrs by subcutaneous infusion. 1600µg/24hrs administered at 10.30. • Midazolam: 20mg/24hrs administered at 08.00. 20mg/24hrs administered at 10.30.	Drug charts	1342-1346	
	08.00: Condition has deteriorated. Very bubbly. *10.20: Still very bubbly. Dr Beasley contacted and verbal order to increase hyoscine to 1600mcg.*	Contact record	1309, 1311	
	Death recorded at 22.30.	Clinical notes Significant events Contact record	1292 1299 1311	

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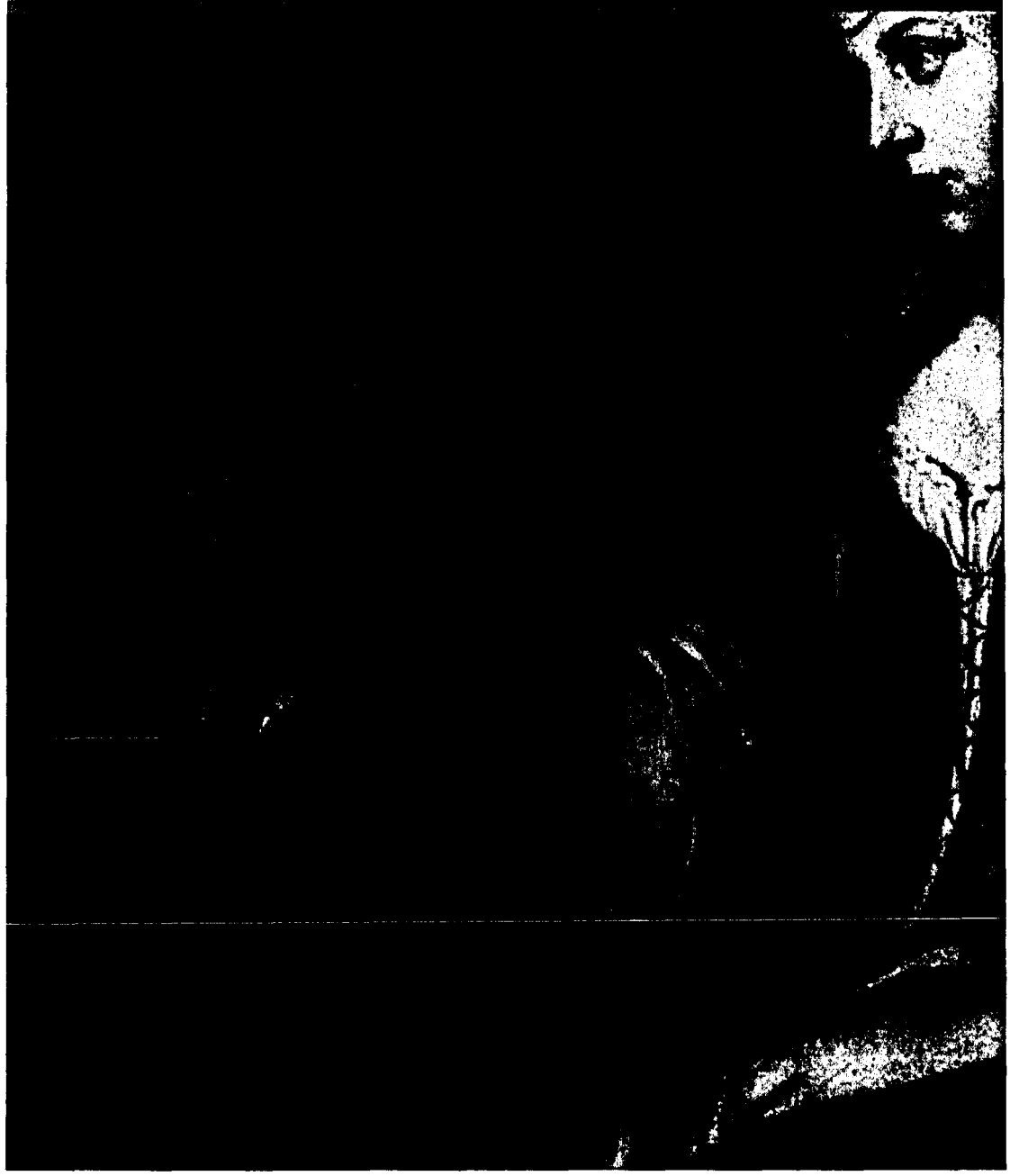

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- respect the right of patients to a second opinion;
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  You should not ask for or accept any material rewards, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

- ***Hospitality***

  You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself.

Signing certificates and other documents

41. Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption that they will only sign statements they believe to be true. This means that you must take reasonable steps to verify any statement before you sign a document. You must not sign documents which you believe to be false or misleading. Similarly, when providing references for colleagues, your comments must be honest and you must be able to back them up.

Advertising – providing information to colleagues and the public

42. If you advertise your services your advertisement must be honest. It must not exploit patients' vulnerability or lack of medical knowledge and may provide only factual information. All doctors' advertisements must follow the detailed guidance in the GMC's booklet 'Advertising'.

Research

43. If you are taking part in clinical trials of drugs or other research involving patients you must make sure that the research is not contrary to the patients' interests. Check that the research protocol has been approved by a properly constituted research ethics committee.

44. You must keep to all aspects of the research protocol and may accept only those payments approved by a research ethics committee. Your conduct in the research must not be influenced by payments or gifts.

45. You must always record your research results truthfully and maintain adequate records. In publishing these results you must not make unjustified claims for authorship.

46. You should read the guidance on confidentiality in research in the GMC's booklet 'Confidentiality'.

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October 1995

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note: numbers refer to paragraphs

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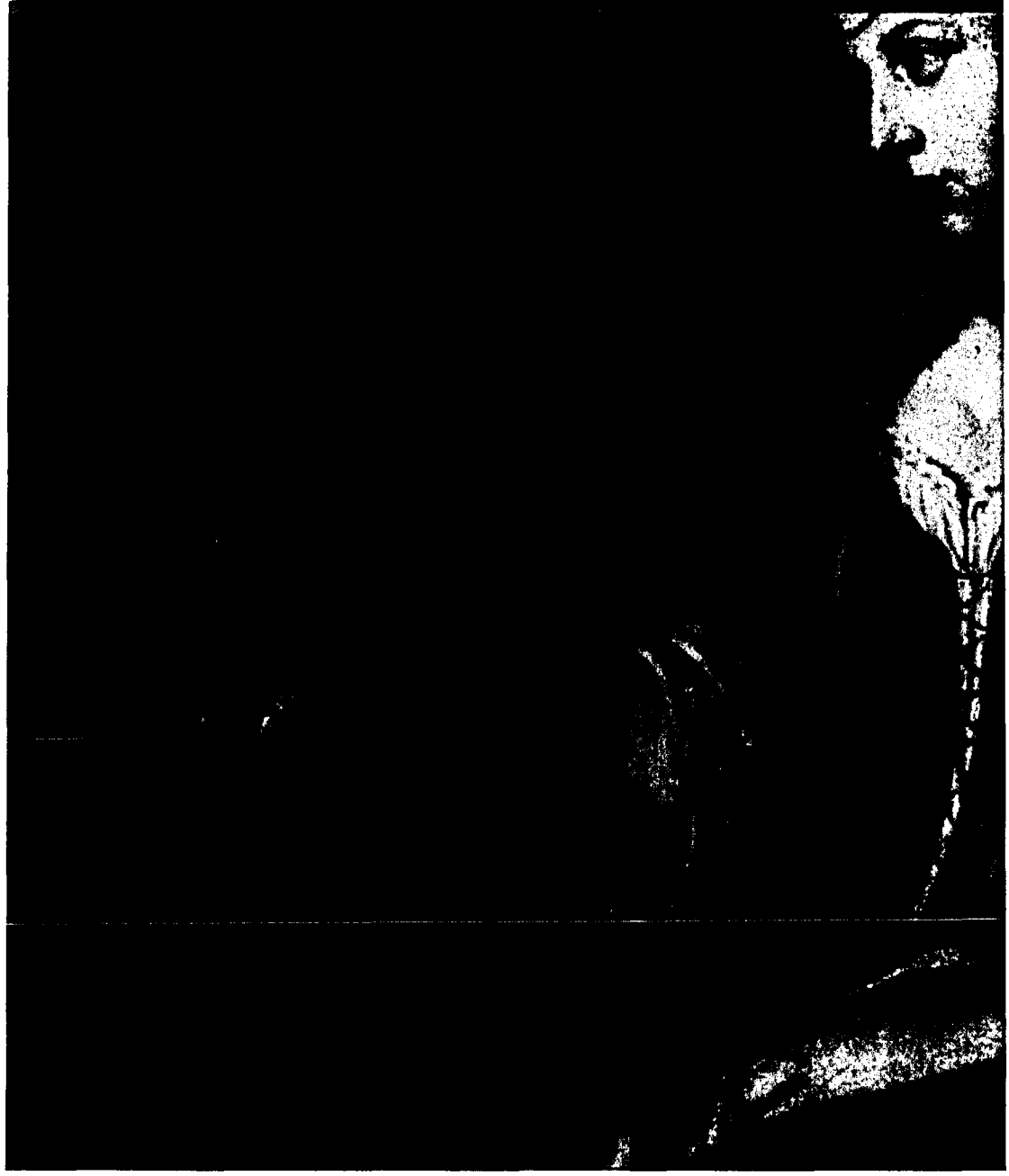

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- ***Financial interests in hospitals, nursing homes and other medical organisations***

  If you have a financial or commercial interest in an organisation to which you plan to refer a patient, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchaser.

- ***Accepting gifts or other inducements***

  You should not ask for or accept any material rewards, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

- ***Hospitality***

  You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself.

Signing certificates and other documents

41. Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption that they will only sign statements they believe to be true. This means that you must take reasonable steps to verify any statement before you sign a document. You must not sign documents which you believe to be false or misleading. Similarly, when providing references for colleagues, your comments must be honest and you must be able to back them up.

Advertising – providing information to colleagues and the public

42. If you advertise your services your advertisement must be honest. It must not exploit patients' vulnerability or lack of medical knowledge and may provide only factual information. All doctors' advertisements must follow the detailed guidance in the GMC's booklet 'Advertising'.

Research

43. If you are taking part in clinical trials of drugs or other research involving patients you must make sure that the research is not contrary to the patients' interests. Check that the research protocol has been approved by a properly constituted research ethics committee.

44. You must keep to all aspects of the research protocol and may accept only those payments approved by a research ethics committee. Your conduct in the research must not be influenced by payments or gifts.

45. You must always record your research results truthfully and maintain adequate records. In publishing these results you must not make unjustified claims for authorship.

46. You should read the guidance on confidentiality in research in the GMC's booklet 'Confidentiality'.

You must always be prepared to explain and justify your actions and decisions.

October 1995

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note: numbers refer to paragraphs

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 4 August 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-SEVEN)

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

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

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

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THE CHAIRMAN: Good morning. Welcome back everybody. Mr Kark and Mr Langdale, the Panel made good use of the time it had yesterday for reading, and I am sure that you both have made good use of your time elsewhere. Are we ready to proceed, Mr Kark?

MR KARK: Yes, sir. Sir, as you know, at this stage your function is to decide, under Rule 27(2), and determine which of any of the remaining facts alleged in the charge and not admitted by the practitioner have been proved to your satisfaction; and that of course is to the criminal standard of proof, so that you are sure – and whether such facts as have been so found proved or admitted would be insufficient to support a finding of serious professional misconduct and you shall then record those findings.

The issues in this case over the many weeks that we have all been sitting here listening to the evidence have become crystallised, and some of the issues which took up many hours of evidence are now so clear that they are hardly worth mentioning. I am not going to even attempt to deal with all the evidence that you have heard, and there will no doubt be witnesses to whom I make no reference at all. I have to try and focus on that evidence which, in the view of the General Medical Council, will most assist you, and it is the evidence that goes directly to the heads of charge which is going to do that.

You have heard a great deal of evidence in this case, some of which might now appear to be somewhat extraneous, and it is worth reflecting upon the charges before turning to the evidence, and the nature of the allegations fall broadly into the following heads. First, the lowest doses of diamorphine and midazolam as prescribed by Dr Barton for specific patients was too high; that the dose ranges of diamorphine and midazolam were too wide; and that doses were administered which were excessive to the particular patient's needs.

The GMC case has not set out to prove that such large prescriptions as were written were written with a specific purpose of hastening death, although on some occasions they may have had that effect. This is not a case in which we, on behalf of the GMC, say that all those patients who entered GWMH went in fit as fiddles and some, we have to recognise, were likely to die there. However, in respect of those patients who were likely to die at the GWMH it is still alleged that prescriptions were in general inappropriately high and wide.

So far as the width of the prescriptions is concerned, that head of charge has largely been admitted, although not in respect of Patients A and K, who we will look at in due course. So far as the excessive nature of the prescriptions is concerned, it is not a complete answer to these charges for Dr Barton to say, "Well I was the one standing next to the patient and therefore I am the only one who can say what the patient needed". You have to look at what reasonable, competent medical practice dictates in any given situation.

The doctor was tackled on this by you, sir, the Chairman, and asked why they did not take the titration approach to find the appropriate level of opiates (Day 31/17), so when one does move on to the syringe driver one has the dose right. She answered,

> "When you saw the sort of doses that some of these patients needed, you would need to escalate the injections quite quickly or you would take a long time to find out what your steady state was going to be".

The difficulty with that answer is the assumption by Dr Barton that she got the amount of opiates right and that the patient needed these very large amounts, and the assumption that

A they were not overstated. Without an element of titration or some similar approach there was no way of knowing.

The doctor also said this about titration, and this was after Panel questions on Day 32/6,

> "Q Are you saying that under your watch titration was simply not being done throughout these three years?
> B A I am saying that. I was not taught it. I was not familiar with using it and it was not practical".

For any medical practitioner who was regularly prescribing opiates that is a surprising and frankly worrying admission.

The next category of charge is that the total amount of drugs prescribed was excessive to the
C patient's needs. Again you will have to consider each individual patient and you will have to take into account not only what is written into the notes of the GWMH, but what was recorded in the notes before the patient arrived there as well as the evidence of the patient's relatives. Dr Barton said this to you, the Chair, at Day 31/18,

> "But if you start from the initial premise that these patients were dying and that that was the process that was going on, then it was perfectly acceptable to give sufficient
> D doses of the drugs to control their distressing symptoms and accept that controlling those symptoms might in some way shorten their life".

That approach raises, in our submission, three central issues. Were all of the patients who Dr Barton thought were dying, actually dying? Secondly, what effect did that approach have on the patient's overall care and treatment? Thirdly, that approach allows for much greater doses to be given than were necessary to govern the patient's pain even applying pretty
E liberal standards of prescribing.

It is a fundamental issue in this case that every time a patient was put on a syringe driver that was, for Dr Barton, for the staff and for the patient, the so-called "terminal pathway" started. When that battery got inserted into the machine and the needle inserted into the patient, that was the beginning of that patient's final journey. Hydration, we know, was not going to happen and that patient was inevitably going to deteriorate and die, and everyone knew that.
F If Dr Barton's attitude can be summed up in those words - she said this,

> "If you start from the initial premise that these patients are dying";

those are the central words – then you may think it says a great deal about what was happening on Dryad and Daedalus Ward under her management.

G There is a charge that both prescriptions and administration of drugs were inappropriate for the particular patient and not in that patient's best interests. We would ask you to pay careful attention to the wording of those charges; that the administration of drugs was inappropriate for the particular patient and not in that patient's best interests. On occasion, we submit, you do not have to look much further than the quantity of the drugs prescribed and administered to these elderly and generally frail patients. For others you will want to examine the claims made that the patients must have been in considerable pain.

H

This, frankly, is a problem for Dr Barton because she made such poor notes that there is nothing on occasion to support her assertions that patients were in great pain or "agony" as she sometimes liked to describe it. If a patient is in agony, then surely that is something that would have been noted by somebody at least. Dr Barton's position though is, "Well, if I look at these prescriptions, the only reason I would have allowed them to be administered or I would have written them was if the patient was in great pain". But that ignores the fundamental force behind the GMC's case which is that here is a practitioner who did just use excessive quantities of opiates, either deliberately or through a lack of understanding.

In looking at whether the prescriptions were or were not in a patient's best interests is not the same as looking into Dr Barton's mind to see what she thought was in the patient's best interests. The fact that there has been a lot of evidence directed at establishing that Dr Barton always had her patients' best interests at heart, does not answer the question of whether or not the prescriptions she wrote out in this style were or were not in fact in the patient's best interests.

In relation to Patient H there is a specific charge that she failed to recognise the importance of the previous alcoholism and consequent liver disease when prescribing her standard "one size fits all" doses. The evidence which was read to you of Gill Hamblin on Friday will bear special attention in this regard, because you may think it became clear from her evidence that actually she had no understanding of the effects of liver disease upon the proper dosage of opiates. In Patient H's case that is an added feature which you will want to consider, and whether any account whatever was taken of his alcoholism when Dr Barton wrote out what was in fact her standard prescription.

The next category of charge is that Dr Barton failed to perform an adequate examination either when the patient's condition changed or an adequate examination prior to prescribing opiates – again those words are important. You may think that there is good evidence that in many cases there was little or no effort made to diagnose properly what was causing the patient's pain, if they were in pain at all, and the easiest option was, on occasion, taken, and that was the option of providing large amounts of prescribed opiates to deal with the pain itself. If you find that there is force in that suggestion, then you may think that Dr Barton's protestation that she always examined the patient fully may sound rather weak.

One also has to bear in mind what Dr Barton's approach to many of these patients was, because she confessed that she had a very pessimistic view of most of these patient's chances of survival. Very often, as we established during the case, her view was much more pessimistic, in fact, either than the hospital which was transferring the patient to the GWMH, or the view taken by her own consultants who were referring patients to a hospital which they knew. So that you may think will undoubtedly have affected her management of each patient, and perhaps the quality of her assessment.

That leads on to the issue of whether she failed to provide an adequate plan of treatment on occasions. There were occasions, you may feel, when there was no real attempt or effort to achieve any form of rehabilitation for some of these patients at all, and the effect of her approach to some of these patients can be summed up in her own words, written as we have seen quite often in the notes, "to sort out analgesia".

Finally, there is criticism which is head of charge 44 that Dr Barton did not sufficiently record the drug regime. Dr Barton has made admissions on all the other subheads within that

charge, but not that one. You may think that although Dr Barton wrote up her prescriptions sometimes with dates and sometimes without, and the prescription itself was clear, what she never did was to make any sufficient note as to the circumstances in which those drugs were going to be administered. There was never any note that we have seen that sets out that drugs were only to be used if the patient has been in considerable pain or an analgesia has been tried first; or the syringe driver is only to be used for certain patients when they become, for instance, unable to swallow; or that a syringe driver is only to be used after full discussion with the doctor, or with the patient and/or with their relatives; or the size of the increments that are allowed and of which drugs. There is an assumption always that both drugs are going to be used together, midazolam and diamorphine. Why? None of these things were recorded.

It cannot be said that they did not need to be because of the great depth of knowledge of the nurses because we have heard from a number of nurses that although no doubt well meaning - some of them were very experienced and all of them were caring - some of them, frankly, had a very limited understanding, for instance, of conversion rates.

In respect of all of these charges you will have to consider whether there is evidence that there were certain practices taking place at GWMH which in reality had little to do with the individual needs of patients but, in the words of one of your Panel members – I think Mr Payne – may have been a "one size fits all" approach. If you find that that was the true position, having considered all of the evidence, then that may take you a long way towards finding the drugs which were prescribed were inappropriate.

Can I say something about Dr Barton's character because you have heard a great deal of good said about Dr Barton from many sources, and I am not going to attempt to undermine or deny that. The GMC does not allege that Dr Barton treated every patient who came under her care in this way, as is alleged in relation to these twelve patients. You know that she is of good character, in the sense that there has been no evidence of any previous finding against her in any disciplinary tribunal, and that helps her. It does not mean that she cannot have acted in the way now alleged; that she may have treated many other hundreds of patients very well. That cannot allow her to escape the consequences of serious malpractice in relation to these patients if you find the evidence supports such malpractice.

If when considering the sufficiency of evidence on the issue of serious professional misconduct, I would say this. Serious misconduct in relation to one patient is still serious misconduct, however many other patients you have treated properly. It may be said, "If she has treated so many other patients well, why would she suddenly have gone off the rails, as it were, with these twelve?" It is important, first of all, to bear in mind that these charges do not just relate to one patient. They relate to twelve. If you find that the failings were serious, then you can find that she has gone off the rails, as it were, in relation to these patients.

These failings are not one-off failings. They are serious failings over a three year period. That is despite the warnings that she had had five years before these events which you are considering.

Many people have told you many good things about Dr Barton: Dr Briggs, Margaret Couchman, Philip Beed, Lynn Barratt, Dr Banks – there is a long list. All said good things about her practice and about her as a caring person.

All of that evidence, though, cannot overcome the plain fact of these prescriptions, of the lack of notes, the lack of assessment as patients deteriorated unexpectedly, the lack of a plan to deal with the source of the pain rather than simply the pain itself, the huge starting doses, the huge width of prescriptions. However caring and compassionate Dr Barton is undoubtedly capable of being, it is clear that there are elements to her contact, which make her a very practical and down to earth person – a person who called a spade a spade and who could be pretty blunt according to many. You may have formed the view, having seen her give evidence of a long period of time, that she is the sort of person whose mind, once made up, is not going to be easily changed. In this case, with these patients, despite her good character, that may have proved to be a serious failing.

As I have said, there are certain themes in this case which I am going to have to lack of briefly: the work or overburdening of Dr Barton, for instance, and the change in the nature of patients during the course of the 1990s; the issues which were raised in 1991 and what relevance they had to the charges which Dr Barton now faces; the acceptability generally of anticipatory prescribing and the necessity of providing the dose range and the acceptability of the ranges prescribed by Dr Barton; the autonomy of the nurses and whether or not they were able to start and increase doses by syringe drivers; the use or lack thereof of rehydration. All of these issues will need to be examined by you and some, frankly, will take you less time than others.

You have to bear in mind whatever those surrounding issues are, that the most important document you have in this case at this stage is the heads of charge. That is the cornerstone of the case and it is a document to which you will need to revert repeatedly.

Can I deal very quickly with the issue of hydration. It will not take me long because there was not any in relation to any of these twelve patients once the syringe driver had started. These patients were all on the terminal pathway once that needle was inserted. Had there been any hydration by way of subcutaneous infusion, it would have been written up. We know that there was no capability of intravenous hydration at the GWMH. There is no note of subcutaneous hydration having happened. Without hydration, the patients are inevitably going to deteriorate, lose consciousness and die. That is perhaps all I need to say about that particular issue. It follows that realistically, therefore, the use of a syringe driver was always ultimately going to lead to the death of the patient.

Let me deal very briefly with the issue of poor note-making. Dr Barton has accepted significant failings in her note-making. She says, however, that none of her patients suffered as a result. Indeed, she says that they would have suffered had she made proper notes because then she would not have been able to devote her time to the patients themselves.

The GMC simply does not accept that as a proposition. She accepted in evidence the importance of making a note of assessment and the diagnosis of a plan of treatment. She told you that in terms of new patients, she would attend at lunch time specifically in order to clerk the new patient in. If that is right, then it is surprising that she claims not to have had time to make notes in those circumstances which surely would have taken just a few minutes to write up.

Her explanation for the lack of notes on first assessment came rather late in the day when she was being asked questions by me after Panel questions. This was Day 32/4. She said this:

A

> "...we did not write out a formal plan at the time of arrival, because we needed a few days to get to know the patient, for the patient to get to know us, and particularly for us to meet the relatives and find out what their expectations and aspirations were."

If that answer was true in explaining why the initial plans of treatment were poor or non-existent, which we I am afraid suggest is not true, it is surprising that Dr Barton felt the need to have a few days before writing up an appropriate plan of treatment but did not need a few
B days to get to know the patient before writing up these enormous variable doses of opiates.

As significant is the time when Dr Barton made changes in the patient's drug regime, that there is nothing in the notes to demonstrate why that was taking place. Also significant were those occasions when Dr Barton set the patient off on what we have decided to call the "terminal pathway". Still there is no note very often being made about that at all.

C I am going to turn briefly to Professor Ford's evidence about note-keeping. What I am going to do on each occasion is to try to give you the day and the page. I am not going to ask you on any occasion to turn up the transcript. You will in due course, like it or not, have a transcript of my speech and you will therefore be able to find the references in due course if you want to check them. This was Day 20/8. I asked Professor Ford:

> "Q We know that Dr Barton was practising not only as a clinical assistant at the
D hospital, going in every morning, but also acting as a GP and treating patients, presumably during her daily practice, but she was going into the hospital on an almost daily basis. Does that in any way lessen or increase the necessity to make notes about the patients that she was caring for?
> A I cannot see the frequency of contact is the issue. Other doctors were still being involved in the management of patients in the care of Dr Barton and the responsible consultant. I think the other reason to make notes is for your own records.
E To carry around in your memory when you have a very large number of patients under your care, exactly what you did and why you did it, is very difficult. One often has the experience of looking back over a set of notes of a patient you managed six or twelve months ago and you find it is often not what your memory was. Because we are so busy and see so many patients, the medical records act as the basis of what you did. There is an aphorism that we tell our junior doctors, that if you did not write down what you did, there may be the assumption that you did not do it. It does not
F mean that you did not do it, but if you did not write it down, it is very difficult to remember exactly what you did do."

Then, Day 20/33, he dealt with the relevant examination on assessment. He said this:

> "You would summarise what their main problems were, what the plan for their admission to that hospital ward was and check that their drug therapy was appropriate
G because that has to be prescribed anyway. That process would take, it depends on the patient and it depends on the experience of the doctor involved, but 20 to 30 minutes would be a reasonable amount of time for most patients. Clearly, if the patient was not straight forward, it would take longer than that."

Dr Barton herself accepted how important it would be to make a note if she was deciding that the patient was entering the palliative care pathway – Day 29/3. She has accepted repeatedly
H that no such note was made by her. Sometimes the only note that we see from Dr Barton to

A give us a clue as to what is to happen to patients are phrases such as, "Please make comfortable"; "Sort out analgesia"; "Happy for nursing staff to confirm death".

Finally on notes, I ought to say something about the nurses' notes. I suggest that caution is needed. I am not going to suggest that nurses have not written down what they genuinely believe, or that notes had been deliberately falsified to assert that pain was present when it was not. However, there are a number of occasions when a note is made that a patient is B agitated or distressed, and that has been interpreted repeatedly as meaning, either by nurses or by Dr Barton now, as meaning that that patient was in pain. One has to be cautious about that. Agitation and distress may be caused by a number of things we have heard. In the case of Gladys Richards, it may be that she needed to go to the lavatory. In the case of Elsie Devine, it may be because of her dementia rather than pain. So when a nurse has interpreted a note as meaning that the patient was in pain, unless the note specifically says so, you may want to exercise caution before automatically accepting that agitation and distress, by way of C example, was caused by pain.

Let me say something about the change in the nature of the patients during the course of the 1990s. It is well established by evidence, you may all think, that there was a change in the nature of the patients this hospital received in the mid- to late-nineties. The hospital was apparently not unique in that happening. How much does that matter, and what difference does that or should that make to your consideration of the evidence? The question is whether D the change in fact affected the patients' standard of care and did it affect Dr Barton' approach to her patients. You may find the answer to those questions in the answers that she gave you. If Dr Barton was so overburdened by work in the late 1990s that she could not properly care for her patients – and I am not seeking to escape from the fact that there was clearly such a change – but if it was such that she could not properly care for her patients, then it was her duty to bring that formally to the notice of the Trust.

E That, though actually is not her case. Dr Barton has not said to you at any stage either that she could not perform her duties properly or that patients were suffering as a result. She does not say that her defence to any of the charges that she faces is, "I was forced into this position because of the burden upon me." That is not, and has never been, her case. Her case is, in fact, "There is nothing wrong with anything that I did in relation to these patients which I have not admitted."

F Dr Barton was asked about this during the course of Panel questions by Ms Julien – Day 31/2. You may think she was given every opportunity that could be given to her to say, "Well, on reflection, now that I look at the pressure that I was under, I do wish that I had done things differently." What she was asked was this:

> "Q ... In retrospect, would that still be your answer in terms of all the cases? Would there be anything you would do differently?
> G A In the case of those 12 patients?
>
> Q Yes.
> A In the days and hours of their dying, I would have done nothing differently.
>
> ...

H

Q So you would not have adjusted any prescription, you would not have referred a patient or asked for a second opinion.
A No.

Q In none of those 12 cases.
A No.

...

Q Okay, putting aside Professor Ford ... is there anything now you have been going over these cases where you think, "Oh, well, maybe I should not have quite done that like that"? Is there anything?
A Nothing at all."

Those answers reveal a woman of absolute conviction, not a woman worn down by the pressures of her job or the exigencies of the situation in which she found herself. She is certain of her decisions. The letter which she wrote to Dr Reid, which you now have as Exhibit D6, and the exhibits thereafter – I am not going to turn them up – you have to bear in mind that that was note written, and that string of correspondence was not started, until January 2000 when there was apparently already a police investigation into attempted murder. This may look as if Dr Barton is trying to shut the stable door well after the horse has bolted. Why were there no letters like that prior to 1999? Why did it take a police investigation to bring about this period of soul-searching and formal concern?

When issues were raised by nurses about the practices of GWMH in 1991, they were not met then with any soul-searching. They were met, as one told you, by a brick wall. Sister Joines was asked extensively about the change in the nature of the patients received by GWMH and the increased workload that that entailed, but she insisted – this is Day 33/26:

"A ... I must point out I had an excellent team of nurses. ... but I never found that the extra workload affected my nurses' care in any way at all."

As you know, and Professor Sikora confirmed this, Day 34/22, the changes in the style of the patients or the ailments of the patients coming to GWMH were not actually unique to Gosport in the late nineties. They were happening up and down the country. Clinical assistants in Dr Barton's role were having to deal with these problems across the UK. Dr Barton was asked about this issue, Day 28/64. I think this was in cross-examination.

"Q What you are telling this Panel is that, although the amount of work you had to do with the patients was greater than it had been before, the actual management of the patients did not suffer.
A I hope not.

...

A

Q Yes. If you had had more time ... would it have affected your management of any of these 12 patients?
A No. ..."

Then at Day 28/83:

"Q Are you saying in relation to any of our 12 patients that you started them on
B opiates or you prescribed opiates earlier because of inadequate staffing?
A No."

Day 28/83. What about the transfers from other hospitals? We have heard much evidence about patients being described as being in one state – and I am going to use the acronyms, if I may – at the RHH and QAH and being in a worst state on arrival at the GWMH. You will have to consider that issue first of all of whether other hospitals were transferring patients
C before the patient was ready. Rear Admiral Farquharson-Roberts denied it on behalf of the Royal Haslar Hospital, the RHH, but said that it might be happening at the QAH. Mrs Mansell picked up the point that, if a patient was too ill for rehabilitation and they needed palliative care, why not simply say so. If that was happening however – and we do have examples in this case where it seems to have happened – you may think that it makes the assessment and the treatment of the patient even more important, not less so. If a patient is arriving in a different state to that which they ought to be arriving in, then an assessment is
D crucial and it is not a passport, you may accept to higher prescriptions.

There were many sources of evidence who spoke about the difference in the state of the patient from one hospital to the other but, at the end of the day of course, you have to focus on these 12 patients and to see what evidence there is in respect of each of them of that happening and, if that did happen, what effect it would have in this case. As I say, if the staff at GWMH found that the pre-transfer assessment was unrealistic, then there must be a duty to
E re-evaluate, to note it and to re-plan. It may be that that patient has simply been affected by the transfer itself; not necessarily an over-optimistic view at the first hospital but, as we heard, the transfer itself, can have an effect and the patient may just need a day or two to recuperate. Dr Barton herself spoke about this and said this was one of the reasons for not doing an assessment immediately and I will just repeat her phrase, Day 32/4:

F "We did not write out a formal plan at the time of arrival because we needed a few days to get to know the patient and the patient to get to know us, to meet the relatives and find out what their expectations and aspirations were".

You will have to ask yourselves, were patients being given the opportunity of demonstrating what their true condition was or were they in reality being pigeonholed almost as soon as they arrived? For each patient for whom a syringe driver was written up on arrival, you may think that their initial assessment set the course for their treatment thereafter and Dr Banks told
G you, Day 15/68, that one must build in a safety margin from the transfer in making an assessment and that whatever course of treatment must be well worked out. You have to ask yourselves in relation to these cases, was that in fact happening?

May I deal with the issue of 1991. Whatever attack or criticism is levelled at the nurses who gave evidence about those issues – and we will look at their evidence briefly in a moment – the fact remains that those issues which are set out in your panel bundle 1 at tab 6, page 2 –
H and I am not going to ask you to turn it up again; I do feel (and I hope I am right) that we all

A know quite a lot of this documentation so well. The fact remains that those issues, which were raised five years before 1996, when the first of the patients you are considering were treated at the GWMH, mirrors much of the problem we are now dealing with.

The reality is that there is no evidence from any source that practice has actually changed as a result and whatever can legitimately be said to denigrate the evidence of Nurse Hallman or Giffin or whoever, the fact is that those nurses were raising concerns about very similar
B issues to those which you are now considering and those concerns were never resolved. Dr Barton told you, Day 29.5, when asked:

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

Let me turn up a little bit of evidence. Sylvia Giffin, Day 13/88-89, said that Sister Hamblin
C encouraged the use of syringe drivers and that, prior to her coming to the unit, we rarely used them and, after that, they escalated. Most patients were going on them even when not in pain. They were used as a matter of course, not need. The decision to place patients on them was Dr Barton's. She said that the dosage of diamorphine would increase automatically and she said, "Eventually, I gave up complaining".

Beverley Turnbull, who gave evidence on Day 14, remembered the disturbance in the staff
D about syringe drivers in the early 1990s. She said, "I shared those concerns". She attended the meetings in October 1991. She said, "Steve Barnes, the RCN officer, became involved because we felt that we were not getting anywhere. We were labelled trouble makers. No protocol was devised as a result. No one at the meeting put their hand up to say, 'hang on'" and that was in relation to questioning the amounts of diamorphine. "We were banging our heads against a brick wall". She accepted that all staff had great respect for Dr Barton and she said, "I am still of that view". She said,
E "I shared the fear that it was becoming routine to prescribe diamorphine to patients who were dying regardless of their symptoms. I did not tell Sister Hamblin of concerns because I felt she would not listen to us".

Beverley Turnbull told us that, after Dr Barton left, doses of syringe drivers changed. Patients would have intramuscular morphine and were then reviewed. The parameters of the syringe driver would be set up; doses are much lower now. In 1991, there was a difference of
F opinion between the day and the night staff re syringe drivers and, by 1996, all the earlier concerns had been dealt with. She said that it was possible that patients were comfortable at night but not comfortable during the day. She said, "After 1991, I think I just accepted what was happening. I think that the process of complaining was threatening to some of the staff. I think that things did get better afterwards and other nurses accepted the situation".

Anita Tubritt also told you that she shared concerns in 1991 about diamorphine being
G prescribed indiscriminately; this is Day 15 of the evidence. She said that concerns from 1991 had been resolved by 1996. Initially she said that her training was not adequate. I was being asked to deal with complicated patients with syringe drivers and no training. I thought then that diamorphine should only be used for pain but Dr Logan explained that it can be used in other circumstances.

Beverley Turnbull, Day 14. She was the nurse who specifically made the comment about the
H feeling that they were banging their heads against a brick wall.

The issues in 1991 are important, we suggest, in the following ways. First, to demonstrate that the practice adopted at GWMH by Dr Barton of anticipatory prescribing was unusual enough for experienced nurses to be very concerned. Secondly, that the practices were recognised by some to be wrong at a relatively early stage. Third, that concerns were raised not just with management but with Dr Barton herself. Fourth, that the practices were so entrenched and, despite being challenged and ultimately accepted by the nurses, it did not lead to any internal review and it did not in fact lead to any real change. It led to a change in the nurses' perception but it does not appear to have led to a change in the reality of what was happening. You may think that here was a perfect time to reflect upon the practices that Dr Barton had by then adopted. It was a perfect opportunity to resolve to speak to someone outside this small hospital to ask for advice, but the only people who received any extra training appeared to have been the nurses themselves. Dr Barton herself did not receive any further training and no one reviewed her practice. Dr Logan of course was part of the system.

When the defence thereafter put to nurse after nurse, "You would not have administered these drugs unless content that they were appropriate", and more often than not, in fact I think on every occasion, the nurse accepted that is to ignore the plain fact that, when the practice actually was challenged by the nurses, it had no affect whatever and things went on as before, and drugs were administered in circumstances where all of the guidelines, the *BNF* and the Palliative Care Handbook, were in fact being fundamentally breached, but no one from the consultants to the pharmacist to the nurses did anything about it after 1991. Whether or not the nurses retained their concerns or whether those concerns were resolved you may think does not matter a great deal.

Professor Ford on Day 24 was answering, I think, Panel questions and he said this about the broader institutional responsibility. He said:

> "I have not been asked to do a review, as Mr Langdale pointed out, an inquiry into what happened, but in my opinion there is a broader institutional responsibility for what was happening and where you place that is a judgment. I think in my opinion – and I am trying to be very balanced about this – to say Dr Barton wrote the prescription and therefore that is the end of the matter in terms of responsibility is somewhat of a narrow perspective on the care of patients over a number of years. There were clearly other people that were aware of this prescribing practice. Senior nurses were and a consultant was in at least one case".

That must have been Dr Reid,

> "Pharmacists would have been reviewing the use of diamorphine and midazolam. I think it is worth pointing out that this prescribing – I have never come across such wide and high prescribing of opiates and from talking to other people, I am not aware of it happening anywhere else. So it is not at all a usual practice and you could argue from that that it should have triggered someone to question it".

The difficulty is that, in 1991 when the practice was questioned, the questions came to nothing. Dr Barton, in her evidence, Day 29/3, explained it in this way:

> "I think the issues were quite different in 1991. The issues were difficulties between existing night staff and a new day sister, and attitudes towards care of patients at the

A end of their lives".

The reality, you may think, is that the issues were in fact almost the same: (1) patients being diamorphine who were not in pain; (2) no other forms of analgesia being considered; (3) the sliding scale not being used appropriately or at all; (4) each patients' needs not being considered and the drugs being used indiscriminately – how close to one-size-fits-all is that? – (5) patients' deaths being hastened unnecessary; (6) no titration or adjustment of doses to
B suit patient needs; (7) too high a degree of unresponsiveness sought from patients.

You may think that all of those issues were in reality mirror images of those which you are examining now and it really is something of an indictment of the system that these specific worries having been raised in 1991 and the practices which led to them were in fact allowed to continue until 2000 when Dr Barton resigned following the complaints and the police investigation.

C

Let me turn to the issue of the acceptability of anticipating prescribing and the necessity of providing a dose range. First of all, unless there is any doubt about it, no one challenges the necessity and pragmatism of anticipatory prescribing generally. It is apparently widely practised and it is a necessity in many parts of the NHS. What is attacked here is the method by which it was done at the GWMH and the doses themselves.

D Professor Ford said this, Day 20/9:

> "... what about anticipatory prescribing with opiates? Professor, is that something you would do in your own practice or have done in your own practice, or not?
> A There are two issues. There is the need to prescribe variable doses of morphine to people who require opiate analgesia. So you would put a range of morphine, for example, or another opioid analgesia to be prescribed within, usually, a not-too-wide
> E dose range, and there is the issue of patients who are expected to require opioid analgesia where there may not be a doctor available to write the patient up for that. Clearly, in most acute hospitals, or any hospital with a resident doctor, this is not an issue ... The issue of anticipatory prescribing in other settings really depends on the consideration of the risks and benefits, and the problem with anticipatory prescribing for opiates, in terms of in a non-acute hospital setting, is that there would have to be expected deterioration in a patient that was going to require opiate analgesia. It would
> F be in that context. This would typically be somebody who was already on moderate analgesia and you might reasonably prescribe PRN as required morphine – that would be the standard oral drug to use – in a narrow dose range, but I think I had never come across before anticipatory prescribing of wide ranges of subcutaneously infused drugs. Even in palliative care settings, my understanding, through talking to palliative care specialists, is it is not at all standard practice for palliative care units to have anticipatory prescribing with wide ranges of opiate and sedative drugs".

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Mr Payne asked Dr Barton about this issue of anticipatory prescribing on Day 31/4:

> "... there were times when you wrote the anticipatory prescription on the day [of arrival]".

H

A

> A Because it was obvious that they were not going to be ... rehabilitated. They were really very seriously ill even when they arrived, and I was looking at them at some stage in the future needing palliative and terminal care".

Dr Barton claimed that these patients were out of the ordinary. She said, "They were out of the run of work we did on the ward", Day 31/4, which is why effectively she said she managed them in this way but, quite frankly, that was not a true claim. First, there was
B nothing which stands out about these particular patients and their variety of ailments, some serious and some less so. She accepted, when I re-examined her after Panel questions, that these were not by any means the only occasions on which she had written up these type of prescriptions. When you look at this broad range of patients which you have before you and then you realise that Dr Barton wrote up very nearly the same anticipatory dose for each one, not quite but almost, you quickly realise that this was a system which took little account of the individual needs of each patient. It was, although she denied it, a one-size-fits-all
C approach.

Sister Joines told you that in her view syringe drivers were never inappropriately prescribed, nor was diamorphine (Day 33/19). You may think that there were a number of nurses who were extremely loyal to Dr Barton and who worked within the system with which they either wholeheartedly approved or, frankly, had become inured to over time. Sister Joines also repeated the evidence that others had given that some other doctors were not prepared to
D prescribe stronger analgesics (Day 33/21) in the way that Dr Barton was willing to prescribe them, although later she told Mr Payne, (Day 33/34) that no doctor ever refused to come in and give what was necessary when it was necessary.

You may think that it is unfortunate, perhaps, that more heed was not paid to those doctors' views who were unwilling to dole out heavy analgesia in the same manner. It seems therefore that Dr Barton felt it necessary to ensure that there could be circumvention by the
E nurses of the wishes of other doctors and, to that end, she did to a certain extent hand control of the syringe and its contents to the nurses who she knew and trusted.

Sister Joines again, Day 33/23,

> "We would never start a patient on a syringe driver without a relative's consent".

F Well that, quite frankly, is obviously not right. She went on,

> "Obviously the outcome inevitably was death".

She said,

> "It was Dr Barton's assessment which always set the tone for a patient's treatment".

G

You may think it is very noticeable that whatever Professor Sikora was able to say on Dr Barton's behalf, the defence have not called before you any expert who has examined these notes and these prescriptions and is able to say that in his or her view they represent an acceptable practice. You may think that if there were such an expert who could be found, they would have been called.

H

Professor Sikora is an eminent cancer specialist, but he was not asked to look at the treatment meted out to these 12 specific patients. That no doubt was a deliberate decision, but it leaves Dr Barton bereft of any expert opinion which supports her management.

How safe were these prescriptions in the hands of these nurses? That may depend on their attitude and what they felt was the purpose of their wards. Lynn Barrett told you (Day 10/75-6) that they seemed to get the patients that no one else wanted. They would, in her words, have been "dumped" – and those are words that have come back into play on a number of occasions.

Anita Tubritt, Day 15, said,

> "It felt that we were taking patients that other hospitals did not want. Some were in very poor condition when they arrived and some very close to the end of their lives".

Dr Tandy told you, Day 18/30,

> "Dryad Ward was for patients too frail to go into nursing homes, patients who we would generally expect would not have a very long length of life".

What about the issue of nurses effectively being delegated the responsibility of starting the syringe driver, which in at least one case – the case of Mr Cunningham and the syringe driver being started at 10 past 11 at night – we know really must have been a nurse decision.

Professor Ford said this about that practice, Day 20/37,

> "We have already talked about the fact that nurses need discretion to adjust the dose of opiates when you are giving morphine. The issue is well accepted that nursing staff had discretion about the use of opiate drugs. That is a principle you would find throughout most practice in the NHS. However, the issue around delegating the decision to commence subcutaneous infused potent drugs, such as morphine and midazolam, I think is very different. Most people would not think it desirable to delegate that in the first instance. If one was going to, one would need a clear protocol that it was absolutely clear that nurses understood when they should move to giving subcutaneous drugs and what doses they should use if you have a dose range".

Of the decision to start a syringe driver, he said,

> "I would say that should be a medical decision by the responsible doctor".

He was asked this, Day 20/38,

> "What if the suggestion is: "Well, we had to leave that decision on occasions open – the decision to start the syringe driver – because the patient might suddenly find themselves in pain and they would need immediate relief, and Dr Barton might not be there over a weekend", or something of that nature? Does a syringe driver necessarily deal with that situation?
> A To me that is not a very strong or sound argument because, as I indicated earlier, when you give a syringe driver, you are giving a continuous infusion and it takes a while before the effect of that has come to what we call a steady state, because it takes

A

a while for it to build up, if you made a change in the equivalent dose. I can see the situation of somebody at a stage due a dose of oral morphine, they now can no longer swallow and you can see they are not going to have any opiates, that it would be appropriate to give some opiate to ensure they remained pain-free. I think we would all recognise the importance of that. But that opiate could be a single subcutaneous injection, which would last for four hours, and I think, from my understanding of the cover at the Gosport War Memorial Hospital, it would not be unreasonable to expect a

B

doctor, at any time of the day or night, to be able to respond within four hours. So I do not see the very strong logic for needing to move to subcutaneous infusions as opposed to giving drugs by a subcutaneous route".

That is all I wish to say about anticipatory prescribing. I am turning to a new topic, unless you wish to take your break now.

C

THE CHAIRMAN: How long will the new topic take?

MR KARK: Around four minutes. I shall endeavour to speed up a bit. It relates to the *BNF* and the Wessex Protocol. I can say I am going to be very short with this because I am not going to take you to them, and frankly I am not going to insult your intelligence by taking you through once again the *BNF* and Wessex protocol. You know them so well by now. I did it when I opened the case. We have looked at it with many of the witnesses and we

D

went through it with Professor Ford. Suffice to say we have not found a word of support for Dr Barton's practice, and she has not been able to point out any single guidelines ever written which support her prescribing practice.

There is clear and specific guidance set out in relation to palliative care, the use of opiates generally and the use of opiates in the elderly who are considered to be particularly sensitive to opiates, and a specific comment in relation to the use of opiates in those with liver damage

E

or renal impairment through alcoholism. You know what the guidelines say and they are there for your personal perusal when you retire to consider your decision.

The reality is that whatever the guidelines say, it was not going to affect Dr Barton's management of these patients or her prescribing policy. We know that she kept a copy of the *Palliative Care Guidelines* apparently in her pocket, but the fact is that despite her relative lack of training, she made a positive decision not to apply the guidelines contained therein.

F

With small fluctuation on one occasion, she gave pretty much the same to all, whether the patient was old, young – or younger – fat, frankly, thin, alcoholic: these patients all got opiates with a wide range and, we suggest, potentially dangerous doses with no special instructions to any of the nurses in any of the cases. So I am not now going to spend time going through the guidelines. I am going to take it that in general terms you know the principles.

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For reference can I tell you this? I went through the guidelines with Dr Barton at Day 28/71. She said this,

"My philosophy in those days, working as a general practitioner and visiting a community hospital, was that I would go in at a higher dose in order to give adequate pain control sooner and then reassess the dosage".

H

Dr Barton accepted that she was well aware of the guidelines, and accepted, Day 28/73, that the danger was that if you went outside the guidelines you would end up over-sedating the patients. Importantly she was also aware, apparently, that mental confusion was a recognised adverse reaction to opiates (Day 28/78). That was also spoken about by Professor Ford. Let me just turn that up very briefly. It is Day 20/18. He was asked this:

> "Q This is an important point, and I think Dr Payne [I do not know if that is a promotion or not] raised this with Dr Reid last week, which is the question of the potential side effects of opiates and the point about whether more opiates cause more side effects. What do you have to say about that?
> A The first thing I say is that opiates are not a treatment for restlessness or confusion. The *BNF* says that, the Wessex Protocols will no doubt clearly state that. Opiates are a treatment for pain and may help restlessness where it is the context of pain. They are not a treatment for confusion per se. If you have a patient who has opiate induced confusion or restlessness, clearly if you give them more opiate that is not going to help the problem, it is, if anything, going to exacerbate it".

That was one of the adverse reactions quoted in the *BNF*. When I asked Dr Barton about the principle of reducing the dosage, for instance by 50 per cent of the adult dose for elderly patients, she gave a surprising answer at Day 28/79.

> "Q ... again is that a principle which you applied in your practice?
> A No.
>
> Q Why not?
> A I applied the principle of what I felt was an acceptable starting dose for the drugs that I was familiar with in this very specialised corner of prescribing".

We will look in due course at the occasions when I suggest that she had effectively ignored the *BNF* within the ranges, but it was at times as if she felt that her particular corner of the Gosport Memorial fell outside the run of the mill and that the guidelines did not apply to her because somehow either she or her patients were an exception. We submit that they were not.

I am going to get on next to the role of the consultants and perhaps that would be a convenient moment to break.

THE CHAIRMAN: Very well. We will return at five minutes past eleven.

(Adjourned for a short time)

THE CHAIRMAN: Mr Kark?

MR KARK: Sir, first I was asked to correct one matter relating to Sister Joines making the comment that they always got a relative's consent. In fact it was pointed out in the nursing notes that they do reveal that on Daedalus Ward there is a note that consent was obtained from relatives, although in fact you will remember that in respect of both the Stevens and Mrs Richards, the relatives themselves said that they had not been spoken to about the syringe driver before it was started. Mr Langdale properly points out that where there is a

A comment in the nursing notes my comment in relation to Sister Joines was perhaps going too far.

In my desperation to finish my last comments with my colleague having his stop watch out I did not say one thing in relation to Professor Ford. This was Day 20/6 in relation to the *BNF*. He said,

B

> "The *BNF* is, I think, probably one of the most used books by any practising doctor. It is a very valuable source of information about drugs, what their indications are, what the potential side effects of drugs are, what the appropriate doses that should be used are and it is laid out into sections about different groups of drugs with some general sections on prescribing in certain settings, such as children, the elderly, palliative care and the like.

C

> Q One of the pieces of evidence that this Panel heard, I think it was from a doctor who we will be referring to as Dr X, was guidelines for narrow minded people. First of all, *BNF* is a protocol or a guideline?
> A It is certainly not a protocol. It is a source of information which gives you guidance about the use of drugs. In a way it is not a guideline because guidelines are generally considered to be documents that outline general management of specific conditions. I have during my professional career had quite an involvement in the

D

> development of guidelines. I was a member of NICE and the British Hypertension Society Guideline on Hypertension, I have also been on a number of stroke guideline groups at both national and European level, so I am aware of the difficulty in crafting good guidelines. An important principle is that guidelines do not apply to every patient. What they do is they provide a framework of care based on evidence which should be looked at by doctors as the basis to underpin their practice".

E He went on to say that patients do not always neatly fit into the guidelines. I will turn also to what Professor Sikora said about that in due course. I was now going to turn, again I hope briefly, to the role of consultants, Messrs Reid, Lord and Tandy. You may think that certainly Messrs Reid and Lord must have known that there was anticipatory prescribing going on and that the prescriptions were sometimes wide ones. Both, you may think, certainly Dr Reid, must take a degree of responsibility for failing to control it or to put a stop to the very wide ranges.

F

Dr Reid, it appears, even had a hand in the protocol or the draft protocol, which looked at one time, in 1999, as if it was going to give Dr Barton effectively carte blanche to write these wide prescriptions of the type that we have seen. Dr Reid himself denied that that ever came into existence. That was Exhibit D5.

There was a protocol which speaks of a starting range of between 10 and 40mg. That is

G within D5. It is not from 20 to 200 mg. You will have to consider that. Barbara Robinson was plainly fairly sure that Dr Reid did know about the so-called agreed protocol which speaks in D4 of Dr Barton regularly using a 20 to 200 range. You may think it is safest to assume that he, Dr Reid, did know about that. The fact that he did not challenge what was plainly inappropriate does not, in our submission, make it appropriate. That they were plainly inappropriate prescriptions is clear because they are, frankly, potentially dangerous and that has been admitted. Dr Reid should undoubtedly have said so.

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A It sounds, you may think, as if the relationship were not the usual one between a consultant and a junior doctor. As Dr Reid readily conceded, Dr Barton had greater experience in this field of palliative care than he did. Equally, the pharmacist who we are told looked at the prescriptions, did nothing. That does not make these prescriptions any safer or better. It may simply demonstrate that there were failures across the board at this particular hospital, but at the end of the day Dr Barton cannot, with respect to her, escape responsibility by pointing to the failure of others to correct them. These were her prescriptions. She was an experienced B doctor. She was effectively, we say, ignoring well known guidelines and her attitude was that this was her hospital, her wards, her nurses and her patients.

I turn to the issue of the police statements that you have. I described those previously as self-serving and carefully crafted. You will have to consider what is the relevance of them now.

Dr Barton does not now have a recollection of these individual patients in general, but she C does seek to justify her prescriptions by saying on a number of occasions that the patient concerned was in great pain. Before you accept that evidence you will have to consider what she told the police abut what she could actually remember of these patients. When she was interviewed, at first she chose to answer no questions and instead she responded with the statements that you have got. If you look at those again you will find her phrase, "I anticipate that", throughout those statements.

D What in fact Dr Barton is saying is that, because the prescriptions and the administration of these drugs was so great, she would not have written them or ordered them to be administered unless the patient were in great pain. But the notes do not in fact bear that suggestion out, nor in many cases does the lead-up to the administration of those drugs, either at the previous hospital or at the GWMH, nor in many cases does the recollection of those nearest and dearest to those patients bear that out. We would ask you to examine those claims now made by Dr Barton about any specific recollection that she does have about patients being in great E pain with great care before you accept them.

As Dr Barton told you, at Day 29/7, she would not and did not leave anything significant out of those statements which she could then remember. There is no reason to mention that her memory now is any better.

And so when you read in the transcript Dr Barton claiming that a patient was in great pain, F what she is really saying – you may think and it is a matter for you – is, "I cannot justify these prescriptions in any other way, other than saying this patient was in great pain because otherwise I should not have done what I am alleged to have done."

Can I turn to the expert witnesses. I have just a word or two about those before I turn to the individual patients. It may be suggested to you – I do not know –that Professor Ford approached these issues as an academic looking down upon these proceedings and those G administrations of drugs from some sort of ivory tower. That is not, we submit, the case because Professor Ford is a clinician with a current clinical practice. He dealt with his won experience at Day 20/3 at the beginning of his evidence in chief.

> "A Following my training in general medicine and geriatric medicine, I was a senior registrar in geriatric medicine and general medicine from 1989 till 1992."

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Then he was appointed as senior lecturer in clinical pharmacology and geriatric medicine. He was at the time at the Freeman Hospital in Newcastle. He said:

> "My practice at that point was, like many geriatricians, even though I was an academic, quite busy. I did acute medical takes on a one in nine basis, a rota through most of the early 1990s. I was responsible for half of an acute geriatric rehab unit on the Freeman Hospital site and I had responsibilities for what became a rehabilitation ward and a continuing care ward on what was the Walkergate Hospital, which still exists. This, I think, can be described as being very similar to Gosport War Memorial Hospital."
>
> ...
>
> A ... In terms of the number of patients, it varied a lot, but I do remember at one point having over 120 patients under my care which, again, you would not see now, but it was not uncommon for geriatricians to have very large numbers of patients with different medical needs under their care in the 1990s."

At Day 20/6, we see:

> "A I realise there are academics around, particularly in London and elsewhere, who may have very little clinical practice, but that is not the way I have ever practised as an academic. My academic work has been very based around my clinical practice throughout my working career."

He had, before he came along here to give evidence to you five, given evidence that he had read all of the evidence, all of the relevant statements, all of the patient notes; he had equipped himself with material to give him a proper foundation from which he could give his expert opinion.

Professor Sikora is, as I have already said, extremely eminent in his field, which is as an oncological physician. He did not have the advantage of having looked at the patient notes or reading the relative statements, or hearing or reading their evidence. He was not asked to comment on each individual case. He gave general evidence, which I will examine briefly. He gave evidence on Day 34, and it quickly became apparent that his opinion was based on a wholesale acceptance of the material put forward in Dr Barton's statements, as if they were fact. He was not what you need to be: cautious about that. He was asked by Mr Langdale to describe how it was possible to judge accurately what a patient's analgesic needs are. You may think – perhaps this is guesswork – that the purpose of that question was to elicit from him his evidence that you have to have the patient in front of you. This has been a constant theme and a legitimate one throughout the defence case. They say that no one other than the doctor looking after the patient is in a better position.

The way that he started his answer to that question was interesting. This is Day 34/6.

> "A The only way is to be with the patient and see what happens after a given dose of an analgesic that is given."

That may well be right. If it is, then Dr Barton broke that first rule because she prescribed large doses in advance of the patient ever needing analgesia. She did so because, frankly, she

A appears to have been gazing into a crystal ball to assess what pain relief a patient might need in the future. There was with her no administration very often of a first dose, and then checking the effect before the patient was given more.

Professor Sikora confirmed the importance of making notes in relation to any major change in the management of a patient's condition and in the drug regime: Day 34/23. Particularly important, he agreed, was the decision to enter into the non-curative palliative care pathway. B He said, when answering questions from Ms Julien, that note-making was an integral part of good medical practice: Day 34/40. In his opinion a range of between 10 and 20 mg was reasonable provided that the patient was already in pain, or very soon to be visited by some serious pain. That is Day 34/24. A "one size fits all" approach would, he said, be wholly inappropriate.

We also established with him the importance of the *BNF* and the Palliative Care Handbook in C the treatment of real patients, not just as an academic exercise. It put to him (Day 34/25) that you do not throw these guidelines out of the window as soon as you are confronted with a patient. He said, "Exactly". He was also an advocate, of course, of titration. To use oral morphine or long-acting morphine and work out over two to three days what the dose is, then use that in a syringe driver – what the dose is required to control the pain. That is Day 34/27.

> "Q Because unless you do that there is a serious danger that you are either going D to start too low or too high.
> A That is the case.
>
> Q With your syringe driver.
> A Exactly."

And he told us that titration does not mean having to have a nurse hover over the patient E every minute, but checking every hour or so, and making a note every four hours. That would not have been beyond the capability of these nurses on Dryad and Daedalus Wards. He confirmed the great caution required when adding midazolam to the mix – Day 34/29. And he also confirmed – and this is of particular importance to rebut one of the assertions made by Dr Barton – that simply because a patient is on so-called terminal pathway, in other words as we might put it more commonly, dying, does not obviate the necessity for using the analgesic ladder and the guidelines. Guidelines do not go out of the window as soon as the F patient is on the terminal path.

So far as going outside the guidelines, Professor Sikora confirmed that he had done that himself. He said that in his cases, his patient had had cancer. they were all patients in really severe pain. In one case there was distress and agitation that was really distressing to the family. He said he was on the spot on those occasions and he said it was very unusual. This is the defence expert. The difference was that from what we see in these twelve cases it was G not at all unusual for Dr Barton to ignore the guidelines. When he spoke about the practice of titrating using a syringe driver, he spoke about how that required considerable monitoring because he said the plateau is reached after about ten hours. If you have started with too high a dose, it will only become apparent after that period of time. You will recall that schedule that was put in, very helpfully, by the defence. I think it was D7. It was D7b which is most relevant to our elderly patients. I asked him:

H

A "Q And so does it follow from that, that your responsibility for monitoring the patient is obviously that much greater?"

He said:

"A It is."

B That is Day 34/54. He said that for a doctor in the position of Dr Barton, without particular specialist training, he agreed that guidelines such as the *BNF*, the Palliative Care Handbook took on a particular significance – Day 34/55.

I am going to turn now to deal with the patients in turn. Again, I am going to assume – I hope not wrongly – a certain degree of knowledge about these patients. We are in our eighth week looking at these various issues. I am not on any occasion going to take you to
C patient notes. I am going to rely, if I may, upon the chronologies that we have, and I am also going to refer you on occasion to evidence given specifically about the patients. Can we look at Patient A. I will leave it to you, as it were, if you want to get out the chronology on each occasion but I am going to give a very, very brief run-through in respect of each patient in any event.

Leslie Pittock, you will recall, had long-term chronic depression. He had been admitted in
D September, I think it was, of 1995, to Mulberry Ward under Dr Banks and he had returned to the Hazledene Rest Home. Then he was readmitted to Mulberry Ward in December 1995. You will remember that rather sad comment in the notes, that he revealed that his thinking that everything was horrible. He was then noted to have a sacral sore. His Barthel was zero and on 5 January he was admitted to Dryad Ward. He had depression and sores. He had a broken sacrum and sores on his buttocks. His overall prognosis by Dr Lord had been described as poor, but it had been suggested that he should have high protein drinks and
E bladder wash-outs. Dr Lord was happy for him to be taken to the GWMH. So here was a patient being referred by the consultant in charge, who must have known GWMH well.

As we know he was prescribed, on 10 January, Oramorph, 30 mg per day, and diamorphine at 40-80 and midazolam at 20-40 mg. This was after he, of course, had been given Arthrotec.

Those ranges are, of course, much lower than the ranges that we later see. I will come back
F to that when we look at the charges with him in due course.

On 15th he had been given Oramorph at 30 mg daily since 11 January. But then, on 15 January, in fact he was given diamorphine for the first time. By then you will recall that the prescription had already been changed so it is first prescribed on 10 January at that limited dose range. Then, the very next day, before anything in fact has happened, Dr Barton has re-prescribed, and this time she has prescribed 80 to 120 mg of diamorphine and 40 to
G 80 mg of midazolam. On the 15 January he is started on diamorphine at 80 mg. That was effectively an increase from, at that time, 30 mg orally to 80 mg subcutaneously. It is an equivalent increase of eightfold, because – again I am not going to spend time on the maths – we know the equivalent rate would be one-third, an increase would be a half of the oral dose. Onto that was added 60 mg of midazolam.

Can I just remind you of some of the evidence that was given about Mr Leslie Pittock. Linda
H Wiles gave evidence about him. She was his daughter. She spoke about his depression

throughout his life. When he was transferred to Dryad Ward, the relatives had understood he was for terminal care although no one had said it to her. This is Day, pages 25-27. They had expected him to die there and he was not eating or drinking. She said they were kept fully informed about his condition by nursing staff.

Dr Jane Tandy spoke about him, and her note on 10 January that he had chronic depression, and she had written "For tender loving care".

We have to be absolutely realistic about this patient. This was a very ill patient who a consultant had recognised was on the terminal care pathway realistically. Dr Tandy said:

> "A ... I suggested a small dose of opiates to see how he was if we took the edge of his pain and then review."

This was Day 18. She said, "I was not aware of the syringe driver prescription. I might also have used a variable dose range but I would have used a lower starting dose. I would not have written that prescription in relation to the 80-120 prescription." She said: "It is a high dose of midazolam." She said though, "It is a reasonable thing to do in a functioning unit where you trust the nursing staff."

You will have to consider that prescription and whether it is so far outside any guidelines, as we submit to you that it was; that it really is unjustifiable.

Professor Ford gave evidence on Day 20 at page 46 about this patient.

> " ... The picture one obtains from the notes is a very frail, older man with severe depression who is deteriorating, has bedsores. I think nearly everybody who saw him as a geriatrician would recognise this man was nearing the end of his life."

So Professor Ford was also realistic about this patient. He then said this at Day 20/48, when he was asked about the variable prescription of between 80 and 120 mg of diamorphine:

> "A ... I cannot, from the information I have seen in the notes, understand why there was such a large increase in the equivalent opiate prescribed for Patient A, which is, using the [WHO] one-third conversion it is an 8-fold increase, at the lower dose of the range, 12-fold [at the higher]."

He was asked:

> "Q Is it consistent with any medical practice you have come across?
> A No, not a magnitude of this increase."

A little later on, the following page, page 49, he was asked about the midazolam. He said:

> "A The problems are, first, it is unlikely he will remain alert. He is going to have a very depressed conscious level, as happened. Secondly, you will bring about respiratory depression and death at an earlier point. This man is dying, I think everybody recognises that. I think there is little disagreement by any of the experts about that or the clinicians involved, but the treatment he is receiving as a dying man should still be appropriate to his needs."

You may think that also reflects the evidence of Professor Sikora. You do not throw the *Palliative Care Guidelines* or the *BNF* out of the window because a patient is dying. The care should still be appropriate.

Then he was asked about the increase in the drugs because the patient was started off on 15 January at 80 mg diamorphine and 60 mg midazolam. That continues. Then, on 17 January, the dosage now becomes 120 mg of diamorphine and the 60 mg of midazolam goes up to 80 mg of midazolam. Haloperidol is added. Then, we know that Nozinan is added to the mix on 19 January and Professor Ford, Day 20/54, was asked, "If we go to page 20 of the chronology, we can see that the diamorphine was continued at 120, the hyoscine was increased and the midazolam continues at 80 mg on the 19th, haloperidol is being administered now we have Nozinan added at 50 mg. Do each of those drugs have a sedating effect?" and he said,

> "A Yes. Not the hyoscine – it does not have major sedating effects".

He said:

> "Q ... I think the major drugs causing sedation here, at this point, would have been midazolam and the Nozinan. To a lesser extent the diamorphine and haloperidol".

He was asked about Dr Briggs discontinuing the haloperidol but increasing the Nozinan and he said:

> "A That would mean more sedation".

I would like to turn to the issue of the width of the initial prescription, Day 20/55 and this is the initial prescription. He said:

> "A The width is within the two-fold I said might be desirable, but the problem here is the starting dose for both drugs is excessively high and was likely to produce significant adverse effects ..."

In the light of that answer, despite the answers that were later given by Dr Barton and then in fact withdrawn, you may think that so far as head of charge 2(b)(ii) is concerned in relation to this patient – and that is the width of the dose – that Professor Ford does not any longer support that head of charge.

He was asked about the notes that were made about the patient remaining tense and agitated once he had been on 80 mg of diamorphine, so once the syringe driver had started, and he was asked whether that was something for a doctor to consider in terms of increasing the analgesia to do something about that and he said, "The difficulty is that the opiates could be indeed contributing to the agitation or it could be that he has uncontrolled pain. It is very difficult to be certain as to the cause of the agitation but that obviously one of the issues is that the opiates could be in part contributing or it could be his underlying problems of depression and agitation from that". This is Day 22/56. He was asked about Dr Briggs having made the visit on 21st January and the slow breathing rate and he said:

"A I find it difficult to accept with a respiratory rate of 6 per minute that any doctor would claim he has not got respiratory depression. I am not saying he did not need at this point necessarily the drugs to achieve symptom control, but he has respiratory depression".

A respiratory rate of six per minute is not normal. When Dr Barton gave evidence about this patient, first of all her justification for her prescription is worth looking at. It is Day 29 and I am just going to read it out to you but in due course you may want to check it yourselves. Dr Barton dealt with this patient at Day 29/12 and I put to her – and I am going to read quite a chunk of this I am afraid but I think it is the only occasion that I am going to do so:

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

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

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

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

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

A Yes.

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

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

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

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

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

A We would ask you in due course to review those answers because they are not just relevant, you may think, to this patient but they are relevant to her attitude as a whole. Asked:

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

She said, "Yet". That is her answer to all of these, "I was anticipating that this was going to B happen".

I asked her why she had put in the increase when the man was on 30 mg of Oramorph. I put to her,

> "Q This now before he started the syringe driver at all is an eight-fold increase is it not?
> C A Yes.
>
> Q Have you read anywhere that that sort of increase is in fact appropriate and justified?
> A No. ... I have never seen it written down how somebody not standing at the patient's bedside can make an assessment of what level of analgesia and anxiolytic treatment they are going to need as they approach death. Guidelines are fine".

D I asked her:

> "Q Do you think that the editors of the *BNF* and those who wrote the *Wessex Guidelines* had never stood at a patient's bedside?"

and she answered revealingly, "I sometimes wondered".

E That is her attitude to the *BNF* and the Palliative Care Handbook.

She said at Day 29/14 that the *Wessex Guidelines* were:

> A Very appropriate in palliative care, not always appropriate when dealing with an individual patient requiring terminal care, dying".

F Neither her own expert, Professor Sikora, agrees with her nor does Professor Ford.

The heads of charge in relation to this patient – and I have dealt with them globally and I am not going to deal with them in any length now – allege that the lowest dose that Dr Barton prescribed of diamorphine and midazolam was too high. In the first prescription of 40 to 80 diamorphine and the second prescription of 80 to 120 mg of diamorphine and 40 to 80 of G midazolam and that is based on Professor Ford's evidence. You may think that it is also based on the Palliative Care Handbook and the *BNF*. What is alleged is that doses were administered which were excessive to the patient's needs, that the prescriptions in combination with other drugs were excessive to his needs and that the drugs were inappropriate and not in the best interests of Patient A. Whether or not Dr Barton had in her heart the best interests of Patient A is not the issue here and I will say this just once more. We are not seeking to look into the mind of Dr Barton, but what you have to consider is H

whether, as a matter of fact, these prescriptions and these administrations were in that patient's best interests and Dr Barton is entirely unsupported by expert opinion in this regard.

Can I turn then to Patient B. Elsie Lavender had either a stroke or a fractured neck depending on which way you looked at it. She was put on a very high dose of diamorphine after two weeks at the GWMH and the next day she was dead. She had been admitted on 5 February 1996 to the Royal Haslar after a fall. There she was dealt with in general terms by means of co-proxamol and dihydrocodeine. She was transferred to Daedalus Ward on 22 February 1996. Then DHC was prescribed. Two days later, MST was prescribed and administered, 20 mg. Then, on 26 February, so four days after her admission – and I am dealing with this very briefly – Dr Barton wrote out her prescription for 80 to 160 mg of diamorphine and 40 go 80 mg of midazolam. At the same time, the MST was increased to 40 mg daily. Then, on 4 March I think it was, MST was increased eventually to 60 mg daily and then finally, on 5 March, diamorphine was started.

You will recall in relation to this patient that first of all she was clearly unwell but Professor Ford told us – and we will look at his evidence in a moment – that it was too early to say that her chances of recovery were small. She had a reasonable chance. She was on MST for a long time but, when you look at the conversion which took place on 26 February 1996 from MST to the prescription that was written out by Dr Barton of 80 to 160 mg of diamorphine, that was a huge increase. Again, it was an increase outside all of the guidelines, no matter which book you care to look at.

She is described on 5 March as being in some pain. Therefore, "start subcutaneous analgesia". There was no evaluation of the cause of the pain or the reason for this patient's deterioration. This was a lady who had no progressive illness as Professor Ford told you, so it would have been important to identify the underlying diagnosis. When she was eventually started on diamorphine, she was started at a rate of 100 mg over a 240-hour period. Up until that point, she had been on a total of 60 mg orally. So, this again is a five-fold increase from the one-third normal reduction to which of course was added a hefty dose of midazolam of 40 mg.

Alan Lavender gave evidence about his mother. In fact, his statement was read on Day 3/1. He told us that his mum had otherwise been healthy, strong and independent. He was told that she had had a brain stem stroke. She had had physiotherapy whilst she was looked after at the Haslar. She had made excellent progress. She was speaking coherently and checking that they had fed the cat. She had learnt to walk with a walking frame. She was told she was going to GWMH for rehabilitation. He said, "I met with Dr Barton after two to three days and she said, 'You can get rid of the cat. You do know that your mother has come here to die'". He said that she deteriorated very quickly.

Alan Lavender, Day 4/3, said, "I did indicate I was keen that she should be pain free. We did not want to accelerate her death either. A conversation about the syringe driver took place after it was installed. Before that, I knew they were going to manage her pain but you can do that with tablets as she was being fed at the time".

Margaret Couchman gave evidence about this patient on Day 7. She said of 5 March that the pain was uncontrolled and the patient was distressed. The syringe driver was commenced. She said this, "I think I remember from my interview that I was told by the night staff how distressed she was, so the note I made was based on what I was told by someone and, if I had

spoken to the patient and she had told me that she was in pain, I would have noted it. It was my decision to begin the syringe driver but not mine alone. It requires two nurses. Dr Barton would have come in and I would have told her how distressed the patient was. I administered the syringe driver. I started at 100 mg because in my opinion it was enough medication. We decided, (me and Beed as it were) decided to give the lowest dose and that is part of the criticism here. This was the lowest dose that these nurses could give and it was frankly simply a great big whack for this patient who had been on oral morphine up to that time.

Professor Ford at Day 21/4 first of all spoke about the initial assessment.

> "... what if any view do you have of the initial assessment and the plan provided for this patient?
> A I think it was reasonable. I would not have expected Dr Barton to question the diagnosis that had been made by Dr Tandy".

You may think that that goes directly to head of charge 3(d)(i). In fact, out of interest, we know from Dr Barton that she did not agree with the diagnosis or the assessment made by Dr Tandy. So, you will have to take a view as to what note she made of it.

Moving on to morphine, he said:

> "I think the use of morphine may have been appropriate but I am critical that there was no assessment of the location of the pain or which might have led to using other strategies such as non-steroidal anti-inflammatory drugs or further investigation".

He said:

> ... using morphine may have been appropriate, but there is not a clear and strong justification, or assessment of the cause of the pain".

He was asked:

> "Q What do you say about the prescription that allows for between 80-160 mg of diamorphine to be given and 40-80 mg of midazolam?
> A It is not indicated or justified, and it is a very high dose".

That is Day 21/5. He said, "It is a four to five or six-fold increase, and if that had been commenced it would be highly likely to cause major adverse effects which is respiratory depression and coma, particularly with the co-prescription of midazolam at the dose range prescribed.

Q Does that apply to the lowest dose?
A It applies to the lowest dose of 80 mg".

He said,

> "Just to discuss the deterioration first, the first issue is why is this lady deteriorating at this stage. It should not be related to her stroke per se. It is possible it was an adverse effect of the opiates. It is difficult to tell from the information in the medical and nursing notes, but it is not clear to me why this lady at this point is not eating or

A drinking, but that could be related to her opiates...she is taking 60 mg of oral morphine, which is the equivalent of 20 mg prescription of subcutaneous infusion of 100 mg, is five times higher than the current equivalent she is taking".

He said that is not justified.

B "Again, I would judge that prescription to be very risky and likely to lead to, as the first prescription if it had been administered, adverse effects, with particular concerns about depression of respiration and conscious level".

He was asked by Mr Langdale,

C "If it were a stroke, what about the use of opiates?
A There should not be the sort of pain. If it is post-stroke pain, it is the wrong approach to use opioids".

Dr Barton accepted that when she wrote up these prescriptions for this patient, Elsie Lavender, she would not have done so either by reference to the *BNF* or the handbook (Day 29/26). She accepted that there was no note of any re-evaluation of a patient, and you have to ask whether there was any re-evaluation taking place at all. Is the reality that once this anticipatory syringe driver had been written up, her destiny had been decided? There is a D total dearth of notes and a lack of assessment in this case.

The doctor directed that the patient should receive on conversion many many times what she had previously been receiving of oral opiates. Our case is that there is not a book nor an expert which supports such an increase. She told you that she was aware when she wrote out that prescription that it may have potentially fatal consequences for her patient (Day 29/28). That is all very well and what she was accepting really was the principle of double effect, but E the dose was outside all medical guidance. She in turn was relying for the beginning of that infusion of the syringe driver on what she had been told by the night staff.

Yvonne Astridge was called by the defence in respect of this patient on Day 30. She could not in fact add to her notes and could not remember the patient specifically, but she was asked specifically about this patient moving to the terminal care route and what note is made when that happens. This was by Mrs Mansell, Day 30/80. She could not point to any note of F any assessment where that crucial decision was made for this patient. She also told you that the nurses would always seek specific authority for starting a syringe driver, but unfortunately the reality in fact is that that did not always happen, and that illustrates the danger of these prescriptions.

Nurse Joines said in answer to Mrs Mansell about this patient, Elsie Lavender, that when the patient was crying out in pain, she did not really concern herself with what was causing the G pain, but set out simply to relieve it. She went on that in essence she would leave that sort of thing up to the doctor. In this case, of course, the doctor had the attitude, you may think, to control the symptoms because they were not going to be able to do anything about the pain.

Dr Barton may have been right about that. She might have been right that they were not going to be able to do anything about this patient's pain. The concern is that there was no assessment as to whether or not that was a possibility. So far as this patient is concerned, H again the criticism is based around the lowest commencing dose of diamorphine and

midazolam being too high, and therefore her prescriptions, as you will see, being inappropriate and not in her best interests.

Specifically there are allegations in relation to Dr Barton's management of the patient; that she did not perform an appropriate examination and assessment of Patient B on admission. I have revealed to you and reminded you of what Professor Ford said about that and you may think there is not much support for that head of charge. But also she did not conduct an adequate assessment as Patient B's condition deteriorated. You may think there is good support for that. She did not provide a plan for treatment and her actions and omissions in respect of this patient were inadequate and not in the best interests of Patient B. If she was doing nothing other than controlling her pain, and controlling her pain with huge doses of opiates which were not justified, then in our submission that cannot be in the best interests of this patient.

I turn then please to Patient C. Sir, I do not know if you were thinking of taking another break or breaking early, just so I can get a sense of where we are.

THE CHAIRMAN: It is quite helpful if we take the breaks in these bite-size chunks so we get some reflection for absorption.

MR KARK: If I were to go on until 20 past, and then we take a short break.

THE CHAIRMAN: Do the next patient and we will see where that ends rather than break in the middle of a patient.

MR KARK: Eva Page did not have any patient relatives who came along to speak to you, and the reality is that this patient was for palliative care. She had a cancer of the bronchus and it appears that she was not generally complaining of pain, but she was understandably frightened. She was opiate naïve before her arrival at the GWMH on 27 February 1998 when Dr Barton wrote her up for Oramorph. In the particular circumstances of this case, Professor Ford thought that was appropriate. There is no complaint in the charges about that initial prescription.

She was, as you will recall, eating and drinking up to the point at which she was transferred, but the opiates were commenced on the first day as well as thioridazine. She was said to be distressed on the second day of her admission, on the Saturday, calling for help and saying that she was frightened. Oramorph did not, apparently, help her.

Then on 2 March we have this note,

> "No improvement on major tranquiliser. I suggest adequate opiates to control fear and pain. Some to be seen by Dr Lord today".

On that day the fentanyl patch was started, in addition to which she was given 10 mg of diamorphine intramuscularly. After that, that patch, we have to recall, was administered at 8 o'clock in the morning. The drug charts indicate that on the following day diamorphine was started at 20 mg and 20 mg of midazolam. Those are the lowest doses prescribed.

I think it is worth mentioning and I will only do it once, that we have become in this case rather inured to the 20 mg dose. There is a danger that we view that as a low dose of

diamorphine. It is not a low dose of diamorphine and one has to recognise that this is the use of a heavy opiate.

Professor Ford spoke about this. Again he had no criticism of the initial use of opiates and in relation to the fentanyl, Day 21/13, he did not think that was an unreasonable thing to do.

> "I think it is quite a high dose of opiate that one is administering".

Then we turn to 2 March when Dr Barton wrote out her prescription for between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. He said first of all,

> "I could not find any indication in the notes that the fentanyl patch had been removed".

He assumed therefore that it was left on. He was asked if the effect of the fentanyl patch would continue after it had been removed, and he said it would. He said,

> "If we recollect, we looked at the British National Formulary yesterday which talked about 17 hours before the concentration would have halved".

He said,

> "I cannot understand the rationale for starting in addition to that a diamorphine infusion".

Obviously, in broad terms, what she is now receiving from the combined prescription, we understand she still has the fentanyl patch on, she has 90 mgs over 24 hours from the fentanyl patch and 60 mgs equivalent of the diamorphine so she is having 150 mgs morphine equivalent over 24 hours at this point which is obviously a very high dose.

> "Q In your view is that consistent with *Good Medical Practice* or not?
> A Only if there was a clear indication that she had pain and required further opiate treatment, but it is a very, very rapid escalation, the introduction of opiates in a patient who was opiate naïve until when she was she receiving oral morphine, a much lower dose of oral morphine, so it is a very large increase".

First of all, Dr Lord approved of this patient having a fentanyl patch and Professor Ford is not over critical of that management. But it was important that nothing else was added, you may think. Dr Barton said on Day 29/33,

> "I would ensure that the patch was taken off, otherwise the patient would receive a higher dose than he would want and that could lead to over-sedation".

But there is no note of this patch being removed, and in the latter case of Elsie Devine, it was noted when the patch was taken off. We know in this case that as soon as the syringe driver was started – almost as soon as syringe driver was started – there was a rapid change in the patient's condition. In relation to this patent it is worth bearing in mind that the charges relate to the prescriptions for diamorphine and midazolam and that they create a situation which allowed for the drugs to be prescribed to Eva Page which were excessive to her needs. It was inappropriate and not in her best interests. You may think that is the case, frankly,

irrespective of the use of the fentanyl patch and whether or not it came off at the time, because the fentanyl was going to continue.

The failure to make any record here of the circumstances in which the diamorphine and the midazolam should be deployed and their administration apparently when the fentanyl patch was still in place is, we submit, a good example of the dangers inherent in Dr Barton's practice.

Only two charges remain in relation to this patient, and that is Dr Barton's wide prescription of diamorphine and midazolam on 3 March when the patient still at that time had the fentanyl patch on her body, which we say was inappropriate and not in her best interest. As you know, the patient died in fact on the same day as the diamorphine and midazolam were administered with, we submit, the fentanyl patch still present.

Can I turn to Patient D, if you are up to dealing with another patient? I am dealing with these very briefly indeed. Patient D, Alice Wilkie, was 81 years old. She had an unresolved urinary tract infection. She had been to the Queen Alexandra Hospital for treatment. She is described as a demented lady and as a lady with advanced dementia. She had had some haloperidol while still at the QAH but she had not had any opiates in the form of diamorphine or Oramorph at all.

Dr Barton says that this patient's care may have been affected effectively by the rumpus made by the relatives of Gladys Richards. She made that clear at Day 29/36. In examining that excuse, it may be worth considering whether the care afforded to Alice Wilkie was in fact any different to that given to any of the other 11 patients or whether again it was the standard prescription and standard treatment.

Right up until the 20th, this patient having transferred on 6 August and she remained in the hospital for some time, you will remember, but right up until the 20th, the day the syringe driver was started, the patient was in fact opiate naïve. Page 8 of the chronology recalls that on 17 August 1998 the patient's condition had generally deteriorated over the weekend. That is a nurse note. There is no note made by Dr Barton. There is no mention of any pain or agitation or restlessness. In fact the last mention of pain was 11 days before, back on 6 August 1998.

On 17 August Dr Barton, on the basis of this deterioration over the weekend, prescribes her usual prescription, 20 to 200 mg of diamorphine, and this says 20 to 80 mg of midazolam. It is interesting to note the basis upon which apparently the syringe driver was started. Marilyn Jackson gave evidence about her mother, Alice Wilkie. She said that she had been in a residential care home. She had been admitted to the QA where she had responded very well to treatment. She was eating and drinking. She was transferred to the GWMH for rehabilitation and she said, "I visited her there".

> "A When I first went to visit for the first few days she was eating and she was drinking and then I started to go in every day so I saw a gradual decline in her health."

She said that Philip Beed told her that he did not think her mother would get better and he would die there. "I said to him, I did not want her to suffer. I went in one lunch time and mum was really very sleepy. She was flinching in the face."

This is before any opiates had started. "She was flinching in the face and I asked her if she had a pain. She said yes. I told a nurse. Philip Beed eventually came and said, 'We did not know your mother was in any pain. We'll give her something to relieve her. You may find that when you come in this evening your mother will be sleepy." She said, "I went back at about eight o'clock and she was unconscious. I tried to rouse her but she never regained consciousness. She died the following evening. Why did they use a high dose of diamorphine in a syringe driver? The syringe driver was never mentioned to me. No one knew she was in any pain at all before 20 August. The only time I saw Dr Barton was in the morning. She walked round, looked at my mum and said, 'It won't be long now', and walked back out. When she came to the GWMH mum was sitting up having a cup of tea and eating a biscuit. Her deterioration over the first few days was that she was very weak and very sleepy, and then she was unresponsive. I do not think the transfer was responsible. Philip Beed told you he had no recollection of this patient, but it was he who started her on 30 mg of diamorphine, this opiate naïve elderly frail lady. He said 30 mg of diamorphine would have been based on the level of pain the patient was experiencing. There had been no other reason for giving diamorphine."

Well, he had not witnessed any pain. He was basing it on what the daughter had told him. I am not suggesting for a moment that this patient was not in pain. The question is the amount of opiate that was used, and the fact that they were allowed to be used because of Dr Barton's prescription.

Professor Ford told you this on Day 21/20:

> "A ... would be critical of going straight to opiates, to strong opiates. I think one could have tried mild opiates, paracetamol and codeine or non-steroidal anti-inflammatory drugs if she was able to swallow."

She said, "If having assessed the patient it was still not clear what the cause of her pain was, and there was no treatable cause in the terms of another intervention which one could take, a reasonable approach would have been to start mid-way or half way up the analgesic ladder.

> "A Say with paracetamol and codeine, for example, if she was able to swallow at this point. Failing that, if the pain was thought to be very severe – and we do not have any assessments which give a clear indication in the notes of how this lady was – again I think a reasonable approach might have been to consider a one off oral dose or a small subcutaneous dose of morphine orally or morphine subcutaneously, but I think to start with such a high dose of a powerful opioid in an opioid naïve patient without a clearer justification is not good practice.
>
> ...
>
> Q The equivalent of the dose that this patient was started on was 90 mg?"

What I think I meant was, the equivalent of the oral dose, the patient was started on 90 mg.

> "A 90 mg every 24 hours, yes, and that is a very high dose and in an opioid naïve, frail older patient one would expect there would be a high probability of adverse effects occurring ...

A

Q ...
A ... respiratory depression, depression of conscious level and that is why one would want to start cautiously with a small dose.

Q The lowest dose that we have seen Dr Barton prescribe for a syringe driver anywhere, I think, in these records is 20 mg. Is it possible to give less than 20 mg?
A Yes. You very definitely can give less than that, and it is often given."

B

They are talking about the coupling of morphine and midazolam.

"A They both potentially have profound depressant effects on conscious level and respiration and I think you would be surprised not to see such effects using this dose of diamorphine and midazolam in a patient like this."

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He said, "It is not the prescription for analgesia which is being crystallised; it is the very high starting doses and the wide range."

He said this – this is Day 23/6 and it is worth just pausing for a moment because, again, in this whole case we have been surrounded by the atmosphere on Dryad and Daedalus Wards and the practices that were regular within that hospital. But Professor Ford said this:

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"A Yes, but I think the problem I have with that [in] clinical practice, you have very few patients who go to this level."

This is just talking about these relatively low doses. This is Day 23/6.

"I mean, after you had asked me the question last week, at the weekend I went and looked at all the diamorphine prescribing on three wards – continuing care ward, Walkergate Hospital rehabilitation ward and the stroke unit – and I looked at the 59 patients who had died in the previous eight months, and 19 had received opiates, which was about a third, which accorded with what my anecdotal impression was, and of those 19 only 4 had received doses more than 5 mg over a 24 hour period, and the highest dose was 20 mg over 24 hours, so this is a very high dose that you would not normally require to achieve pain control in terms of usual clinical practice.

E

F

Q ...
A ... I cannot conclude that this lady definitely would not have required 30 mg every 24 hours of diamorphine if it had been titrated up to that, but my view would be it would be very unusual for a patient like this to require that amount to achieve symptom control, and I think there still remains the issue of the midazolam and the lack of clear indication for that if she did not have terminal restlessness."

G

This dose is only appropriate, you may think, if it was the lowest dose which would control this patient's pain, and there is simply nothing to support that contention, because there is no attempt at titration here. Neither Dr Barton nor Philip Beed nor Professor Sikora can possibly say that it was justified. The lack of notes about decision-making in this case frankly is pretty appalling. This patient was transferred to Daedalus on 6 August from QAH. Dr X made an extremely brief note on clerking her in. Four days later there is a clinical note by Dr Lord which says that the patient was eating and drinking better, and the only clinical note made by Dr Barton in the records was on 21 August, the day before syringe driver was started, and the

H

day after the patient died. I am sorry – the only note she made was on 21 August, the day after the syringe driver was started. So Dr Barton only makes a note on the day this patient died in her hospital.

The allegations are restricted to the width of the prescription which was, we submit, for this patient inappropriate, not in her best interests and was, frankly, the standard "one size fits all frail old ladies". If one asks oneself what was it about this lady's presentation or her symptoms at the time that Dr Barton wrote that prescription out, which justifies it, it is impossible frankly to see any justification for it whatever.

I am going to turn now to Patient E. You may need another break, I expect. Sir, I do.

THE CHAIRMAN: We will come back at twenty twelve, please, ladies and gentlemen.

(After a short adjournment)

THE CHAIRMAN: Yes, Mr Kark.

MR KARK: The best I can say is that we are getting through it. We are now on Patient E, Gladys Richards. We have spent, in fact, a great deal of time during the course of the proceedings reviewing issues around Mrs Richards' care, but it is worth reminding ourselves that the heads of charge in relation to her are almost more limited than in respect of any other patient. They are that the initial doses prescribed on her admission on 11 August were inappropriate and not in her best interests. Although there were two admissions for this patient, of course, because of the dislocation which we all remember, in fact all the charges go back to those initial prescriptions. I am not going to spend a great deal of time on this case although of course I hope to do it justice.

At her pre-transfer hospital, she was described, after her neck of femur fracture on 29 July, as fully weight bearing. She was cared for not at the Queen Alexandra Hospital, but at the Royal Hospital Haslar. You will remember the evidence of Rear Admiral Farquharson-Roberts, called by the defence on Day 33, when he said at page 62, that he dismissed the suggestion made by Yvonne Astridge (Day 30/74) in effect that his nurses were a bunch of beefy sailors who would not know the difference between a patient being able to take their own weight and not. He did not like that suggestion very much and he described the expertise of his nurses and his physiotherapists.

It is worth also bearing in mind, of course, that again this is another patient who, on the day of her transfer, was opiate naïve. Just looking briefly at her summary, she is transferred to Daedalus Ward on 11 August. She had previously had haloperidol but nothing else apart from when she was actually first operated on. This was the lady for whom there was the note: "When she becomes fidgety and agitated, it means she wants the toilet." Although that is not particularly relevant in her case, because that was not the reason for the start of the syringe driver, it is just worth bearing that evidence in mind in relation to others, and when you look at nurses' notes to support the start of a syringe driver on the basis of a patient becoming agitated or upset. In her case, when she became fidgety or agitated, she wanted the toilet.

She was transferred to Daedalus and reviewed by Dr Barton. It is interesting to compare the referral letter with Dr Barton's assessment. Her referral letter says this:

> "Now fully weight bearing. Walking with the aid of two nurses and a zimmer frame. Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. She is continent. When she becomes fidgety and agitated she wants the toilet. Occasionally incontinent at night. Occasionally says recognisable words. Wounds healed clean and dry. Pressure areas all in tact."

Wounds healed clean and dry. Then she is transferred and Dr Barton's clinical notes reveal this:

> "Frail demented lady, not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL. Barthel 2. Happy for nursing staff to confirm. Deaf."

On that day she – Dr Barton – wrote out prescriptions for Oramorph, which were administered the same day twice – 10 mg twice; diamorphine, the usual prescription, 20 to 200; midazolam, the usual prescription, 20 to 80.

Lesley O'Brien gave evidence about her mum. She was a former registered general nurse. She said of the Haslar that she was in pain there, and she was given morphine and haloperidol, but thereafter her recovery was "remarkable". Within two to three days she could be –

> "...stood up with a zimmer frame and walk a few steps. She was lucid, she was off all her medication, she was able to hold good conversations with us, she was having three meals a day, she was completely hydrated and getting better every day. Her wound site was absolutely perfect."

She had needed analgesia after the operation, but after that she was pain free. On the day of her transfer she had porridge and orange juice for breakfast. "I was there when she arrived. She was sitting in an ambulance. She was there for rehabilitation." She spoke about the following day, 12 August, her mother being unrousable and totally out of it. "I tried to rouse her but couldn't. She wasn't having any food or drink. She had not appeared to be in significant pain before this time."

It is right to point out that although she was given Oramorph on the day of her admission, she was given it the day after on the 12th, which is this day that Lesley O'Brien was talking about, at 6.15 in the morning, but not thereafter but she was, as we understand it, on haloperidol. In the evening of that day she was not given medication because she was said to be too drowsy.

"In the late evening she became rousable," said Lesley O'Brien, "and I gave her a bottle of fruit-flavoured drink, which she had in full." Then we move on to the time when she had a fall and she is discovered on the fall, and that fall has dislocated her new hip which undoubtedly must have been painful and required reduction. So she went back to her hospital. Lesley O'Brien told us, "Within 24 hours she was standing up and weight-bearing again – back to how she was before. Then, on 17th, she was transferred back to Daedalus. When I arrived at 12.15 she was screaming in pain, lying in a terrible position. She said to me, 'Don't just stand there, do something, pain, pain'. Her hip was in an awful position. With the nurse we repositioned her, and that nurse, you will recall, was Nurse Couchman."

Then she said, "Dr Barton spoke to me and said it was not appropriate for a 92-year old to go back for a further procedure. Mum was given Oramorph for the pain, and I was happy for her to have something to stop the screaming. She said she was given four doses in seven hours, including two injections. She never then regained consciousness thereafter."

Philip Beed said she had a massive haematoma. The daughter said this, and it is relevant to evidence we have had form other relatives. "I wanted her to be pain free, but it doesn't mean she had to be unconscious for the rest of her life until she died. She was not hydrated. On the 18th, Dr Barton came into the doorway, folded her arms, lent on the wall and said, 'The next thing will be a chest infection.' On the 18th she was not conscious. She was not screaming or moving or doing anything at all. The syringe driver was already in situ."

As I say, Nurse Couchman spoke about this re-admission, about the patient being in a lot of pain and distress.

Can we look at what Professor Ford said focusing on those initial prescriptions. Day 21/26:

> "Focusing first on the Oramorph for this patient, do you have any commendation or criticism of first of all the prescription and secondly the administration of that drug?
> A On the information available in the medical and nursing notes, there is no rationale presented for prescribing morphine at this point. This lady was mobilising a few days before at the Royal Hospital Haslar and taking regular co-codamol. So that would be the appropriate analgesic to continue, unless there had been a major change in her situation. In fact, I am not sure whether we know she was still taking co-codamol after 7 August, between the 7th and the 11th, but even if she had stopped it or was still taking it, the appropriate prescription for analgesia would be to continue the co-codamol in my view. That could have been written up either as a prn or a regular prescription. ... But to move to prescribing morphine, when obviously there is the potential for significant adverse effects, without a clear description of there being a change in the pain severity or lack of control on other painkillers, means the prescription has no justification".

My question:

> "Prescribing diamorphine for this patient on the day of her admission, starting at 20 mg with a variable dose going up to 200, with midazolam. What view, if any, do you have about that?
> A I cannot find any information in the medical and nursing notes that would provide any justification for that prescription. This is a lady who, having had a major change in her level of function, against a background of slow deterioration, is now improving from a major surgical procedure. She has been referred for further rehabilitation in an attempt to improve her mobility, with a recognition that that may not be possible, to get her back to her previous level of functioning. So there is no information which would justify why this patient would potentially need nursing staff to commence infusions of diamorphine and midazolam. The notes do not say at this point that this patient is deteriorating and has symptoms which require those drugs.
>
> [They are] ... are high starting doses in what is at this point essentially an opiate naïve patient. ... there is a high risk of serious adverse events again".

When the patient returned after her reduction, we know that she was in pain. We know that there was this unfortunate event when she was transferred on a sheet. It seems a long time since we heard all of that evidence but you will recall it, I am sure. We also know that she had demonstrated that she had been particularly sensitive to midazolam after the operation and there was that note about that. Professor Ford said:

> "A Given we know she is very sensitive to a single 2 mg dose she has had, the 20 mg – which is as we have said before a high dose to start with in an older person – would be, again, very likely to produce adverse effects when it is started at the same time as a significant increase in the opiates.
>
> Q It is the combination again?
> A It is the combination, but even without the opiates, that dose of midazolam on the basis of her prolonged sedation after the 2 mg, might be expected to produce profound depression of conscious level".

So, when she comes back on 17 August and the syringe driver is started on the 18th with 40 mg of diamorphine, which was high but not unreasonably so given her pain, in addition to that she received 20 mg of midazolam and that administration was unjustified but remember in the charges you go back to what was her presenting condition then. The fact is that those prescriptions on the first day of her admission allowed for the later administration of that high dose of diamorphine and midazolam together.

It is also worth reminding ourselves – and it is worth doing this on more than this one occasion – to compare the medication that she received at the Royal Hospital Haslar with the medication that she received at the GWMH. At the Royal Hospital Haslar, she broke her hip, having broken her hip on 29 July 1998. On 8 August, there is a note in the chronology that she was agitated. She had a single dose of haloperidol to deal with that and that seems to have helped her but at the same time keeping her alert and conscious so that she was able to eat and drink. Well, that of course was not the case once she got back in due course to the GWMH.

As I say, although you have had a huge amount of evidence about this particular patient, I have to and you have to focus on the specific charges that you now have to deal with and that is all that I say about them.

Can I turn to Patient F, Ruby Lake. Again, the charges are very limited in relation to Ruby Lake. They relate to the first prescription for Oramorph on 18 August, the standard diamorphine and midazolam prescriptions of the same date, and the allegations being that those prescriptions were inappropriate and not in her best interests. As with all patients, there is the additional allegation at paragraph 15 that Dr Barton failed properly to assess the patient before prescribing opiates and that charge, which you will be asked to consider in due course, is different to some of the patients where we have specifically charged failing to assess on admission or failing to assess when there is deterioration. It is a charge which is directed specifically to the issue of an assessment before prescribing opiates. In other words, what was the foundation of the prescription of opiates. If you find that actually Dr Barton was simply prescribing opiates without making an assessment that justified them, then, in our submission, head of charge 15 is well made out.

A This lady of course had a fractured neck of femur following a fall at home. Of course, we accept that that is capable of being and is sadly very often a terminal event in an old person's life, but, on 14 August 1998, so eight days or so after her operation, she is described in the notes as being frail and unwell but standing with frame and moving with physio assistance. She is given paracetamol with good effect and, on 18 August, she is described as being well, comfortable and happy. She had had a spike of temperature the day before but then her temperature was normal on the say of her transfer. There is a transfer letter that you have
B revealed in the chronology at page 14 at page 23 of your bundle speaking about

> "[This patient] had had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload ... now resolved, it appears.
>
> Presently ... slowly mobile with a Zimmer frame and supervision. She is able to
C wash her top half ... [She had] bilateral leg ulcers and a broken area on her left buck and in the cleft ..."

which was improving. She had a small appetite but her hearing aid unfortunately had gone missing.

When she got to Dryad Ward, her past medical history is set out by Dr Barton and the plan
D for her, "Needs some help with ADL. Barthel of 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death". She is immediately prescribed oral morphine, she is immediately prescribed diamorphine and midazolam in the usual amounts and she is given Oramorph the same night. This was the patient – I expect we may all remember it – who, on the night of her transfer woke up at night and she was distressed and she was anxious. She was obviously in a new environment and she was not very well. She was given Oramorph to deal with that. Dr Barton told you that when she wrote out her note about gentle
E rehabilitation, that was slightly tongue in cheek, Day 29/54. This was potentially a very ill elderly lady. That does reveal, you may think, an extraordinarily pessimistic attitude, not that this lady was well, as it were, I am not going to suggest again that this lady was going to be up and about within a few days, but to say that the comment "gentle rehabilitation" was slightly tongue in check is frankly quite depressing.

Until her transfer, this patient and her pain had been controlled by paracetamol; she was
F totally opiate naïve. Dr Barton accepted when she wrote out her prescription on admission that she was ignoring – and that is my word and you can check what she actually said about this at Day 29/55 – both the Palliative Care Handbook and the *BNF*. That night, instead of having someone to sit with her and as a direct result of the prescription that Dr Barton had written out, a nurse gave her not paracetamol and not temazepam but morphine and Dr Barton accepted, Day 29/56, that, with a confused patient, Oramorph was not necessarily going to help them. It might help congestive heart failure, but there is no evidence that that
G night that is what the patient was suffering from. She was simply anxious and distressed at her new environment.

Of her prescription for the variable dose, Day 29/57, I put to Dr Barton that, if nurses had given even half of that full amount that might well have killed her and the answer was "yes".

By four o'clock the next day, this lady was put on the terminal pathway. Diane Mussell, her
H daughter, gave evidence and she told you frankly that there was nothing that struck them as

being out of the ordinary with her care. She was in the GWMH, a private room, and able to talk. She said, "I can't recall any real concerns. Nobody actually spoke to us about a syringe driver". Pauline Robinson said, "I visited her at the Haslar after her fall. She did not want a nurse at first but I saw her a week later and she wanted to be taken out around the grounds. We took her on to the seafront. She seemed quite bright. She was in a wheelchair. When I saw her on the 20th – and that is two days after admission – she was unconscious and did not know we were there. She did not speak back to us at all. I think we were aware that she was on a syringe driver".

Timothy Coltman gave evidence about this patient and, if you want to look at his evidence, it is at Day 4 starting on page 14 and he talks about how, on 18 August, it was he who had recorded that the patient was well, comfortable and happy and mobilising well. "She did not seem to be in any distress and she did not seem to be in any pain. She seemed fairly normal for a patient of her age who had gone through a fractured hip and that operation. If she had been exhibiting pain, I would have made a note of it. She had been prescribed analgesia but she was not taking any" and then he spoke about the associated mortality with patients with this sort of fracture.

You heard from a number of nurses about this patient; I am not going to go through them all. You heard from Shirley Hallman, Beverley Turnbull and Anita Tubritt. They spoke about the syringe driver being started after the Oramorph had been given and Shirley Hallman said, "The diamorphine was started at 20 mg. Possibly I would have done that as the Oramorph was not enough and she was still in pain. I clearly was not happy with the dose" meaning of Oramorph "as I gave it". As we know, the dose was also increased by Nurse Hallman.

Again, the start of the syringe driver and these increases were all allowed for by the initial prescription by Dr Barton. Started on 19 August at 20 mg, doubled the following day to 40 mg and then increased to 60 mg the day thereafter.

At the start there is of course a huge increase on the few milligrams of Oramorph that she had had up until then.

So again, if we came back to the heads of charge for this particular patient, they are again relatively limited. Again, the dose ranges were of course too wide, etc., and particularly that the action in prescribing the drugs, 7(a)(ii) and (iii) which is the Oramorph and the diamorphine, were inappropriate and not in the best interests of the patient.

Again I come back to the point, if I may very briefly, to the question: what was there about this lady's representation which conceivably justified those doses? The analgesic ladder has gone out of the window. The Palliative Care Handbook has gone out of the window; the *BNF* has gone out of the window. There is nothing in this lady's presentation, in our submission, which justified those particular doses.

Professor Ford – I can deal with this quite briefly, I hope – gave evidence on Day 21/43 about this. He was asked specifically about the first night when the patient woke up just after midnight and was anxious. He was asked,

> "If that were the basis for giving this lady Oramorph, what do you say about it?
> A I think it can be criticised. The patient is anxious, they have come to a new environment, they have been quite unwell, they are saying they want someone to sit

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> with them. The first response would be for a nurse to sit with the patient. Nurses would not necessarily be able to sit with her all night, but you would expect, unless there were major staffing problems or other problems on that unit, a nurse to be able to sit with the patient for 20 or 30 minutes. If they were no better at the end of that, I think it would be perfectly reasonable to give either a hypnotic, temazepam, which I think she was written up for, or an antipsychotic drug such as thioridazine or haloperidol, but not morphine".

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He said,

> "I think it did raise to me concerns that the nurses had interpreted that prescription of morphine to be used to treat anxiety or agitation in older people, in the absence of pain. I think most nurses would look at morphine being used to treat pain. So I thought that was potentially a confusion or maybe that was the general

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> understanding of nurses",

And that appears to be what happened here. He is then asked about the increases on 20th and 21 August. He said,

> "One would want to see clear rationale for these large increases. The increases are greater than those which are recommended in the Wessex protocols and other

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> guidelines, which would be a 50 per cent increase".

He also said – Day 21/45 –

> "One would generally increase one drug at a time to treat a specific symptom, but the escalation of doses over that period in an older patient like this would be expected to cause very marked sedation...I was of the view that the doses administered over the

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> period would very likely contribute to her death, yes, but again, because she had a lot of other medical problems, you cannot conclude that the drugs were the cause of her death".

Again, pausing there for a moment, it is the two drugs together. It is the assumption that seems to be made that when one is given the other should be given. There does not seem to be any particular approach as to what the midazolam is there for and what the diamorphine is

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there for separately, and they are not necessarily there to treat the same condition. When one goes up, we see regularly that the other goes up and you have to ask yourselves whether that is an appropriate or inappropriate approach.

That might be a good time for us all to take some lunch, sir.

THE CHAIRMAN: We will return at 2.15 ladies and gentlemen.

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(Luncheon adjournment)

THE CHAIRMAN: Thank you, Mr Kark.

MR KARK: Sir, I was going to move on now to the case of Arthur Cunningham, Patient G. Again it is worth going back to the heads of charge, which once again are fairly limited. This

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patient was admitted for treatment to his very bad sacral ulcer. He was admitted from the

Dolphin Day Hospital by Dr Lord, who well knew the abilities of GWMH and he had also, of course, been reviewed by Dr Barton herself. Dr Lord cannot surely be accused of an over-optimistic approach.

The heads of charge, so far as this patient is concerned, start at paragraph 8 and are specifically in relation again to the doses for diamorphine and midazolam on two occasions, 21 September and 25 September, and failing to obtain the advice of a colleague, or not obtaining the advice of a colleague when the patient's condition deteriorated.

As I say, the charges are very confined. There is also, of course, a lack of assessment before prescribing opiates and the additional charge that Dr Barton did not obtain the advice of a colleague is put simply in this respect. That is a fact which has been admitted and in due course you will have to decide whether that contributes in any way to an allegation of serious professional misconduct.

So far as the patient's progress is concerned, he was seen at the Dolphin Day Hospital on 21 September and reviewed by Dr Lord. He had a large necrotic sacral ulcer, which was described as "extremely offensive". He was being admitted with a view to more aggressive treatment of the sacral ulcer, and that was going to need this unpleasant chemical, apparently, called acerbine. But his social worker was to keep open his place at the Thalassa Nursing Home.

He was noted on 21st to have had tablets still in his mouth, although later on in fact we know he was able to drink some milk, so he was not unable to swallow anything. The plan from Dr Lord was that he should have acerbine for his sacral ulcer; he should be nursed on his side and he should have a high protein diet. Dr Barton saw him in the Dolphin Day Hospital and then he was literally wheeled, as we understand it, down the corridor to Dryad Ward.

The reality is that as soon as that patient was wheeled from one ward to another, he was almost literally on the terminal pathway because that is how we suggest this doctor approached his treatment. In her view it was not even practical to try to give him a high protein diet, as directed by Dr Lord – Dr Barton's evidence Day 29/62. Whatever the nurses were going to try to do for this patient, Dr Barton agreed with me that she would have spoken to the nurses and given her opinion that the best that could be done for this patient was to make him comfortable (Day 29/64).

That is quite important. The approach is governed from the top and in this case, on this ward, Dr Barton was the top. You will all recall that on the night of 21 September, on the day in fact of his admission, he has a period of agitation and frankly of behaving badly. Oramorph is given to him at 8.20. Ten minutes later he is described as no longer being agitated. Two and a half hours later the night staff appear to have thought it right to put this man on a syringe driver prescribed by Dr Barton. It is noted that that is "as requested" and nobody seems to know who made that request.

Pausing for a moment, and going back and stepping away from this for a moment, we all know now because it has been agreed by a number of witnesses, that the starting of a syringe driver for any patient is the terminal pathway. So when this patient is wheeled from one ward to another and that same night he has got a syringe driver set up for him, that quite frankly was the end of any idea of treating his sacral sore, of rehabilitation or anything else.

A You heard from his stepson, Charles Stewart-Farthing, who described his step father as being, "Can be difficult. Had strong opinions". In summary he said, "When I first saw him on Dryad Ward he was perfectly normal. He said he had a sore butt. They said they decided to take him in for aggressive treatment so he knew what he was there for. He was quite frail and he had lost a fair bit of weight. He could not walk on his own but he could get in and out of a wheelchair himself. Nurse Hamblin said it was one of the worst sores she had ever seen".

B He said, "The following day I telephoned the ward and was told he had become aggressive to the staff. They had given him something to calm him down. I said I would be in the next day and would have strong words with him. On 23rd I went to the ward. He was unconscious, unrousable. He was totally different. He had gone from a normal person to someone who was totally comatosed. On 23rd I discovered the syringe driver and asked for it to be removed".

C This was first of all to Nurse Hamblin. "She said she couldn't. It was only the doctor who could authorise that. We came back the next day and Dr Barton did not come until the 24th at around 5 pm. He had not been conscious all day. Dr Barton told me bluntly that he was dying from the poisons emanating from his bed sores and she refused to remove the syringe driver due to the pain he would experience. I accused her or murdering him. The interview terminated rather quickly".

D That was Day 6, pages 2 to 23, where you will find his evidence. You will have to consider that. You have had a lot of evidence about the appropriateness or otherwise of reducing a dose so that a patient can at least speak. But let us go right back to the charges. What happens as this patient is wheeled from one ward to another? Dr Barton first of all prescribes him Oramorph. She then prescribes him diamorphine at the usual prescription and midazolam between 20 and 80 mg. We know that that night he had this episode of either acute bad behaviour on one view or acute distress on another. But the initiation of the
E syringe driver was some hours after that had happened and some hours after apparently this patient was no longer being agitated or aggressive.

Can I just remind you of the evidence of the nurses? Ingrid Lloyd told you at Day 15, page 84, that she had agreed that a syringe driver would commence in order that he remain in a pain-free and peaceful state. She said, summarising, "Although he was peaceful at 8.30 pm, it was not certain that he would remain so, and the syringe driver was commenced at 23.10.
F The drugs were prescribed to be given at our discretion".

That is a worrying circumstance, you may think, in which this gentleman who had been admitted to that ward on the same day for treatment of the sacral sore, is put by nurses on to the terminal pathway.

Professor Ford gave evidence about this patient on Day 21/50. He said in terms of the
G assessment and plan,

> "I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated",

So far as his plan is concerned. Then he was asked about the diamorphine and midazolam, and he said this:
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"It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?
A He is taking Oramorph, so he is getting morphine to control the pain, so there is no need to change that unless he is refusing to take medication, which this note
B does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness".

He was asked,

"First, if the nurses had started diamorphine and midazolam inappropriately and the
C doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving".

He said,

D

"That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent".

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...
A ... You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care."

Just pausing for a moment, if the nurses had that night inappropriately put this patient on a syringe driver, the doctor needs to review that – needs to review the reason for that – the next
F day. In this case, the doctor had every reason for reviewing it because Mr Stewart-Farthing was asking her to do so. Dr Barton agreed when she gave evidence. We will go back to what happened with the doses of midazolam which in fact were tripled. Dr Barton agreed that Charles Stewart-Farthing was clearly a caring and loving relative, but she described as inhumane and abhorrent the suggestion that the patient's infusion should be stopped or reduced – Day 26/69 and Day 31/11.

G This patient, two days earlier, when Charles Stewart-Farthing had seen him, had been sitting up in bed asking for chocolate. You may think it would have done little harm to reduce the dose sufficiently to be able to speak to the patient, even if it was for the final time. You will recall – and I am sorry I do not have the reference for this – that Dr Barton eventually agreed that if the patient says to her, "Please, take that thing out. I am not consenting to have a syringe driver," she would have to follow that instruction. One wonders what would have happened in this case if that conversation had taken place. Dr Barton's comment to me, Day

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A 29/72: "...your idea of withholding analgesia from somebody who was dying was just abhorrent to me."

As you know, he was started on the syringe driver that night, and it continued. It continued throughout the next day and then, on 23 September, there is a comment that he became a little agitated again at night, and the following day the diamorphine continues, but the midazolam is tripled up to 60 mg.

B Professor Ford said this, Day 21/53:

> "A ... One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody
> C dying who is no longer alert who might otherwise be."

This was a very large dose. This is page 53 again – "this was a very large dose, a very large increase" in relation to the midazolam. There was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point and see what happened. He was variable in his agitation. We had the problem that it was possible that it was the diamorphine and its metabolites that might be worsening his agitation. If you have somebody
D who is over-sedated, it is best to stop for a few hours and then see what happens to the patient, and re-start the infusion at a lower rate. He said:

> "A ... I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death."

E Finally this, in relation to 24 September, which was the day when the diamorphine was first of all doubled to 40 mg, and then the same day increased again to 60 mg, the midazolam then went up to 80 mg, there was this CPN note: "Physical decline. Pressures sores development. Admitted to Dryad Ward, terminally ill. Not expected to live past the week-end." That is referring to a staff report on 24 and 25 September, the 24th being the day when these drugs were increased, as I have just indicated. Professor Ford said, "It is unclear what they are
F observing in their response to pain. This is a man who was, as far as we can see, not complaining of major pain. He was obviously thought to have some discomfort when he was seen at the Dolphin Day Hospital. Then he has escalated within a very short period to a very high dose of diamorphine. It is a very dramatic change. At the same time, he has also been escalated to a very high dose of midazolam. I find it very difficult to know what signs the nurses were interpreting, as to whether this man was in pain or not." That is Day 23/25.

G So we submit that there is substantial support for the contention that the drugs which were prescribed on his admission, and then increased on 25 September, were inappropriate and not in his best interests for this particular patient.

Can I turn then, please, to the next patient, Patient H, Mr Robert Wilson. This gentleman, again, we no doubt all recall. We had pretty graphic evidence about this gentleman's drinking habits. He was a heavy drinker. To say he enjoyed a drink I think is probably
H putting it too low. He had as a result, it would seem, alcohol liver disease. Then, in

September, he fell, breaking his left humerus. He was admitted to QAH. He did not want to have the fracture fixed, and that undoubtedly caused him considerable pain whenever he knocked it or tried to move it. He was given morphine at first and then codeine phosphate and paracetamol. Prior to transfer, he was on a mixture of codeine, paracetamol and occasionally small doses – I think 5 mg doses – of intramuscular morphine. Then, on 14 October he was transferred to Dryad Ward.

The fact that this patient was known to have alcohol liver disease was also well known to Dr Barton. Indeed, her clinical notes on 14 October revealed past medical history "alcohol problems". There is no suggestion that people did not know generally about that issue with him.

Can I just remind you of something that Professor Ford said in a general way about those with alcohol problems. This was Day 20/27, and he was again dealing with *BNF*. He said the guidance is about careful monitoring.

> "If you have somebody with significant liver disease who is in severe pain, you are not going to want to deny them opiate analgesia and you would give a lower dose and monitor carefully. It is important to emphasise it is not saying these patients should not receive morphine or other opiates. In renal impairment, the problem is, again, more sensitive and there is this risk, because of the accumulation of metabolites, of a greater likelihood of getting confusion and agitation but I think now their recommendation is to use alternative opiates to morphine in renal impairment. I think however at this time you would still use opiates. You would just use them more carefully."

Then we heard from Sister Hamblin, whose statement was read to you on Friday last. She told us, at Day 36/55 when her statement was read, one of the reasons for increasing the diamorphine.

> "The diamorphine has been increased from 40 mg to 60 mg."

We will go through the chronology in a moment.

> "This would have been to control his pain. I must point out that as well as his multi organ failure, Mr Wilson was suffering from a fractured upper left arm.
>
> Midazolam was increased from 20 to 40 mg. This was increased because he was suffering from liver failure and, as a result, the medication would not be working as effectively. Therefore, the dosage was required to be increased.
>
> ...
>
> Oramorph was administered to Mr Wilson due to the pain from his fractured arm and also because he was an alcoholic. By this, I mean that his liver was not functioning as well as it should be. He was also suffering from renal and liver failure."

That is a slightly worrying admission, you may think. Sister Hamblin was extremely experienced, obviously. We have heard a great deal about her. Unfortunately we have not heard from her. If that was her understanding, then it rather belies Dr Barton's evidence that

she was entitled to rely on the experience of her nurses, because this was her most experienced nurse. She may, it appears, have been getting this wrong.

The prescription written on the day of his admission, as we know, is the usual one, if I may call it that, including Oramorph. It is exactly the same prescription that we have seen throughout. Forget his liver disease. Forget his alcohol problems. This is – and I am sorry to use the expression again – the "one size fits all dose". No special instructions to the nurses warning, "This man is an alcoholic. Be careful how you use these." It is just the same dose as before. Up until this point, he is in our submission effectively to be regarded as opiate naïve, although he had had some small amounts of diamorphine previously.

He is commenced on 15 October on 40 mg a day of Oramorph. He deteriorates. The condition deteriorated overnight on 15 October, and he is described as being "very chesty", and he becomes, it would appear, incontinent. Then the Oramorph seems to go up. He is given 50 mg. Then he is described on the 16th as unresponsive to spoken orders, suffering from shortness of breath and on the Friday, the 16th, the syringe driver is commenced with 20 mg of diamorphine. On this occasion, there is no midazolam.

Thereafter, on the following day, on the 17th, the diamorphine is doubled and the midazolam is started. The day after that, the diamorphine goes up again. The midazolam is doubled and the patient dies eight hours later.

This is a patient whose pain hitherto had mostly been controlled by codeine. His deterioration mirrors the increase in his opiate dosage. His deterioration did not cause Dr Barton to consult with any senior colleagues. Dr Knapman saw him on his second day and Dr Barton appeared at one stage to suggest that it must have been Dr Knapman who authorised the syringe driver but you will recall, and it was pointed out, that Dr Knapman saw the patient in the morning, and increased his frusemide, saying nothing about a syringe driver. It was not until that afternoon that the syringe driver was started, and Dr Barton accepted that it would have been very surprising if Dr Knapman, at least, had not made a note about that decision.

Professor Ford gave evidence about this on Day 22/3, and he commented on the fact that the patient had been getting at most paracetamol and codeine. He said:

> "A ... I think it would have been most appropriate to continue paracetamol regularly and increase the dose of codeine to say 60 mg four times a day. He had not had that level of regular moderate opioid dosing prior to his admission to Dryad Ward as far as I could tell. The dose is a large increase on what he had been having before of intermittent doses of 2.5, so I think it would have been reasonable, if one had decided he was unlikely to be controlled or had not been controlled on the moderate opioid, to start with a more cautious dose of 2.5 to 5 mg, given his liver disease...".

This is speaking of his first dose of diamorphine.

> "So I think the 10 mg is in my view an excessive dose, given his age and liver disease."

Gillian Kimbley had travelled with him to the hospital, of course. She described him as being "not too bad and able to hold a conversation, but he was exhausted. Dr Barton had said, 'Get

straight into bed and I will give you something to calm you down'. That is not a criticism of Dr Barton at all, but in less than 24 hours she said there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense and he was semi-conscious. I spoke to a sister, and she said, 'Your husband is dying. He will be dead with a week.' I could not believe it. From the 16th he was unconscious. He did not indicate that he was in pain."

Shirley Hallmann gave evidence about this patient on Day 13. She told you that she did not know who made the decision to start at 10 mg of diamorphine prior to the syringe driver and she could not say who started the syringe driver, but she accepted that Dr Barton appeared not to be there that day. She said it could well have been a nursing decision. "It could have been my decision. There were occasions where we decided to start the driver without consulting the doctor to stop the patient being in unnecessary pain. I did not think the doses were excessive."

Professor Ford, of course, said that you need to reduce the dose because of the damage to the liver.

You may take the view, again, I am afraid, with this patient, that there was no particular care taken to ensure that the particular dose was appropriate to the particular patient.

Ian Wilson told you that he had been along to see his father and his father had complained that the staff were killing him, and those were the last words that his father said to him. That may no doubt have been the unintended consequence of the nurses' actions, but it may appear to you to be one of the consequences nevertheless because of too large doses for a man with this sort of liver.

I should mention that there is a specific set of charges in relation to Mr Wilson which you will find at 9(b) all of which refer to the fact that, in the light of a patient's history of alcoholism and liver disease, the decision to give him Oramorph was inappropriate and potentially hazardous, and also the prescription for diamorphine at a dose range of 20 to 200 is also said to be hazardous and likely to lead to harmful consequences and not in his best interests.

Can I turn then to Patient I, Enid Spurgin. Again, in relation to Patient I, the charges are limited. They focus on the prescriptions for diamorphine and midazolam and the assessment for this patient was inadequate and not in her best interests and the doses prescribed were inappropriate again and not in her best interests as were those which were in fact administered to her. This was a 92 year old lady who was pulled over by her dog which unfortunately broke her hip, again a potentially terminal even for any old person. The charges in relation to this patient do need perhaps more careful consideration. The assessment on admission is criticised. The usual dose range is criticised as being inappropriate, the administration of the syringe driver and the dose of 80 mg of diamorphine and 20 mg of midazolam – you will remember Dr Reid later intervened and ordered a reduction – is particularly attacked as being inappropriate and potentially hazardous. None of those allegations have of course been admitted.

At the time that this patient was transferred to Dryad Ward, she had last had any morphine five days earlier and she had received five days earlier 5 mg. Again, we think legitimately make the point that, when you compare the sort of doses of these patients at the previous

hospital with the doses that they were subsequently to receive on transfer, there really is no comparison at all. On the day of her arrival, which was 26 March, this patient received some 25 mg of Oramorph, 30 mg having been prescribed. Up until then, she had been on a regular dose of 1 gm of paracetamol a day. My understanding is – and I got it from looking at a box of paracetamol that I have at home – that the standard paracetamol is 500 mg, so this is two paracetamol provided by any chemist a day and that, up until that stage, had been controlling this patient's pain, so it would appear or at least the doctors thought so. So, for her to start on 25 mg on 26 March, you may think that the analgesic ladder has gone out of the window, as has the *BNF* and as has the little green Palliative Care Handbook.

Carl Jewel whose evidence you heard on Day 8, the nephew of Mrs Spurgin, said that she was sat up in the bed back at the Haslar. She was transferred to the GWMH, he visited her four to five times, initially speaking happily. The staff said she was too uncomfortable to be moved. Then there was a phone conversation, "I said she is an old lady, please, make her as comfortable as you can" and then, on the 12th, she was found to be unconscious and unrousable.

Let us look briefly at what happened to this lady from her admission. On 26 March, she is transferred. She was complaining of pain and she is given Oramorph. You will remember that Professor Ford was critical of the lack of further assessment because this patient should not have been suffering from pain for this long period after the operation itself. She continues on Oramorph. On day two of her admission, she now finds herself on 40 mg of oral morphine. That is on Saturday 27 March. She then on the Sunday is vomiting the Oramorph and so that is stopped and she is put on to co-dydramol. Then, on the Wednesday of the following week, she is put on to MST. So, long-acting morphine. Her wound is noted on Thursday 1 April to be oozing large amounts of serous fluid. That was not swabbed that day and indeed it was not swabbed until some four days later. She was reviewed by Dr Barton on 6 April, although there is no note about Dr Barton herself about that, and swabs are then taken.

Then, on 7 April, so the day after this review by Dr Barton, she is seen by Dr Reid and he notices that this patient's right leg is two inches shorter than the left. You may ask yourselves, why on earth, if proper assessments were being made by Dr Barton, is that something that was not noted by her? He ordered that an X-ray be taken. Then the MST is continued, but nothing apparently is going to happen until Dr Reid sees the X-ray. Dr Reid gave evidence at Day 16/38. He was concerned that the head of femur may have collapsed. He said that Dr Barton could have ordered an X-ray. He was asked about the 20 to 200 mg prescription and he said, "I do not think that is acceptable". As I have said, according to Professor Ford, this patient should not have continued to be in pain for so long without action being taken. Dr Reid having ordered an X-ray, Dr Barton told you this on Day 29/89, "I would not have looked at the X-ray because it would not have altered my management". You have to ask yourselves why it is that Dr Barton is not going to react to an X-ray? Why is she not, at least potentially, going to go through that thought process of sending this patient back to the orthopaedic department? By the weekend of course, this patient deteriorates very markedly. The X-ray has been ordered but nothing has happened and, on the Monday morning, Dr Barton, before the X-ray apparently comes back, starts the patient on 80 mg of diamorphine. Up until that point, she had been on 40 mg MST and 5 mg of Oramorph. So this is – and again I am going to use the word – a massive jump. It is the equivalent of giving her from 45 mg orally 240 mg orally over a 24-hour period and the day before that infusion was started, she was described as being very drowsy and unrousable at times.

Dr Barton readily accepted that she had not been consulting the guidelines when she administered that dose and even Dr Reid, who you may think was not exactly quick to take any supervisory role, thought it was too high and halved it. A nurse apparently then, either deliberately or otherwise, doubled the dose of midazolam which Dr Reid thought was an astonishing thing to do in the light of his reduction of the diamorphine. However you look at that increase in the midazolam, it is extremely unfortunate. Whether it was a mistake or whether it was done deliberately, again it is one of those pieces of evidence that does undermine Dr Barton's trust in the nurses.

Daniel Redfern, the consultation orthopaedic surgeon, gave evidence of a general nature about this patient on Day 16. He told you that it sounded very much as if the implant ... I am sorry, I should not put it that high. He said that a shortening of the leg would raise concern that the implant had failed. A sound fixation without other complications would expect analgesic requirement to diminish the ability to mobilise would improve. At no time at the GWMH did the pain improve and that would worry him. He said that the shortening of the leg by 5 cm is a long way short. To be requiring morphine still two weeks after the operation is very uncommon. He said that the correct thing to do would be to take an X-ray and check the fixation was sound and "we would expect non-orthopaedic, non-surgical doctors of one or two years post qualification to exercise that course of action. He said that the bar for re-surgery would be set fairly low.

Professor Ford spoke about this patient's first administration of Oramorph as a high dose to start with. "She is very elderly and one would start with 2.5 to 5 mg". So, either a tenth or a fifth of what she was actually started with. He said, "I think the key issue with this lady for instance on 3 April was that one would not expect her to have severe pain after the surgery at this point in time. This should have led to an evaluation".

He said – and this is at Day 22/15:

> "But one would want to be particularly cautious about increasing the opiates. So one would want to only do the 30 to 50 per cent increase and hope tolerance came to the drowsiness in a patient who is experiencing the probable adverse effects and the opiates are the most likely cause. ... So if one increases that by a third or a half, on the basis she has some pain, one would reasonably give 20 to maybe 25 mg of diamorphine over 24 hours. So the commencement of 80 mg is clearly much, much greater than one would administer if one were going by the guidelines. In this patient, because she has evidence of adverse effects already, I think one would have to have very good reason not to follow the generally accepted guidelines of a 30 to 50 per cent increase.
>
> Q You mean you would go less?
> A Certainly less. As I say, a reasonably appropriate dose to give to control [the pain] would be somewhere between 20 and 25 mg of diamorphine ...
>
> Q What would be the likely effect of this, which is I think a four to five-fold increase?
> A That she would become very drowsy and it could suppress respiratory function".

A He said of the reduction by Dr Reid:

> "My view was that that reduction probably was not sufficient to prevent the toxicity she was experiencing at this point in terms of having a depressed conscious level",

So far as the increase in midazolam was concerned which was allowed for by Mr Barton's prescription and it was put to him:

B

> "Q Dr Reid described that increase as "astonishing".
> A Well, it is. It is a huge dose for an older person. It will induce deep sedation and coma".

On Day 22/17, he said:

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> A I think it is very difficult to conclude that that combination of the diamorphine and midazolam did not contribute to her death through sedation and respiratory depression".

When he was cross-examined by Mr Langdale, he gave this answer, "We seem to always be trying to conclude that the drugs which we know cause drowsiness are not the cause of a patient's drowsiness that we are looking at". He said, "I would say about that there was no
D clear evidence presented in the notes that she was septicaemia in terms of having an elevated blood pressure". In other words, the other possibilities for making her so drowsy.

Her cause of death in this case was given by Dr Barton as being a CVA for which you may think there was precious little basis.

I am going to move on to Mr Packman if the Panel are alert enough to bear with me for
E another patient. I can tell that there is not huge enthusiasm but it would be better to get on nevertheless.

THE CHAIRMAN: We will get on to Mr Geoffrey Packman.

MR KARK: Mr Packman. Again, I expect that we will all remember always hereafter this case the reason for this poor man's admission to hospital having had this accident in this
F bathroom and unable to get out. He was terribly obese and he had serious sores. He had been on Clexane at the QAH since ... Well, he was admitted on 6 August and he was put on Clexane shortly after that to make sure that he did not have DVD and then, on 18 August, there is the comment that he had a black stool overnight.

He was admitted to Dryad on 23 August and reviewed on the ward by Dr Ravindrane. Doctor Ravindrane made quite a good note, you may think, of his admission and his findings
G on admission. He had a very good mental test score. He had lower leg oedema. He was still being prescribed clexane, but that was stopped quite shortly after that on 25 August. There was an order to withhold the clexane and review with Dr Barton mane, because he had been found to be passing fresh blood per rectum. It was described by Dr Ravindrane, I think as, "This could be something serious".

Thereafter he is seen by Dr Barton on 26 August 1999 and he is described as, "clammy,
H unwell". There was concern that he might have had a myocardial infarction. An alternative

possibility was a GI bleed. That, it appears, is what actually did for this old man. On that day of that review, Dr Barton writes out her prescription for diamorphine, 10 mg stat; Oramorph up to 60 mg a day. Rather strangely here there are two prescriptions for Oramorph, one up to 60 mg a day and another up to 100 mg a day, and on the same day diamorphine was also prescribed, between 40 and 200 mg, and midazolam between 20 and 80 mg. So suddenly this rather large cocktail, frankly, of drugs is prescribed all on the same day without any specific instruction about how any of these prescriptions are meant to be used, presumably all down to the discretion of the nurses.

We know that the Oramorph was administered and he was given, from 28 August onwards, 60 mg a day. That is on the Saturday and Sunday. On the Monday he is complaining of left abdominal pain. His condition remains poor and at 14.45 – this was a Bank Holiday Monday, 30 August – the syringe driver was started, 40 mg the minimum dose allowed on the prescription and 20 mg of midazolam.

That is 30 August. Betty Packman, his wife, told us on Day 8/5-15, that he was very heavy; he had reached 23 stone. He did not complain of being in pain. He was transferred to GWMH for rest and rehabilitation. She visited every day there and on 26 August Dr Barton asked her to come to another room. She told her that his organs were not working properly and "he was going to die". "I was shattered".

Summarising, she said, "When I went back into his room he asked me what she had said and I did not tell him. At the time he did not complain of pain. I continued to visit. He got weaker and I could not converse with him easily. Eventually he was completely out of it. I did not know he was given Oramorph, but I was later aware he had a syringe driver".

Victoria Packman, his daughter, describes him at QAH as being in a "sorry state", but at GWMH, "When he first got there he was cheerful. He looked the best I have seen him in years. If anything the transfer had benefited him. He was fine for the first three days. Then we got a call saying he had had a heart attack". That may well be a reference to the myocardial infarction that Dr Barton speaks about. "We went down. He said to mum that he had had a bad case of indigestion. Two days later he was away with the fairies. He was drowsy. He could not feed himself or drink. It was shocking. He went downhill from there".

Dr Reid explained that when he saw the patient, I think on 1 September, by then the patient was terminally ill because he had had, or was having, a very significant GI bleed. At Day 16/50-60, he said, "Had the problem been recognised earlier, it is possible something could have been done for him, but his pre-existing problems would remain". He thought giving this patient diamorphine was an appropriate measure. He said, "I would not have written prescriptions for diamorphine between 40 and 200 mg or midazolam between 20 and 80 because the range was too great".

Professor Ford talks about the review by Dr Barton where she makes the comment about the myocardial infarction on 26 August. He said,

> "I would have expected some other observations in this context, certainly a blood pressure and heart rate recorded by nursing staff".

This is Day 22/20:

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> "given he is clearly unwell and at this stage there is no suggestion in the notes from what is recorded that he is for end of life care, certainly I would have expected the appropriate response was to contact the acute hospital, either the on-call medical doctor depending on the structure, medical registrar or the coronary care unit".

He was asked about the note which was made by Dr Barton, "Not well enough to transfer to an acute unit". He said,

B

> "I cannot really follow the logic of that. It indicates he is very unwell and that is even more of a reason why he needs to be in an acute hospital".

He was asked about the 10 mg that was given to the patient intramuscularly, and he said,

C

> "Yes, one would normally give it to people complaining of chest pain with myocardial infarction but I think if that is the working clinical diagnosis, although the absence of an ECG, if that could have been obtained, there is some question over it, I would not consider that is unreasonable".

Sir, can I just ask you please to turn up head of charge 11(c)? It is rather complex, I am afraid,

D

> "Your actions in prescribing the drug described in paragraphs 11(a)(ii) and or (v)",

Head of charge 11(a)(ii) refers to the verbal permission for 10 mg of diamorphine to be administered to Patient J, and the criticism is that that was inappropriate, and in the light of Professor Ford's concession, just to give you the reference again it is Day 22/21, you may think that in respect of that particular prescription, and also in relation to 11(c)(iii), that it was not in the patient's best interests, that the criticisms in relation to that 10 mg dose fall at this

E

stage.

However, when he looks at the rest of the prescription, he was less complimentary. He said,

> "he is a big man, although weight does not have necessarily a large impact on the dose required. Again, one would want to start with the usual suggested dose of I would have thought 10 mgs but not 20 mgs and observe the response, but I am not

F

> clear from the notes what the opiates are treating because he is not being described as being in pain at this point".

In relation to the 40 mg start of diamorphine, he says,

> "Yes, Yes, it is very high and, again, there is no - he has got abdominal pain, he seems to have been placed on an end-of-life care pathway, if one wants to use that phrase at

G

> this stage. His abdominal pain is being treated with high doses of opiates".

The fundamental issue here is that there has not been an approach for assessment to try and treat the underlying problem. There is not a clear justification for prescription or the subsequent doses administered of diamorphine and midazolam.

Then,

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> "He should be transferred back, or at the very minimum a discussion had with the on-call medical team to accept him for management that cannot be provided and interventions on the Dryad Ward site".

He said,

> "I think the vast majority of rehabilitation teams would have attempted to mobilise this patient, recognising that it could take a very long time".

B

That is Day 23/48. Asked again about the decision not to refer him back to the acute unit – Day 23/49 when he is being cross-examined by Mr Langdale – he said,

> "I do not think that decision should have been made by the clinical assistant without discussion with the on-call acute physician or on-call geriatrician. I find this statement, 'not well enough to transfer to acute unit', difficult to understand. He is clearly very unwell. In my view that argued even more strongly for the case to transfer him to an acute unit for treatment. His prognosis is extremely poor without treatment as we have seen. I do not think the situation for this man was completely hopeless. In my view I do not think he was destined to die".

C

With those words, I have just one other comment to make about this patient. It is worth remembering that the first prescription for this patient by Dr Barton was an anticipatory prescription and that means, of course, that she was apparently foreseeing not only that the patient would need opiates in due course, but somewhat surprisingly that he would need no less than 40 mg of diamorphine, and we say that that was unjustifiable in these circumstances.

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That is all I say about that patient. There are two more to go, but it may well be that you could all do with a break.

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THE CHAIRMAN: We will return at 20 minutes to four.

(Adjourned for a short time)

THE CHAIRMAN: Mr Kark?

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MR KARK: I move on to Patient K and the final furlong, as it were. This is Elsie Devine who had nephritic syndrome or kidney failure, but apparently fortunately, no multiple myeloma. You will have seen that she had been under the care of Dr Cranfield. She had worsening creatinine levels at the time she was in QAH and then on Dryad Ward, but her mental test score was in keeping with severe dementia but she was described as a very pleasant lady. You will recall her daughter, Ann Reeves, gave evidence on Day 5, pp 1 to 19, and she described how this had all come about because her husband had been unfortunately [redacted] and was being treated.

G

She described her mum as being, "like a rock". Then on 9 October she came down to find that mum had decided to have a tea party which sadly nobody had attended, and she realised that things were not quite right. That is what had caused her admission to QAH.

H

A She was treated there, having been admitted also with a history of UTI, but actually no pain for this patient, and that may be significant in terms of later events. On 21 October she was said to be suitable for a rehabilitation programme. She was transferred to GWMH and reviewed by Dr Barton, who on this occasion said that she had a Barthel of 8. The plan was, "get to know". Assess rehabilitation potential. Probably for rest home in due course, and she had a very low mental test score of nine out of 30, which Professor Ford thought was in keeping with severe dementia.

B She is then reviewed. She is described as being confused on occasion, and disorientated. From around 11 November she is put on thioridazine, which is a major tranquiliser, to try to make her less agitated because she was at times agitated, and she stayed on the thioridazine. On 15 November she is being described as "very aggressive at times".

C She is reviewed on 18 November by Dr Taylor and at that stage, unfortunately, the patient was refusing medication, not eating well and was at times more restless and aggressive again. Dr Taylor was going to arrange for her to go on the waiting list for Mulberry Ward, and Dr Joanna Taylor gave evidence to you on Day 5/22. She described that letter of hers on 18 November. She said,

> D "I got the impression that she was happy and had no complaints. She told me that the tablets she was taking made her mouth sore. I recorded my plan to transfer to Mulberry Ward when a bed was available. By 'deteriorated' I meant that her mental health had deteriorated and she was now more aggressive, more restless and refusing medication".

So obviously this patient was unwell. What happened thereafter, after that review by Dr Taylor however was that this patient had suffered a deterioration. First of all, she is put on a fentanyl patch the same day as that review by Dr Taylor. That fentanyl patch was described E by Dr Barton. It is a 25 mcg patch which, at the time was the lowest that could be given, and it was given at 9.15 in the morning of 18 November. That may be prior to her review by Dr Taylor.

Then, the following morning, she has this very aggressive incident. Dr Barton apparently was in attendance. She is given chlorpromazine, which is a major tranquiliser, but which Professor Ford regarded as a reasonable response to that serious disturbance, but then an hour F after the chlorpromazine was given the patient was put on a syringe driver at 09.25. Again, just to remind you, if you need reminding – I am sure you do not – it does not look as though the fentanyl patch was removed until three hours later at 12.30. On 19 November this patient is on fentanyl, chlorpromazine and diamorphine and midazolam. The lowest rate prescribed by Dr Barton for this totally opiate-naïve patient was 40 to 80 mg. So the lowest dose 40 mg, and midazolam 40 mg, which Professor Ford, as we will see, describes as extremely excessive.

G Dr Reid was asked about this. He said: "I would expect a note to have been made as to why the fentanyl had been started. Dr Barton on the 19th wrote, 'Confused and aggressive'. I would have been more cautious, he said, in my use of diamorphine and midazolam. I would have had reference to the *BNF* and followed guidance. I did not see the prescription." Then he said, "I must have done but I don't recollect it." He then said, "I should have done something about it." This is Day 16/60-66.

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A Professor Ford was first asked about the morphine solution, the Oramorph solution, which was prescribed on Patient K's admission on 21 October. She was prescribed on the day of her admission thyroxine, frusemide, temazepam and Oramorph between 5 and 10 mg. That is long before, of course, the syringe driver started. He was asked:

> "Q ... At this stage, is there any basis for that prescription?"

B And Professor Ford said:

> "A I could see no basis for the prescription on the information in the notes."

This is directly relevant to head of charge 12(a)(ii), the criticisms of this prescription. He said:

C

> "A ... She is not in pain. Certainly if one has agitation and confusion in a patient with dementia, in the vast majority of cases it is not due to pain. It is a common problem that one sees in patients with dementia.
>
> Q Is Oramorph a suitable medication for confusion or dementia?
> A It is not at all a suitable medication."

D He was asked on the following page:

> "Q ... Help us, please, with your view on fentanyl. ...
> A Again, the medical and nursing notes do not indicate that the patient is complaining of pain. ..... There are two issues about the fentanyl prescription in my view. One is that there is no indication, appropriate indication, recorded in the notes. If she was in pain, there is no indication that it would not have been feasible or
E appropriate to give either an oral or subcutaneous small dose of opiates, but I could not find any evidence she was in pain. Secondly, the use of a fentanyl patch, because of the very high dose in an elderly patient with moderate renal failure, was highly likely to result in adverse effects."

You should bear in mind, and I respectfully remind you of it, that so far as the fentanyl is concerned, there is no specific criticism in fact in the heads of charge, although it stated that
F it was given. The criticism is in relation to the first prescription of oral morphine and then 12(a)(iv), which is the diamorphine and the midazolam. Of course, however, those prescriptions were written by Dr Barton on 19 November when she knew that this patient was already on fentanyl. That is the relevance of the attack, as it were, in relation to that particular prescription.

Professor Ford said, "If you give a dose that renders the patient unconscious, that will stop
G them wondering round, but that is unacceptable, and a dose of opiate does not produce that. It is actually just as likely to make the confusion worse. So opioid is not an appropriate treatment for behavioural disturbance in patients with dementia."

When he was asked about the administration of 40 mg of diamorphine and midazolam, he said at Day 22/28:

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A

"A Well, again, the approach appears to being taken to increase the opiate dose to deal with her symptoms of agitation, behavioural disturbance, and I say that is not appropriate and is not an indication for opiates. There may have been a lack of appreciation about the extent to which the fentanyl effects would continue, so you have got the background fentanyl effect which is going to be there for quite some hours, and then you are adding in another 120mg equivalent of morphine."

B

Professor Ford said this:

"I mean, this is a very, very large opiate dose in an elderly lady with renal failure. Then, looking at the use of midazolam, so going back for the treatment of terminal restlessness, well, she is certainly restless, we know that, that is part of the problems with her dementia. Is she terminal? Well, a decision seems to have been taken that she is now having terminal care, but even if one were to accept that that decision was

C

appropriate and therefore she had a terminal restlessness, the dose used is extremely excessive, in that, you know, the recommendations are to start with 10mg for 24 hours in an elderly person, and this will result in profound sedation. There has been no titration up to that to see if it was appropriate, and I do not believe it was appropriate. To start at 40mg over 24 hours was a very high, excessive dose."

He said:

D

"... I think it is difficult to conclude they did not contribute to her deterioration and death."

Those are really our criticisms of the prescriptions administered to Patient K. Again, we come back to the issue of no titration at all. The handbook has gone out of the window, quite frankly. The *BNF* has gone out of the window.

E

When Professor Sikora was giving evidence and I said to him that Dr Barton had accepted that she had ignored the *BNF*, Mr Langdale took up the cudgels, as it were, on Dr Barton's behalf. Can I just remind you, and this is just a smattering of what Dr Barton said about the *BNF* (I am going to move on to Patient L in any event, but just to interject. This was in relation to Patient A, and the first prescription. I asked her at Day 29/14:

F

"Q Can we take it that if you had the palliative care hand book in your pocket at the time that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

G

Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you

H

were not looking at those were you?

A

A Not on this particular occasion, no."

In relation to Patient B, Day 29/26:

"Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?
A Yes."

B

This was the 40 mg dose.

"Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?
A Yes."

C

Patient F. This is Day 29/55.

"Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

D

Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the *BNF* of course.
A Of course."

E

If you have any doubt that Dr Barton had frankly given those guidelines a miss, then you may wish to remind yourselves of her specific evidence about it.

Can I turn then finally to the case of Jean Stevens and Patient L, who had had the misfortunate on 26 April 1999 to collapse at home with a right handed stroke. In relation to this patient, all of the opiate prescribing by Dr Barton is criticised, including the Oramorph, and it is alleged that there was, even though the patient was ill and may not have recovered

F

from her stroke, insufficient clinical justification for her prescriptions. This was the patient, you may remember, when she had been at the QAH, who had her problems with the nasogastric tube, which might or might not have caused her later broncho-pneumonia problems. She had at the QAH occasionally been given diamorphine. She was transferred on 20 May to Daedalus Ward. The last time that she had been given diamorphine was on 15 May, when she had been given 5 mg subcutaneously.

G

There was from the QAH, when she was reviewed on 18 May, liaison with the GWMH who were said to be happy to take her with the blood results that they then had. The patient seemed then to have recovered from her aspiration pneumonitis. There had been a slow improvement in her orientation, her speech and her strength, but she was still faecally incontinent and required a catheter. She was transferred to Daedalus Ward on 20 May. Diagnosis and treatment in hospital – stroke; for rehabilitation. Her aspiration pneumonia was said to be resolved. She was reviewed by Dr Barton on 20 May, on the day of her

H

transfer. She was said to be for slow stream/rehabilitation as she needed help with all daily

A living activities, catheterised, her Barthel was zero. There is no real reference to any plan there and she was prescribed on the day of her admission with Oramorph, 5 to 10 mg, of which she received 15 mg that day as soon as she got there at 2.30 in the afternoon, and then at 6.30 at night and 10.45. She was also prescribed the usual diamorphine and midazolam.

One has to ask, on what clinical basis were those prescriptions written. She had been at the Haslar for a month with a minimal amount of diamorphine and that was irregularly. By the B day after her admission, on 21 May, she is given 60 mg of Oramorph. This is to a lady who is suffering from a stroke. She is said to be uncomfortable through the afternoon. She is seen by her husband, Ernest. He said at Day 9: "I did not see Dr Barton at all at the GWMH. I was by the bedside of my wife the whole time. She was not in any sort of pain. She did not show any sign of pain or distress. She was not administered with any fluids. She had had previous pain from her bowel." He said that when she was transferred, "... she had development sufficient swallow for transfer and she was in good spirits. She was transferred C on 20 May. When I visited her she was lying in bed in a coma. I did not know why she had deteriorated so quickly. A nurse called Philip said she was in a lot of pain and he wanted permission to double her morphine. He said he would phone Dr Barton for permission to increase the dose. At the GWMH she never made any sound, never gave any indication of pain or discomfort. Her daughter, June Bailey, told you that she had visited her mum at the Haslar, but when she had seen her there after the stroke, she was propped up in bed chatting. She had lost the use of her left arm and leg but she still had all her faculties. I visited her on D the evening before transfer. She was in good spirits and they were planning a party for her return home. I visited her at the GWMH the following day. She was asleep and unrecognisable. She never made a sound or gave any indication that she was in pain, and on the 21st there was no response."

Professor Ford gave evidence about this patient, Day 22/32. He says:

E "A The notes do not record there was a physical examination."

He said:

"A ... I think the issue is around if this lady was complaining of pain should she have been examined, and particularly around the issue of the abdominal pain, which is referred to...

F

...

A ... you would not treat chronic abdominal pain with opiates?

Q Why not?
A Because with chronic pain, opiates you try to avoid because they are not G particularly effective, and you do get problems of dependency and difficulty getting people off opiates for non-malignant chronic pain...

Q Being realistic with this lady, the question of getting her off opiates probably is not going to be a significant issue, is it?
A No, but it is a lady you are intending to rehabilitate, you want to avoid the adverse effects of opiates as well. Just because she has a severe level of disability H from her stroke is not an indication, or lessens the issue of giving her opiates. We

A would not in any circumstances start approaching this sort of problem in a patient with a severe stroke who is complaining of abdominal pain by prescribing opiates."

"Not in any circumstances", was his view.

> "Q ... We can see that she prescribed 20-200 mg, midazolam 20-80 mg by syringe driver. Again, I am not going to take up time, you have commented
B extensively on these sorts of prescriptions, in your view appropriate or inappropriate?
> A Inappropriate, because this lady has been transferred because it was thought she was medically stable, she has got a stroke, she is coming for rehabilitation, her outlook, as I describe in my report, is poor. I mean, this is a lady who is going to require care either in a nursing home or with considerable care package from her family and other carers if she were to be able to return home after what would likely be a very prolonged period of rehabilitation, but she is not in any way expected to be
C dying within the near future, from the information presented in the notes.
>
> ...
>
> A ... A Well, I have already commented that I, from reviewing the notes, was not of the opinion that the opiates were indicated..."

D and then he talks about, if they were going to be used, the diamorphine equivalent would have been slightly less than in fact they were.

> "Q In your view, is the diamorphine and the midazolam likely to have had any significant effect upon her?
> A Again, this was a lady with a severe stroke. She could have died suddenly from a pulmonary embolus or other problems, but the timing is very suggestive that
E the drugs contributed to her death"

and,

> "... opiates are not good in terms of patients engaging and effectively recovering rehabilitation".

F Day 23/63. So, this lady who is effectively opiate naïve apart from her co-dydramol when she arrived at the GWMH, on her first day she receives opiates and on the next day she is put on a syringe driver at what we have come to regard, as I say again, a low dose but, for this elderly, frail lady, perhaps it was not and it was, according to Professor Ford, wholly inappropriate.

It was Dr Beasley, we know, who increased the hyoscine on the second day on 22 May, but
G Dr Barton was not, I think, suggesting that it was he who ordered the syringe driver to start and she accepted, Day 30/40, that it looks as though the syringe driver was started by nurses and it was started because her own prescription allowed it, again with no indication to the nurses of how it was to be used and the patient died the day after that syringe driver was started. Professor Ford's view was that that lady should never have been treated with opiates, full stop.

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That is all that I say about the individual patients and I have one or two concluding comments. You may think that one of the central problems here is that no one from the outside medical world looked in and examined what the customs and practices were which had built up over a period of time at the GWMH. Consultants appear to have accepted in part what was happening even when they must have been looking at prescriptions way outside the norm. One of the most startling pieces of evidence that I expect you have heard in the last eight-or-so weeks was when Dr Barton told Mr Langdale that the criticisms of Professor Ford did not give her cause to question her judgment and I asked her again about that on Day 29/61:

> "Q Do you mean that? That they do not even give you pause for thought about your judgment?
> A I do".

When you consider the evidence and consider whose evidence to accept and whose to reject that if it comes to that in relation to any particular issue, it may be worth coming back to that reply because it reveals a doctor frankly who is absolutely convinced of the infallibility of her own judgment and who will stand before you and justify what we submit to you is frankly unjustifiable. When Dr Barton was asked whether she felt it mattered whether or not a patient who was dying was overdosed, her reply was revealing. Day 31/8 and it was the Panel questions, I think from Mrs Mansell;

> "That is a very good question, is it not? If you believe that and you think that is true, why am I here?"

She said that she thought that probably overdosing with anything was wrong, incorrect and unprofessional. She also said later when I questioned again, Day 32/4,

> " ... I think that if I was accused of over analgesia or sedation rather than under analgesia or sedation, I know which direction I would wish to err".

Luckily, you do not have to consider the very wide issues that this case might be thought to throw up. You have to consider the specific evidence in this case at the specific charges. We ask doctors to abide by *Good Medical Practice* and have regard to the guidelines for prescribing opiates. When Dr Barton says, as we submit that she did, that she ignored the *BNF* and the *Wessex Protocols* time and time again, when that same doctor makes no note about what she is doing or why she is doing it and when she delegates responsibility to nurses for deciding quite often how much to give and on occasion when to start the terminal path, then you have to consider whether those actions could ever be in the best interests of her patients and although there are many other people who might be looked at and upon whom the shadow of blame can be cast, in terms of ultimate responsibility, this was, in Dr Barton's own words, Day 31/9, "my wards, my patients, my nurses" and the responsibility, we submit, ultimately is hers.

Sir, those are my submissions.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Mr Langdale, I do not suppose that you want to start today?

MR LANGDALE: I could but I would not want to be accused of sadism or indeed

masochism!

THE CHAIRMAN: I think you would suffer from both accusations!

MR LANGDALE: Really, it would make much more sense from everybody's point of view if I start tomorrow.

THE CHAIRMAN: Yes. Do you have any sense of the time that you will be taking? I imagine that it will be certainly no less than Mr Kark.

MR LANGDALE: I certainly will not be less. I shall certainly take all of tomorrow and I may spill over into Thursday.

THE CHAIRMAN: That is very helpful. We will rise now, ladies and gentlemen, and reconvene tomorrow morning at 9.30.

(The Panel adjourned until Wednesday 5 August 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 30 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-FIVE)

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

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

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

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THE CHAIRMAN: Good afternoon everybody. In so far as three o'clock is not before two, my estimations yesterday were not entirely wrong, but I do apologise for the extra time that we have taken.

DECISION

Before the end of proceedings yesterday, you made an application to adduce evidence on behalf of Dr Barton from three witnesses, two of whom are patients of Dr Barton, and all of whom have had a parent treated by Dr Barton during her time at the Gosport War Memorial Hospital (GWMH). You stated that their evidence will give the Panel some insight into Dr Barton's general disposition and patient care practices at the time. It is your submission that their evidence is relevant to certain aspects of the fact-finding exercise that the Panel has shortly to perform.

Mr Kark, Counsel for the GMC, opposed your application on the basis that any evidence given by these witnesses would be either character evidence, or evidence not specifically relating to the allegations in the case. Mr Kark submitted that the GMC's case relates only to the care received by the twelve patients that have been considered during this hearing.

The Panel has considered your application. It has had regard to your submissions and those of Mr Kark. It has also noted the advice of the Legal Assessor in relation to relevant evidence at the fact-finding stage. The Legal Assessor has advised that it may be helpful to consider separately the proposed evidence as to good character and general medical skills on the one hand, and Dr Barton's examination practices on the other.

Dealing with Dr Barton's examination practices, the Panel notes that there are specific allegations as to failures in her examination and assessment of twelve patients. It appears that

A the proposed evidence does, in part, concern the issue of patient examination by Dr Barton at GWMH during the period under consideration.

B It is not in dispute that Dr Barton assessed patients other than the twelve with whom we are directly concerned. The Panel notes that the fact that Dr Barton assessed other patients does not however, mean that she necessarily assessed these twelve.

C The Panel recognises that a large number of witnesses have already been asked general background questions by all Counsel and by members of the Panel. As you pointed out, there were questions for example, as to the safety of the wards and Dr Barton's interaction with relatives. It would appear to be inconsistent if evidence on such issues were now to be

D excluded. If adduced, the proposed evidence might or might not assist the Panel in determining the factual issues before it. The Panel will only be in a position to make such a judgement, if it permits the evidence to be adduced.

E

As to evidence concerning the Doctor's good character and general medical skills, the Panel recognises that such evidence can have no relevance to the fact-finding process, and the Panel notes your concession that such evidence is not for the Panel to consider in relation to serious

F professional misconduct under Rule 27(2)(ii). However, the Panel recognises that, for the reasons given by the Legal Assessor, such evidence has already been elicited from many witnesses. The Panel takes the view that it is well able to set aside consideration of such

G evidence until the appropriate stage is reached, and that it would be wrong and unnecessary to require witnesses to return on a second occasion to give such evidence.

H It is on this basis that the Panel has determined to accede to your application.

There is a matter that the Legal Assessor would like to raise.

THE LEGAL ASSESSOR: Thank you, Chairman. It is simply this. If one looks at the transcript of yesterday's hearing, Day 34, 29 July, there are two matters which need correcting in terms of the transcript of the legal advice I gave. I am confident that I gave advice, in fact, in the terms which I am about to correct. Could people please go to page 64 of the transcript.

MR KARK: Sir, we do not yet have it.

THE LEGAL ASSESSOR: Perhaps a note can be made of it.

THE CHAIRMAN: We have the transcripts just coming out. (Same circulated)

THE LEGAL ASSESSOR: If one looks at page 64 of the transcript, the bottom paragraph on that page starts with the words "In order to be relied upon by you", the third sentence in that paragraph should read as follows:

> "Although it is a matter entirely for you, you will no doubt wish to consider the position very carefully before you conclude that any character evidence or general evidence as to medical skills...".

That is the first correction. In that paragraph if one goes to the third last sentence, starting with the word "Furthermore", that should read:

> "Furthermore, I anticipate that you will hear...".

I am confident, in fact, that those are the words I used when I gave my advice yesterday. Thank you.

MR KARK: Sir, certainly I accept those corrections. Can I just make a comment about your determination and it is not in any way seeking to go behind it at all.

At the beginning of the determination, it certainly sounded as if you were indicating that in your view as a Panel at this stage which you are soon to reach, in other words the fact-finding stage, character cannot be relevant. There are circumstances where character can be relevant if it is character evidence of a particular nature. In due course, no doubt, your Legal Assessor will give you advice about that. It is just to put down a marker now that I am sure you were not indicating that, should you receive contrary legal advice in future, the Panel was indicating in no circumstances would you be accepting character evidence as being relevant to the allegations. If, in so far as the Legal Assessor advises you that it may be, then no doubt you will review that position.

THE CHAIRMAN: I am sure that that would be right. We were looking at the position from the point at which we are currently. I think that you had indicated to us that it was not appropriate for us to take character evidence into account at that fact-finding stage, in terms of the allegations.

MR KARK: What I was saying was, character evidence of this nature, rather than character evidence generally.

THE LEGAL ASSESSOR: Perhaps I could just emphasise the fact that in the advice I gave yesterday – in fact we have just looked at it – I have already stated that I will advise the Panel formally in due course that Dr Barton's good character may be take into account, assuming that is a matter which is agreed. That part of the determination, I am sure, will be read in the light of the advice that I gave yesterday.

MR JENKINS: I am going to ask if the determination you have just reached has been reduced to writing. I am sure it has. I would like the chance to have five minutes just to look at it, to ensure we adhere to it.

THE CHAIRMAN: It has, and there can be no reason why you should not now be given a copy. If you would like five minutes to read it, you will certainly have that five minutes.

MR JENKINS: Thank you. I would be grateful. (After a short pause) Sir, thank you very much. Can I say, we have had to re-jig the witnesses slightly as a result of matters yesterday. I would like to call one lady who was the practice nurse at the GP practice. She did not, in fact, have a relative who was at the War Memorial Hospital. To the extent that I said yesterday she did, I had mis-recalled the information I had been provided about her, and that is my fault. However, I would like to call her. Knowing as I did this morning that I had misled you yesterday about that, it is right that I should say that before I call her. She is a practice nurse. She will have seen Dr Barton dealing with patients on a regular basis, and I raise that before calling her in case anyone wants to raise any objection, given the ruling that you have given. We have had to re-jig patients. I am going to call someone other than someone we were intending to call, but this person did have a relative who was treated at the War Memorial Hospital and I hope to call her this afternoon as well.

THE CHAIRMAN: While we are on the subject of *mea culpa*'s, on reflection, Mr Kark, I think that we might better have drafted that paragraph in relation to good character by the simple addition of three words. Where the paragraph begins "As to evidence concerning the doctor's good character and general medical skills, the Panel recognises that such evidence *from these three witnesses* can have no relevance to the fact-finding process." I think that was the implication, albeit a silent one of what we were intending at that point.

MR KARK: It is always slightly difficult thinking these things through on one's feet, but having indicated that you need to hear it before you can decide whether it might have relevance, it might be better to reserve your judgment, as it were, on that amendment.

THE CHAIRMAN: That is a further interesting point. I am grateful. I was not suggesting I would make an amendment in any event. It was merely to illustrate, I think, what was in our mind rather than the general point of evidence. It was the specific evidence that was sought to be adduced today.

MR KARK: Just having heard from my learned friend in the spirit of abiding, as it were, with your clear wish to hear evidence and then deciding afterwards what weight you are going to give it, I am not going to raise any further argument at this stage which might delay us even more.

THE CHAIRMAN: Thank you very much.

MR JENKINS: I will get on and call some witnesses if I may. I am going to start with Patrick Carroll, please.

PATRICK GWYLYM CARROLL, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

MR JENKINS: I am going to ask you to give us your full name, please.
A My full name is Patrick Gwylym Carroll.

Q What do you do, Mr Carroll?
A I am a qualified occupational therapist.

Q When did you qualify?
A I qualified in 1989.

Q I think you are registered with the Health Professional's Council.
A Yes, that is correct.

Q At some stage did you work in Gosport?
A Yes, I worked at Gosport War Memorial from 1994 until 2004 delivering occupational therapy to in-patient wards as well as direct referrals from general practitioners out in the community.

Q We know about several wards at the War Memorial Hospital during the 1990s, Daedalus Ward and Dryad Ward, and we have heard of Sultan Ward, which we have been told was a GP led ward. Is that right?
A Yes, that is correct.

Q We know that Dr Barton worked there from before the time you started in 1994 and she left the War Memorial Hospital in the year 2000.
A Yes.

Q Did you come across Dr Barton during the time you and she both worked at the Gosport War Memorial?
A Quite routinely in terms of working with patients from Dryad Ward and Daedalus Ward as well as occasionally patients on Sultan Ward. Sometimes I would also take direct referrals from Dr Barton to see patients who were out in the community still living at home.

Q How would you be seeing patients on Dryad or Daedalus Ward? How would you come to see them?
A The role of occupational therapy is to facilitate discharge from those wards. Generally, going back to 1994 to 2000, those wards were very slow stream rehab, or what was called continuing care then, so we would only occasionally get referrals for patients who were considered to have improved or stabilised to a point where they were to be considered to go home to live independently or with support, or alternatively we might occasionally do assessments related to the level of care they might need in terms of whether they were going to go into residential care or nursing home care.

Q How would you come to know that a patient was on those wards and that your involvement might be beneficial.
A They would generally be referred by the sister in charge of the ward and then that would mean that I would go along to either a ward round or a specific meeting with the multi-disciplinary team to discuss the referral.

Q What would you say was the level of cover that you were able to provide patients on those two wards, Dryad and Daedalus Ward?
A For general referrals it was ad hoc cover. Traditionally the patients who were admitted to those wards were not anticipated reaching a level where they would be able to live independently in the community. So the service I worked for at the time was not funded to cover those wards but we covered the hospital anyhow, and as they were not that frequent, we would be able to cover it on an ad hoc basis. So we were able to deliver what was required, but there was not a formal agreement or formal service in order to do it.

Q Ad hoc means just that, as required, does it?
A Yes. If they asked we would go and see the patient.

Q Does it follow from what you said that it was not part of your job description to provide cover for those wards? It was not planned that those wards would have cover.
A Not specifically, but we had capacity to be able to do it and because they were not frequent referrals it would be a case of prioritising the workload so a referral from Dryad Ward may take an extra few days to pick up, but we would be able to do it. If we were overloaded with referrals from the other wards, particularly Sultan, those would have to take priority, but it was not unmanageable.

Q How much time were you able to allocate to the patients on Dryad or Daedalus Ward?
A As much time as was needed to discharge the patient. If they were capable of being discharged home they would get a full, comprehensive occupational therapy assessment in the hospital, usually because those patients had been so dependent we would take them out and do a home visit to see whether they could manage in their home environment as well.

Q What, during the period that you and Dr Barton overlapped – 1994 to 2000 – was the general level of mobility and the prospects of rehabilitation for those patients on those wards that you were aware of?
A I guess we probably saw between 10 and 20 per cent of the patient population going through those wards. It tended to be that it was fairly unusual for a patient to stabilise and recover to the point where you could consider them living independently in the community with special services support.

Q Did the mix of patients on those wards stay the same over that period of time?
A I think yes and no. Yes, they did, but what changed was the expectation of rehabilitation and getting patients home. The drive became that it was much more expected that we would not just shrug our shoulders and say, "This person has to go into care". It would be, "How can we enable them to go back and live in their own home?" So it was a general shift, I would say, within the hospital and the drive of the NHS to move away from continuing care; i.e. somebody who is admitted on an open-ended admission to the expectation that they would move through the ward and move on to some other place, either their own home ideally, but often into residential care or nursing home care.

Q How much contact would you have had with the senior nursing staff on the two wards, Daedalus Ward and Dryad?
A I would be on there at least weekly, sometimes three times a week. What we do is we walk the wards and we would ask and see who were the new admissions; what was the likely potential for their care; what was the estimate in terms of was their medical diagnosis such that they were likely to stabilise and improve? Could we think about them going home? So it is a case of primarily building a relationship with the ward sister and keeping an eye on it, because it is a two-way process. You do not just rely on the ward telling you. You want to be seen on the ward so that you are giving advice because sometimes the opinion of the occupational therapist that somebody can go home is going to be different to the ward team's.

Q Absolutely. Would you have had time to form a view as to the standard of care being afforded to patients on those two wards, Dryad and Daedalus Ward?
A Yes, because you are on the wards quite frequently and from my perspective there was never any concern that the standard of care was anything other than good to excellent. I think within health services you sometimes do get a feel that people will be wary about wards, but that was never anything that I picked up or felt within the War Memorial.

Q I have asked you about two wards, Dryad and Daedalus Ward and you have just given me an observation. Does that apply to both wards?
A Yes, and Sultan as well.

Q What would you say of the standards of nursing care for the patients, again on both of those wards?
A I think the standard of nursing care was good to excellent. I would not characterise any of the wards at the War Memorial as being anything other than having above average care generally on the wards.

Q The Panel knows that on Daedalus Ward Sister Sheila Joines was in charge on the nursing side for much of the time that you were there.
A Yes.

Q Then the ward manager was Philip Beed.
A Yes.

Q On Dryad Ward, throughout the time with which we are concerned, certainly from the time you were there, it was Sister Gillian Hamblin.
A That is correct.

Q Again, what would you say about those three individuals as nurses, sisters in two cases and ward manager in the other?
A I think if I had to list them in order of people I had the best rapport with, I would probably say Sister Hamblin first, then Philip Beed and then Sister Joines. Sister Hamblin and Sister Joines were what I suppose we would now describe as classic, old school ward sisters where basic nursing care was paramount and they did rule the ward. They were the authoritative figure on the ward. I had no difficulty working with either of them. I would say the level of patient dependency was often higher on Dryad ward than Daedalus Ward and so we did not necessarily, as an occupational therapist, anticipate a high number of referrals from that ward. We tended to get a few more from Daedalus Ward.

Q What would you say from your perspective about the success that was being had with patients being treated, both by the nursing and medical staff but also yourself?
A I think if you consider what the wards were there for, it was a balance between sometimes the frustration that they had a tendency to get patients better when maybe it was less expected. They get patients to a level of independence where you really could consider discharge home and that would create more work for my service and myself because domiciliary visits would be required for those patients because they had been so dependent. You could not trust what you saw in the hospital. You had to see it within the patient's own environment, so if anything I think they tended to get rather more patients than I would have expected to the level where they could live independently.

Q What would you put that success down to?
A I could only put it down to the care that they received because sometimes patients would be transferred in pretty poor states and it would takes sometimes several weeks to stabilise them. On Dryad Ward I would often say to Sister Hamblin, "Let us see what the patient is like in a couple of weeks or three weeks", just to be sure that they had stabilised and part of that was me protecting myself so I could actually plan my diary in enough time. So my impression was that they provided very high levels of care.

Q What about Dr Barton, what would you say about her?
A From my perspective I think sometimes it is difficult to build a rapport with general practitioners because sometimes they hold themselves aloof, often for very understandable reasons, or there is a tendency to prescribe other professional's practice. They would say, "I want Patient X to have occupational therapy" and then do not define that; they do not define the problem, whereas referrals from Dr Barton would be much more of an open discussion about, "Do you think you could see this person? Do you think they would benefit? Could you get them out on a home visit/" It was much more of a professional dialogue rather than a fire and forget type of referral, which I think generally my experience of general practitioners is that they like to fire and forget.

Q What would you say, from what you saw, of Dr Barton's commitment to patient care?
A I think the level of involvement she had with the patients was extremely high. It was certainly different to other GPs I have worked with. She was very concerned that patients received a good level of care within the context of what is quite a difficult thing; it was quite difficult to provide in those days good medical care within a community hospital. It tended to have been developed, I felt, from an informal agreement and Dr Barton, if you were going to see a GP, you would see Dr Barton. Generally I would say I would have expected or been aware that she would have popped into the hospital almost daily, and that is really quite unusual in comparison to some of the patients who were admitted on to Sultan under the care of their GP. Dr Barton would be somebody who is around that you could have a dialogue with and you felt your point of view was being heard and very much felt like you were part of a team being led to provide the best outcome for the patients concerned.

Q You would have been on those wards doing a walk through, you have told us.
A Yes. That is how I would pick up the referrals. In terms of working with the patients, if we were carrying out assessments to see whether somebody could wash and dress, we might be on the ward for an hour, an hour and a half, in the morning

A where we would take over that process with the patient from the nursing staff in order to see how much the patient can actually do for themselves so we can make a clinical judgment about how they might cope at home where carers might not be completely reliable and they might have to get themselves washed and dressed.

Q You told us you might be dealing with 10% or 20% of the patients on the wards.
B A Yes.

Q Why were you not dealing with the other 80 or 90?
A Sometimes because they were simply too medically unwell. Sometimes it was - I do not know whether now it would be, but then it would be obvious that the patient was not going to be able to go home. Some of the patients were, effectively, receiving palliative care. They were not going to improve to the point
C where perhaps they could even be discharged from the hospital. A lot of transfers into that ward would come from the acute hospitals and there is great pressure on the acute hospitals to clear their beds, they need to get their beds clear, and if they have a patient who is clearly not going to be able to go home they would want to transfer them into a continuing care bed or a very slow stream rehab bed in order to relieve the pressure on the acute side, and sometimes there would be a tendency for those hospitals to perhaps - I think the kindest way would be to enhance the
D patient's capabilities and potential in order to facilitate the transfer, so we might be told somebody is mobile with one and then when they are on the ward and we carry out an assessment they either are not mobile or they are mobile with three physiotherapists and a walking frame. I suppose it is playing within the system in order to move patients through.

Q Are you able to help us with the practice of transferring patients from one facility to another and whether that may have any consequences for the patient?
E A I think it is sometimes underestimated that a patient in the acute trust might have transferred through three wards and then, sometimes very late at night, would have been transferred by ambulance to the War Memorial. So somebody who could be described as stable after 24/48 hours in an acute hospital, the stress of the ambulance journey, the stress of the transfer, could set them back quite considerably and have a marked impact on their medical state. So often we would want to delay even thinking about an assessment or a referral for several days after
F somebody had been transferred.

MR JENKINS: Thank you very much, Mr Carroll. Would you wait there because you may be asked a few questions by others.

Cross-examined by MR KARK

G Q I have very little to ask you. Can I just deal with the comment you just made about, effectively, playing the system to get the patients transferred out of hospital? Are you saying that in relation to both the QAH and the Royal Haslar?
A They were the primary transferring hospitals so, yes, it was certainly known that it would happen.

Q So far as the patients that you saw on Dryad and Daedalus wards, do we take
H it you saw those patients who were referred to you by the medical staff?
A Yes, and we would also discuss potential referrals in the ward rounds, so we

A would discuss other patients in terms of what their likely potential was because I would be trying to establish what my workload might become in the next couple of weeks or so.

Q I understand, but if Sister Hamlin or one of the nursing staff or, indeed, Dr Barton says of a particular patient, "Well, this one is for palliative care", or end of life care, would you make your own individual assessment of that patient?
B A Not generally. Occasionally we would because if somebody was for palliative or end of life care and they wished not to die in the hospital, they wished to go home, then the Occupational Therapy Service would be involved in terms of identifying providing equipment and assessing that the equipment was appropriate to that person's needs.

Q If that was an option for that particular patient?
C A Yes.

Q I understand. Forgive me, but you have been speaking about occupational therapy. How close is that to physiotherapy?
A The two professions overlap quite a lot. Occupational therapy is centred around functional activity. So a physiotherapist would work with somebody to retrain them to gain range of movement and particularly around gait and transfers.
D An occupational therapist is concerned with how you might use that ability. So, for instance, a patient might regain fully after a stroke their ability to move their arm but if they have cognitive deficits it will be the occupational therapist who identifies that through their inability to make a discrimination between their shirt and their underpants when you are doing washing and dressing practice. So occupational therapy is what can you do with the ability; physiotherapy is much more focused around regaining an ability.

E Q Can we take it you work quite closely with the physiotherapists at the same time?
A Yes. Often we would do joint visits to somebody's home in order to ensure, for instance, that if we were looking at them being able to ascend and descend a staircase you might take a physiotherapist with you because that is their area of expertise and I would be concerned with looking at whether the patient needed, for instance, an extra rail.

F Q For those patients who were referred to you, no doubt there were times that you were busier than others but you did not find you were unable to fulfil your commitments?
A No. If the patients needed to be seen we were able to see them. Occasionally they might wait maybe a week maximum before we could pick up the referral but that was understood on the ward as well.

G Q Was that the same, as far as you were concerned, with the physiotherapist?
A I believe the physiotherapists were contracted to provide a service to the wards so they would tend to have more capacity to be able to do it.

Q They had greater capacity than you did?
A Yes.

H MR KARK: That is all that I ask you. Thank you very much.

MR JENKINS: I do not have any re-examination. Thank you.

THE CHAIRMAN: Thank you. We have reached the stage, Mr Carroll, when it is open to members of the Panel to ask any questions of you if they have any and I am going to look now to see if they do.

Questioned by THE PANEL

MRS MANSELL: It is just a point of clarification really about the multidisciplinary teams that you talked about. Who would form the multidisciplinary teams?

A The core of the multidisciplinary team would be the doctor, whoever was responsible for that particular patient, it would be the nursing team on the wards, it would be the physiotherapist, the occupational therapist, occasionally speech and language therapy might be involved, often a social worker or somebody from adult services would be along for planning meetings if patients needed support in the community post-discharge. Also I would argue the patient and their relatives were part of the multidisciplinary team as well.

Q Thank you. So on Dryad and Daedalus it could be either Dr Barton, could it, who would be the doctor or would it be the patient's GP because it was always about patients going home?

A On those wards it was Dr Barton. On Sultan Ward it would be other doctors because a patient would be under the care of their GP then.

Q How easy did you find it to get a multidisciplinary team pulled together?

A I think sometimes you would struggle getting somebody from adult services, but, generally, the rest I would say nine times out of ten we were able to get everybody together for the planning meetings and to deliver the care.

Q Without a tremendous amount of planning or forward thinking?

A I would say providing you had around about five days to seven working days you could pretty much guarantee to get everyone together.

Q Some of those patients, because it was a slow stream stroke patient that you may be rehabilitating, was a lot of that not just about getting patients home but to increase their capacity on the wards?

A I think expectations have changed in the last ten years in terms of the standards that we set ourselves as clinicians. Going back ten years, I think we were only just learning the necessity to keep working with everybody all the time. That is not to say that we would write patients off, but if a decision was made that somebody was going into nursing home care I had a limited resource so I would make the decision that there was little or no point in carrying out washing and dressing training with somebody because after discharge that was pretty much going to be done for them by the care staff in whatever residential home they went to.

Q So your focus was primarily for the patients who were going to go home?

A Yes.

THE CHAIRMAN: That concludes the questions from the Panel members. There is one final hurdle. I now have to ask the barristers whether they have any questions arising out of the Panel questions.

MR KARK: No, thank you very much.

MR JENKINS: Nor I, sir. Thank you very much.

THE CHAIRMAN: Very well. That concludes your testimony. Thank you very much for coming to assist us today. I do apologise if you have had to wait a bit but you are now free to go. Thank you.

(The witness withdrew)

MR JENKINS: Sir, I am going to call Susan McConnell, please.

SUSAN LESLEY MCCONNELL, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q I am going to ask you to give us your full name, please?
A Susan Lesley McConnell.

Q Ms McConnell, I wonder if you would give us your professional qualifications?
A I am a State Registered Nurse and a Registered Midwife.

Q When did you register as a nurse?
A 1969.

Q As a midwife, I think about four years later?
A 1973.

Q Have you worked as a nurse alongside Dr Barton?
A As a midwife.

Q And when and where was that?
A I first met Dr Barton in 1985 when I went to work at the maternity unit in Gosport as the senior midwife.

Q You say "Gosport"'; is that the War Memorial Hospital?
A No, it was not that. It was Blake Maternity, which was a GP unit.

Q And did that subsequently close, and was it transferred to the War Memorial Hospital?
A It transferred to the War Memorial Hospital in 1992, I think.

Q You would have worked with Dr Barton from 1985?
A Yes.

Q And how did she come to be working with you at the Blake unit?
A Blake maternity unit was a GP-led maternity unit at the time and Dr Barton together with all the other GPs in Gosport were responsible for the care of their patients whilst they were in Blake.

Q And did that system follow, once the unit was moved to the War Memorial Hospital?
A Not precisely. A lot of GPs opted out of maternity care or obstetric care, but they did continue to see their patients in the War Memorial.

Q So you would have seen Dr Barton in the Blake maternity unit?
A Yes.

Q When it was running. And would you have worked with her after the Blake unit closed?
A Yes, into the War Memorial.

Q In the War Memorial Hospital?
A Yes.

Q So how many years in total would you say you had worked with Dr Barton?
A About eighteen.

Q Did you have the opportunity during that time to form a view as a fellow professional of Dr Barton's skills and abilities as a doctor?
A Yes, I think so. I think Dr Barton was an excellent GP.

Q Tell us why you say that?
A Because her care was always for the benefit of the patients. She was careful and considerate to the patients. She valued the opinion of colleagues, like myself, and always acted in the best interests of her patients.

Q Do not all doctors value the opinion of colleagues?
A No, I am afraid they do not, at least not nursing colleagues or midwifery colleagues. Whenever we called Dr Barton or asked her to come in, she always came in immediately and would always say, "Why are you calling me? What is the problem? What do you think?" And would listen to the staff, the midwifery staff, and not just come in and do what she thought.

Q Right?
A She would discuss it with us and was delightful to work with.

Q You would have seen her dealing one to one with patients?
A Oh yes, yes.

Q How was she in dealing with patients?
A She was always extremely kind and caring towards her patients, and they were always delighted to see her because when we went to the War Memorial the patients used to come in from either St Mary's, the main maternity unit, or they would deliver in Blake, and we would always ring the GPs to say, "Your patient has arrived." When we told the patients, "Your GP

A is coming in to see you", Dr Barton's patients were always very excited that she was coming in to see their new baby, or to see them.

Q Could you say the same for all the other patients, about their GPs?
A Not always, no. Some of the patients would say, "Why? Why is my doctor coming in? We do not need to see them."

B Q Tell us a bit more about the War Memorial Hospital. I think a relative of yours was a patient there for a period?
A My mother was in the War Memorial Hospital for a number of years. She was often admitted. She was chronically ill for about 15 years before she died and she was admitted to all the local hospitals, including the War Memorial, and whichever hospital she was admitted to she always wanted to go to the War Memorial Hospital, because she loved it there. The care that she received was excellent and she was very happy there. She was in all the wards C in the War Memorial Hospital at one stage.

Q We know of Sultan Ward as a GP-bedded ward.
A She was in Daedalus.

Q There was Dryad and Daedalus Wards as well?
A She was in both of them.
D
Q Was she in Dryad too?
A Yes.

Q And we know that Dr Barton was there as the clinical assistant from when Daedalus and Dryad opened in 1993 to when she resigned in 2000. Would your mother have been on Dryad or Daedalus within that period, between 1993 and 2000?
E A I would think she was because she was in and out of hospital so much, and she must have been in at one stage because she was MRSA positive. It was Dr Barton who came to tell me she was MRSA positive. She came to tell me because she felt I should know, to get myself tested, because obviously I was working with newborn babies.

Q Again, what was the standard of care that your mother got when she was at the War Memorial Hospital?
F A It was very, very good. She was very well cared for.

Q The Panel has heard evidence from various sources about the War Memorial Hospital. They have heard observations from different people: many people who worked there and some others who had relatives who were treated there. But as someone who worked there, and someone who had a relative treated there, what would you say of the general standards that were applied on Dryad and Daedalus Wards, as examples?
G A I think the standards of care were very good. As a nurse you notice the way people are treated and the way people look when you walk into a hospital ward. You can see if they have been cared for, if they have been bathed and their bed has been made and if they are comfortable. I always felt whenever I went into any of the wards in the War Memorial Hospital that that was a good, high standard of care that the patients were receiving.

MR JENKINS: Thank you, Ms McConnell. Would you wait there, because you may be
H asked a question or two by others.

MR KARK: No thank you, no questions.

THE CHAIRMAN: Clearly no re-examination.

MR JENKINS: No.

THE CHAIRMAN: And no cross-examination. We have reached the point now where members of the Panel can ask questions of you if they have any. I am going to look to see if there are any questions. (The Chairman conferred with Panel members) There are no questions from members of the Panel so you have completed your testimony.

Thank you very much indeed for coming to assist us today. It is most helpful when we have witnesses who are able to come and tell us from their own experience what happened and how things were, often many years before. It assists us in the task that we ultimately have to address. Thank you for coming. Thank you for your assistance, and you are free to leave.

THE WITNESS: Thank you.

(The witness withdrew)

MR JENKINS: I am going to call Gillian Hughes, please, as the next witness.

GILLIAN TINA CAROL HUGHES, Affirmed

(Following introductions by the Chairman)

Examined by MR JENKINS

Q Can you give us your full name, please?
A Yes. It is Mrs Gillian Tina Carol Hughes.

Q Mrs Hughes, I think you know Dr Barton?
A I do.

Q How long have you known her?
A About 25 years.

Q I think you are a patient of her general practice?
A Yes. She is my GP, to myself and my two children, who are 23 and 13.

Q And did she also look after your father at some period of time?
A Yes. She looked after my father. My father was transferred from Haslar Hospital to Gosport War Memorial Hospital in the very beginning of 2000. When he was transferred, Dr Barton met us on his arrival.

Q Right?
A And introduced herself, and told us that she would be looking after my dad's welfare while he was in hospital there.

Q Was she his GP? Is that right?
A No, no.

Q So she had not met him before?
A No, never.

Q So it was the beginning of 2000 he was transferred from the Haslar. Was it Dryad Ward, did you say?
A Yes, yes. He went to Dryad Ward, yes.

Q And I think sadly he died at the War Memorial Hospital?
A Yes. He died on January 24, 2000.

Q Dr Barton was the clinical assistant, the doctor looking after him, whilst he was there?
A Dr Barton was the doctor who met us on the arrival of my dad and explained to us the situation of what was going to happen, carrying on and everything. We said to her, we knew that my dad was dying. He had cancer and we did not want him to be in any pain whatsoever. We wanted to make sure that he was well looked after while he was in there.

Q How old was your dad when he was transferred there?
A 86.

Q What would you say about the standard of care that he got when he was at the War Memorial Hospital?
A We were always kept up to date what was going on. After about a week, my father was in there, he was put onto a syringe driver and I cannot remember the nurse's surname – Gillian somebody. I do not know her surname. She told us and explained to us what had happened and everything, and that my dad was on the syringe driver. Dr Barton also told us that the reason was, it was because he was... You know. We knew what was going to happen. We knew he was gradually dying, but we would go in there a couple of days after. He would be there chatting away to us. He was aware of what was going on. I could not have asked for better care that was given to my dad at the time when he was in there.

Q But you have your own experience of Dr Barton?
A Yes.

Q That is your doctor, and that of your two children?
A Yes, especially my little girl. Mind you, she is not little any more. She is thirteen.

Q I do not want to ask about any particular medical conditions that anyone may have for either you or your children.
A Oh, no, no.

Q But you have needed to see the doctor a few times over the years?
A Oh yes. Many, many times. Yes, especially with my little girl. She suffers from epilepsy. I was a nervous wreck when she got taken into hospital, but Dr Barton reassured me that under proper medication everything would be controlled and she would be all right. Nothing would happen to her. Of course, as a parent you always think the worst. I used to say... She would say, "Look, she is going to be fine." She gave her nickname, and she called her "Baggage". After a period of time when she got on with the medication, my little

girl sent her a picture of "Thank you" for looking after her, and she put on there, "Thank you, Dr Barton. Love from Baggage."

Q What would you say about Dr Barton from our perspective as a patient?
A As a patient?

Q Yes.
A I have never had any qualms or anything wrong. She has always been there. She always reassures me, whatever the matter is. After my father sadly passed away, she constantly contacted me to make sure that I was okay, and if I needed any help she was there for me, and especially a period of time when my son – I had a bit of trouble with my son. She just guided me through and said he was 18, and he had a life. "He'll still be there. You'll still be there for him." A couple of times I wanted to go on depressants, and I thought "No." But the reassurance I got from her was that I did not need it. She was just there to tell me that everything would be all right, and it was, and it always has been.

Q It sounds as though she was going beyond the medical problems.
A Yes. I mean, if I had a problem, I knew I could go and talk to her and come out of there feeling on Cloud 9, and I knew that whatever advice she gave me, I knew would be correct and I would be all right, even with my children as well.

Q Can I come back to your father?
A Yes, of course you can.

Q He was put on a syringe driver after a period of time when he was in hospital.
A Yes.

Q Can you just remind us, after he was put on the syringe driver, you obviously went in to see him.
A I used to go in and see my dad every day. I took my little one in with me.

Q How was he coping on the syringe driver?
A He was fine. One day he would be asleep when you went in. It depended on what time of day you went in and most of the time it used to be about dinner time I would go in. He would be awake and start gobbing off at us, "What you doing here? Get out of here. I don't want you here", sort of thing.

Q So he would be his usual self?
A Yes, typical, and I thought, "Here we go again". Then like one time you could go and he would just be asleep and he would be quite happily laying there asleep, and we knew that he was not in no pain. He was quite comfortable and looked after by all the staff that were in the hospital. Unfortunately the day he died is the hardest thing that I have really got to try and get over, because the hospital phoned us the night my dad died. They said they phoned me and I never ever received a phone call. They assured me they did, but I was there and it is something that I have had to live with since.

Q I understand.
A As I say, when we finally did get the message it was via the police, because they were trying to get hold of my brother as well. We went in on the following day and that day, later on, I received a phone call from Dr Barton to say to me, "I am here if you need me", which I

thought was marvellous. I did not expect a response like that and if I needed help with any arrangements whatsoever, she was there to help me.

Q Did you need to call her in fact after that?
A No. But if I needed her she was there. She phoned a couple of times even after my dad's funeral. She phoned a couple of times just to make sure that we were still all right. As I say, I never expected that sort of thing and to me that shows that she really cared what she was doing. She was caring about people.

MR JENKINS: Please wait there because you may be asked one or two questions.

MR KARK: I have no questions, thank you very much.

THE CHAIRMAN: It seems that members of the Panel do not have any questions, so thank you very much. You have completed your testimony. Thank you very much for coming to assist us today. It is very much appreciated. You are free to go.

(The witness withdrew)

ANN DEAN, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

Q I am going to ask you to give us your full name, please.
A It is Ann Dean.

Q Would you give us your professional qualifications?
A Registered General Nurse and Registered Midwife.

Q I do not think you qualified on the south coast.
A No. I qualified in Glasgow.

Q What was your nursing career after you qualified?
A I think I was a staff nurse for about 18 months perhaps and then became a ward sister. I was a ward sister then for about 10 and a half years before getting married.

Q That was in Glasgow where you were a ward sister, was it?
A Yes.

Q What kind of ward?
A Surgical ward. I then became a practice nurse thereafter. I worked initially for my husband who was a single-handed general practitioner. I worked for him for a very short time.

Q Was that in Birmingham?
A That was in Birmingham. Then he joined the Navy and we moved to Gosport, and that is where I encountered Dr Barton.

Q I think you worked at the practice where she was a general practitioner.
A I worked at Forton Road Surgery, yes.

Q Did you work there for two periods of time?
A I did. I am a bit hazy about the dates.

Q I do not think the precise dates matter.
A I think it was 1994 until the end of 1995, so maybe for 18 months. I was then gone for about 18 months and then came back and worked for about five years, approximately.

Q So six or seven years in total that you have been practice nurse at the practice where Dr Barton and other doctors worked.
A Yes.

Q We know that there were a number of doctors in the practice.
A Yes, six I think.

Q How did you find Dr Barton whilst you were working with her there?
A I found her to be an excellent colleague. She was very approachable, very supportive of the nursing staff and by my observation all the other staff in the practice. I found her to be very caring and considerate of patients.

Q Would you have seen her with patients?
A Not a lot but on occasions. I did work with her when we were doing childhood immunisations and also perhaps when I would call her to the treatment room to have a look at a leg wound or whatever, or maybe to examine a patient that I did not feel should wait to be seen really.

Q If there were discussions about patients, or if you were seeing patients together with Dr Barton or in meetings at the practice, would you have been able to form an impression of Dr Barton's commitment towards her patients?
A Absolutely.

Q Tell us what that impression was?
A She was totally committed to them. She was very caring. She always put them before herself on many occasions. She would be ready to leave the practice, ready to go out of the door and I certainly have asked, could she possibly see another patient and she would just turn about and go back and see the patient. She had a lovely manner with the patients and always came over as very caring, and as for her clinical expertise, I was very impressed. I never had any occasion to doubt that at all.

Q I am not asking for names, but could you say the same of her colleagues, the other doctors in the practice?
A She stood out as being particularly caring and attentive.

Q What about her clinical judgment, so far as you were able to see that being exercised?
A I never had any worries. She always concurred with my own judgment. As an experienced nurse I never had any doubts about that.

Q Would you have had feedback from patients?

A A Yes.

Q As the nurse did you find yourself talking to patients about which doctor they might want to see?
A I do not think it was every necessary for me to talk to them about which doctor they would want to see. The vast majority of patients wanted to see Dr Barton.

B Q That is in a practice of six doctors.
A Yes.

Q Was that always possible?
A Not always possible at all. They would come to see us specifically because they wanted a back door in to see Dr Barton, because she was so caring and just so wonderful with them. Lovely manner with every patient, no matter who they were; patients with all sorts of
C difficulties, she was so nice and so good to them.

MR JENKINS: Thank you very much. Will you wait there because you may be asked questions by others.

MR KARK: I have no questions. Thank you.

D THE CHAIRMAN: There are no questions from the members of the Panel so it follows that that completes your testimony. Thank you very much indeed for coming to assist us today. It is very much appreciated and you are free to leave.

(The witness withdrew)

MR JENKINS: Sir, that is all the live witnesses I have this afternoon. What I can do,
E though, if it is convenient, is read some statements to you. These are statements that are agreed, as I understand it, and there is no objection to them being read from across the room. I am going to start – I have a copy for the shorthandwriter (document handed) – with Angela Southam. Her statement is dated 19 July 2009. It is signed by Angela Southam and it has this endorsement:

> F "This statement consisting of two pages 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".

MR KARK: I am sorry to interrupt. Is there a spare copy of this statement?

MR JENKINS: Yes of course. Can I say, I am going to be reading a statement from Fiona
G Smart and two statements from Dr Grunstein.

MR KARK: We have the Grunstein statement and the one from Fiona Smart. (Document handed)

MR JENKINS: The statement reads as follows:

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STATEMENT OF ANGELA SOUTHAM, Read

"I am Angela Southam of Jubilee House, Medina Road, Cosham, Portsmouth. I am a Clinical Nurse Manager at Jubilee House, which is a continuing care assessment/end of life unit based in the community. I have held this position since 2005. Prior to this I was a senior nurse from 2002 – 2005 at Jubilee House, and a staff nurse there from 1998 – 2002".

B

Forgive me, I break off from the reading. This is relevant in relation to the evidence the Panel heard from Shirley Hallman. She gave some evidence about Jubilee House and this is Jubilee House. I go back to reading the statement,

"The unit is essentially nurse led, with local GPs carrying out the day to day medical care of the patients under the authority of Consultants. Consultants will carry out

C

ward rounds every two weeks.

The Unit has 25 beds, most of which are occupied at any one time.

"The GP on duty will attend to see patients for about three hours each day, usually between 12.00 pm – 3.00 pm. These hours do vary slightly depending on the needs of the patients. On occasions they may be a little less or a little more. The only

D

variation on this is when the consultant attends to carry out a ward round, usually each Thursday, when a GP will then be in attendance for that ward round which takes place in the morning.

On occasion, when patients are admitted to the Unit in the afternoon or when a patient deteriorates, the GP may return to the Unit following afternoon surgery, in order to attend to the patients. If it is necessary for there to be clinical input out of hours, an

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out of hours service is available to the Unit.

These arrangements, in terms of the nature of the medical input at the Unit, the periods and amount of time spent each day by the GP and the number of beds have not altered since 2000".

The next statement I read is that of Fiona Smart. Her statement is dated 15 July 2009. It is

F

signed by Fiona Smart and it carries the same endorsement as the statement that I have just read to you, namely that it is true to the best knowledge and belief of the maker. I will not re-read that. The statement reads as follows:

STATEMENT OF FIONA SMART, Read

"I am Fiona Smart of Omega House, 112 Southampton Road, Eastleigh, Hampshire.

G

I am Associate Director for Clinical Standards at NHS Hampshire at the above address.

Having worked as Services Manager for Community Hospitals in East Hampshire, I was appointed as Interim Divisional General Manager for Fareham and Gosport Division of Portsmouth Healthcare NHS Trust in January 2000. As such, I was responsible for two community hospitals in the area, Gosport War Memorial Hospital

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and St Christopher's Hospital, District Nursing and health visiting and physiotherapy,

dentistry and occupational therapy Trust wide. My appointment was initially on an acting basis and I was then appointed to the substantive post.

In my capacity as Divisional General Manager, I met Dr Jane Barton on a number of occasions. I believe that she was involved with the Primary Care Group at this time.

I recall that Dr Barton came to see me on one occasion, when we had a conversation about the pressures associated with her work at the Gosport War Memorial Hospital (the Hospital) where she was a Clinical Assistant in Geriatrics. I recall that I was told Dr Barton would come to the Hospital at 7:30 in the morning in order to do a Ward Round, and would also have to undertake weekly Ward Rounds. I was told that her partners were not sufficiently supportive of her to enable her to get back to the Hospital to carry out further work as she would wish. Our discussion was about the need for her to be available in the hospital later than had been her practice. Whilst I recall that the level of dependency of patients had increased over time and they were generally less well on admission, I cannot now recall if this was specifically discussed by us.

The demands on Dr Barton were such that she felt obliged to resign at the end of April 2000. A copy of her resignation letter was passed to me",

Sir, I break off. The Panel have it.

"and in consequence of that I felt it appropriate to write to her, which I did by way of a letter dated 19th May 2000."

Again, the Panel have it.

"A copy of that letter is attached to this statement and marked 'FS1' [an exhibit], the letter being written in my previous married name of Fiona Cameron. In that letter I made the point that over the period Dr Barton had been at the hospital (which I stated in error as 7 years) there was little doubt that both the Client Group and the workload had changed. I was aware of and acknowledged that Dr Barton's contribution, commitment and support to Gosport War Memorial Hospital. I fully acknowledged her 'contribution to the service whilst working under considerable pressure'. I would not have complimented Dr Barton in my letter unless I had felt that this was clearly appropriate and deserved.

Although I did not know Dr Barton well, I felt she was a person of integrity. She had a reputation for being very straight talking, and her level of forthrightness may have meant that some would feel that she was brusque. I considered her very easy to deal with.

In my letter to Dr Barton I stated 'acceptance of the above pressures, coupled with your resignation, has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising'. The review proposed enhanced medical input. In due

A

course a number of changes were made to the service at the War Memorial Hospital. A full-time staff grade doctor was appointed in September 2000, providing greater medical input. There was also an additional consultant session to provide greater consultant support."

That statement is signed "Fiona Smart".

B

STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

Sir, I am going to read three statements from a Dr John Grunstein. The first is a police statement. It is dated 4 November 2005. He gives his age as over 18 and his occupation as a retired medical consultant. The statement carries the same endorsement in the same terms that I have read before. He says:

C

"I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000."

He sets out his qualifications and CV. I will read them all, if I am asked to, but he gives his date of birth in 1935, the medical school was the London Hospital, Whitechapel, between 1968-1963. That is what it says. His medical

D

qualifications, 1963 MRCS, LRCP, 1963 MB, BS Lond. Higher registrable medical qualifications, 1968 MRCP Lond, FRCP Lond. Relevant appointments, 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital. 1971, appointed Consultant Senior Physician in Geriatric Medicine to the Portsmouth Health District and successor organisations. 2000 retired.

"Since retirement I have continued to work as a part-time locum in various

E

capacities.

Responsibilities in Gosport:

a. Shortly after I was appointed I initiated an outpatient service in Gosport.
b. I shared responsibility for the continuing care wards in Gosport.

F

Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.
c. In 1992, I believe, I gave up all responsibilities in Gosport.

Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her

G

application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants."

Sir, the Panel have it and have seen it in bundle 1.

"This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall

H

whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment,

I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr BARTON was an experienced doctor with her own general practice in Gosport. I remember her being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed with similar capacities). She had a liking for these very frail elderly patients. Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attends ward rounds, outpatients and day hospital sessions in order to get 'hands on' training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as 'in depth'.

Dr BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I remember her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Programme - Elderly (CATPE). This was a series of lectures given in the training of most aspects of Elderly Medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would have also heard about the 'analgesic ladder' which describes the incremental use of drugs to control pain and distress. The analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

Routine business ward rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients. I would expect my advice to be followed as ultimate responsibility for patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON",

A - he then names a doctor that we have heard named as "Dr X" -

"and others from other practice worked on the wards while she was unavailable."

"She" obviously meaning Dr Barton.

B "My department did not vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.

Admissions to all elderly medicine continuing care wards (long stay wards) were authorised by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

C During their time in hospital the patients own General Practitioner had no responsibility for supervisory rights.

During the time that I had specific responsibilities in Gosport (1971-1992). Patients transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in
D Gosport.

Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

The bulk of patients transferred to Gosport were considered too
E incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

The survival time of new admissions was short (on average less than a
F month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.

I considered Dr BARTON to be an outstanding, caring and compassionate Physician."

G SECOND STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

Dr Grunstein wrote a second statement for the police. That one bears the date of 19 January 2006. It carries the same endorsement which I do not read. It says:

"I am Dr John Albert Henry GRUNSTEIN, a retired Medical Consultant and previously worked at the Queen Alexandra and Gosport War Memorial
H Hospitals, Hants.

I worked for a time with Dr Jane BARTON.

I produce as exhibit ...",

- he gives the exhibit number -

"... Dr BARTON's application for the post of Clinical Assistant in Geriatric Medicine dated 17/3/88, a letter from Miss K SOUTHWELL, Portsmouth and South East Hampshire Health Authority of 18th March 1988 to me and my correspondence of 19th April 1991 confirming that Dr BARTON received ten half day sessions from 27th - 31st November 1989.

I cannot recall why she was trained a year and a half after her appointment. The letter is addressed 'To whom it may concern' so I think there may have been something in the GP contract which required additional formal training.

I do not believe I ever interviewed Dr BARTON formally."

That, like the previous statement, is signed by Dr Grunstein.

FURTHER STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

There is a further statement from Dr Grunstein. That carries the same endorsement as the others before it. This one is dated 2 June 2009. Again, signed by Dr Grunstein. He says:

"I am Dr John Albert Henry GRUNSTEIN",

- and he gives his address in Soberton, Hampshire. He says:

"I was ... a Registered Medical Practitioner, and was formerly a Consultant Physician specialising in elderly medicine, employed by the Portsmouth and District Health Authority and successor Trust organisations. I retired from full-time practice in 2000.

As indicated in my statement to the police of 4th November 2005 I qualified at the London Hospital, Whitechapel, in 1963."

He gives his qualifications that I have already given. He says:

"Although I retired from full-time practice in 2000 I continued to work for a time as a part-time locum in various capacities until 2006.

Again, as I indicated in my police statement, shortly after I was appointed, I initiated an outpatient service at the Gosport War Memorial Hospital. In addition, I shared responsibility for the continuing care wards in Gosport which were initially sited in the Northcote and Redcliffe annexes of the Hospital. I believe I shared Consultant responsibilities for these Annexes with Consultant, Dr Bob Logan.

Initially my responsibilities in Gosport included carrying out outpatient clinics, and visiting the GP Wards, when asked to see patients admitted by local General Practitioners. As I have indicated, I shared responsibility for the medical care of the patients on Northcote and Redcliffe Annexes.

GP clinical assistants provided day today clinical care and dealt with emergencies. Elderly medicine consultants and registrars were available for telephone advice and occasional emergency visits. It was more usual to transfer patients with difficult problems back to the DGH.

From my appointment in 1971 I saw a number of clinical assistants come and go at the hospital. In due course, when the post became vacant, Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Hospital - in March 1988. Indeed, I believe that she was the only applicant for the post at the time. I think we were very glad to get someone who had an interest in elderly medicine, who had a liking for frail, elderly patients, and who was competent. Unfortunately, in my experience there were others involved in elderly medicine who were less competent, reliable and dedicated than Dr Barton. For example, when asked to see a patient one might have the impression that they were somewhat reluctant to do so. Dr Barton was certainly in the category of a good Clinical Assistant.

As a Consultant in Geriatric Medicine I did not send patients to Gosport whose medical needs were unsorted or where rehabilitation had realistic prospects for discharge from hospital. This was because fundamentally it was a long stay or so called slow stream unit not equipped to deal with patients requiring this type of active management. Thus patients sent to Gosport were in the main those we did not think could be discharged to their own homes or residential homes.

Exceptions might be those with large sores requiring lengthy healing and those awaiting transfer to alternative accommodation.

Over the period 1988 to 1992, when I ceased to have responsibilities in relation to Gosport. I think the needs of patients did not alter that much. I, and the other Consultants, chose to send patients to the hospital who needed care, as opposed to investigation and very active treatment. The patients we admitted there were not those in need of rehabilitation, diagnosis and active medical management. We would have admitted patients there because we had concluded that there was no other place for them to go, and they were unlikely to improve. Geriatricians and other specialists need to keep empty beds in District General Hospitals (DGH) so that it is always possible to admit emergencies. None the less I resisted attempts to fill vacancies in our Gosport beds with unsuitable patients, when there was pressure on DGH beds, for the reasons outlined above.

I recall that when I arrived in 1971, some of the patients had been there for many years, inevitably due to the initial unsuitable selection for the unit.

I believe that in 1988 Dr Barton as Clinical Assistant was not likely to have been required to care for patients with technically demanding medical needs on a day-to-day basis. I felt that Dr Barton was able to do the amount of work required of her at that time within the allocated sessions. (I have been reminded that this was 4 sessions to include out-of-hours work). I believe the wards were visited daily, new patients were briefly clerked and there were weekly ward rounds with the consultant. I think we alternated both consultants and annexes.

In working with Dr Barton, I felt I was in the presence of someone who knew her stuff. I am conscious that Dr BARTON did not write much by way of medical records. However, I felt she was doing a very reasonable job. It is fair to say that in my last years as a Consultant we had much better notes in long stay units because we had doctors there who were expected to create much more detailed notes. However, I believe that by the time I retired we would have effectively had 1.5 doctors to cover what Dr Barton was responsible for at Gosport.

As a comparison, Kingsclere Ward at St Mary's Hospital was a double ward with acute rehabilitation patients on one side, and long stay beds on the other. I think there were about 40 beds on the Kingsclere Ward. By comparison with Gosport, I remember being surprised that we were able to fund a full-time medical appointment to look after the medical needs of those patients.

Over the period of Dr Barton's appointment until 1992, I thought that in the context of the type of patient coming to the hospital, the patients were being properly and adequately assessed on admission by Dr Barton. At the same time, I knew that it was impossible to insist on the dotting of Is and the crossing of Ts which might seem to have been required by the job description.

I felt it was extremely important for the referring unit (preferably the consultant) to write usually no more than about a paragraph with essential information for the admitting doctor at Gosport, as I know how difficult it was for the receiving doctor to go through what would be a very thick set of notes and distil the most pertinent information. I am afraid this did not always happen.

Although I was not at the War Memorial Hospital after 1992, my understanding was that the Wards there started to be used for patients transferred for rehabilitation. Certainly in the 90s there was a great deal of pressure on District General Hospitals to get patients out of hospital who were perceived to be bed blockers. It would have been patently obvious that work at the War Memorial Hospital would have become much more onerous, with more patients being taken on for rehabilitation.

When I retired, I was involved in the transformation of the long stay ward in Petersfield to a Rehabilitation Ward. In consequence of this, the GPs who were involved in providing care were given more sessions. None the less there were protests from the GP's, nurses and ancillary staff at the number of admissions.

Another difficulty was the tendency for patients to arrive from the DGH late in the day. This causes particular difficulties for GPs.

After my close Gosport involvement ceased in 1992, I was not directly aware of acutely ill patients being sent down to Gosport, although it is possible that I might have been made aware of disquiet from Dr Barton that patients were being transferred to the Hospital who were too ill. Certainly I would never countenance the transfer of an ill patient – ie someone in need of active management. The transfer of an ill patient would only be appropriate where everything possible had already been done for them at the District General Hospital. Geriatricians recognise that the act of transferring a frail ill patient often has a deleterious effect on their health. Mortality rates amongst this group are increased.

I have a recollection of being aware of some sort of problem on one of the Annexes with one or two of the nursing sisters there at some point before I ceased working at Gosport in 1992. I do not recall any Nursing Staff expressing concern about the use of opiate medication and syringe drivers.

I understand that Dr Barton came to employ a method of prescribing for patients on an anticipatory basis – where it was perceived that the patient might require medication at some point in the near future. I can see that from a background in general practice, someone might be concerned to consider provision of medication in anticipation of the development of pain for example, over a weekend when a doctor might not be immediately available.

I recall that we had policies whereby it was not necessary to call out a doctor from the Surgery or at night in order to confirm death if a patient had died. The nursing staff could then confirm the death. I believe that this was permitted at the War Memorial Hospital. I do not recall a specific phrase being utilised to the effect that the doctor was happy for the Nursing Staff to confirm death, but there would be nothing odd about this. Indeed I do recall that some such instruction was sometimes written in the notes, if the Clinician perceived that the patient might die.

Of Dr Barton, I would say that she was someone in whom one was able to place confidence. She was intelligent and knew her stuff. She could be quite blunt on occasion, but she looked after her elderly patients in a way which I felt was caring and expert.

She was assiduous in attending the educational training sessions provided for her upon her appointment and subsequent sessions described in my statement to the police.

We thought ourselves lucky to have her as a colleague in Gosport."

That statement is signed by Dr Grunstein.

THE CHAIRMAN: Thank you very much indeed.

MR JENKINS: We have run out of evidence, I am afraid, for the day.

THE CHAIRMAN: Good, because I think we are out of time too. Thank you very much indeed. You have given us a great deal to digest. I think we are going to rise now and we will resume tomorrow at 9.30, please.

MR JENKINS: May I tell you what I have for you. There is another nurse that we are going to call who deals with a number of patients. I do not propose to go in great deal with the entries that she has, but it is right that you should know that a number of patients can be dealt with tomorrow.

THE CHAIRMAN: It is always helpful to have an insight into what is coming. Thank you for that.

MR KARK: Speaking of what is coming, can I just raise timing. I know it is late in the day, but I will just raise timing and try to look forward for a moment.

Tomorrow it is very likely that Dr Barton will be closing her case and that is the last of the evidence that we are going to hear on her behalf. Then we come to the issue of speeches, unless there are any further submissions to be made, but I do not think there are.

So far we have managed to get through, I think, seven weeks of the case without asking for any time, but I am considering asking for time, just for a day in fact. That is in order to prepare speeches. What we have been working on as the evidence has progressed is a document which we hope is going to assist. The nature of the document is this. We have broken up the case into the various issues that you are going to have to decide and then in relation to each patient, and within each of those sections we have put what we view to be the relevant evidence from every single witness.

Taking an issue such as Patient A, by way of example, you have a précis from the transcript, with transcript references, of every witness that the GMC called or read who spoke about that patient, coupled with direct lifts from the transcript of everything that Professor Ford said about that particular patient.

It is a fairly lengthy document. I do not hesitate to tell you – I think at the moment it is about 130 pages long. However – however – it does distil what is in fact, so far as we are concerned, the first 24 days ---

MR LANGDALE: Sir, I am sorry to interrupt. It is always irritating. I was aware today of the general nature of the document that my learned friend Mr Kark is talking about. I would rather he did not go on any more telling you about it because I think whatever document is produced by the GMC will be something which more properly would be a product of discussion between us. I can see certain difficulties which may arise in relation to the format. What I ask is that we have an opportunity of discussing it. My learned friend has been kind enough to indicate he is going to send me, much as I am enjoying the thought of 100-plus pages to look at tomorrow, the document as it is – it may not be in its final form – so I can see what it is in general terms. I can see there may be an issue as to what should or should not be placed by way of a document before the Panel.

I can fully see, and I join with him in suggesting that we have a day to consider speeches, which will probably mean what Mr Kark has in mind – beginning his speech on Tuesday rather than Monday. If that is what he is asking for, and I think it is, I certainly agree that

would be sensible. However, I think we had better have some discussion about what may or may not be appropriate, as I stress, to place before the Panel as a document, as opposed to references and so on.

THE CHAIRMAN: I agree with that entirely, Mr Kark. At this stage in the proceedings, I think we can hear about this tomorrow if you do not mind.

MR KARK: Yes, sir. I was raising it because we were asking for time. I was going to invite you on Monday to take time to read that document because that will shorten matters considerably on which I have to address you. I was not revealing what was in the document, rather the nature of it. This is not going to be an agreed document necessarily. It is part of our case. There we are; we will raise it again tomorrow.

THE CHAIRMAN: But your aim would be that we would spend Monday reading that document? And whilst we were reading, that would give counsel the opportunity to be ---

MR KARK: Elsewhere.

THE CHAIRMAN: Yes. Very well. Can I ask you – is that document going to be a preface to a skeleton argument or is that, in a sense, the skeleton itself?

MR KARK: It is not a skeleton. It is all of those transcript references to which I will be referring in my speech. It is to avoid you having to turn up transcripts.

THE CHAIRMAN: Yes.

MR KARK: That is the point of it.

MR LANGDALE: Perhaps we can have some further discussion of that tomorrow when I have seen what it is. In any event, whether the Panel needs time on Monday to read any document or not, I suspect it will still be appropriate for us to have a day, apart from tomorrow and no doubt the week-end, so that speeches will be given on Tuesday.

THE CHAIRMAN: I think that must be right. I think the Panel have an interest in knowing not today, but tomorrow perhaps after some discussion, whether we will have the benefit of written skeleton arguments or whether that is not going to be the case.

MR LANGDALE: As I say, it is not going to be a case of skeleton arguments but perhaps we can discuss this some more tomorrow.

THE CHAIRMAN: I will just put a marker down for one other point that perhaps can be dealt with immediately after we finish evidence tomorrow. That is that the Legal Assessor himself has a number of points which he would like to raise with counsel, to ensure that they will be dealt with by counsel in your later submissions.

Very well. Thank you very much. 9.30 tomorrow, please.

(The Panel adjourned until Friday 31 July 2009 at 9.30 a.m.)

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT A – LESLIE PITTOCK

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
27/4/92	Reviewed at Knowle Hospital, primarily in respect of depression. Treatment continues through 1992 and into 1993.	Clinical notes Correspondence	8-35 76	
	27/4/92: Admitted for respite cover by Dr Bagley. Diagnosis agitated depression. Deterioration in mental state over the last two months. Decreased appetite.	Clinical notes	9	
29/1/93	Reviewed at Hazledene Rest Home following discharge from Knowle Hospital. *Coping well. Anxious. Feels safe. No suicidal thoughts.*	Clinical notes	36	

21/6/93	Admitted to Knowle Hospital for depression. Discharged on 9/7/93.	Clinical notes Correspondence	37-39 78	
	Admission to Alverstoke Ward. Diagnosis chronic resistant depression. Feeling v low. Sleep v poor. Good appetite. Constipation a problem for a long time.	Clinical notes	37	
1/9/95	Reviewed at Hazledene Rest Home due to reported change in condition. *Manager of rest home reports change in condition. Loss of 1st 2lbs in two months. Physically frailer, anxious, falling at times. To be admitted to Mulberry Ward for reassessment of drug regime and provision of interim intensive support.*	Clinical notes	45-46	

14/9/95	Admitted to GWMH under Dr Banks, consultant psychiatrist, suffering from depression. Reviewed by registrar, Dr Bayly. *Chronically depressed. Patient feels main problem is constipation. Constant anxiety. Appetite poor. Embarrassed about feeding in public. Flat effect on mental state examination. Cognitive function 8/10. Low mood, not agitated. Very immobile, shuffling gait. Pale. No oedema. Chest clear. Soft abdomen. Mood and self-image deteriorating. Plan to continue medication, encourage diet.*	Clinical notes	48-52	
	Care plan: Goal: To help elevate mood to a level where he is able to return to his rest home.	Care plan	169	
	Specific events: Admitted at request of Dr Banks. Recently more depressed. Less able to care for self – requiring assistance with washing, dressing etc.	Specific event notes	181	

		Drug charts Admission notes	96 158	
18/10/95	Reviewed by Dr Banks. *Eating well. Seems better and brighter. Receiving visitors. For discharge next week.*	Clinical notes	55	
		Ward round notes Nursing notes Specific event notes	168 175 182	
24/10/95	Discharged to Hazledene Rest Home. *Discharge letter: Admitted complaining of exacerbation of chronically depressed mood. Physical examination: Mobility was very poor, but otherwise little abnormality. Medications were continued. Food intake very good. Mood improved.*	Correspondence	57-59	

13/12/95	Admitted to Mulberry Ward, GWMH, under Dr Banks. *Complains "everything's horrible." Verbally aggressive. Staying in bed. Not eating well. Hopeless + suicidal. Withdrawn. No hallucinations or delusions. Monosyllabic. Shuffling gait. Two to mobilise.*	Clinical notes	63-64	
	Admission notes: The rest home cannot cope with him. He has put himself to bed and refuses to get up. Physically and verbally aggressive. Lack of energy and self-motivation.	Admission notes	126	
	16.30: Admitted from Hazledene R/H as the nursing staff have found it increasingly difficult to manage him as he has become both physically and verbally aggressive. Examined by Dr Bayly on admission. Prior to admission he had put himself to bed and refused to get up. *20.10: Las has been settled since admission. No problems.*	Nursing notes	145	

		Care plan	143	
22/12/95	Prescribed erythromycin (antibiotic) for chest infection. *Diarrhoea this morning. Generally weak. Left basal crepitations. Chest infection. Encourage oral fluids.*	Clinical notes	65	
	Has been drowsy. Commenced on erythromycin. Nursed in bed. Remains physically unwell. Sleeps most of afternoon.	Specific event notes	149	
23/12/95	*2 small broken areas noted on buttocks. Very red (ie heat rash or acid burn) to back of both legs, scrotum and to inside thighs. Sudacrem applied.*	Specific event notes	149	

27/12/95	Reviewed by Dr Banks. Prescribed cephalosporin (antibiotic). Chest x-ray and abdominal x-ray conducted. *Chesty, poorly, abusive, not himself at all. Reassess mood once physically better. Possible further investigation of bowels. Catheterised last week due to urine retention. Geriatrician review may be helpful.*	Clinical notes	66	
		Ward round notes Care plan Nursing notes Specific event notes	136 139 141-147 150	
2/1/96	Referred by Dr Banks to Dr Lord, consultant geriatrician. *On this admission, mobility deteriorated dramatically and developed chest infection. Chest now clearing. Remains bed-bound. May well be secondary to depression. Grateful for suggestions for improving physical health.*	Clinical notes	67	

		Radiological report Specific event notes	117 151	
3/1/96	Reviewed by Dr Banks. *Poor food intake. Fluids OK. Deteriorating. Some breaks in skin now. To start fortisips and high protein diet. Needs more time to convalesce. Probably will need NH.*	Clinical notes Nursing notes Specific event notes	67 142 151	
	Les has been out of bed for couple of hours, but back into bed. Not eating and drinking very well.	Nursing notes	142	
	8.10pm: Seems a little brighter today. Up in his chair for short while this morning. Not eating but drinking really super, supplemented with fortisip.	Significant events	151	

		Drug charts Ward round notes	82 137	
4/1/96	Reviewed by Dr Lord. *Chronic resistant depression. Very withdrawn. Completely dependent – Barthel 0. Superficial ulceration of left buttock and hip. Hypoproteinaemia. Suggests high-protein drinks, bladder wash-outs. Happy to take him to GWMH. RH place can be given up as unlikely to return there.*	Clinical notes	68	
	All nursing care given.	Nursing notes	142	
	Lord: Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall, prognosis poor. Happy to arrange transfer to Dryad Ward, GWMH.	Correspondence	188	

		Specific event notes	152	
5/1/96	Admitted to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer from Mulberry. Immobility. Depression. Broken sacrum. Small superficial areas on right buttock. Both heels suspect. Catheterised. Transfers with hoist. Longstanding depressive on lithium and sertraline.*	Clinical notes	196	
	Poor physical condition – broken pressure areas to buttocks and hip. Fully catheterised. Broken skin on scrotum – nursed on Pegasus mattress. Weight-bearing to a very minimal degree.	Transfer details	194-195	
	Shaw: Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Has sore on R buttock. Has taken a small amount of puree as reluctant to eat sandwiches. Needs to be encouraged with diet and fluids.	Significant events	208	

	Drugs patient was receiving prior to transfer prescribed – sertraline, lithium, diazepam, thyroxine.	Drug charts	199	
		Specific event notes	152	
8/1/96	Drug charts indicate: * Arthrotec: Dr Barton prescribes one dose to be given twice daily. Two doses administered.	Drug charts	199	
9/1/96	Reviewed by Dr Barton. *Painful R hand held in flexion. Try arthrotec. Also increasing anxiety and agitation. ? sufficient diazepam. ? needs opiates.*	Clinical notes	196	

	Barrett: Small amount of diet taken. Very sweaty this evening but is apyrexial. Stated that he has generalised pain. To be seen by Dr Barton in the morning.	Significant events	208	
	Full bed bath given. Scrotum very sore, under fore skin or penis sore, discharge present from around catheter, sacrum small sore area above anus. Bioclusive removed from sore area on left hip.	Nursing care plan	218	
	Drug charts indicate: • Arthrotec: Two doses administered.	Drug charts	199	
10/1/96	Reviewed by Dr Tandy. *Depression. Catheterised. Superficial ulcers. Barthel 0. Will eat and drink. For TLC.* *Telephone call with wife – agrees in view of v poor quality for TLC.*	Clinical notes	196	

	Hamblin: Condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on oramorph 4 hrly this evening.	Significant events	208	
	Drug charts indicate: * Arthrotec: One dose administered at 09.00, then discontinued. * Oramorph: Dr Barton prescribes 2.5ml (5mg) to be given five times daily. 5mg administered at 22.00.	Drug charts	199, 200	
		Nursing care plan	218	
Undated	Drug charts indicate: * Diamorphine: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. * Hyoscine: Dr Barton prescribes 200-400µg/24hrs by subcutaneous infusion. * Midazolam: Dr Barton prescribes 20-40mg/24hrs by subcutaneous infusion.	Drug charts	200	

11/1/96	Drug charts indicate: * Oramorph: 5mg administered at 06.00. Dr Barton then prescribes 2.5ml (5mg) four times daily plus 5ml (10mg) nocte. 5mg administered at 10.00, 14.00 and 18.00. 10mg administered at 20.00. This dose regimen continues until 06.00 on 15/1/96. * Diamorphine: Dr Barton prescribes 80-120mg/24hrs PRN by subcutaneous infusion. * Hyoscine: Dr Barton prescribes 200-400µg/24hrs PRN by subcutaneous infusion. * Midazolam: Dr Barton prescribes 40-80mg/24hrs PRN by subcutaneous infusion. * Sertraline and lithium, which had been prescribed by Dr Barton and administered since 5/1/96, discontinued.	Drug charts	199, 200-202	
13/1/96	*Rigg: Catheter bypassing. Mr Pittock appears distress.*	Significant events	208	

	Rigg: Catheter bypassing x 2. Patient appears distressed. Suby C washout given. Some exchange of fluids. Catheter bypassing +++ at 8pm so catheter removed. Tip of catheter very mucky. Pad and pants in situ.	Nursing care plan	225	
15/1/96	Drug charts indicate: • Diamorphine: 80mg/24hrs administered. • Hyoscine: 400µg/24hrs administered. • Midazolam: 60mg/24hrs administered.	Drug charts	201	
	Rigg: S/B Dr Barton. Has commenced syringe driver at 08.25. Diamorphine 80mg + midazolam 60mg + hyoscine 400mcg. *Douglas: 19.00: Daughter informed of father's deterioration during the afternoon. Now unresponsive, unable to take fluids and diet. Pulse strong and regular. Comfortable night.*	Significant events	208-209	
		Nursing care plan	218-228	

16/1/96	Drug charts indicate: • Diamorphine: 80mg/24hrs administered. • Hyoscine: 400µg/24hrs administered. • Midazolam: 60mg/24hrs administered. • Haloperidol: 5-10mg/24hrs prescribed. 5mg/24hrs administered.	Drug charts	201-203	
	20.00: Condition remains very poor. Some agitation was noticed when being attended to. S/B Dr Barton. Haloperidol 5mg-10mg to be added to driver. *Night: Condition remains poorly. All care comtinued.*	Significant events	209	
	Rigg: Bed bath given. Liquid paraffin to penis + scrotum. Emulsifying to sacrum and all boney prominences. Right ear very blistered and swollen – please protect by nursing left side/back alternately. All pressure areas marking easily.	Nursing care plan	218-228	

17/1/96	Drug charts/nursing notes indicate: * Diamorphine: Dosage increased by Dr Barton to 120mg/24hrs (dated 18/1/96 but administered from 17/1/96). 120mg/24hrs administered at 08.30. 120mg/24hrs administered again in new syringe driver at 15.35. * Hyoscine: Dosage increased by Dr Barton to 600µg/24hrs (dated 18/1/96 but administered from 17/1/96). 600µg/24hrs administered at 08.25. Dosage then increased by Dr Barton to 1200µg/24hrs (dated 18/1/96 but administered from 17/1/96). Previous dose discarded. 1200µg/24hrs administered at 15.35. * Midazolam: 60mg/24hrs administered at 08.25. Dosage then increased by Dr Barton to 80mg/24hrs (dated 18/1/96 but administered from 17/1/96). 80mg/24hrs administered at 15.35. * Haloperidol: 10mg/24hrs administered at 08.25. Dosage then increased by Dr Barton to 20mg/24hrs. 20mg/24hrs administered at 15.35.	Drug charts	190, 201-203	

	Douglas: 09.00: S/B Dr Barton medication increased 08.25 as patient remains tense and agitated, chest very bubbly. Suction required frequently this morning. Bed bathed. Hourly turning. Remains distressed on turning. *14.30: S/B Dr Barton medication reviewed and altered. Syringe driver renewed. Daughter informed of deterioration.* *Hamblin: 20.30: Further deterioration in already poor condition. Appears more settled – although still aware of when he is being attended to.* *Night: Little change in poor condition. Appears more peaceful.*	Significant events	210	
		Nursing care plan	218-228	
18/1/96	Reviewed by Dr Barton. *Further deterioration. SC analgesia continues. Difficulty controlling symptoms. Try nozinan.*	Clinical notes	198	

	Poorly condition continues to deteriorate. *15.00: Syringe driver recharged with diamorphine 120mg, midazolam 80mg, hyoscine 1200µg, haloperidol 20mg and nozinan 50mg. Appears comfortable in between attentions.*	Nursing notes	210	
		Nursing care plan	218-228	

	Drug charts/nursing notes indicate: • Diamorphine: Dr Barton prescribes 120mg/24hrs by subcutaneous infusion (actually commencing on 17/1/96). 120mg/24hrs administered. • Hyoscine: Dr Barton prescribes 600µg/24hrs, then 1200µg/24hrs, by subcutaneous infusion (both actually commencing on 17/1/96). 1200µg/24hrs administered on 18/1/96. • Midazolam: Dr Barton prescribes 80mg/24hrs by subcutaneous infusion. 80mg/24hrs administered. • Haloperidol: Dr Barton prescribes 20mg/24hrs by subcutaneous infusion. 20mg/24hrs administered. • Nozinan: Dr Barton prescribes 50mg/24hrs PRN. 50mg/24hrs administered.	Drug charts	189-190	
19/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Haloperidol: 20mg/24hrs administered. • Nozinan: 50mg/24hrs administered.	Drug charts	189-190	

	Barrett: 15.05: Marked deterioration in already poorly condition. All nursing care continued. Breathing very intermittent. Colour poor. *15.00: Syringe driver recharged.*	Nursing notes	211	
		Nursing care plan	218-228	
20/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered at 18.00. • Hyoscine: 1200µg/24hrs administered at 18.00. • Midazolam: 80mg/24hrs administered at 18.00. • Haloperidol: Discontinued. • Nozinan: Dosage increased to 100mg/24hrs (verbal order by Dr Briggs). 100mg/24hrs administered at 18.00.	Drug charts	189-190	
	Dr Briggs: Has been unsettled on haloperidol in syringe driver. Verbal order to increase nozinan 50mg to 100mg.	Clinical notes	198	

	Rigg: Dr Brigg contacted regards drug regimen. Verbal order taken to double nozinan and quit haloperidol. Syringe driver recharged at 18.00. Appears comfortable.	Nursing notes	211	
		Nursing care plan	218-228	
21/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189-190	
	Dr Briggs: Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue.	Clinical notes	198	

	Rigg: Very settled today. All care given. *18.15: Condition unchanged. Driver recharged at 17.45. Appears comfortable.* *Breathing quietly and slowly.*	Nursing notes	211-212, 228	
22/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189	
	Poorly but very peaceful. Driver recharged.	Nursing notes	212	
		Nursing care plan	219, 228	

23/1/96	Drug charts/nursing notes indicate: • Diamorphine: 120mg/24hrs administered. • Hyoscine: 1200µg/24hrs administered. • Midazolam: 80mg/24hrs administered. • Nozinan: 100mg/24hrs administered.	Drug charts	189	
	Barrett: Poorly condition remains unchanged. Remains peaceful. *15.45: Driver recharged.*	Nursing notes	212	
		Nursing care plan	225	
24/1/96	Death recorded at 1.45am.	Clinical notes Nursing notes	198 212	
	Cause of death: Bronchopneumonia.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT B – ELSIE LAVENDER

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
6/5/89	Admitted to GWMH. Clerked in by Dr Barton.	Clinical notes	976	
11/3/95	Admitted to Royal Hospital Haslar, following a collapse. Discharged on 31/3/95.	Haslar notes Correspondence	32-46, 464-488 73	
5/2/96	Admitted to Royal Hospital Haslar, following a fall. X-rays conducted of skull and shoulders. *Admitted via Casualty having suffered a fall on 5/2/96. Known to suffer from insulin-dependent diabetes. Had multiple bruising but no fractures.*	Correspondence	61	

	This lady was found at the bottom of the stairs. ? fell full length? on floor for 1hr + sustained laceration to front of head and pain in R shoulder (p136). *Normally very independent, but can only walk a few yards. Goes out once a week (taken by son). Son says that she sleeps a lot now. Forgetful but not confused (p144).*	A&E notes Clinical notes	124-134 136-142	
6/2/96	Temperature developed. Commenced on amoxicillin (antibiotic). *Talking, alert and orientated. Cannot remember yesterday's events. Complaining of pain in right arm. Tender over humerus. Bilateral hand swelling. Hips seen OK. Chest clear. Plan: Social work involvement, OT assessment.* *Later: Temp 38.5°. Start amoxicillin.*	Clinical notes	142-143	
	Prescribed coproxamol and dihydrocodeine. Administered until transfer to GWMH.	Drug charts	669, 675	

		Nursing notes	642-644	
8/2/96	Seen by Elizabeth Thomas, physiotherapist. *C/O shoulder tenderness and abdo pain. No voluntary movement on request due to bilat shoulder pain. Sitting to standing with 2. Full support required for a few steps. Pain in shoulders seems to be major problem.* *Later: Has been having hypos regularly. For analgesia – shoulders painful.*	Clinical notes	146	
	Very high risk on Waterlow score. Poor mobility due to fall. Shoulders very painful. Action: Give analgesia as prescribed by doctor regularly. Encourage Mrs Lavender to do as much as she can for herself. Assist with feeding as she has difficulty eating. *Regular analgesia given with poor effect. S/B physio, walked two steps. Pressure areas intact (p643).*	Nursing notes	643-644	
9/2/96	Ward round by SHO. *Feeling better but still c/o pain in arms/shoulders.*	Clinical notes	147	

12/2/96	*Shoulders still very painful.*	Clinical notes	147	
13/2/96	Referred to Dr Lord, consultant geriatrician. *The cause of her collapse was ? hypoglycaemia as she is a poorly controlled IDDM. Over the time on the ward, has been slow to mobilise, needs help to walk, dress, feed and wash. Barthel score 5. Reluctant to go into a home, but feels she cannot go home in present condition. Diabetes now under control. Not sure how mobile she really is, as does not seem able to do anything for herself.*	Clinical notes	147-149	
		Nursing notes	637-643	
14/2/96	Ward round by SHO. *Still not able to do much for herself because of "pain in arms."*	Clinical notes	150	

16/2/96	Seen by Dr Tandy, consultant geriatrician. Transfer recommended to Daedalus Ward, GWMH. *Since the fall, patient has had weakness in both hands and has been unable to stand. Complains of pain across shoulders and down arms. She feels mobility starting to improve in her hands and she stood with physios. Still requires 2 to transfer. Has no problems eating or drinking. Long-standing stress incontinence. Denies any other problems. Examination confirmed atrial fibrillation. Does have weakness in hands. Most likely problem is brain stem stroke leading to fall. Might want to consider aspirin. I'll get her over to Daedalus Ward for rehab as soon as possible.*	Correspondence	242, 244	
		Clinical notes Nursing notes	151-153 642-648	

20/2/96	Reviewed by physiotherapist. Seen by SHO on ward round. *Requires encouragement to mobilise. Function improving. Starting to feed herself with encouragement. For OT assessment today. Still c/o shoulder pain. Mobility remains poor. Sitting to standing with 2. Standing balance poor. Discharge to own home seems unlikely in near future.*	Clinical notes	154-155	
		Nursing notes	645-646	
21/2/96	Nursing referral made to Daedalus Ward, GWMH. *Insulin-dependent diabetic. Almost no adverse effects from the head injury. Main problem now immobility. Has pain in arms and shoulders, needs encouragement to use them. Able to mobilise from bed to chair with two nurses. Has stress incontinence on standing or mobilising.* *Needs minimal assistance with feeding, full assistance with hygiene needs. Ulcers to both legs dressed every other day. All pressure areas intact although buttocks very red.*	Nursing referral form	1001	

22/2/96	Transferred to Daedalus Ward, GWMH, under Dr Lord. Reviewed by Dr Barton. *Fell at home top to bottom of stairs. Lacerations on head. Leg ulcers. Severe incontinence. Needs a catheter. Insulin dependent. Regular series BS. Transfers with 2. Help to feed and dress. Barthel 2. Assess general mobility. ? suitable for rest home if home found for cat.*	Clinical notes	975	
	Probable brain stem CVA on 5/2/96. Problems with grip in both hands. Experiences pain in arms and shoulders. Can transfer with 2. Seen by Dr Barton. Catheterised, ? retention. Leg ulcer on right leg redressed. Area on left appears healed.	Significant events	1021	
	Settled and slept well. C/O sore shoulders. Analgesia given (p1017).	Nursing care plan	1003-1017	

	Drug charts indicate: • Dihydrocodeine: Dr Barton prescribes PRN, dose unclear. Dates and times of administration unclear.	Drug charts	995	
23/2/96	Reviewed by Dr Barton. *Catheterised last night. 500ml residue. Blood + protein Trimethoprim.*	Clinical notes	975	
	Joines: 17.20: Pathology phoned – Platelets 36 ? too small sample. To be repeated Monday. Dr Barton informed – will review mane (p1021).	Nursing care plan Significant events	1003-1017 1021	
24/2/96	Reviewed by Dr Barton. *Significant events (Joines): Pain not controlled properly by D.F.118. Seen by Dr Barton – for MST 10mg BD.* *Nocte: Comfortable night.*	Significant events	1021	

	Red and broken sacrum. Broken area sprayed (p1004). Comfortable (p1017).	Nursing care plan	1003-1017	
	Drug charts indicate: • MST: Dr Barton prescribes 10mg bd 06.00 and 18.00. Administered.	Drug charts	997	
25/2/96	Drug charts indicate: • MST: 10mg bd 06.00 and 18.00 administered.	Drug charts	997	
	Appears to be in more pain. Screaming "my back" when moved but uncomplaining when not. Son would like to see Dr Barton (p1022).	Nursing care plan Significant events	1003-1017 1022	

26/2/96	Reviewed by Dr Barton. *Not so well over w/e. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute sc analgesia if necessary.*	Clinical notes	975	
	Seen by Dr Barton. MST→20mg BD. She will see Mrs Lavender @ 14.00 (Joines). *14.30: Son and wife seen by Dr Barton – prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained (Joines).*	Significant events	1022	

	Drug charts indicate: • MST: 10mg administered at 06.00, then discontinued. 20mg bd commenced at 22.00. • Diamorphine: Dr Barton prescribes 80-160mg/24hrs PRN by subcutaneous infusion. Not administered. • Midazolam: Dr Barton prescribes 40-80mg/24hrs PRN by subcutaneous infusion. Not administered. • Hyoscine: Dr Barton prescribes 400-600µg/24hrs PRN by subcutaneous infusion. Not administered.	Drug charts	995, 997	
27/2/96	Drug charts indicate: • MST: 20mg bd administered. Continued until 22.00 on 3/3/96.	Drug charts	997	
	Sacrum: No spray applied. Dressed. Area blackened and blistered (p1004). *Catheter draining satisfactorily – haematuria (p1005).* *Analgesia administered. Fairly effective. Able to help when dressing this am (p1013).*	Nursing care plan	1003-1017	

1/3/96	*Complaining of pain in shoulders on movement (p1013). Refused medication at 22.00h. Took a while to persuade her to take them. Eventually took them at 23.30h. Leaking faeces+++ (p1017).*	Nursing care plan	1013, 1017	
2/3/96	*Slight pain in shoulders when moved (p1013). Took medication well. Still leaking PR (p1017).*	Nursing care plan	1013, 1017	
4/3/96	*Patient complaining of pain and having extra analgesia PRM. MST dose increased to 30mg BD by Dr Barton.*	Significant events	1022	
	S/B physio. Exercises – 3 turns of head to right and 5 neck retractions every 2 hours. Elsie needs reminding. Analgesia increased (p1013).	Nursing care plan	1003-1017	

	Drug charts indicate: • MST: Dr Barton increases dose to 30mg twice daily. Administered.	Drug charts	992	
5/3/96	Reviewed by Dr Barton. *Has deteriorated over last few days. In some pain therefore start sc analgesia. Let family know.*	Clinical notes	975	
	Patient's pain uncontrolled. Very poor night. Syringe driver commenced at 09.30. Son contacted by telephone, situation explained (Couchman).	Significant events	1022	
	Pain uncontrolled – patient distressed. Syringe driver commenced 09.30. Son informed.	Nursing care plan	1013	

	Drug charts indicate: • Diamorphine: Dr Barton prescribes 100-200mg/24hr by subcutaneous infusion. 100mg/24hrs administered. • Midazolam: Dr Barton prescribes 40-80mg/24hrs by subcutaneous infusion. 40mg/24hr administered. • Hyoscine: Dr Barton prescribes 400-800µg/24hrs PRN by subcutaneous infusion. Not administered.	Drug charts	990-991	
6/3/96	Reviewed by Dr Barton. *Further deterioration. SC analgesia commenced. Comfortable and peaceful. Happy for nursing staff to confirm death.*	Clinical notes Nursing care plan	975 1003-1017	
	S/B Dr Barton. Medication other than through syringe driver discontinued.	Significant events	1023	

	Pain well controlled. Syringe driver renewed at 9.45am.	Nursing care plan	1013	
	Drug charts indicate: • Diamorphine 100mg/24hr administered. • Midazolam: 40mg/24hr administered. • Medication other than by syringe driver stopped.	Drug charts	991	
	Death recorded at 9.28pm.	Clinical notes Significant events	975 1023	
	Cause of death: (I) CVA (II) Diabetes mellitus.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT C – EVA PAGE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
30/4/97	Admitted to Queen Alexandra Hospital, following a collapse. Diagnosed with a reversible ischaemic neurological deficit. Commenced on aspirin. Discharged back to residential home on 7/5/97.	Correspondence Discharge summary Nursing notes Clinical notes	52-57 58 136-139 160-165	
6/2/98	Admitted to Queen Alexandra Hospital, Department of Medicine for Elderly People. Diagnosis includes probable carcinoma of the bronchus and depression. *GP referral. In residential home. General deterioration, c/o nausea, ↓ appetite, now dehydrated. Feels "depressed" last few weeks. GP prescribed sertraline.* *Past medical history: AF, CCF.* *Chest clear. No ankle oedema.* *Patient willing to accept ↑ oral fluids.*	Clinical notes	296	

		Spell summary Patient profile Care plan Nursing notes X-ray report	202 207 228 232 290	
16/2/98	*Bed bath given this AM. Fed Eva her breakfast as she was too tired, remained in bed with bed side up.* *PM: S/B Doctor [name unclear]. Charles Ward list. Inform son [ticked]. Continue TLC. Medication reviewed. Spoke to son re beds, he is happy for mum to go to Charles Ward, no beds at Gosport. Placed on list for Charles.*	Nursing notes	234-235	

19/2/98	Transferred to Charles Ward, Queen Alexandra Hospital, under Dr Lord. *Referral to Charles Ward. CA bronchus probably (no histology). Diagnosis based on CXR. Admitted 6/2/98, general deterioration. Exam: Sleepy but responsive, answers appropriate, states he is frightened but doesn't know why, says she has forgotten things. Chest clear. Abdomen soft. Legs ° oedema ° pressure sores. Patient feels in general tired and very thirsty.* *Plan: Encourage oral fluids, s/c fluid overnight if tolerated. Continue antidepressant.*	Clinical notes	302	
	Ate soup and puddings for supper. Fluids encouraged. Needing a lot of reassurance. Appears reluctant to go to sleep. s/c midazolam 2.5mg given @ 18.50 with effect.	Nursing notes	235	
		Transfer form Spell summary Care plan	196 198 218-230	

25/2/98	Reviewed by Dr Lord. *Confused and some agitation. Says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try thioridazine. Transfer to GWMH.*	Clinical notes	304	
27/2/98	Transferred to Dryad Ward, GWMH. *Diagnosis: Ca bronchus, anorexia, depression, dehydration, falls. Diet: Normal as tolerated. Requires assistance with ADLs. Drugs administered: Thioridizine, paracetamol PRN. Remains withdrawn and anxious at times. Calls for assistance frequently. Indwelling catheter for retention. Requires total assistance with hygiene needs. Using Pegasus mattress. Red sacrum. Transfers with 2 nurses at the moment.*	Transfer form	196-197	
	Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. Diagnosis of Ca bronchus made on CXR on admission 6/2. Generally unwell, off legs, not eating. Catheterised. Needs help with eating and drinking. Needs hoisting. Barthel 0. Plan: Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death.*	Clinical notes	304	

	Admitted today from Charles Ward for palliative care. An anxious lady who calls out frequently and needs reassurance. Normal diet and fluids. She is incontinent of faeces. Needs total help with hygiene needs. Able to hold a beaker and pick up small amounts of food, but needs a lot of encouragement. *Night: Settled for short time only. Calling out quite frequently. Drinking well.*	Significant events	170	
	Past medical history: LVF and AF 95. Digoxin toxicity 95. TIA 97 (p169).	General information Nursing care plan Spell summary	166, 169 174-192 194	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5ml-5ml (5-10mg) PRN. • Thioridazine: Dr Barton prescribes 25mg PRN. • Dr Barton also prescribes digoxin, frusemide, ramipril, sotalol, sertraline and lactulose.	Drug charts	272	

28/2/98	*Very distressed, calling for help and saying she is afraid. Thioridazine given with no relief. Patient remains distressed. Oramorph 2.5mg given with no relief. Doctor notified. S/B doctor for regular thioridazine and heminevrin nocte.*	Significant events	170	
	Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Urinary catheter (p178). *Independent turning in bed. Two members of staff for bath/shower, with hoist (p179).* *Encourage fluid intake (p184).* *Needs help with personal hygiene but should be encouraged to do for herself what she can (p186).*	Nursing care plan	174-192	
	Drug charts indicate: • Oramorph: 5mg administered at 16.20. • Thioridazine: 25mg administered at 13.00. Further 25mg dose then prescribed. • Heminevrin: 250mg in 5ml prescribed. Administered at 22.00.	Drug charts	272, 274, 276	

1/3/98	Drug charts indicate: • Thioridizine: Two doses administered. • Heminevrin: One dose administered, then discontinued.	Drug charts	276	
	Slept well but calling+. Shouting from approx 05.30. Spat out all medication.	Nursing care plan	181	
2/3/98	Seen by Dr Barton. *No improvement on major tranquilliser. I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today.*	Clinical notes	305	

	Reviewed by Dr Lord. *Spitting out thioridazine. Quieter on prn SC diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present. Diagnosis (1) Ca bronchus, (2) ? cerebral metastases. Continue fentanyl patches.* *Later: Son seen. Concerned about deterioration today. Explained about agitation and that drowsiness probably due in part to diamorphine. Accepts his mother is dying. Agrees to continue present plan of medication.*	Clinical notes	305	
	Commenced fentanyl 25µg this am. Very distressed this morning. Seen by Dr Barton. To have diamorphine 5mg i/m. Given at 08.10. *S/B Dr Lord. Diamorphine 5mg I/M given.* *For syringe driver s/c diamorphine boarded.*	Significant events	170	

	Drug charts/nursing notes indicate: • Fentanyl: Dr Barton prescribes Fentanyl 25 patch x 3 days PRN. Patch administered at 08.00. • Diamorphine: Dr Barton prescribes 5mg. Administered at 08.00 and 15.00. • Thioridizine: One dose administered, then discontinued.	Drug charts	272, 276	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs (in daily review prescriptions, marked "PRN") by subcutaneous infusion.	Drug charts	278	
3/3/98	Drug charts indicate: • Diamorphine: 20mg/24hrs administered from 10.50. • Midazolam: 20mg/24hrs administered from 10.50.	Drug charts	278	

	Hamblin: Rapid deterioration in condition this morning. Neck and left side of body rigid – right side flaccid. Syringe driver recommenced at 10.50.	Significant events	170	
	Death recorded at 21.30.	Significant events Nursing care plan Clinical notes	171 181 306	
	Cause of death: (I)(a) Carcinomatosis. (II) Carcinoma of bronchus.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT D – ALICE WILKIE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
31/7/98	Admitted to Queen Alexandra Hospital, Department of Medicine for Elderly People, from care home with unresolved urinary tract infection. *Admitted via GP from care home with unresolved UTI, decreased mobility, pyrexia. Incontinent of urine x 2 since admission. Could the daughter be informed as soon as Alice is seen by doctor.*	Clinical notes	98A	
	PC: Demented lady. Has been in psychogeriatric care home for 1yr. UTI early this week, has not responded to antibiotics. Barthel = 1. Pyrexial.	Clinical notes	166-168	
	Catheterised due to incontinence of urine.	Nursing notes	105	

	Communication very poor. Suffers from dementia. Mobilises with lots of encouragement. Some pain in abdomen.	Handling profile	118	
		Referral letter	150	
	Drug charts indicate: • Promazine syrup: Dr Wilson prescribes 25mg PRN. Not administered. • Dr Wilson also prescribes as regular prescriptions fluoxetine (Prozac), co-danthramer, zopiclone, lactulose and promazine.	Drug charts	139, 142	
1/8/98	*81yr old lady with advanced dementia. In Addenbrooke House 1yr. Admitted with pyrexia. UTI did not respond to [unclear]. Plan: Continue with [unclear]. Encourage oral fluids.*	Clinical notes	169	

	Slept all night. Catheter draining. Full wash given. Dressed and sitting in chair, food and fluids encouraged. *19.30: Quiet afternoon. Needs plenty of encouragement with food and fluids.*	Nursing notes	105	
	Drug charts indicate: • Haloperidol: Dr Wilson prescribes 2.5-10mg PRN, max 60mg/24hrs. 2.5mg administered at 20.45. • Augmentin: Dr Wilson prescribes 1.2g iv tds. Two doses administered. Replaced with augmentin elixir from 2/8/98.	Drug charts	139, 144	
		Care plan	107-113	

4/8/98	Reviewed by Dr Lord. *MTS 0/10 – usually quiet and withdrawn.* *Barthel 1/10.* *CXR and ECG – NAD.* *Catheterised – RV 500mls.* *Pressure areas vulnerable.* *Plan: Continue oral augmentin. SC fluids. Overall prognosis poor + too dependent to return to Addenbrooke's. Transfer to Daedalus continuing care on 6/8/98 am → for 4-6/52 observation + then decide on placement. Keep bed at Addenbrookes. DNR.*	Clinical notes	98A, 99A	
	Drug charts indicate: • Magnesium hydroxide: Dr Wilson prescribes 10mls PRN. Not administered.	Drug charts	139	
		CPN notes	302	

6/8/98	Transferred to Daedalus Ward, GWMH. *Dr Peters: Transferral from Phillip Ward for 4-6/52 obs. On augmentin for UTI.*	Clinical notes	99A	
	Joice: S/B Dr Peters and clerked in.	Contact Record	206	
	Admitted to QAH for UTI, pyrexia and dehydration. Past medical history: Dementia. Too dependent to return to Addenbrooke's Rest Home. For 4-6 week observation then decide on placement. Oral antibiotics for UTI. Waterlow 16. Barthel 2. Fluid intake still being supplemented with sub cut fluids. Mentally she is dependent and needs feeding. Pressure areas intact.	Referral letter	148	
	Slept very well. S/cut fluids continued. For Dryad Ward Gosport today. Assisted with washing and dressing. Catheter draining poor.	Nursing notes	116	

	Due to restricted mobility, Waterlow Score 15.	Nursing care plan	212	
	Joice: Transferred from Philip Ward QAH for 4-6 weeks assessment and observation + then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration.	Significant events	196	
	Patient has dementia – withdrawn + does not communicate. Appears to hear well. Urethral catheter. Diet: Normal – needs feeding. Appetite: Poor. Does have pain at times, unable to ascertain where.	Assessment sheet	198	
	Joice: Withdrawn – does not communicate well. Can be agitated at times. Does have pain occasionally but cannot advise us where.	Handling profile	222	

	Visited on Daedalus Ward. Daughter was also there. Alice has a Barthel of 1 at present. Alice did require haloperidol @ QAH for the 1st few days there. I will contact ward in 3-4 weeks time.	CPN notes	303	
		Discharge plan	96	
10/8/98	Reviewed by Dr Lord. *Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrookes. R/W in 1/12 – if no specialist medical or nursing problems D to a N/Home.*	Clinical notes	99B	
12/8/98	*Alice on Daedalus Ward, physically unchanged. Very needy, not expected to return to Addenbrooke.*	CPN notes	303	

17/8/98	Deterioration recorded. *Condition generally deteriorated over the weekend. Beed: Daughter seen – aware than mum's condition is worsening, agrees active treatment not appropriate & to use of syringe driver if Mrs Wilkie is in pain.*	Contact record	206	
	Nutrition: Small amount of Ensure plus taken.	Nursing care plan	210	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous infusion.	Drug charts	145	
20/8/98	Drug charts indicate: • Diamorphine: 30mg/24hrs administered from 13.50. • Midazolam: 20mg/24hrs administered from 13.50.	Drug charts	145	

21/8/98	Entry in clinical notes by Dr Barton. *Marked deterioration over last few days. SC analgesia commenced yesterday. Family aware and happy.*	Clinical notes	99B	
	Joice: 12.55: Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free.	Contact record	206	
	Drug charts indicate: • Diamorphine: 30mg/24hrs administered. • Midazolam: 20mg/24hrs administered.	Drug charts	145	
	Death recorded at 18.30.	Clinical notes Contact record	99B 206	
	Condition remained poorly, pronounced dead @ 21.20hrs.	Nursing care plan	221	

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT E – GLADYS RICHARDS

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
4/2/98	Assessed by Dr Banks. *Severe dementia. Deteriorated since Christmas. Does not seem over-sedated, but spends significant part of the day asleep. At times quite agitated and distressed during the day. Mobile and able to wander. Try regular haloperidol.*	Correspondence	108	
		Correspondence Nursing home notes GP notes	90 677 773	
2/3/98	Reviewed by Dr Banks. *More settled. Conversation, although very minimal, is more coherent.*	Correspondence	106	

3/3/98	Reviewed by Dr Bassett (GP), and on 4/6/98, 9/7/98 and 23/7/98. *Pain in back from fall. No apparent injuries. Paracetamol to be taken PRN.*	Clinical notes	550	
		Nursing home notes GP notes	677 773-777	
29/7/98	Taken to A&E, Royal Hospital Haslar, after fall in nursing home, fracturing right neck of femur. *Fall onto right hip. Pain on movement of right leg. Quality of life has decreased markedly last 6/12. For admission, operation, PRN analgesia.*	Clinical notes	168 172	

30/7/98	Admitted from A&E, Royal Hospital Haslar. Undergoes operation – right hip hemi-arthroplasty.	Referral letter Significant events Clinical notes Operation record Drug charts Nursing notes Care plan	22 36 174 176 238-243 245 258	
31/7/98	Reviewed on ward round. *Up and eating. X-ray. Back to nursing home next week.*	Clinical notes	175	
		Nursing notes	244	
2/8/98	Reviewed by SHO.	Clinical notes	175	

3/8/98	Geriatric referral made. *All well on ward round. Sitting out. Has nursing home place but family not happy for her to return.* *→ GWMH. Geriatric referral made.*	Clinical notes Nursing notes	184 280	
	Reviewed by Dr Reid. *Confused, but pleasant and cooperative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH.*	Correspondence Clinical notes	24 185	
8/8/98	Reviewed by HO.	Clinical notes	185-186	
	Quite distressed first thing, but settled after haloperidol. Little breakfast taken, but ate well at lunchtime.	Nursing notes	296	

10/8/98	Referred to GWMH. *Now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. Continent. When becomes fidgety and agitated means she wants toilet. Occasionally incontinent at night. Occasionally says recognisable words. Wound healed, clean and dry. Pressure areas all intact.*	Referral letter	22/188	
11/8/98	Transferred to Daedalus Ward, GWMH. Reviewed by Dr Barton. *O/E frail demented lady. Not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL. Barthel 2. Happy for nursing staff to confirm death.*	Clinical notes	30	
	Admitted from Haslar. Sustained fractured neck of femur. Has now had right cemented arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame.	Significant events	36	

	No apparent understanding of her circumstances due to impaired mental condition (p38). *Barthel 3 (p41).* *Waterlow score 27 (p42).*	Assessment notes	38-43	
	Drug charts indicate: * Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 10mg administered at 14.15 and 11.45 (possibly pm). * Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion. Not administered. * Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion. * Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion. * Haloperidol: Dr Barton prescribes 1mg twice daily. One dose administered. * Lactulose: Dr Barton prescribes 10ml twice daily. Administered until 14/8/98 and on 17/8/98.	Drug charts	63-67	

12/8/98	Reviewed by nursing team *Requires assistance to settle and sleep at night. Nursing action: Night sedation if required. Observe for pain. 23.30: Haloperidol given as woke from sleep very agitated. Did not seem to be in pain.*	Nursing care plan	50	
	Drug charts indicate: • Oramorph: 10mg administered at 06.15. Dr Barton also prescribes 5mg four times daily and 10mg nocte PRN (in regular prescriptions section, marked "PRN"). These prescriptions not administered. • Haloperidol: Two 1mg doses administered.	Drug charts	63-67	
13/8/98	Found on floor at 13.30. *Beed: Found on floor at 13.30. No injury apparent on checking. Hoisted into safer chair. Pain right hip. Dr Brigg contacted. Advised x-ray and analgesia.*	Contact record	46	
		Nursing care plan	51	

	Drug charts indicate: • Oramorph: 10mg administered at 20.50. • Haloperidol: Two 1mg doses administered. Dr Barton also prescribes 0.5ml/1mg PRN "if noisy" (in regular prescriptions section, crossed out with "PRN" written in). One dose administered.	Drug charts	63-67	
14/8/98	Reviewed by Dr Barton. *Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to oramorph. Fell out of chair. Right hip shortened. X-ray. Is this lady well enough for another surgical procedure?* *Later note: Appears to have dislocated right hip. Referred for relocation.*	Clinical notes	30-31	
	Hip x-ray. *Right hemiarthroplasty dislocated.*	X-ray report	78	

	Hip x-ray – disclocated. Daughter seen by Dr Barton. Informed of situation. For transfer to Haslar A&E for reduction and sedation.	Contact record	46	
	Letter from Philip Beed to Haslar A&E. *For reduction of disclocated R hip. No change in treatment since transfer to us 11/8/98 except addition or oramorph PRN. 10mg oramorph given at 11.50. Happy to take her back following reduction of dislocation.*	Correspondence	23	
	Drug charts indicate (GWMH): • Oramorph: 10mg administered at 11.50. • Haloperidol: One 1mg dose administered.	Drug charts (GWMH)	63-67	
	Re-admitted to Royal Hospital Haslar, for relocation of right hip. *Underwent closed relocation of right hip hemiarthroplasty under IV sedation. Catheterised. Given splint to discourage further dislocation. Can however mobilise, fully weight-bearing.*	Transfer letter	8	

		Contact record Nursing care plan A&E notes Clinical notes Operation notes Drug charts (Haslar) Nursing notes (Haslar)	46 51 194 196 202 286-291 297	
17/8/98	Transferred back to Daedalus Ward, GWMH.	Transfer letter	8	
	Reviewed by Dr Barton. *Readmission to Daedalus from RHH. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Plan: Continue haloperidol. Only give oramorph if in severe pain. See daughter again.*	Clinical notes	31	

	Joice: Patient very distressed, appears to be in pain. No canvas under patient – transferred on sheet by crew. To remain in straight knee splint. *Couchman: 13.05: In pain and distress – agreed with daughter to give her oramorph 2.5mg. Daughter reports surgeon to say she should not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an x-ray.*	Contact record	46-47	
	Hip x-ray. *Right hemiarthroplasty is relocated.*	X-ray report	76	
	Drug charts indicate: • Oramorph: 5mg administered three times during the day and 10mg administered at 20.30. • Haloperidol: One 1mg dose administered.	Drug charts	63-67	

		Nursing care plan Clinical notes Discharge record Nursing notes (Haslar)	51 197 208 294	
18/8/98	Reviewed by Dr Barton. *Still in great pain. Nursing a problem. I suggest SC diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable.*	Clinical notes	31	
	Beed: 7am: Reviewed by Dr Barton. For pain control on syringe driver. *Beed: Later: Treatment discussed with both daughters. They agree to use of syringe driver to control pain and allow nursing care to be given.* *20.00: Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs.*	Contact record	47-48	
		Nursing care plan	51	

	Drug charts indicate: • Oramorph: 10mg administered twice in early hours. • Diamorphine: Dr Barton prescribes 40-200mg/24hrs by subcutaneous infusion. 40mg/24hrs administered at 11.45. • Midazolam: 20mg/24hrs administered at 11.45. • Haloperidol: Dr Barton prescribes 5-10mg/24hrs by subcutaneous infusion. 5mg/24hrs administered at 11.45.	Drug charts	63-67	
19/8/98	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 11.20. • Midazolam: 20mg/24hrs administered at 11.20. • Haloperidol: 5mg/24hrs administered at 11.20. • Hyoscine: 200µg/24hrs administered at 11.20 (writing unclear – possibly 400µg).	Drug charts	63-67	
	AM: Mrs Richards comfortable. Daughter seen. Unhappy with various aspects of care.	Contact record	48	

		Nursing care plan	51, 59	
20/8/98	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 10.45. • Midazolam: 20mg/24hrs administered at 10.45. • Haloperidol: 5mg/24hrs administered at 10.45. • Hyoscine: 400µg/24hrs administered at 10.45.	Drug charts	63-67	
21/8/98	Reviewed by Dr Barton. *Much more peaceful. Needs hyoscine for rattly chest.*	Clinical notes	31	
	Joice: Patient's overall condition deteriorating. Medication keeping her comfortable.	Contact record	48	

	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 11.55. • Midazolam: 20mg/24hrs administered at 11.55. • Haloperidol: 5mg/24hrs administered at 11.55. • Hyoscine: 400µg/24hrs administered at 11.55.	Drug charts	63-67	
	Death recorded at 21.20.	Clinical notes Contact record	31 48-49	
	Cause of death: (I)(a) Bronchopneumonia.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT F – RUBY LAKE

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
23/1/98	Reviewed by Dr Barrett, consultant dermatologist.	Clinical notes Correspondence	231 236, 240-241	
24/2/98	*I would be grateful if you would see this very pleasant elderly lady who has osteo-arthritis, rheumatoid arthritis and gout. She has impaired renal function and cannot easily take non steroidal anti-inflammatory drugs. I would be grateful for you advice on her further drug management as she seems to get a lot of joint pain.* *Diseases or operations:* *1988: Cardiomegaly: On CXR.* *1990: Cardiomegaly: On CXR.* *1993: Acute renal failure.* *1993: Aortic atherosclerosis.* *1993: Left ventricular failure.* *1993: Atrial fibrillation: Controlled.*	Correspondence	355	

27/4/98	Assessed by Dr McCrae, consultant rheumatologist. Possible diagnosis of CREST syndrome.	Correspondence	352	
29/6/98	Admitted from home for treatment of leg ulcers.	Clinical notes Significant events Care plan	74-77 300-301 306	
5/8/98	Admitted to Royal Hospital Haslar, following fall at home and fractured left neck of femur. Undergoes surgery – left cemented hemi-arthroplasty. *Previously well. 84. Fell this am. Fractured neck of femur. PMH: MI 3 yrs ago. No residual angina. °DM °COAD °Hypertension. No chest pain. Walks 100yds (stops due to arthritis). Lives alone. Mobile, independent and self-caring. Plan: Consent, theatre, hemiarthroplasty, IV fluids.*	Clinical notes	495	
	Fell over at 10.00. c/o pain L hip – shortened and externally rotated. Fractured neck of femur. Unable to weight bear.	A&E notes	445-447	

	Returned from theatre safely. Has taken fluids and passed urine post-operatively. Compression bandages in situ for leg ulcers. For x-ray and bloods tomorrow morning and then to mobilise when comfortable.	Nursing notes	604	
		Transfer letter Operation notes Care plan Drug charts	23-25 500 563-565 567-574	
6/8/98	Reviewed by physiotherapist and HO. *Lives alone, previously independent + self-caring. Previously only able to walk approx 100yds before rest due to arthritis. Awaiting chest x-ray. Currently unwell. R/V mane.*	Physio notes	460	
	Vomiting. No bowel movement. No abdo tenderness. SOB. Denies pain or discomfort. Chest – bilateral fine basal crackles. Imp – (1) Fluid overload – LVF (2) Infection. Stop ivi for 8hrs. Start augmentin.	Clinical notes	503-504	

	Fully-assisted bed bath this morning. Commenced on analgesia to wean her off PCA. Leg bandages for ulcers. IV fluids continue.	Nursing notes	604-605	
7/8/98	Reviewed by physiotherapist and HO. *CXR – OK. Mobilised bed → chair with frame + 2 – managed v well with encouragement.*	Physio notes	460	
	Looks better today. Awaiting report hip x-ray. *Bilateral chest crackles.*	Clinical notes	505-506	

	Remains on bed-rest until after x-ray this morning. Assisted bed bath. Oxygen saturation remains at 93-94% on air, so oxygen discontinued. *19.00: IV fluids have been stopped. Became breathless on movement from commode to bed. Given some oxygen.* *Nocte: Awakes frequently throughout night. Frusemide given IV with good effect. Bed bath in morning. Open area noted in crease of buttock – surrounding area appears fragile. Analgesia given x 1 with effect.*	Nursing notes	605-606	
8/8/98	Reviewed by HO. *Reduced urine output. Bilateral basal crackles. To give frusemide. Monitor urine output.*	Clinical notes	507	
	All care given. Assisted wash. Remains very breathless. Pressure areas poor. Sacrum broken in sacral crease. Waterlow 29+. Sat out for half an hour. Mobility poor. Unable to tolerate nursing on side. Poor fluid intake. Paracetamol given for pyrexia. Agitated at times. Cyclizine given.	Nursing notes	606-607	

9/8/98	Reviewed by SHO. *Urine output much improved post-diuretic. Problems: Poor mobility, SOB, diarrhoea.*	Clinical notes	507-508	
	Full bed bath. IV fluids recommenced. Fluid and diet intake remain minimum. Walked around bed with zimmer frame and assistance. Sat out for one hour. Unable to tolerate nursing on side, always rolls onto back. Hip dressing changed.	Nursing notes	608	
10/8/98	Reviewed. Blood tests conducted. *Physio: Appears unwell today. ?MI ?chest infection. R/V mane. Mobilise as able.*	Physio notes	460	
	Patient unwell. Vomiting/diarrhoea, drowsy, denies pain, orientated. Apyrexial. Chest clear. Sats on air 94%. Plan: ECG, continue IV fluids. *ECG: Sinus tachycardia.* *14.30: Much improved, alert, bright and orientated.* *CXR – chest infection. On augmentin.*	Clinical notes	509-512	

	Restless night (9th-10th). Temazepam given but vomited up. Bottom red and tender. Sudacrem applied. Diarrhoea overnight. All care given in morning. Area between buttocks moist and broken. Antibiotics changed to IV as unable to swallow large tablets. Ate small amount of ice cream. Ulcers need redressing – both legs. Very unsettled night (10th-11th). Incontinent of faeces. Able to move and turn on bed. Sacral area remains red.	Nursing notes	608-609	
		Blood test results	552	
11/8/98	Reviewed by physiotherapist and HO. *Remains unwell. L base remains quiet. Good cough.*	Physio notes	460	

	Pt feeling nauseous + abdo pain. Plan further IV dextrose, cyclizine. *Later: Much improved, apyrexial, good urine output. Chest: Good expansion R = L. Plan: Switch to oral augmentin, encourage fluids, Ensure.* *11.30pm: Urine output↓ Plan: Stop IV fluids, give IV frusemide. CXR tomorrow.*	Clinical notes	512-514	
	11.20: Full wash this morning. Bottom and sacral area very red and breaking down in cleft. Incontinent of faeces. Complained of stomach pain this morning. IV dextrose commenced. Cyclizine given. Tolerated v little food. Much better at time of report. *19.30: Remains very sleepy. To encourage oral fluids. Urine output satisfactory.*	Nursing notes	609-610	
12/8/98	Reviewed by SHO. *Much improved. Has sat out today. Developing sacral bed sore. U+Es improving. Plan: Mobilise with physiom encourage oral fluids, stop augmentin, no IV fluids.*	Clinical notes	514-515	

	Fair morning. Sat out for one hour. Bottom remains extremely red. Fluids taken in reasonable amounts. Ulcers redressed. New bed arrived. 1 episode of diarrhoea , no other problems, appears a lot brighter.	Nursing notes	610	
13/8/98	Referred to Dr Lord, consultant geriatrician. *Assess this lady re future management. Post-op recovery was slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work on her mobilisation. Previously lived in ground floor house. Physio has visited for past 6 weeks.*	Clinical notes	515	

	Reviewed by Dr Lord. *Hemiarthroplasty on 5/8/98. Catheterised. Diarrhoea and vomiting have been problems. Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease and LVF have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement.*	Correspondence	26-27	
		Clinical notes (Lord)	516-517	
	Physio: Unable to mobilise at present due to chest pain.	Physio notes	461	

	Unsettled night overnight. Continues to be very restless. Fluid intake improved. *AM: Pressure areas remain red. c/o central chest pain. GTN spray given. Reviewed by doctor, no further action required.* *PM: Comfortable afternoon. Oral fluids taken. No c/o chest pain. For transfer to GWMH next week.*	Nursing notes	611	
14/8/98	Reviewed by physiotherapist and on ward round. *Physio: Brighter today. Sitting out. Walked short distance with frame + 1 – managed very well. To gradually ↑ distance walked as energy increases.*	Physio notes	461	
	Ruby spent a comfortable night. Turned frequently to rest sacrum. Fluid intake satisfactory. *AM: Has had a wash with minimal assistance. No chest pain. Walked with physio into middle of ward with minimal assistance.*	Nursing notes	611	

	Well. Has stood with frame. Plan: Mobilise. → GWMH next week.	Clinical notes	517	
15/8/98	Reviewed by SHO and HO. Codeine phosphate prescribed. *L sided chest pain in ribs through to back – since being manhandled. ECG – nil change, no effect with GTN. Imp: Muscular-skeletal pain, consider PE or angina. Plan: (1) Analgesia codeine phosphate (2) [Unclear] (3) Consider spinal CT or VQ or pulmonary angiography.*	Clinical notes	518	
	07.00: Some pain due to arthritis in left shoulder overnight. Had paracetamol to good effect. Frequently assisted to turn and move up the bed to make her comfortable. Fully alert. *AM: Full assistance given with hygiene. Sacrum broken on both left and right buttocks + sacral cleft. Dressing applied. Sat out in chair for lunch. Now back to bed. Hip would clean. c/o pain in left shoulder/chest on inspiration.*	Nursing notes	612	

17/8/98	Reviewed by SHO. *Well. ° chest pain. Mobilising slowly. Awaiting transfer to GWMH.*	Clinical notes	519	
	Bright – sitting out in chair. Indep sit→st. Mob with ZF + supervision – managed well.	Physio notes	461	
	Had quite a good night's sleep after settling late and frequently calling out. Taking good amounts of oral fluids. Bowels satisfactory. *20.15: Seemed confused this afternoon, reluctant to move herself from bed. Pyrexial at 38.8°C at 19.45. Paracetamol given.*	Nursing notes	613-614	
		Drug charts	617-618	

18/8/98	Reviewed by SHO at Royal Hospital Haslar. *Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well. →GWMH today.*	Clinical notes	519	
	02.00: Increased shortness of breath. Recommenced on oxygen therapy. Encouraged to expectorate. Apyrexial. Sacral dressings changed.	Nursing notes	614	
	Transferred to Dryad Ward, GWMH. *Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved, it appears. Presently she is slowly mobile with zimmer frame and supervision. Able to wash top half independently but requires help to wash back and bottom. Bilateral leg ulcers redressed very 4-5 days. Has broken area on left buttock and in cleft of buttocks – improving. Has small appetite, oral fluids need encouraging. Urinary catheter in situ. Diarrhoea resolved. Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing.*	Transfer letter	23	

	Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. HPC: Fracture n o femur L 5-8-98. PMH: Angina, CCF. Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death.*	Clinical notes	78	
	Barrett: Communicates well. Compliance: Yes. Pain: Yes. Skin: Leg ulcers and sacral pressure sore (p387). *Collins: Settled and slept well 22.00 until midnight. Woke very distressed & anxious, says she needs someone with her. Oramorph 10mg given 00.15 with little effect. Very anxious during the night. Confused at times (p388).* *Patient's understanding of condition: To mobilise slowly and feel better all round. Diet normal. Appetite poor, needs encouragement (p392).*	Nursing care plan	374-393	

	Slow post-op recovery. Leg ulcers on both legs. Break on sacrum. For slow mobilisation. Catheterised. Pleasant lady, happy to be here. Complexion pale, skin dry. MI 3 years ago. Renal failure 1993. *PM: Seems to have settled quite well. Fairly cheerful this pm.*	Significant events	394	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5ml (5-10mg) PRN. 5mg administered at 14.15. • Temazepam: Dr Barton prescribes 10-20mg PRN. Not administered. • Also prescribed: Digoxin, Slow K, Bumetanide, Allopurinol.	Drug charts	369	
Undated	Drug charts indicate: • Diamorphine: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. • Hyoscine: Dr Barton prescribes 200-800µg/24hrs by subcutaneous infusion. • Midazolam: Dr Barton prescribes 20-80mg/24hrs by subcutaneous infusion.	Drug charts	368	

19/8/98	*Hallman: 11.50: c/o chest pain, not radiating down arm – no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver.*	Significant events	394	
	Drug charts indicate: • Oramorph: 10mg administered at 00.15 and 11.50. • Diamorphine: 20mg/24hrs administered at 16.00. • Midazolam: 20mg/24hrs administered at 16.00.	Drug charts	368-369	
20/8/98	*12.15: Condition appears to have deteriorated overnight. Driver recharged 10.10. Family informed of condition.* *Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when moved. Syringe driver recharged at 07.35 (on 21st).*	Significant events	394	
		Nursing care plan	374-393	

	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 09.15. Increased to 40mg/24hrs at 16.50. • Midazolam: 20mg/24hrs administered at 09.15. Increased to 40mg/24hrs at 16.50. • Hyoscine: 400µg/24hrs administered at 09.15. Increased to 800µg/24hrs at 16.50.	Drug charts	368	
21/8/98	Drug charts indicate: • Diamorphine: 60mg/24hrs administered at 07.35. • Midazolam: 60mg/24hrs administered at 07.35. • Hyoscine: 800µg/24hrs administered at 07.35.	Drug charts	368	
	Condition continued to deteriorate slowly. All care continued. Family present all afternoon.	Significant events	395	
	Death recorded at 18.25.	Clinical notes Significant events	78 395	

	Cause of death: Bronchopneumonia.	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT G – ARTHUR CUNNINGHAM

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
5/3/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Episodes of breathlessness are not too bad. Hasn't had any episodes for three weeks until the early hours of this morning. Feels that anxiety brings them on. Has found diazepam beneficial. Has not had oedema. Backache still a considerable problem. Able to get around on his scooter. Has whole body dystonia with very little stiffness, mild tremor affecting left upper limb. Able to transfer off scooter and walked about 25 paces with a stick and a little assistance of one person. Pulse 72 and regular. Heart sounds normal, chest clear. Wonder if he could have had problems with intermittent left ventricular failure, but overall symptoms not too bad at present. Taking Leva-dopa for Parkinsons. Medication: Sinemet, amlodipine, ranitidine, diazepam, solpadol 5-8 a day.*	Correspondence	140	

		Clinical notes	635	
19/6/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Loss of weight since last seen. Low in spirits but settling in. Able to get out of bed with assistance of one person. On a soft diet. Bowels regular. Breathless occasionally, but denies angina. Oedema not a problem. Has had two falls since moving to Rest Home. Hallucinations not a problem in last few days. Seen after Levodopa and was extremely dystonic, affecting body, right upper and lower limbs. Transfers extremely hazardous, had to be steadied by two people. Levodopa to be reduced. Need to ascertain whether he will remain at Rest Home over next few months.*	Correspondence	134-138	
	Referral to Dr Lord: Has moved to Merlin Rest Home. Has developed dystonic movements involving face, trunk and arms. Loss of independence and mobility. Possible visual hallucinations due to medication.	Correspondence	515	

	Cunningham suffers from Parkinson's and hallucinations. Rest home say he is a difficult man to manage. They find his mobility is either excellent or non-existent.	Correspondence	52	
22/6/98	Reviewed by Dr Scott-Brown (psychiatrist) at GWMH. *Reviewed on behalf of Dr Banks. Has Parkinson's. Has experienced some visual hallucinations, probably secondary to medication for Parkinson's. Not troublesome recently. Scored 23/29 on MMSE. No acute mental health problem. Did not require admission.*	Correspondence	126	
		Clinical notes	62	
	Dr Lord: Cunningham should attend Dolphin Day Hospital once a week. Extremely dystonic and lost a lot of weight. Tests to be carried out.	Correspondence	342	

6/7/98	Reviewed at GWMH. *Re-referral via GP after DV. ↓ mobility/dystonia. ↓ weight. Problems with moving out of flat with its adaptations. Now at Alverstoke House. Plan: Investigate weight loss, ↓ L-dopa, treat constipation. On examination: Mask-like face, left hand tremor – not dystomic at 12 noon. Obvious weight loss since last seen. Said eating poorly until recently, but better now.*	Clinical notes	637	
		Nursing notes	898	
7/7/98	Reviewed at Alverstoke House Nursing Home. *Dr Scott-Brown: Settled in well. Low in mood. Appetite reasonably good, although significant weight loss in last months. Constipated. Anxious re future. Clean and tidy in appearance. Talkative. Mobility very limited. Moves short distances with frame. Often needs help transferring from chair to bed. Felt Cunningham was clinically depressed and would benefit from anti-depressant. Prescribed sertraline.*	Correspondence	118	

		Correspondence Clinical notes	44 61	
9/7/98	Reviewed at Dolphin Day Hospital. *Low in mood, having a bad day. In wheelchair. Commenced on sertraline as requested.*	Nursing notes	899	
20/7/98	Reviewed by Dr Lord at Dolphin Day Hospital. *Parkinson's and transfers stable overall. Able to transfer with one. Stability not deteriorated too much. Weight even lower at 67.2kg. Low in mood. Short-term memory much worse. Dysphonic. Tremors in left uppoer limb, more than right. No dystonia. Denies hallucinations now. Mentioned difficulty swallowing, but able to feed himself and usually finishes main meal and pudding. Meds to continue. Speech and Language Therapist to assess swallow. To be admitted to Mulberry Ward on 21/7/98.*	Correspondence	112	

		Clinical notes Nursing notes	639-640 900	
21/7/98	Informal admission to Mulberry Ward, GWMH. Discharged to Thalassa Nursing Home on 29/8/98. *Transferred to Mulberry Ward for assessment. Diagnosis: Parkinson's Disease and dementia, depressive episode, mylodysplasia. Prognosis: Poor. Low in mood and irritable on admission. Distressed by lack of mobility and independence. Behaviour at times very difficult. Sertraline stopped. Carbamazepine introduced. Had regular reviews by Dr Lord. Mylodysplasia remained stable. Needed to be catheterised for urinary retention. Placement found at Thalassa Nursing Home.*	Discharge summary	465-466	
	27/8/98: Review by Dr Lord: Catheterised for retention of urine. Denies constipation. Eating better. Weight improved to 69.7kg. Much better in mood. Parkinson's a little worse. Takes 1 or 2 people to transfer. Not really mobile. Not keen to increase Levodopa.			

		Clinical notes Correspondence Discharge checklist Admission checklist Nursing notes	66-93 98, 106 234 240 900	
17/9/98	Reviewed at Dolphin Day Hospital. Infection to sores diagnosed. Metronidazole prescribed. *Dr Rachel Ross: A little brighter than couple of months ago. Weight steady at 68.6kg. Not eating too badly, sleeping reasonably. Some increase in stiffness, probably due to anti-psychotic medication. Sinemet increased. Cunningham still harping on about placement at RAF home. To be seen by occupational therapist re adaptations.*	Correspondence	460, 463	

	Attended DDH. OT will order wheelchair. Wound swab results positive. Commenced oral metronidazole. Pressure sore exuding ++ - not redress due to ↓ compliance from Cunningham. Would not wake after a rest on bed. Refusing to talk, drink, swallow medication. Expressing a wish to die. SB Dr Lord – may possibly admit on Monday when reviewed.	Nursing notes	902	
	The results of the swab to the sores on your bottom show that you have an infection in it.	Correspondence	318	
21/9/98	Reviewed by Dr Lord at Dolphin Day Hospital, in respect of sacral ulcer. Admitted to Dryad Ward, GWMH. *Reviewed in DDH today. Has large necrotic sacral ulcer, extremely offensive. Some grazing of skin around necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be very frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance. Social worker to keep open place at Thalassa Nursing Home.*	Correspondence	458	

	Dr Lord: DDH. BP 110/70. Very frail. Tablets found in mouth – some hrs after they're given. Offensive large necrotic sacral ulcer with thick black scar. Left lateral malleous – small black scar and reddened. PD no worse. *Diagnosis: (1) Sacral sore (2) PD (3) Old back injury (4) Depression and element of dementia (5) Diabetes mellitus – diet (6) Catheter for retention.* *Plan: (1) Stop codanthramer + metronidazole + [unclear] (2) Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet, oramorph prn if pain (3) N/Home to keep bed open for next 3/52 at least (4) Patient informed of admission – agrees (5) Inform N/Home, Dr Banks + social worker. Prognosis poor.*	Clinical notes	644-645	
	S/B Dr Lord. Pressure sore looks worse although NH felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to keep bed for 2/3 weeks at least. Plan of care for ward written in med notes by Dr Lord.	Nursing notes	903	

	Reviewed by Dr Barton on Mulberry Ward. *Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. Happy for nursing staff to confirm death.*	Clinical notes	647	
	Admitted from DDH with history of Parkinson's, dementia and diabetes. Large necrotic sore on sacrum. S/B Dr Barton. Back pain from old spinal injury. *14.50: Oramorph 5mg given prior to wound dressing.* *Lloyd: Remained agitated until approx 20.30. Syringe driver commenced as requested at 23.00. Peaceful following.*	Significant events	861	
	Driver commenced at 23.10 containing diamorphine 20mg and midazolam 20mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this am. Sacral sore oozing but left exposed as requested.	Nursing care plan	870	

	Requires assistance to settle for the night (p869). *Waterlow score – 20 (p871).* *Shaw: Large sacral sore present on admission. Desired outsome: Aim to promote healing and prevent further breakdown (p873).* *Dressing applied to left buttock @18.30. Aserbine cream to black necrotic area + zinc + castor oil to surrounding skin. Very agitated at 17.30. Oramorph 10mg/5ml @20.20. Pulled off dressing to sacrum (p874).* *Shaw: Catheterised on admission (p879).*	Nursing care plan	869-880	

	Drug charts indicate: * Oramorph: Dr Lord prescribes 2.5-10mg PRN. 5mg administered at 14.50. 10mg administered at 20.15. * Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN). 20mg/24hrs administered at 23.10. * Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN). 20mg/24hrs administered at 23.10. * Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion (in daily review prescriptions, but marked PRN).	Drug charts	754, 758	

22/9/98	*Hallman: Mr Farthing has telephoned. Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when Arthur tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. Also tried to remove catheter and empty the bag and removed sacral dressing throwing it across the room, finally he took off his covers and exposed himself.* *Later: Syringe driver charged at 20.20. Contains diamorphine 20mg and midazolam 20mg. Appears less agitated this evening.*	Significant events	861-862	
	Driver running as per chart. Very settled night. B/S 5 @ 06.00 (p870). *23.00: Dressing came off. Reapplied (p874).* *Shaw: Requires assistance with personal hygiene due to Parkinson's disease. Action: Daily bed bath/bath/shave...report any changes in skin condition (p877).*	Nursing care plan	869-880	
	Barthel score: 0.	Nursing notes	867	

	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 20.20. • Midazolam: 20mg/24hrs administered at 20.20.	Drug charts	758	
23/9/98	Reviewed by Dr Barton. *Hallman: S/B Dr Barton. Has become chesty overnight. To have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to commencement of syringe driver. Informed that Cunningham on small dosage which he needed.*	Significant events	862	
	Became a little agitated at 23.00, syringe driver boosted with effect. Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chesty this morning. Catheter draining, urine very concentrated.	Nursing care plan	870	

	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 09.25, then discarded. 20mg/24hrs administered at 20.00. • Midazolam: 20mg/24hrs administered at 09.25, then discarded. 60mg/24hrs administered at 20.00. • Hyoscine: 400µg/24hrs administered at 09.25, then discarded. 400µg/24hrs administered at 20.00.	Drug charts	758	
24/9/98	Reviewed by Dr Barton. *Remains unwell. Son has visited again today and is aware of how unwell he is. sc analgesia is controlling pain just. Happy for nursing staff to confirm death.*	Clinical notes	645	
	CPN: Physical decline, pressure sore's developed, admitted to Dryad Ward. He is terminally ill & not expected to live past the W/E according to sister on ward.	CPN notes	94	

	Hamblin: Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 40mg, midazolam 80mg and hyoscine 800mcgm. Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. In the event of death Brian is for cremation. *21.00: Nursed on alternate sides during night, is aware of being moved. Sounds "chesty" this morning. Catheter draining.*	Significant events	863	
	All care given. Nursed from side to side. Peaceful night's sleep. Syringe driver running. Starting to sound chesty this morning.	Nursing care plan	870	
	Drug charts indicate: • Diamorphine: 40mg/24hrs administered at 10.55. Then increased: 60mg/24hrs administered – time unclear. • Midazolam: 80mg/24hrs administered at 10.55. • Hyoscine: 800µg/24hrs administered at 10.55.	Drug charts	758	

25/9/98	*All care given this am. Driver recharged at 10.15 – diamorphine 60mg, midazolam 80mg, hyoscine 1200mcg. Son present.*	Significant events	863	
	Remains very poorly. On syringe driver. For TLC.	Clinical notes	647	
	Peaceful night. Position changed [unclear].	Nursing care plan	870	
	Drug charts indicate: • Diamorphine: Dr Barton prescribes 40-200mg/24hrs by subcutaneous infusion. 60mg/24hrs administered at 10.15. • Midazolam: Dr Barton prescribes 20-200mg/24hrs by subcutaneous infusion. 80mg/24hrs administered at 10.15. • Hyoscine: Dr Barton prescribes 800µg-2mg/24hrs by subcutaneous infusion. 1200µg/24hrs administered at 10.15.	Drug charts	758, 831	

26/9/98	*Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. Mouthcare given. Driver recharged at 11.50.*	Drug charts	863 869-880	
	Drug charts indicate: • Diamorphine: 80mg/24hrs administered at 11.50. • Midazolam: 100mg/24hrs administered at 11.50. • Hyoscine: 1200µg/24hrs administered at 11.50.	Drug charts	758, 831	
	Continues to deteriorate.	Clinical notes Nursing care plan	647 870	
	Death recorded at 23.15.	Significant events	864	
	Cause of death: (I) Bronchopneumonia (II) Parkinson's Disease, Sacral Ulcer	Death certificate		

GMC – v – DR JANE BARTON

CHRONOLOGY: PATIENT H – ROBERT WILSON

Date of Birth: Code A

Date:	Event:	Source:	Page(s):	Comments:
17/2/97	Admitted to Queen Alexandra Hospital with epigastric pain. Diagnosed with Code A liver disease. Discharged on 5/3/97. *Presented with 1½hr history of epigastric pain. Relieved by vomiting. No haematemesis. At least one previous episode 6 months ago.* Code A *On examination, he was comfortable, pitting oedema to thigh, large sacral pad. Some bi-basal crackles. Abdomen tense but not tender. No masses palpable. Full blood count was abnormal with white cell count of 20. ECG showed rate of 75 in sinus rhythm with poor R wave progression. Chest x-ray showed increased shadowing in left zone. Liver function tests abnormal. Admitted, difficult to treat as uncooperative. Antibiotics given. Started on diuretics. Small bright liver ? cirrhotic with marked ascites in the gut. Liver function increased a little. Abdominal pain settled. Discharged home.*	Discharge summary	130	

		Clinical notes Nursing notes	148-157 395-399	
21/9/98	Attends A&E at Queen Alexandra Hospital by ambulance, following a fall, fracturing left humerous. *Pt fallen over forward onto left shoulder. Pt drank ETOH whisky. c/o pain & unable to move left arm. On examination: L shoulder tender, deformed, sensation [ticked]. X-ray shoulder fractured humerous. Plan: Advice, sling, review, if OK socially home, clean and dress forearm, discharge → fracture clinic.*	Clinical notes	158-162	
		A&E notes	126-128	

22/9/98	Admitted to ward, Queen Alexandra Hospital. Reviewed by Dr Hand, registrar in trauma and orthopaedic surgery. *Diagnosis: Left greater tuberosity fracture. Assessed in fracture clinic. Sustained injury when fell. X-ray reveals some displacement of the fragment. Not keen to undergo surgical intervention. Aware that he will have restricted range of movement. Will review in two weeks time.*	Correspondence	142	
	Plan: Observe for vomiting. Analgesia (p160). *Pt adamant he will cope at home. Very unsteady on his feet. Vomiting. Transfer to Dickens Ward (p164).*	Clinical notes	160, 164	
	Lives with wife in 2 bedroom house. Usually independent. Code A *(p10-12).* Code A *07.10: Pt prescribed IV morphine for analgesia therefore paracetamol given as nurse prescription (p26).*	Nursing notes	10-12, 26	

	Very poor appetite. Skin: Couple of small breaks from fall. Complains of a great deal of pain – dislikes being touched on R side. Needs help dressing.	Nursing care plan	40	
23/9/98	*02.30: S/B SHO. For morphine & cyclidine (prescribed IV).* *AM: Morphine is now SC injection and codeine phosphate has been added. Was administered this morning for pain.* *Mrs Wilson has contacted the ward. She will be returning from holiday on Sunday and will contact us again (p12).* *Pt refused wash, complains of pain/severe discomfort – given codeine (p26).* *Barthel 13 (p70).* *Waterlow score 7 (p72).*	Nursing notes	12, 26, 70, 72	
	L arm in sling. Painful to touch and painful on movement. Summary: 75 year old, left fractured humerus, vomiting, pain, Code A *apyrexial, painful L arm.* *Analgesia: Not helped by present pain relief so try morphine 2-5mg IV.*	Clinical notes	166-169	

	Paracetamol 1g administered. Codeine phosphate 30mg administered twice. Morphine 5mg administered.	Drug charts	106	
24/9/98	*Experiencing severe pain this morning. Addressed with diamorphine. Also lost sensation and movement in left hand. Referred to fracture clinic urgently. By time he attended, symptoms diminished. Now has sensation and movement (p12).* *06.15: Complaining of pain in L arm, diamorphine 2.5mg given with little effect. Diamorphine 2.5mg s/c given @06.50.* *10.30: States pain not as bad as early morning. Bioclusive applied to skin tears on L arm. Cooperative despite obvious pain from fracture. Poor nutritional intake (p26-27).*	Nursing notes	12, 26-27	
	C/o left forearm ↓ sensation, pain left shoulder → elbow. Diamorphine 5mg given in last 1hr. On arrival, more settled → effect of diamorphine. V painful from shoulder to elbow. Plan: Regular analgesia.	Clinical notes	170-171	

	Compliance good, hard of hearing. Pain +++ from L fractured humerus. Skin tears to L arm. Independent gentleman normally.	Handling profile	68	
	Morphine 2.5mg administered twice. Codeine phosphate 30mg administered three times.	Drug charts	106	
25/9/98	*Regular analgesia prescribed + aperients (p13).* *Very withdrawn c/o pain in back of neck. Extensive bruising to inner aspect of lower arm (p27).*	Nursing notes	13, 27	
	Drowsy. Sit → stand with 1. ↓ balance.	Physio notes	290	
	Codeine phosphate administered once. Codydramol administered three times.	Drug charts	106, 114	

26/9/98	*Barthel 10.*	Nursing notes	70	
	Codydramol administered four times.	Drug charts	114	
27/9/98	*Wife returned from holiday, made clear she would be unable to care for husband in present condition. Explained concerns centred around poor nutrition, improving pain control, rehabilitating him, monitoring healing fracture (p13).* *Not eating great amounts. Very lethargic + disinterested. Still very sleepy this PM. Encourage diet and fluids. Pain remains bad in L humerus. Nocte: Appears comfortable with regular analgesia (p28-29).*	Nursing notes	13, 28-29	
	Codydramol administered four times.	Drug charts	114	

28/9/98	*Two sons visited. Very concerned. Only just found out about hospitalisation. Commenced on IV fluids (p13).* *Arm remains extremely bruised, swollen and tender. Remaining sleepy and uncooperative (p29).* *Barthel 7 (p70).*	Nursing notes	13, 29, 70	
	Note renal function deteriorates. Dehydrated. Stop diuretic. IV fluid.	Clinical notes	171	
	Drowsy. Sit → stand with 2. Mob short distance with 2.	Physio notes	270	
	Codydramol administered four times.	Drug charts	114	

29/9/98	*S/B Dr Birla. Will be reviewing resuscitation status. Says medically there is little more to be done. May need nursing home placement. IV fluids continue (p14).* *11.00: Able to left his L arm quite well without any pain. Managed to wash own face and front top half. Skin tear to inner aspect of R wrist granuflex applied. All other pressure areas intact. Sat out in chair. Asleep for most of afternoon. Not eating and drinking this pm. Nocte: Settled well with analgesia (p29-30).*	Nursing notes	14, 29-30	
	Impaired renal function. **Code A** *hepatitis. Hypothyroid. Review resusc status. Not for resuscitation in view of poor quality of life and poor prognosis.*	Clinical notes	172	
	Codydramol administered three times.	Drug charts	114	

30/9/98	*Top of left arm oedematous, weeping in small areas. Reviewed by* **Code A** *– cont IV + stop sedation. Left arm remains very swollen and exuding serous fluid. Remains drowsy (p15).* *Appetite remaining extremely poor. Full assistance required with all ADLs. Restless night. Complaining of pain in L arm, says the tablets are inadequate (p30-31). Waterlow score 18 (p72).*	Nursing notes	15, 30-31, 72	
	Renal function better. Still drowsy.	Clinical notes	172	
	Codydramol administered once. Paracetamol 1g administered three times. Prescribed four times daily from this point until discharge. Frequently refused by patient.	Drug charts	114	

1/10/98	*Robert states he is desperate for sleep, tends to be awake at night and asleep during day (typical of alcohol withdrawal) therefore chlordiazepoxide 10mg written for 21.00 nocte (p15-16).* *L arm painful +++ on movement. No c/o pain at rest. Pt v sleepy. IVI continues. Appetite poor. Nocte: Discomfort continues. Analgesia spat out. Up in chair from midnight (p31).*	Nursing notes	15-16, 31	
	Paracetamol 1g administered three times.	Drug charts	114	
2/10/98	*Consultant review: Discontinue IV fluid, encourage oral fluid. High protein diet. Psychogeriatrician referral. To be put on continuing care list (p16).* *L arm remains painful on movement. Transferring with help from two nurses. Sat out in chair. Nocte: Refused analgesia. Arm looks swollen and blistered (p31-32).* *Barthel 3 (p70).*	Nursing notes	16, 31-32, 70	

	Still very sleepy. Awake at night. Oedematous. Low alb. Chest crepts. Stop IV fluid. Encourage protein drink. Referred to psychogeriatrician. *S/B dietician: Poor nutritional intake. High protein diet. Encourage with supplement drinks. Possible NG tube.*	Clinical notes	173-174	
	Paracetamol 1g administered once.	Drug charts	114	
3/10/98	*Discomfort continues on movement. Transfer to commode with two nurses. Pressure area to sacrum red but intact. PM: Walked to toilet with help from family and staff. Nocte: Boarded for morphine 2.5mg IM for painful arm because oral analgesia refused. Given at 23.10 with good effect. Settled and slept.*	Nursing notes	32	
	Morphine 2.5mg administered.	Drug charts	107	

4/10/98	*Left arm remaining extremely painful + bruised. Does not tolerate sling. Arm elevated on pillow (p17).* *Full assistance with washing and dressing. Intake poor. Still in great pain due to fracture. PM: Incontinent of faeces. Standing quite well with help from 2 nurses. Fair amount of fluid taken. Quite alert and chatty. Nocte: Refused paracetamol, states not worth taking. Morphine 2.5mg given 02.00 as unsettled and uncomfortable (p33).*	Nursing notes	17, 33	
	Paracetamol 1g administered twice.	Drug charts	114	
5/10/98	*Knocked left arm this afternoon, causing small laceration. Fluid leaked from wound. Opsite applied (p17).* *AM: Not very alert. PM: Very alert and orientated. Transferring well with 1 person. Drinking well, eating well. Nocte: Speech clearer, some discomfort at times, still refusing paracetamol (p34).* *Waterlow score 15 (p72).*	Nursing notes	17, 33-34, 72	

	Morphine 2.5mg administered.	Drug charts	107	
6/10/98	*Reviewed by medical team. Continue fortisips. Increase protein intake. Plan N/Home care as Barthel ↑ 5. OT care management requested.* *S/B Dietician: Nutritional intake slightly improved. Continue with high protein diet and supplement drinks (p17-18).* *PM: Comfortable afternoon. No complaints. Nocte: Incontinent of faeces. Sat out in chair for short periods. Taking prescribed analgesia for pain in arm with only small effect (p34).* *Barthel 5 (p70).* *Medication: Thiamine, multivitamins, senna, magnesium hydroxide, paracetamol QDS (p76)*	Nursing notes	17-18, 34, 70, 74, 76	
	Still in pain in L arm. Obs OK. Plan: Paracetamol → soluble, ? add codeine. *S/B dietician: Intake has improved but still below requirements.*	Clinical notes	175	

	Paracetamol 1g administered twice.	Drug charts	114	
7/10/98	*S/B physio. More alert today. Mobilised at 8am with 2 to assist. Wishes to return home (p18). Uncomplaining. Soluble paracetamol as prescribed (p34).*	Nursing notes	18, 34	
	Left arm remains bruised and sore. Bioclusive applied to left hand, as puffy and slightly torn skin.	Nursing care plan	50	
	Brighter, talking well, eating and drinking. Obs fine. Still some swelling L hand/arm.	Clinical notes	175	
	Much brighter today. Sit → stand with 2. Mob 10m with 2. A very shuffling gait, slightly SOBOE (shortness of breath on exertion). Managed well. P – Continue.	Physio notes	291	

	Paracetamol 1g administered four times.	Drug charts	114	
8/10/98	Reviewed on Dickens Ward by Dr Lusznat, consultant in old age psychiatry. *During current admission had become rather sleepy and withdrawn and low in mood. Had raised MCV, impaired renal function, active alcoholic hepatitis and hypothyroidism. Was treated with IV fluids and gradually improved. Now eating and drinking well, appears much brighter in mood. Appeared calm, friendly and cooperative. Speech coherent. Low in mood, easily tearful but able to smile. Full orientation in place, partial orientation in time and mildly impaired short term memory. MMSE was 24/30. Physically obese. Left hand grossly swollen and bruised. Marked oedema of both legs. Mobility remains poor. May have developed early dementia. Might be early Alzheimer;s disease of vascular type dementia. Also depression. Suggest trazodone.*	Correspondence	117-118	
	Dr Lusznat's notes.	Clinical notes	176-177, 420-425	

	Eating and drinking. Obs fine. Swelling still sore.	Clinical notes	176	
	S/B OT – refusing to wash for 2nd day running. No longer requiring acute bed. At risk of self injury, hand very very oedematous + at risk of breakdown due to low albumen (p19). *No problems. Eating well. Elbow and cuff in situ arm remaining swollen although less today. Refused wash. Very chatty and funny. Hand remains very red and oedematous. Sacral cleft quite red with penile discharge. Ankles very oedematous and tender. Appetite variable. Paracetamol given as prescribed.* *PM: Sat out for most of afternoon, but was very tired and needed to rest in bed by the end of the afternoon.* *Nocte: Communicating quite well although varies according to mood. Asked doctor to consider stronger analgesia, now prescribed codeine phosphate prn (p34-35).*	Nursing notes	19, 34-35	

	Pain: Remains bruised and swollen – quite painful (p46). *Hygeine: Very oedematous ankles. Reluctant to participate in early morning but more cooperative later. Requires full assistance. Buttocks very red in anal crease. Scrotum oedematous and penis red with discharge (p48).*	Nursing care plan	46, 48	
	Bright and alert. Sit → stand with 2. Mob 15m with 2.	Physio notes	291	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	

9/10/98	*Social work assessment. Mr Wilson's need indicate nursing home placement on discharge. Soc Serv will not fund short stay in N.H. and can we look at SCH/GWMH?* *Doctor informed of patient's penile discharge and ulceration (p21).* *Still talking about going home. Had visitors all afternoon. Chatty and appears well. Has some pain – slightly ulcerated with discharge (p36).*	Nursing notes	21, 36	
	Gross oedema. Eating well. Barthel 5. On trazadone and diuretics. For NH placement.	Clinical notes	177	
	Requires help with all activities of daily living. Discharge home is totally unrealistic. Collar and cuff in situ on L arm which is very oedematous and at risk of further injury. Placement recommended.	OT notes	182-183	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	

10/10/98	*Tried to put forward for continuing care bed, but not accepted because Barthel too high at 7. Appropriate for rehab (p22).* *Good night's sleep. PRN codydramol now prescribed although no extra analgesia required overnight (p36).*	Nursing notes	22, 36	
	Paracetamol 1g administered four times.	Drug charts	114	
11/10/98	*A bit clearer with speech. Good diet taken. Pain remains quite bad in L arm. Managed to shave himself. Transferring much better today. Nocte: Drinking well. Appears comfortable with regular analgesia (p36-37).* *Barthel 7 (p70).* *Waterlow score 15 (p72)*	Nursing notes	36-37, 70, 72	
	Paracetamol 1g administered four times.	Drug charts	114	

12/10/98	*Remains in a lot of pain when being cared for. Nocte: Drinking well. Arm, hands and feet remain swollen and very uncomfortable.*	Nursing notes	37	
	WR SHO: Swelling in L arm seems better. Bit brighter today. → continuing care or rehab.	Clinical notes	178	
	Mobilisation chart.	Nursing care plan	56	
	Lying on bed reluctant to mobilise. Mob 15m with 2.	Physio notes	291	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	

13/10/98	*Reviewed by medical team. Continues to require special medical/nursing care as oedematous limbs at high risk of breakdown. Foot R already about to breakdown. This is due to oedema secondary to cardiac failure and low protein (p22).* *Weight up to 114.4kg. In good mood this am. Remained in bed all pm. No complaints of any pain. Passing urine independently using bottle. Peaceful night (13^{th}-14^{th}). Slept well. No complaints of pain (p37-38).*	Nursing notes	22, 37-38	
		Clinical notes	178-179	
	Referral letter: Fractured left humerus. Has alcohol problems. Lives with wife in 2 bedroom house. Prior to admission was independent. Transfer for continuing nursing care needs. Barthel is 7. Still in a lot of pain in his arm and difficulty in moving. On high protein diet. Legs very oedematous, at high risk of breakdown secondary to cardiac failure and low protein. Needs 24hr nursing care. Medication: Paracetamol 1g QDS.	Referral letter	81	

	Refused to mobilise. Remains oedematous. Transfer summary: Ensure L arm supported. Sit → stand practise with 2. Transfer practise with 2. Gait practise with 2. Plan: Continue with active movements, mobility and transfer practice.	Physio notes	291-292	
	Codeine phosphate 30mg administered. Paracetamol 1g administered four times.	Drug charts	107, 114	
	Biochemistry report forms for QAH stay.	Analysis results	184-254	
14/10/98	Transferred to Dryad Ward, GWMH. Reviewed by Dr Barton. *Transfer to Dryad Ward continuing care. HPC: Fractured humerus L 27-8-99. PMH: Alcohol problems, recurrent oedema, CCF. Needs help with ADL. Hoisting. Continent. Barthel 7. Lives with wife Sarisbury Green. Plan gentle mobilisation.*	Clinical notes	180	

	Hallman: Code A *LVF. Chronic oedematous legs. S/B Dr Barton. Oramorph 10mg given. Continent of urine – uses bottles.*	Significant events	266	
	Barthel 4 (p274). *Patient's understanding of condition: Fully comprehending. Bladder normal (p276).* *Restless at times. Used urinal with assistance as he wanted to stand. Oramorph 10mg given for pain control (p279).*	Nursing notes	274-283	
	Drug charts indicate: • Paracetamol: Dr Barton prescribes 1g every four hours PRN. Not administered. • Dr Barton also prescribes frusemide, spironolactone, bendrofluazide, trazodone, thiamine, multivitamins, magnesium hydroxide and senna.	Drug charts	259, 261-262	

Unclear	Drug charts indicate: • Hyoscine: A doctor other than Dr Barton prescribes 600µg/24hrs PRN by subcutaneous infusion "if requested." Not administered.	Drug charts	259	
Unclear	Drug charts indicate: • Oramorph: Dr Barton prescribes 2.5-5mls (5-10mg) four hourly PRN (written in regular prescriptions, those words crossed out and "PRN" written in). 10mg administered at 14.45 and 23.45 on 14/10/98. • Diamorphine: Dr Barton prescribes 20-200mg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in). • Hyoscine: Dr Barton prescribes 200-800µg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in). • Midazolam: Dr Barton prescribes 20-80mg/24hrs PRN by subcutaneous infusion (written in regular prescriptions, those words crossed out and "PRN" written in).	Drug charts	263	

15/10/98	*Shaw: Commenced oramorph 10mg 4 daily for pain in L arm. Wife seen by Sis Hamblin who explained Robert's condition is poor.*	Significant events	266	
	Settled and slept well. Oramorph 20mg given 12midnight with good effect. Oramorph 10mg given 06.00. Condition deteriorated overnight. Very chesty + difficulty swallowing medication. Incontinent urine ++ WSP to sore groins (p279). *Lyons: Bed bath. [Unclear] to groinds, penis + scrotum. Liquid paraffin to feet and legs (p283).*	Nursing notes	279, 283	
	Drug charts indicate: • Oramorph: Dr Barton prescribes 10mg four times daily. 10mg administered at 10.00, 14.00 and 18.00. Dr Barton also prescribes 20mg nocte. Administered at 22.00 then discontinued.	Drug charts	262	

16/10/98	Reviewed by Dr Knapman. *Declined overnight with SOB. O/E bubbling. Weak pulse. Unresponsive to spoken orders. Oedema in arms and legs. ? silent MI ? ↓ liver function. ↑ frusemide.*	Clinical notes	180	
	Seen by Dr Knapman am as deteriorated overnight. Increased frusemide to 80mg daily. For ANC. *Hallman: PM: Very bubbly chest this pm. Syringe driver commenced. Wife informed of patient's continued deterioration.*	Significant events	266	
	Florio: Has been on syringe driver since 16.30. A little bubbly at approx 22.30 when repositioned. More secretions = pharangeal – during the night, but Robert hasn't been distressed. Appears comfortable (p279).	Nursing notes	279, 283	

	Drug charts indicate: • Oramorph: 10mg administered at 06.00, 10.00 and 14.00. • Diamorphine: 20mg/24hrs administered at 16.10. • Hyoscine: 400µg/24hrs administered at 16.10.	Drug charts	262-263	
17/10/98	Reviewed by Dr Peters. *Comfortable but rapid deterioration. N/S to verify death if necessary.*	Clinical notes	180	
	Florio: 05.15: Hyoscine increased to 600mcg as oro-pharangeal secretions increasing overnight. *Hamblin: PM: Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver renewed at 15.50 with diamorphine 40mg midazolam 20mg and hyoscine 800mcg.*	Significant events	266-267	

	Florio: 05.15: Hyoscine increased to 600mcg as secretions increasing. During day diamorphine 40mg and hyoscine increased to 800mcg, midazolam 20mg added. Night: Noisy secretions but not disturbing Robert. Suction given as required during night. Appears comfortable, hot at times.	Nursing notes	279	
	Drug charts indicate: • Diamorphine: 20mg/24hrs administered at 05.15. Then increased to 40mg/24hrs at 15.50. • Hyoscine: 600µg/24hrs administered at 05.15. Then increased to 800µg/24hrs at 15.50. • Midazolam: 20mg/24hrs administered at 15.50.	Drug charts	263	
18/10/98	*Hamblin: Further deterioration in already poor condition. Wife remained overnight – seen by Dr Peters who spoke to Mrs Wilson. Syringe driver renewed at 14.50 with diamorphine 60mg midazolam 40mg and hyoscine 1200mcg. Continues to require regular suction.* *PM: All care has been given. Oral suction has been required and performed. Condition continues to deteriorate.*	Significant events	267	

	Bed bath given, all cares continued (p283).	Nursing notes	279, 283	
	Drug charts indicate: • Diamorphine: 60mg/24hrs administered at 14.50. • Hyoscine: Dr Peters verbally prescribes 1200µg/24hrs by subcutaneous infusion. 1200µg/24hrs administered at 14.50. • Midazolam: 40mg/24hrs administered at 14.50.	Drug charts	263	
	Death recorded at 23.40.	Clinical notes Significant events	180 267	
	Cause of death: (I)(a) Congestive cardiac failure (b) Renal failure (II) Liver failure.	Death certificate		